NEW PHYSICIAN

WELCOME

to Western Health Advantage

We hope this welcome packet will help acquaint you with Western Health Advantage's clinical and administrative practices.

WE'RE PASSIONATE ABOUT HEALTH CARE

We're all about helping people obtain quality health care. We offer affordable coverage to employer groups, individuals and families, for every stage of life. As a provider-sponsored health plan, we support the doctor-patient relationship and offer access to quality doctors and hospitals. We advocate for medical innovation and promote whole-person health to suit the various needs of the communities we serve. We provide our members with access to a wealth of preventive health information and resources from 24/7 nurse advice to travel assistance services.

PROVIDER INFORMATION

WHA is pleased to be affiliated with you and looks forward to building a long-term relationship. In your role as a provider of medical services to our members, you are the backbone of WHA's success as a health plan. Thank you for your professionalism and service to our members. We understand that from time to time a dispute may arise. Please consult the enclosed information and complete the appropriate forms so we can amend the situation as quickly as possible.

GUIDELINES AND STANDARDS

Like all health plans, WHA adheres to industry practices such as the Access and Availability Standards, which are requirements of the California Department of Managed Care (DMHC) and National Committee for Quality Assurance (NCQA). WHA uses nationally recognized sources for Adult and Childhood Immunization Guidelines and Preventive Health Guidelines. These sources include the Center for Disease Control and Prevention (CDC), U.S. Preventive Services Task Force (USPSTF) and the National Institutes of Health (NIH).

The enclosed information and forms are also available on our website at **westernhealth.com/providers**. Please don't hesitate to contact us with any questions or to request additional resources. Call 916.563.2250 or toll-free at 888.563.2250.

Western Health Advantage

westernhealth.com
916.563.2250 | 888.563.2250

advantage you

ELIGIBILITY VERIFICATION

PROVIDER ACCESS

Online with Western Health Advantage

Please follow these directions to register for online access to secure features on our website.

1. Go to **mywha.org/provideraccess** to get started
2. Select the ACCOUNT TYPE most applicable to you. Click SUBMIT.
3. Complete all required information. Click SUBMIT.
4. Enter a username (minimum six characters).
   - Make note of your username; it will not be provided to you separately.
   - Choose a security answer and enter it in the answer field.
   - Select SUBMIT.
5. Read the Terms & Conditions of use. Click I AGREE. Click SUBMIT.
6. The new provider account should be available within one business day.

Western Health Advantage

Membership with WHA means choices and flexibility.

westernhealth.com
916.614.6096 | 844.870.2178

advantage you

Provider Information

Western Health Advantage

WHA INFORMATION SOURCES

WHA Website

Access WHA's website at westernhealth.com/provider. From the Provider home page, you have access to valuable tools and information. You will find proprietary information under password-protected web pages, including the verify eligibility tool. To gain access to password-protected pages, visit mywha.org/signup to get started.

WHA's Provider Manual

A current copy of WHA's *Provider Manual* has been provided to your medical group and is available online at westernhealth.com/provider under Provider Communications. The *Provider Manual* contains information about the health plan, WHA's administrative and clinical policies and procedures, references to documents available on the WHA website, and other helpful information to support you and your staff.

WHA's Physician Newsletter — *Provider Insider*

The *Provider Insider* is a quarterly publication mailed to all WHA network practitioners and made available online at mywha.org/providerinsider. The newsletter contains updates on regulatory and accreditation requirements that will likely need to be incorporated into your practice. It also includes articles on current medical practices, behavioral health education for the primary care setting, HEDIS outcomes, as well as updates from WHA's Pharmacy and Therapeutics (P&T) Committee.

WHA Member Services Department

If you need information on a subject or are seeking clarification regarding member eligibility or benefit information please contact WHA's Member Services Department at 916.563.2250 or toll-free at 888.563.2250, Monday through Friday, 8 a.m. to 6 p.m. (except holidays). A representative will assist you in obtaining information or will direct you to the appropriate party.

WHA Provider Directory

WHA's provider directory can be accessed on WHA's website and is available in print format upon request. The provider directory contains information regarding WHA network providers, including participating pharmacies and radiology centers, along with WHA contracted hospitals. The directory is searchable by name, gender, specialty, hospital and medical group affiliations, languages spoken by the physician, office locations if the practitioner is accepting new patients and other information. The hospital directory is searchable by facility name and location.

QUALITY MANAGEMENT

WHA's Quality Improvement (QI) Program

WHA's Quality Improvement Committee (QIC) has responsibility for oversight of WHA's QI Program. QIC membership includes primary and specialty care practitioners from WHA's contracted medical groups/IPAs, Magellan's Behavioral Health Medical Director, WHA's Chief Medical Officer, Medical Director, Assistant Medical Director, WHA's Clinical Pharmacist and key WHA management staff. Contracted medical group physicians participate in the QI program and its activities through:

- QIC, P&T Committee, Utilization Management and Credentialing Committee membership;
- Review and development of WHA's Preventive Health Guidelines and Clinical Practice Guidelines;
- Peer review activities associated with grievances, appeals and potential quality of care issues;
- Participation in health promotion/prevention and disease management program activities; and
- Sharing best practices with other network practitioners.

WHA is a National Committee for Quality Assurance (NCQA) accredited health plan. Additionally, a report card on WHA's performance on health care and service measures is available on the State of California's Office of the Patient Advocate (OPA) website located at opa.ca.gov.

Additional information about WHA's QI Program and current goals can be found on WHA's website.

QI Program Scope

The QI Program applies to all network providers who offer services to WHA members and have the potential to impact the member's clinical care and services. Included are:

- Inpatient settings: hospitals, skilled nursing facilities, residential and sub-acute facilities and behavioral health/chemical dependency facilities;
- Outpatient settings: home health, diagnostic services, ambulatory surgery centers, pharmacies, and behavioral health/chemical dependency related services;

- Primary care, high-volume specialty care, and behavioral health services;
- UM services including prior authorization, concurrent review, retrospective review, continuity of care and long-term care;
- Case management including routine and complex case management; and
- Disease management and wellness programs and health care related services provided through web-based programs and the Nurse Advice Line that's available 24/7.

Grievances, Appeals and Potential Quality Issues (PQIs)

All grievances and appeals received by WHA are documented, investigated and resolved within the time frames required by regulatory and accreditation agencies. Those grievances related to quality of care and practitioner office site quality are treated as potential quality issues (PQIs). WHA's providers are required to maintain a supply of and provide members a copy of their Plan's grievance form upon request. The grievance form is included in this packet.

WHA's contracted providers are required to comply with the PQI investigation process. When a PQI is identified and reported to a contracted medical group the group must provide WHA's Medical Management Department with member medical records and a timely response to the inquiry. Most often that response will come from the practitioner named in the grievance. The practitioner's response and all pertinent medical records are to be faxed to WHA's Medical Management Department (Attn: QI) by the medical group/IPA Quality staff. WHA's Medical Management confidential fax line is 916.382.8145.

Following receipt of all corresponding supporting documents including the practitioner's response, WHA's Medical Director or Assistant Medical Director will review the case and assign a Severity Level. A Severity Level of 2 or higher requires review by WHA's QIC and may require a Corrective Action Plan (CAP). Levels 2 through 4 peer review findings are forwarded to the Medical Director of the practitioner's medical group and/or Quality staff for further review and action. Findings are also included in the practitioner's credentialing file as part of the ongoing quality monitoring activities that are conducted between recredentialing cycles. WHA defines its Severity Levels as follows:

Level 0 NO QUALITY OF CARE ISSUE
Unfounded complaint, unavoidable complication, unavoidable disease progression

Level 1 NO POTENTIAL HARM TO PATIENT
Includes issues of poor documentation, poor communication, non-compliance, may reflect a health care problem such as office wait time, etc.

