



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-563-2250 or visit [mywha.org](http://mywha.org). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

| Important Questions                                                             | Answers                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$3,400 per calendar year (\$1,700 if enrolled as single-only)                                                                | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, including <a href="#">preventive care</a> , infertility, and annual hearing and adult vision exams                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .                                                               |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                            | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$3,400 per calendar year (\$3,300 if enrolled as single-only)                                                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> and health care the plan doesn't cover                                                               | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://mywha.org/directory">mywha.org/directory</a> or call 1-888-563-2250 for a list of network providers. | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes                                                                                                                           | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                   |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                 | Services You May Need                                                                      | What You Will Pay                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                      |                                                                                            | Network Provider<br>(You will pay the least)                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                               | Primary care visit to treat an injury or illness                                           | No charge                                                      | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                      | <a href="#">Specialist</a> visit                                                           | No charge                                                      | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                      | <a href="#">Preventive care/screening/immunization</a>                                     | No charge; <a href="#">deductible</a> does not apply           | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                                                                                                   |
| If you have a test                                                                                                                                                                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)                                        | No charge                                                      | Not covered                                        | For <a href="#">diagnostic tests</a> , <a href="#">preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                                                               | No charge                                                      | Not covered                                        | For imaging, <a href="#">preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://mywha.org/pharmacy">mywha.org/pharmacy</a> | Tier 1 (Preferred generic and certain preferred brand name medications)                    | Retail: \$10/prescription;<br>Home Delivery: \$20/prescription | Not covered                                        | At Retail, 30-day supply is allowed, or up to 90-day supply for maintenance medications; retail copayment applies per 30-day supply. Home Delivery allows up to 100-day supply. Specialty medications limited to 30-day supply and must be obtained through Optum Specialty Pharmacy as described in the EOC/DF. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services |
|                                                                                                                                                                                                      | Tier 2 (Preferred brand name or non-preferred generic medications)                         | Retail: \$20/prescription;<br>Home Delivery: \$40/prescription | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                      | Tier 3 (Non-preferred medications)                                                         | Retail: \$35/prescription;<br>Home Delivery: \$70/prescription | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                      | Tier 4 (Specialty medications <a href="#">specialty drugs</a> and other higher-cost drugs) | \$100/prescription                                             | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                      |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                  |
|                                                                           | Physician/surgeon fees                           | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                    | No charge                                          | At <a href="#">urgent care</a> centers, services from an <a href="#">out-of-network provider</a> are covered only when obtained outside the service area. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                    | No charge                                          |                                                                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Urgent Care Center</a>               | No charge                                    | No charge                                          |                                                                                                                                                                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                    | Not covered                                        | <a href="#">Preauthorization</a> required for outpatient mental health and residential treatment center. <a href="#">Preauthorization</a> may be required for inpatient mental health. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.                     |
|                                                                           | Inpatient services                               | No charge                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| If you are pregnant                                            | Office visits                             | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , including routine prenatal care and first postnatal visit. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. <a href="#">Preauthorization</a> may be required for inpatient services. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services |
|                                                                | Childbirth/delivery professional services | No charge                                            | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | Childbirth/delivery facility services     | No charge                                            | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No charge                                            | Not covered                                        | 100 visits per calendar year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                | <a href="#">Rehabilitation services</a>   | No charge                                            | Not covered                                        | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Habilitation services</a>     | No charge                                            | Not covered                                        | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Skilled nursing care</a>      | No charge                                            | Not covered                                        | 100 days per calendar year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Durable medical equipment</a> | No charge                                            | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                | <a href="#">Hospice services</a>          | No charge                                            | Not covered                                        | <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge; <a href="#">deductible</a> does not apply | Not covered                                        | One comprehensive eye exam per year (including dilation if medically indicated).                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | Children's glasses                        | Not covered                                          | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                | Children's dental check-up                | Not covered                                          | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

## Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                     |                                                      |                        |
|---------------------|------------------------------------------------------|------------------------|
| • Acupuncture       | • Hearing Aids                                       | • Private-Duty Nursing |
| • Chiropractic Care | • Long-Term Care                                     | • Routine Foot Care    |
| • Cosmetic Surgery  | • Non-emergency care when traveling outside the U.S. | • Weight Loss Programs |
| • Dental Care Adult |                                                      |                        |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                     |                         |                          |
|---------------------|-------------------------|--------------------------|
| • Bariatric Surgery | • Infertility Treatment | • Routine Eye Care Adult |
|---------------------|-------------------------|--------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhca.ca.gov](http://www.dmhca.ca.gov), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help you if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). Additionally, a consumer assistance program can help you file your [appeal](#). For more information about your rights, this notice, or assistance, contact the California Department of Managed Health Care at 1-888-446-2219 or 1-888-877-5378 (TTY) or visit their website [www.dmhca.ca.gov](http://www.dmhca.ca.gov).

## Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

## Does this plan meet Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standard](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

See addendum for notification of nondiscrimination and language assistance.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                          |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                              |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| ■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>                                                                                                                                                                                                                                  | \$3,400         | ■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>                                                                                                                                                                                        | \$3,400        | ■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>                                                                                                                                                                                            | \$3,400        |
| ■ <a href="#">Specialist Copayment</a>                                                                                                                                                                                                                                                           | \$0             | ■ <a href="#">Specialist Copayment</a>                                                                                                                                                                                                                 | \$0            | ■ <a href="#">Specialist Copayment</a>                                                                                                                                                                                                                     | \$0            |
| ■ Hospital (facility) <a href="#">Copayment</a>                                                                                                                                                                                                                                                  | \$0             | ■ Hospital (facility) <a href="#">Copayment</a>                                                                                                                                                                                                        | \$0            | ■ Hospital (facility) <a href="#">Copayment</a>                                                                                                                                                                                                            | \$0            |
| ■ Other <a href="#">Copayment</a>                                                                                                                                                                                                                                                                | \$0             | ■ Other <a href="#">Copayment</a>                                                                                                                                                                                                                      | \$0            | ■ Other <a href="#">Copayment</a>                                                                                                                                                                                                                          | \$0            |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                        | <b>\$12,700</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                              | <b>\$5,600</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                  | <b>\$2,800</b> |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                  |                 | In this example, Joe would pay:                                                                                                                                                                                                                        |                | In this example, Mia would pay:                                                                                                                                                                                                                            |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                              |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                    |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                        |                |
| Deductibles                                                                                                                                                                                                                                                                                      | \$3,400         | Deductibles                                                                                                                                                                                                                                            | \$3,400        | Deductibles                                                                                                                                                                                                                                                | \$2,800        |
| Copayments                                                                                                                                                                                                                                                                                       | \$0             | Copayments                                                                                                                                                                                                                                             | \$400          | Copayments                                                                                                                                                                                                                                                 | \$0            |
| Coinsurance                                                                                                                                                                                                                                                                                      | \$0             | Coinsurance                                                                                                                                                                                                                                            | \$0            | Coinsurance                                                                                                                                                                                                                                                | \$0            |
| <i>What isn't covered</i>                                                                                                                                                                                                                                                                        |                 | <i>What isn't covered</i>                                                                                                                                                                                                                              |                | <i>What isn't covered</i>                                                                                                                                                                                                                                  |                |
| Limits or exclusions                                                                                                                                                                                                                                                                             | \$20            | Limits or exclusions                                                                                                                                                                                                                                   | \$0            | Limits or exclusions                                                                                                                                                                                                                                       | \$0            |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                | <b>\$3,420</b>  | <b>The total Joe would pay is</b>                                                                                                                                                                                                                      | <b>\$3,400</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                          | <b>\$2,800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at <https://www.westernhealth.com/legal/non-discrimination-notice/>.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 711 (TTY), 916.568.0126 (fax), [memberservices@westernhealth.com](mailto:memberservices@westernhealth.com), <https://www.westernhealth.com/legal/grievance-form/>. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at <https://www.westernhealth.com/legal/grievance-form/>.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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## ENGLISH

If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

## SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

## CHINESE

如果您，或是您正在協助的對象，有關於 Western Health Advantage 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 888.563.2250 或聽障人士專線(TTY) 711。

## VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

## TAGALOG

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

## KOREAN

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

## ARMENIAN

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

## PERSIAN-FARSI

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث آدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره 711 پیام تاییپی ارسال کنند

## RUSSIAN

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией ТТУ для лиц с нарушениями слуха по номеру 711.

## JAPANESE

ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

## ARABIC

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

## PUNJABI

ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

## CAMBODIAN-MON-KHMER

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ឬ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសាបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកឆ្អឹង តាមលេខ 711។

## HMONG

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

## HINDI

यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

## THAI

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 711