Level 2 MINIMUM ADVERSE EFFECT
Includes systems issues and possibly less severe clinical judgment issues and/or process issues

Level 3 MODERATE ADVERSE EFFECT
Includes preventable complication and/or readmission or delay in diagnosis and/or treatment

Level 4 SIGNIFICANT ADVERSE EFFECT
All serious issues of medical mismanagement

At least semi-annually, WHA sends provider/practitioner-specific reports to each contracted medical group/IPA noting the grievances and appeals WHA has received. Quality staff also monitors provider/practitioner grievance, appeal and PQI trends, which are reported to the QIC. Office site quality complaints are monitored as well. The criteria for monitoring practitioner office site quality can be found on page 6.

Provider Satisfaction

WHA measures provider satisfaction through its Annual Provider Satisfaction Survey conducted by an outside vendor, SPH Analytics. Survey results generated from this survey and an analysis of practitioner complaints and appeals assist WHA with the identification of improvement opportunities.

SAFETY

Hospital Safety

WHA uses information from reputable quality reporting organizations, such as the Leapfrog Group and Cal Hospital Compare, to evaluate the quality of care, service and safety of the Health Plan's contracted hospitals. WHA's contracted hospitals are asked to attest to meeting the ACA requirements for patient safety standards and programs and are encouraged to participate in the Leapfrog Hospital Survey.

Leapfrog Group

The annual voluntary Leapfrog Hospital Survey assesses hospital performance based upon national performance measures, which cover a broad spectrum of hospital services, processes and structures. These measures provide hospitals the opportunity to benchmark the progress they are making in improving the safety, quality and efficiency of the care they deliver. Their website, leapfroghospitalsurvey.org/cp, includes information on hospitals' Hospital Safety

Scores. This survey is open from April 1 to December 31 of each year, and is free to all hospitals. The survey results are publicly reported, by hospital, at leapfroggroup.org/cp each month. Leapfrog issues a hospital safety score from A-F for each participating hospital.

Metrics include, but are not limited to:

- Preventing medication errors
- Appropriate ICU staffing
- Steps to avoid harm
- Managing serious error
- Safety-focused scheduling
- Hospital-acquired infections

Cal Hospital Compare (formerly CalQualityCare.org)
Cal Hospital Compare is a performance reporting initiative managed by a multi-stakeholder Board of Directors, with representatives from hospitals, purchasers, health plans, and consumer groups. Prior to 2016, Cal Hospital Compare was known as the California Hospital Assessment Task Force (CHART). CHART was first established in 2004 for the purposes of developing a statewide hospital performance reporting system using a multi-stakeholder collaborative process. CHART aggregated data from participating hospitals until 2011, when its Board of Directors moved to using only publicly available data sources for all hospitals, not just those participating voluntarily. CHART, and now Cal Hospital Compare, are supported by a generous grant from the California Health Care Foundation (CHCF).

Comparison is over a broad array of quality of care areas, including:

- Patient Experience
- Mother & Baby
- Hip & Knee
- Patient Safety
- Healthcare Acquired Infections (HAIs)
- Cancer Surgery
- Emergency Department (ED) Care
- Heart & Lung Conditions
- Stroke
- Surgeries/Other Conditions

Pharmaceutical Safety: Retrospective Drug Utilization Review Program

WHA's retrospective drug utilization review program, The RationalMed® Program, works in collaboration with the Pharmacy Benefit Manager (PBM), Express Script, Inc. This program was designed to address pharmaceutical safety issues by providing timely safety alerts, which serve to help prevent unnecessary and costly hospitalizations and adverse events. Using proprietary clinical analysis of integrated prescription, medical and lab data, RationalMed® identifies and addresses significant safety risks across the total patient population. The actionable data provided by RationalMed® increases the effectiveness of clinical care by making it easier for pharmacists and physicians to make decisions that improve patient health and safety.

The RationalMed® program reviews integrated medical claims, pharmacy claims, and lab data against thousands of clinical, evidence-based rules to identify safety risks across three areas:

- Adverse drug risk: interactions between the drug and a patient's disease state or between drugs; excess dosing; duplicate therapies
- Coordination of care issues: Potential misuse/abuse; polypharmacy
- Omission of essential care: under dosing; omission of essential therapy or drug-related testing/diagnostic; poor adherence

UTILIZATION MANAGEMENT

WHA delegates utilization management (UM) functions, to WHA's contracted medical groups/IPAs. Excluded from the UM delegation agreements are the management of member and provider appeals, which are managed by WHA.

UM Criteria and UM Decisions

A description or copy of WHA's current UM criteria for a specific condition can be obtained through your medical group's UM Department or WHA's Medical Management Department at 916.563.2274. WHA, at the health plan level, primarily uses current MCG™ medical necessity criteria, UpToDate online resources, InformedDNA, and Hayes, Inc. guidelines for experimental/new technology decisions. Criteria, plan benefits, the member's individual circumstances, local delivery system, and the appropriateness of the care or services requested are taken into consideration when making UM decisions. If certain specialty expertise is needed to make a medical necessity decision, some cases are referred for Independent Medical Review from a non-network appropriately qualified board certified professional. Denials made by WHA or its contracted medical groups/IPAs, are never linked to financial incentives or compensation to the person(s) conducting the review to avoid decisions that might result in over- or underutilization. To ensure consistency, review decisions are evaluated annually. If you have questions about WHA's UM criteria you may email WHA's Chief Medical Officer at d.hufford@westernhealth.com.

UM Physician-to-Physician Communication

WHA and its contracted medical groups/IPAs must provide 24-hour/7-days-a-week access to physicians to address UM decisions. During regular business hours, Monday through Friday, 8 a.m. to 5 p.m. (except holidays), physician reviewers are available to discuss denial or appeal decisions with providers. To discuss a decision that was made by WHA, please contact WHA's Medical Director or Assistant Medical Doctor by calling 916.563.2274 or 888.563.2250 (Option #3). After business hours, WHA maintains a toll-free number 888.563.2250 (option #2) and fax (916.568.0278) as well as email capability for accepting incoming messages. WHA responds to after-hours messages on the next business day. WHA's Member Services Department may also be contacted regarding UM issues by calling 916.563.2250 or 888.563.2250.

Medical Treatment Decisions/ Member Participation

Practitioners may freely communicate with their patients about treatment options available to them, including medication treatment options, regardless of the member's benefit coverage and limitations. Members have the right to participate fully in all decisions regarding appropriate and medically necessary treatment regardless of cost or benefit coverage limitations. This includes discussion of all risks, benefits, and consequences of treatment or non-treatment, and the opportunity to refuse treatment and express preferences about future treatment decisions.

To facilitate greater communication between patients and providers, WHA will:

- Disclose information to the member, upon their request, such as methods of compensation or ownership of or interest in health care facilities that could influence advice or treatment decisions; and
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual language that restricts the ability of health care providers from communicating with or advising their patients about Medically Necessary treatment options.

Case Management

Both routine Case Management and Complex Case Management services are available at no cost to WHA members when deemed appropriate. These functions have been delegated to WHA's contracted medical groups/IPAs. Contact your group's Medical Management Department for information or to make a referral requesting case management program services for your patients.

Experimental and New Technology

Experimental requests are defined as services, devices, drugs, treatment or procedures that:

- Are outside the usual and customary standard of practice,
- Have not been FDA approved, or
- Have not yet been proven to be efficacious or safe per valid clinical trials.

Contracted medical groups/IPAs are to refer all requests that might be experimental in nature to WHA's Medical Management Department for review and determination. Relevant clinical information and/or records should be included with the request.

WHA uses UpToDate® decision support resources, InformedDNA Genetic Testing UM Guidelines, and Hayes, Inc., New Technology Assessment criteria to support decisions regarding experimental services. When an individual case requires independent medical review, iMedecs, the parent company of Hayes, Inc., conducts the review using board certified clinical experts who provide an opinion/recommendation based on the treating physician's request, the member's medical condition/circumstances, specialists' expertise, clinical trials and other current scientific evidence/opinions obtained from reliable medical sources. WHA may also use InformedDNA for evaluation of genetic testing requests.

When an experimental request is reviewed at the health plan level, WHA provides the medical group/IPA a determination as to whether the requested service is considered by current criteria/standards to be experimental. If WHA decides a request is experimental, WHA issues the denial letter(s) and states the reason as: "not a covered benefit" and refers the member to the EOC exclusions. Services, devices, treatment and procedures determined by WHA to be experimental are not covered benefits for WHA members.

There are a few rare exceptions where a member may be allowed an experimental service. The following are examples of situations when coverage of an experimental service may be approved:

- A regulatory body requires WHA to provide/cover the service
- The member has undergone every known conventional treatment, or
- The member's condition is life-threatening and there is no other alternative.

If WHA determines the request is not experimental, the medical group/IPA must review the request for medical necessity and will be financially responsible for the services provided. WHA does not make medical necessity

determinations on these cases.

For more detailed information about WHA's experimental/new technology processes and requirements and Hayes' ratings, see WHA's UM policies titled: "New Technology Evaluation and New Technology Benefit Assessment" on WHA's website. For general information about Hayes, Inc., visit their website at hayesinc.com.

Second Opinions

Second opinions must be provided to members regarding any diagnosis and/or prescribed medical procedures. The contracted medical group/IPA is financially responsible for in-network second opinions while WHA assumes responsibility for approved out-of-network second opinions. If possible, the second opinion is to be arranged with an appropriately qualified health care professional of a like-specialty within WHA's provider network, which includes providers who accept Advantage Referrals in any of WHA's contracted medical groups. If such an individual is not available, please submit an out-of-network second opinion request and pertinent clinical records to your medical group's UM Department for physician review. WHA's confidential Medical Management fax number is 916.568.0278. Routine second opinion decisions must be made within five business days of receipt of the request and all required clinical records. Expedited cases must be completed within 72 hours. For more detailed information about the second opinion process and requirements, see WHA's UM policy "Second Opinions" available at westernhealth.com/provider.

Standing Referrals

A Standing Referral allows a member access to a specialist and/or specialty care services from a provider with expertise in treating a medical condition or disease that requires ongoing monitoring. A standing referral will be issued if a PCP determines, in consultation with a specialist or specialty care center and the medical group's Medical Director, that the member needs continuing specialist care. After the standing referral is made, the specialist will be authorized to provide health care services to the member that are within that person's area of expertise and training in the same manner as the member's PCP, subject to the terms of the treatment plan.

The contracted medical group may limit the number of specialist visits or the period of time that the visits are authorized and may require the specialist to provide the PCP regular reports on the health care services provided to the member. The treatment plan should be agreed upon by the PCP, specialist and medical group Medical Director or designee, with the member's approval.

HIV/AIDS Standing Referrals

Specialists in WHA's provider network with specific expertise to treat HIV or AIDS are noted in the provider directory. Determinations regarding the need for a member to receive ongoing care from an HIV/AIDS Specialist will be made within three (3) business days of the date the request is received, or within four (4) business days of receiving the proposed treatment plan (if needed). The member, the PCP, and the HIV/AIDS Specialist will be notified in writing of approval for the standing referral within established decision/notification time frames and per plan/group UM protocols.

CREDENTIALING/RECREDENTIALING

WHA has delegated credentialing/recredentialing functions to its contracted medical groups/IPAs.

Practitioner Rights

The following rights are afforded to all practitioners being credentialed/recredentialed:

- The right to review information submitted to support their credentialing/recredentialing application;
- The right to correct erroneous information in their credentialing file; and
- The right to request and be informed of the status of their credentialing/recredentialing application

Credentialing/recredentialing decisions cannot be based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Commercial) in which the practitioner specializes. If a practitioner feels they have been discriminated against during the credentialing/recredentialing process conducted by their medical group, they may contact WHA's Medical Management Department at 916.563.2250 or 888.562.2250 (Option #5). If a practitioner wishes to review their credentialing information, correct erroneous information or check the status of their credentialing/recredentialing application they should contact their medical group.

Right to a Fair Hearing

A practitioner who has received notice of an adverse action being taken against them may request a hearing within 30 days receipt of such notice. If you have any questions regarding the credentialing/recredentialing process contact your medical group.

MEDICAL RECORD DOCUMENTATION & MANAGEMENT

WHA delegates medical record management functions to its contracted medical groups/IPAs. WHA retains responsibility for ensuring the medical record documentation standards are met. Annually WHA audits both electronic and hard copy medical records to assess practitioner compliance to the documentation standards.

The standards for medical record documentation and medical record-keeping can be found on the WHA website, in the Provider Manual and in this packet. A passing score for these standards is 90%. Both your medical group/IPA and WHA conduct medical record audits to assess the level of compliance to these standards.

Practitioner Office Site Quality Criteria

WHA maintains practitioner office site standards for physical accessibility, physical appearance and the adequacy of a practitioner's waiting and examining room space. Member complaints and grievances related to these issues are continually monitored by WHA and are reported to the appropriate contracted medical group/IPA within 5 days of being received by WHA. If a physician has reached WHA's established threshold of more than three (3) member complaints regarding office site quality in a rolling 12-month period, the contracted medical group/IPA must conduct an office site visit using the office site standards within 60 days of reaching the threshold. Depending on the outcome of that visit the practitioner may be required to complete a CAP. WHA's office site quality standards can be found on the WHA website, in the Provider Manual, and in this packet.

HEALTH PROMOTION & DISEASE MANAGEMENT

Disease Management (DM)

WHA's DM Programs are provided as a benefit to WHA members at no additional cost. The programs are managed by Optum®, an NCQA-accredited disease management organization, and overseen by WHA. The Programs use evidence-based interventions that follow the recommendations of nationally recognized sources. WHA's DM programs are available for the following conditions and age groups:

- Coronary Artery Disease: Ages 18+ years
- Diabetes: Ages 18+ years
- Asthma: Ages 5 to 64 years

Program Goals: To assist members in managing their chronic conditions while reinforcing the PCP's care plan.

Members can be enrolled through 1) PCP referral to WHA or Optum; 2) member self-referral; 3) claims, pharmacy, and lab data; or 4) health assessment results.

Once enrolled, participants can choose to "opt out" of a program at any time. Interventions are based on the severity of the participant's condition and may include telephonic outreach from a DM care manager and/or health education materials related to the condition.

The the program works with you, the practitioner, to support your patient's treatment plan through reinforcement and education of the member. When necessary, evidence-based treatment recommendations are faxed that support your efforts in managing your patient's care. For more information about WHA's DM programs, contact Member Services and ask to speak to a Health Promotion and Disease Management (HPDM) representative or contact Optum directly at 877.793.3655 Monday through Friday, 8 a.m. to 6 p.m. (PST).

An online DM referral form is available at mywha.org/DMRF. The completed form can be sent by mail, secure email or faxed to Medical Management's confidential fax line at 916.568.0278.

PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

WHA's Preventive Health Guidelines are available online at mywha.org/PHGs and include:

- Childhood: Birth to 19 years
- Adult: 20 to 65 years
- Perinatal Care

CLINICAL PRACTICE GUIDELINES

WHA's Clinical Practice Guidelines are available online at mywha.org/CPGs and include:

Asthma – Updated

- National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma. National Heart, Lung and Blood Institute, 2007

Coronary Artery Disease – Updated

- AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease, 2011 Update
- Effectiveness-Based Guidelines for Cardiovascular Disease Prevention in Women, 2011

Diabetes

- ADA Standards of Medical Care in Diabetes, 2018
- ADA National Standards for Diabetes Self-Management Education and Support, 2017

Feedback on the guidelines is always welcome and can be directed to the Chief Medical Officer at d.hufford@westernhealth.com.

Wellness & Interactive Health Tools

WHA provides an internet-based wellness program to WHA members at mywha.org/wellness. WHA members can complete a health appraisal and track their numbers such as blood pressure, lab value or BMI. They have access to online audio and video health education classes, a robust health library and more.

For more information about WHA's wellness programs, contact the Member Services Department.

PHARMACEUTICAL MANAGEMENT PROCEDURES

WHA's large employer group prescription plans have a three-tier incentive formulary. Drugs in each tier have a different copayment or cost-sharing amount, if applicable. In most instances, generic drugs are covered at the lowest copayment (Tier 1), preferred brand name drugs are covered in the middle tier (Tier 2), while non-preferred brand name drugs have the highest copayment (Tier 3). In all three-tier levels there are a number of drugs that require a prior authorization to ensure appropriate use. Medications for self-injection, except insulin, are covered under the medical benefit and not the pharmacy benefit. These drugs are also limited to a 30-day supply at all pharmacies and require a prior authorization.

Affordable Care Act (ACA) compliant plans for small employer groups and individuals and families, including Covered California plans, have an additional tier (Tier 4). Specialty medication can be obtained through WHA's exclusive specialty pharmacy network. This network includes Accredo (Express Scripts' specialty pharmacy), UC Davis, Dignity Health and NorthBay Cancer Center on-site pharmacies. WHA may allow up to two initial fills at local retail pharmacies to make sure patients are started on new medications in a timely manner. All other fills are limited to WHA's specialty networks. All specialty drugs are limited to a 30-day supply and may require prior authorization.

The Preferred Drug List (PDL) can be found online at mywha.org/pharmacy. The PDL lists the drug tier and whether a prior authorization is required. To check the tier level online you must select existing/large group or individual/small group before indicating the drug you are searching.

WHA's pharmaceutical management procedures can be found on the password-protected section of the WHA website. WHA's Preferred Drug List can be found in the "general" Provider section of the WHA website. California law now requires the use of a standard prior authorization form, which can be found at westernhealth.com/provider.

If you have questions about pharmaceutical management procedures you may email WHA's Chief Medical Officer/ Medical Director at d.hufford@westernhealth.com or contact WHA's Clinical Pharmacist at 916.563.2273.

PROVIDER DISPUTE RESOLUTION

Most provider appeals are handled initially at the contracted medical group/IPA level then forwarded to WHA for second level review and decision-making. If the issue involves a medical necessity or UM decision, the provider appeal can be made directly to WHA, bypassing the contracted medical group's/IPA's internal appeal process.

Provider appeals must be submitted in writing to WHA's Claims Department within 60 business days of receiving the written determination. Provider appeals submitted after 60 business days will be rejected by WHA. The appeal is to be submitted on the Provider Dispute Resolution Request form and must include the provider's name, identification number and contact information. Additional information regarding the Provider Dispute Resolution process and the Provider Dispute Resolution Request form is available on the password protected section of the WHA website and the online Provider Manual. A copy of the Provider Dispute form is also included in this packet.

ACCESS & AVAILABILITY

Access standards reflect the timeliness by which a member can obtain covered health care services for routine/regular care, routine specialty care for non-urgent conditions, emergency care, urgent care/after-hours care, behavioral health care, and ancillary services. The standards also include guidelines for Extending Appointment Waiting Time and Rescheduling Appointments.

Since January 2011, all health plans and providers, including WHA and its contracted medical groups/IPAs, are subject to the Department of Managed Health Care's (DMHC) Timely Access to Health Care Services standards. WHA annually assesses organization-wide and practice-specific performance against the standards and reports findings as required to the DMHC. As a contracted provider, your participation in these assessments is vitally important to ensure an accurate representation of the WHA provider network.

The Timely Access standards are included in this packet and should be reviewed by all practitioners to ensure they understand their role in meeting the requirements.

Nurse Advice Line

WHA provides our members with access to a Nurse Advice Line 24/7 through Optum's Nurse24℠ services. Nurse24 employs California licensed nurses experienced in screening, triage and health education.

Members can access an advice nurse by calling 877.793.3655 or by visiting mywha.org/healthsupport for secure chat/email. Additional information about Nurse 24 is included in this packet.

CONTINUITY & COORDINATION OF CARE

WHA has responsibility for ensuring there is continuity in the delivery of care and that care is coordinated between providers across the health care network. WHA's continuity of care activities focus on:

- Transition of care between providers of care
- Transitions between settings of care
- Transitions to other care when a member's benefits end or transition from pediatric to adult care
- Coordination and access to a practitioner when the member's PCP terminates
- Coordination and access to a practitioner when a practitioner's contract is discontinued and
- Continuity and coordination between behavioral health care providers and general medicine.

Transition of Care Between Providers of Care

In most circumstances WHA's practice is to accept continuity of care requests received within 30 days of a new member's effective date of enrollment with WHA. If a contracted medical group/IPA receives a retrospective request for continuity of care from a new member after services were rendered by a non-participating provider (beyond the 30-day eligibility time frame), or receives a bill for those services, the group may be responsible for making the determination regarding financial responsibility. WHA ensures that new members that fall into the categories listed below are allowed, upon request and when appropriate, to continue receiving limited uninterrupted care from their non-participating provider for a specified length of time, or until a safe transition to a WHA network provider, as determined by legal requirements and the condition of the patient, can be accomplished. Applicable situations are as follows:

- A member with an acute condition—for the duration of the acute condition;
- A member with a serious chronic condition—for a period of time necessary to complete a course of treatment and to arrange for safe transfer to another provider, not to exceed twelve months from the members effective date of coverage;
- A pregnancy—for the duration of the pregnancy and the immediate postpartum period;
- A terminal illness—for the duration of the terminal illness that may exceed twelve months from the date of the members effective date of coverage;
- Care of a newborn child, whose age is between birth and 36 months—for a period to not exceed twelve months from the date of the member's effective date of coverage;
- Performance of surgery or other procedure that has been authorized by WHA as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the member's effective date of coverage.

Transition of Care Between Settings of Care

Hospital discharge planning staff and medical group case managers coordinate member care between practitioners, practice sites and transitions of care between different levels and settings. WHA Clinical Resource nurses assist in the coordination of care for members hospitalized outside the area due to an emergency situation.

Transitioning Care When Benefits End

If a member's benefits are exhausted while the member still needs care and they are in a case management (CM) or disease management (DM) program, the CM or DM staff can discuss alternatives for continuing care and how to obtain care. If the member is not receiving these health care services, ask to speak to a WHA Clinical Resources representative who will be happy to assist the member. Other alternatives such as COBRA coverage, Individual plan, Medi-Cal, ACA Exchange coverage or community resources can be explored to meet the member's individual need.

Transitioning from Pediatric to Adult Care

Generally, pediatric patients begin transition of care from a Pediatrician to a Family Practice, Internal Medicine or OB GYN Physician between the ages of 19 to 26 years. However, there are chronic conditions that may warrant a pediatric patient to continue their relationship and health care services within the pediatric setting.

WHA encourages members and their families to discuss this important transition with their individual physicians, as this decision should be based on each individual's health care needs.

A WHA Clinical Resources representative is available to

help should the member need assistance in transitioning health care services or have any questions. For more information, the member can call WHA's Member Services and ask to speak with a Clinical Resource Nurse.

Termination of Network Provider

WHA must provide written notification to the member at least 30 calendar days prior to the effective date of a termination or upon receipt of a termination notice.

WHA also ensures that members who fall within the categories listed under "Transitions of Care Between Providers" whose current providers are terminated from WHA's network and who are receiving active treatment from the provider at the time the contract is terminated, are allowed, upon request and when appropriate, to continue receiving ongoing care and treatment from that provider for a specified amount of time, or until it is considered reasonably safe to transition their care to another appropriate participating provider, depending on relevant legal requirements, and the patient's diagnosis and treatment plan.

Termination of Coverage

When a member's coverage ends and they still need care, WHA offers information regarding alternatives for continuing care. Members are encouraged to contact WHA's Member Services.

Continuity and Coordination of Care Between Medical and Behavioral Health (BH) Practitioners

WHA and Human Affairs International of California (HAI-CA)/Magellan Health Services, our contracted provider of behavioral health services, support continuity and coordination of care between general medicine and behavioral health practitioners through the following performance measures:

- Anti-depressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment
- Follow-up care for children prescribed ADHD medication (continuation and maintenance)

HAI-CA/Magellan Health Services conducts an annual Treatment Record Review (TRR) on WHA members receiving outpatient services for evidence of coordination of care. Records are reviewed for consistent and complete documentation of continuity of care through evaluation of:

- Timely, confidential communication with PCP/Specialist when consent has been granted by the patient,
- Timely exchange of information with relevant organizational providers, and
- The attempt to obtain member consent for sharing of clinical information with the PCP.

Transition of Care for New Enrollees

The BH provider facilitates continuity of care for all new members who are receiving services from a non-network provider during a current episode of care for an acute condition.

Other BH Continuity of Care Measures

- Psychotropic medications ordered for a member by a BH specialist are reported to the PCP if the member has given consent.
- Members diagnosed with Serious and Persistent Mental Illness (SPMI) are monitored to mitigate any adverse impact from identified medication issues such as multiple medications, lack of adherence or inconsistent refill patterns.
- InterQual™ discharge planning criteria are used to identify members hospitalized in the acute care setting who have co-existing BH disorders. BH consultations are available within 24 hours.
- BH practitioners facilitate outpatient appointments for members discharged from inpatient care within seven (preferable) or 30 calendar days of the discharge, prioritizing by urgency of the case.
- Members requesting BH services that are not a covered benefit are offered fee-for-service alternatives or referral to community services on an ability to pay basis.
- When BH is managing a member with co-existing medical and BH disorders, the BH case manager notifies WHA's Medical Management staff to coordinate case management of the medical disorders. WHA staff sends a CM referral to the contracted medical group who initiates the case management screening process upon receiving member consent.

For more details regarding Continuity and Coordination of Care issues please see WHA's policies titled: "Continuity of Care (Transition of Care or Care Management)", "Continuity and Coordination of Medical Care" and "Continuity and Coordination of Behavioral Health Care" online at westernhealth.com. A copy of the Continuity of Care Request Form is available at mywha.org and in this packet.

PRIVACY AND SECURITY OF INFORMATION

WHA and its contracted medical groups/IPAs must comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), California's Confidentiality

of Medical Information Act and other federal and state laws with respect to the security, privacy and confidentiality of medical records and all other protected health information (PHI). WHA's privacy and confidentiality policies, including its Notice of Privacy Practices, are available at westernhealth.com. Below are some key components of the regulations. For additional information about HIPAA, visit the website of the US Department of Health and Human Services (DHHS) at hhs.gov/hipaa.

Use and Disclosure of PHI

Privacy Safeguards

PHI may only be used or disclosed as permitted or required by the HIPAA Privacy Rule or as permitted or required by the Business Associate Agreement (BAA) with WHA. If PHI is to be used or disclosed for purposes other than those required or permitted, the member's or as appropriate WHA's written authorization is required.

WHA and its contracted medical groups/IPAs must also take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose.

Medical Groups/IPAs, as WHA Business Associates and covered entities under HIPAA, must:

- Develop and implement written privacy policies and procedures consistent with the HIPAA Privacy Rule.
- Train workforce members on its privacy and security policies and apply appropriate disciplinary action on those who violate policies and procedures.
- Mitigate any harmful effect caused by the inappropriate use or disclosure of PHI by its workforce members.
- Obtain satisfactory assurances that subcontractors to whom it provides PHI received from, or created on behalf of, WHA, agree to the same restrictions and conditions that apply to the Business Associate with respect to such information under the BAA and under HIPAA regulations.

Security Safeguards

The HIPAA Security Rule requires covered entities and their business associates to put in place administrative, physical, and technical safeguards to secure electronic PHI. Providers are obligated to:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information it creates, receives, maintains, or transmits on WHA's behalf,
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information,
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA rules, and
- Ensure compliance by its workforce.

Incident Reporting

Pursuant to the HIPAA Breach Notification Rule, the California Information Practices Act of 1977 and the BAA with WHA,

- Business Associates are required to notify WHA of the occurrence of a security incident and/or a breach of unsecured PHI. A "breach" is defined as the unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom the information is disclosed would not reasonably have been able to retain the information, and as defined under HIPAA regulations. "Unsecured" means the information is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of an encryption or destruction technology or methodology specified by the HHS Secretary. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.
- The notification to WHA must be made without unreasonable delay after discovery of the security incident or breach but in no case later than 15 days after such discovery.
- The notification must include to the extent possible the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used or disclosed during the breach.
- The notification must also include all other information that WHA may require in order to make timely and appropriate notifications as required by regulations.

The obligation of a contracted medical group/IPA to report a breach to WHA is limited to a breach involving PHI created, received, used or disclosed by the contracted medical group/IPA on WHA's behalf.

To report breaches, submit an email to privacy@westernhealth.com. To make any other notifications of security incidents required by the BAA between you and WHA, submit an email to informationsecurity@westernhealth.com. If your notification includes PHI, please email the information as an encrypted attachment. Be sure to provide the password in a separate communication other than email (phone call or private fax, for example).

CULTURAL AND LINGUISTIC SERVICES

WHA and its partner entities must comply with regulatory requirements for cultural and linguistic services including, but not limited to, the American with Disabilities Act (ADA), the Knox-Keene Health Care Services Plan Act, the Affordable Care Act, and the NCQA accreditation standards.

WHA uses various mechanisms to ascertain a member's preferred written and spoken language and their race and ethnicity at the time of enrollment. This information is included in the member's enrollment/eligibility record and is available to WHA's medical groups through the eligibility verification process or by contacting Member Services.

Members are informed of their right to language assistance services through various documents and sources. WHA's Provider Directory is searchable by preferred language. WHA and its health care providers are required to provide interpretation services in the member's preferred language, including American Sign Language (and appropriate assistive technology). WHA and its providers must also be sensitive to the cultural differences of their members and patients, including the cultural variation in the management of disease. WHA's Provider Manual provides additional information and resources on cultural competency.

Language Assistance Program (LAP)

Verbal Translation Services

Federal and state law requires that health plans provide language assistance services at no cost to their members. Oral interpretation services must be available at all points within the health plan including the contracted medical groups/IPAs in any language the member needs. To meet this requirement, WHA contracts with a language services vendor to provide interpretation services via the telephone for members who contact WHA or the practitioner's office or are in the practitioner's office.

It is WHA's policy to use phone interpretation services whenever possible. Requests for in-person interpretation should be forwarded to WHA's Member Services Department where they will be considered on a case-by-case basis. American Sign Language interpreters can also be provided.

Written Translation Services

All standard and non-standard enrollee-specific written materials falling under the category of "vital and significant documents" must be translated and made available in the Plan's threshold language(s). Based on census data for the WHA service area and a survey of members, Spanish is WHA's threshold language. "Vital documents" include, but are not limited to:

- Enrollment applications
- Consent forms
- Letters containing eligibility information and participation criteria
- Prior authorization notices
- Grievance and appeal rights and forms
- Notices about the availability of free language assistance and how to access it and
- Explanation of benefits or other claim processing information

Non-standard, member-specific materials that must be translated include, but are not limited to, prior authorization notices and claims denials. WHA-specific service denial and delay-extension template letters are available under the UM Templates and Tools (Commercial UM LAP Templates for LAP Regulations Effective on and after 1/1/09) on the Industry Collaboration Effort (ICE) website at iceforhealth.org/library.asp?sf=&cid=337#cid337. Any document that contains vital member-specific information that is sent in English to a WHA member must include a Notice of Language Assistance (NOLA). The notice is included in this packet.

If a member desires translation of a document, they can call WHA Member Services. Member Services may offer to interpret the document over the phone using the language services vendor, if applicable. If a member prefers to receive a written translation of the document, Member Services will initiate the translation process.

Alternatively, a member may request translation from his or her medical group/IPA. Requests for translation of a non-urgent "vital document" sent from a medical group must be sent to WHA within two (2) business days of member request. Urgent documents must be provided to WHA within one (1) business day of the request.

The medical group/IPA must keep a log of the date the member translation request was received and when the document was provided to WHA.

WHA will provide members an oral interpretation or written translation within twenty-one (21) days for non-urgent and 72 hours for urgent requests.

Provider Responsibilities Related To Language Assistance Services

In addition, WHA's contracted medical groups/IPAs and the practitioners associated with those entities are responsible for the following:

Member Notification
Providers must inform members of the availability of language assistance services. This may be accomplished in two ways:

- By posting a multilingual sign in areas likely to be seen by members or
- By informing members that they may receive important written materials in Spanish or their preferred language. Providers who send claim/UM denial notices must add the attached NOLA to their written communications to inform members of the availability of translated documents.

Use of Family Members as Interpreters
Providers must not require or suggest that Limited English Proficient (LEP) members provide their own interpreters or use family members or friends as interpreters. In addition, providers cannot use minor children as interpreters and must not rely on minor children to facilitate communication with LEP patients. The only exception to this rule is an emergency involving an imminent threat to the safety or welfare of an individual or the public where no qualified interpreter is immediately available. If a member insists upon using a family member or friend as an interpreter after being informed of the availability of language assistance services, the provider should document this choice in a prominent place in the member's medical record.

Adequate Accommodation
Provider offices should be equipped to facilitate the use of interpretive services. Examples include additional phones for three-way calling, dual handset phones or speakerphones.

Confidentiality
Providers must take steps to maintain patient confidentiality when using an interpreter. This includes private areas for three-way calling or for conference calls using a speakerphone.

Updating Member Records
Providers should ascertain a member's need for language assistance at the time an appointment is made or when the member appears for services, and document this information in the member record. On the Provider portion of the WHA website and in the *Provider Manual*, there is a Language Identification Guide that may be of assistance in determining the language the member speaks.

After-hours Linguistic Access
Providers are encouraged to accommodate LEP members by having multilingual messages on answering machines and training their answering services and on-call personnel on how to access interpreter services after hours. (WHA's Nurse Advice Line meets the requirements for this standard.)

Provider Directory Updates
Providers must notify WHA of changes in the language capabilities of their office staff to ensure information on the WHA website and in the printed Provider Directory is current.

Questions regarding language assistance services should be directed to WHA's Member Services Department at 915.563.2250 or toll-free at 888.563.2250.

Full and Equal Access
WHA members are entitled to full and equal access to covered services. This includes access for members with disabilities, as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

PAY FOR PERFORMANCE (P4P)

WHA participates in the Integrated Healthcare Association (IHA) sponsored collaborative: "Pay for Performance (P4P)." WHA's P4P program includes the measures selected by the IHA/Pay for Performance Steering Committee, as well as additional Bonus measures.

WHA will budget a maximum amount of one dollar ($1.00) per member per month (pm/pm) for each medical group. Each category of measures is worth a percentage of the maximum. The maximum achievable is 100%. Measures fall into one of the following categories:

- Clinical
- Patient experience
- Meaningful use of health IT
- Diagnosis coding improvement
- Bonus Measures:
  - Diabetic retinal eye exams
  - Medication management program for diabetics
  - Patient centered medical home certification
  - Meet the IHA Cost and Quality Gates
  - Readmission rate
  - Appeal overturn rate
  - Generic prescribing rate

For more detailed information regarding your medical group's priorities and goals related to their participation in the WHA P4P program, please contact your Provider Relations/Medical Staff office.

Western Health Advantage

GETTING CARE: access & eligibility

NETWORK A — Effective **9.1.18**

advantage we offer access to quality providers

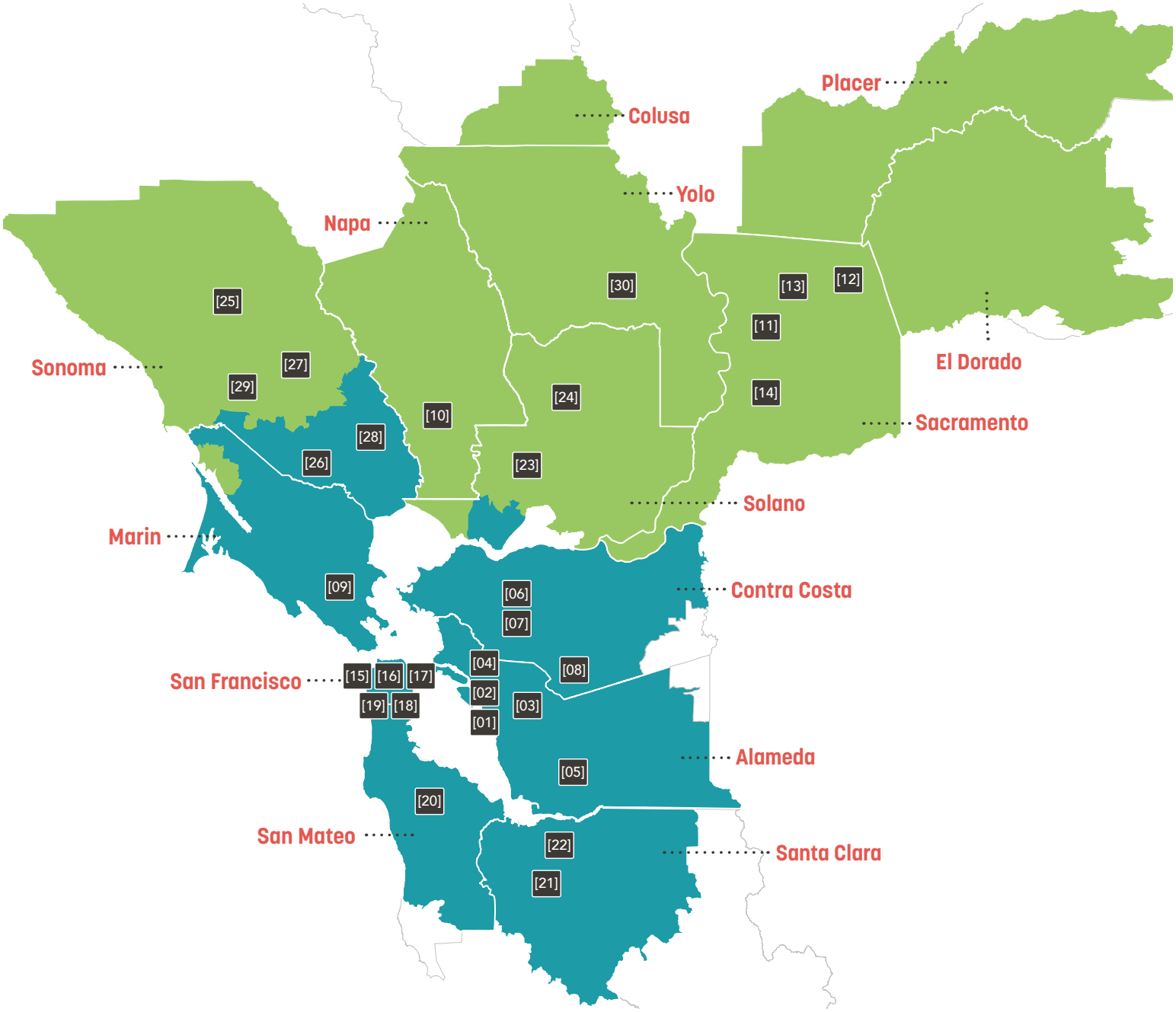
- Dignity Health
- NorthBay Healthcare
- Hill Physicians
- John Muir Health
- Meritage Medical Network
- SCCIPA Santa Clara County IPA
- UCSF Health
- St. Joseph Health

As a provider-sponsored health plan, we support the doctor-patient relationship and offer access to quality doctors and hospitals.

we've got you covered

our service area

Selecting a primary care physician (PCP): Each member should select a PCP close enough to his or her home or place of work to allow reasonable access to care.



The area in blue represents the Canopy Health network > licensed in San Francisco, and parts of Alameda, Contra Costa, Marin, San Mateo, Santa Clara, Sonoma and Solano counties. You must live or work in a zip code represented in blue in order to choose a PCP from the Canopy Health network.

Note: This is a general representation of our service area. See zip code and hospital lists for corresponding details.

Coverage Eligibility: Western Health Advantage is licensed in the following counties and zip codes:

Alameda	partial coverage [**eligible for Canopy Health**] — 94501, 94502, 94536, 94537, 94538, 94539, 94540, 94541, 94542, 94543, 94544, 94545, 94546, 94550, 94551, 94552, 94555, 94557, 94560, 94566, 94568, 94577, 94578, 94579, 94580, 94586, 94587, 94588, 94601, 94602, 94603, 94604, 94605, 94606, 94607, 94608, 94609, 94610, 94611, 94612, 94613, 94614, 94615, 94617, 94618, 94619, 94620, 94621, 94622, 94623, 94624, 94649, 94659, 94660, 94661, 94662, 94666, 94701, 94702, 94703, 94704, 94705, 94706, 94707, 94708, 94709, 94710, 94712, 94720
Contra Costa	partial coverage [**eligible for Canopy Health**] — 94506, 94507, 94509, 94511, 94513, 94516, 94517, 94518, 94519, 94520, 94521, 94522, 94523, 94524, 94525, 94526, 94527, 94528, 94529, 94530, 94531, 94547, 94548, 94549, 94553, 94556, 94561, 94563, 94564, 94565, 94569, 94570, 94572, 94575, 94582, 94583, 94595, 94596, 94597, 94598, 94801, 94802, 94803, 94804, 94805, 94806, 94807, 94808, 94820, 94850
Colusa	partial coverage — 95912
El Dorado	partial coverage — 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762
Marin	All Zip Codes [**eligible for Canopy Health** except for 94929, 94940, 94970]
Napa	All Zip Codes
Placer	partial coverage — 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765
Sacramento	All Zip Codes
San Francisco	All Zip Codes [**eligible for Canopy Health**]
San Mateo	partial coverage [**eligible for Canopy Health**] — 94002, 94005, 94010, 94011, 94013, 94014, 94015, 94016, 94017, 94018, 94019, 94020, 94021, 94025, 94026, 94027, 94028, 94030, 94037, 94038, 94044, 94061, 94062, 94063, 94064, 94065, 94066, 94070, 94074, 94080, 94083, 94099, 94128, 94401, 94402, 94403, 94404, 94497
Santa Clara	partial coverage [**eligible for Canopy Health**] — 94022, 94023, 94024, 94035, 94039, 94040, 94041, 94042, 94043, 94085, 94086, 94087, 94088, 94089, 94301, 94302, 94303, 94304, 94305, 94306, 94309, 95002, 95008, 95009, 95011, 95013, 95014, 95015, 95026, 95030, 95031, 95032, 95033, 95035, 95036, 95042, 95044, 95050, 95051, 95052, 95053, 95054, 95055, 95056, 95070, 95071, 95101, 95102, 95103, 95106, 95108, 95109, 95110, 95111, 95112, 95113, 95114, 95115, 95116, 95117, 95118, 95119, 95120, 95121, 95122, 95123, 95124, 95125, 95126, 95127, 95128, 95129, 95130, 95131, 95132, 95133, 95134, 95135, 95136, 95137, 95138, 95139, 95140, 95141, 95142, 95148, 95150, 95151, 95152, 95153, 95154, 95155, 95156, 95157, 95158, 95159, 95160, 95161, 95164, 95170, 95172, 95173, 95190, 95191, 95192, 95193, 95194, 95196
Solano	All Zip Codes [**eligible for Canopy Health: 94510, 94591**]
Sonoma	All Zip Codes [**eligible for Canopy Health: 94931, 95442, 95452, 94951, 94952, 94954, 94928, 95476**]
Yolo	All Zip Codes

we offer choice

our medical groups

We are proud of our provider network – and you will be too.

Hill Physicians
Call 800.445.5747
Visit hillphysicians.com

John Muir Health
Call 925.952.2887
Visit johnmuirhealth.com

Mercy Medical Group
Call 916.733.3333
Visit mymercymedicalgroup.org

Meritage Medical Network
Call 415.884.1840
Visit meritagemed.com

NorthBay Healthcare
Call 707.646.5500
Visit northbay.org

Santa Clara County IPA
Call 800.977.7332
Visit sccipa.com

Woodland Clinic
Call 530.668.2600
Visit woodlandhealthcare.org

our value-added benefits

We are committed to working with premier service providers.
All plan choices include the following benefits.

behavioral health
Magellan Behavioral Health®
Human Affairs International
Call 800.424.1778
Visit magellanhealth.com/member

chiropractic & acupuncture
Landmark Healthplan of California
Call 800.298.4875
Visit www.lhp-ca.com

nurse24℠ advice line & disease management
Optum®
Call 877.793.3655
Visit mywha.org/healthsupport

global emergency services
Assist America®
Call 800.872.1414
Visit assistamerica.com

health & wellness
MyWHA Wellness | Optum®
Call 877.793.3655
Visit mywha.org/wellness

prescription benefits
Express Scripts®
Call 800.903.8664
Visit express-scripts.com

we offer convenience

our facilities

You will find conveniently located hospitals as well as full-service care centers that offer a wide array of services under one roof.

Alameda County

- [01] Alameda Hospital
- [02] Highland Hospital
- [03] San Leandro Hospital
- [04] UCSF Benioff Children's Hospital, Oakland
- [05] Washington Hospital

Contra Costa County

- [06] John Muir Medical Center, Concord
- [07] John Muir Medical Center, Walnut Creek
- [08] San Ramon Regional Medical Center

Marin County

- [09] Marin General Hospital

Napa County

- [10] Queen of the Valley Medical Center

Sacramento County

- [11] Mercy General Hospital
- [12] Mercy Hospital of Folsom
- [13] Mercy San Juan Medical Center
- [14] Methodist Hospital of Sacramento

Refer to the service area map to locate our facilities.

San Francisco County

- [15] Saint Francis Memorial Hospital
- [16] St. Mary's Medical Center
- [17] UCSF Benioff Children's Hospital at Mission Bay
- [18] UCSF Medical Center at Mission Bay
- [19] UCSF Medical Center at Parnassus

San Mateo County

- [20] Sequoia Hospital

Santa Clara County

- [21] Good Samaritan Hospital
- [22] Regional Medical Center of San Jose

Solano County

- [23] NorthBay Medical Center
- [24] NorthBay VacaValley Hospital

Sonoma County

- [25] Healdsburg District Hospital
- [26] Petaluma Valley Hospital
- [27] Santa Rosa Memorial Hospital
- [28] Sonoma Valley Hospital
- [29] Sonoma West Medical Center

Yolo County

- [30] Woodland Memorial Hospital

Visit choosewha.com/network for contact information and addresses to our full network.

we're always here for you

We're here to provide exceptional service to our members, providers and broker partners. You can easily reach us in person or on the phone. We're responsive and make decisions without delay.

call **916.563.3198**
888.499.3198

For TDD/TYY services: 888.877.5378

NOTE: Please refer to your Combined Evidence of Coverage/Disclosure Form (EOC/DF) and Copayment Summary(ies) for a detailed description of coverage benefits and limitations.

frequently asked questions

What if I live outside the WHA Service Area?

As a member, you and/or your dependents must live or work within the WHA service area. If a member or dependent no longer lives in the WHA Service Area, they will no longer be eligible for coverage through WHA. You must choose a primary care physician (PCP) from the WHA network, and you are required to receive all routine and preventive services there.

Is my son/daughter covered while attending college away from home?

If your dependent child is a full-time student living outside of our service area, he or she is eligible for in-network coverage.

Note: Those students who reside outside the service area must obtain all routine, preventive and follow-up care from WHA network providers. When outside the service area, these students are covered only for urgent or emergency care.

Is my doctor in the WHA plan?

To obtain covered services, you must see a contracted provider. Our online provider directory, available online at **mywha.org/directory**, is a great tool to get the most up-to-date information about participating PCPs and specialists in your network. You can also search for a provider by name, provider type, location of the practice(s), medical group affiliation or languages spoken. Printed directories are available upon request.

What if I'm receiving treatment from a non-network physician?

Typically, out-of-network services are not covered unless in an urgent or emergency situation. However, if you are a new member currently undergoing acute treatment with a non-participating provider, you may qualify for Continuity of Care (CoC). For more information or to obtain a Continuity of Care Request Form, contact WHA Member Services. You may also access the CoC Form online at **mywha.org**.

Who can be my PCP?

PCPs can be practitioners of family, internal or general medicine, pediatricians and in some cases, obstetricians and gynecologists. At the time of enrollment, you are required to select a PCP from one of the medical groups in your provider network. Your provider network and medical group are shown on your member ID card. Your PCP is responsible for coordinating all of your medical care. It is extremely important to get established with your doctor as soon as your coverage becomes effective.

What should I consider when choosing a PCP?

These questions may be useful when selecting a PCP:

- What's the most convenient location for your PCP's office — near work or near home?
- Would you prefer a male or female PCP?
- Would you like to see your PCP in a private office or in a setting that offers multiple services under one roof?
- Do you prefer to speak to your PCP in another language or have specific cultural needs?
- Referrals are a great way to find the right PCP. Can your friends or colleagues recommend a doctor?

What if I need help with complex medical issues?

WHA provides routine and complex Case Management (CM) services to members who qualify for them—generally, those with conditions that require a high level of coordination of care among multiple specialists and other health care providers—at no additional cost. To learn more about our CM services or to determine if you qualify, contact WHA Member Services.

Additionally, Disease Management (DM) programs are available to members living with chronic conditions to assist with identifying strategies to optimize their health and reach personal health goals. To learn if you qualify for these no-cost DM programs, go online to **mywha.org/dm** or contact WHA Member Services.

What happens if I need to see a specialist?

While your PCP will treat most of your health care needs, if he or she determines that you require specialty care, you will be referred to an appropriate provider.

Referral Programs: With WHA you have choices for specialist referrals beyond your PCP's medical group. Your PCP's medical group will determine whether you have access to Advantage Referral or Alliance Referral. Visit **mywha.org/referral** for additional information on these referral programs.

Does WHA have a nurse advice line?

In addition to receiving standard advice for medical issues, Nurse24 provides access to registered nurses who are ready to answer your specific questions on general health and wellness, 24 hours a day, including direct referrals to disease management nurses. Call 877.793.3655 (800.877.8793 for TTY) to speak to a nurse or visit **mywha.org/healthsupport** to chat online with a nurse or to send a secure email. Of course, you can always call your PCP's office if you are unsure if your situation needs immediate attention.

What if I have an out-of-area emergency?

WHA covers urgent care and emergency care services wherever you are in the world. If you are hospitalized at a non-participating facility because of an emergency, WHA or your PCP must be notified within 24 hours of the emergency or as soon as possible. Please note that emergency room visits are not covered for non-emergency situations. Also, call your PCP for all follow-up care to your emergency treatment. If you return to the emergency room or a non-participating provider for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost of the service. If your emergency health problem requires a specialist, your PCP will refer you to an appropriate participating provider as needed.

Western Health Advantage

find a doctor | choosewha.com/directory

EFFECTIVE SEPTEMBER 2018
WHA 113A 12.18

REFERRAL PROGRAMS

Members with Western Health Advantage have choices for **specialist referrals** outside of the medical group affiliated with their primary care physician (PCP). A patient's medical group will determine whether they have access to Advantage Referral or Alliance Referral. By visiting **mywha.org/referral**, WHA members can find additional information on these referral programs.

WESTERN HEALTH'S ADVANTAGE REFERRAL

WHA's Advantage Referral program provides members with access to specialists from the following medical groups, expanding access to specialty care outside of their PCP's medical group:

- Mercy Medical Group / Dignity Health
- Woodland Clinic Medical Group / Dignity Health
- Hill Physicians Medical Group – Sacramento
- Meritage Medical Network
- NorthBay Healthcare Group
- Hill Physicians providers associated with UCSF Health

CANOPY HEALTH'S ALLIANCE REFERRAL

Canopy Health's Alliance Referral program allows members to access in-network services within the entire Canopy Health alliance of doctors and specialists, which include:

- Canopy Health Hill Physicians – San Francisco
- Canopy Health Hill Physicians – East Bay
- Canopy Health Hill Physicians – Solano
- Canopy Health Meritage Medical Network
- Canopy Health John Muir Physician Network
- Canopy Health Santa Clara County IPA (SCCIPA)

Note: Members are eligible for either Advantage Referral or Alliance Referral based on the medical group of the member's Primary Care Physician (PCP). UC Davis-affiliated enrollees are not eligible to participate in the Advantage Referral Program regardless of PCP/medical group affiliation.

The Alliance Referral program is owned and operated by Canopy Health and is offered at Canopy Health's discretion. WHA offers information about Canopy's Alliance Referral program as a courtesy to our members. All program rules and benefits are managed by Canopy Health.

For more information on these referral programs, WHA network providers should refer to the Advantage Referral Handbook available online at **mywha.org/ARhandbook**.

Western Health Advantage

Membership with WHA means choices and flexibility.

westernhealth.com
916.563.2250 | 888.563.2250

advantage you

advantage

LIVE A HEALTHIER LIFE USING

MyWHA Wellness

Western Health Advantage offers these value-added benefits via the MyWHA Wellness program to help you maintain your health and reach your wellness goals.

24/7 Nurse Advice — Call or Chat

Worried about your child in the middle of the night? Wondering if you need to see a doctor about a health concern? You have 24/7 access to an advice line staffed with California-licensed registered nurses. With Nurse24℠, you can speak directly to a nurse by calling our dedicated phone number [877.793.3655] or even chat online through the portal. Registered nurses are available to answer any of your health questions. Interpreters are available upon request. Get advice on:

- Symptoms you are experiencing
- Minor illnesses and injuries
- Chronic conditions
- Medical tests and medications
- Preventive care
- How to prepare for doctor visits

Online Wellness Portal

WHA's MyWHA Wellness program helps you set personal wellness goals while providing easy online tools to help you achieve those goals. Your health and wellness portal at mywha.org/wellness is the central hub for all wellness program components. Start by taking the wellness assessment, which will give you a wellness score along with a personalized report about your medical and behavioral health risks. Within the portal you can set individual health goals, get personalized action plans, track your progress, access helpful health content and be part of a supportive online community.

Library and Decision Aids

WHA's wellness library covers a variety of health topics and includes an interactive program known as Decision Aids that guides you through important health decisions. Decision Aids combines medical information with your personal values on medical tests, medicines, surgeries and other treatments. It guides you to make informed decisions about your health care. Good health decisions take into account:

- The benefits of each option
- The risks of each option
- The costs of each option
- Your own needs and wants

Western Health Advantage

learn more: Member Services
916.563.2250 | 888.563.2250

advantage you

Western Health Advantage

BetterDoctor

Help Patients Find You with BetterDoctor

Consumers rely on up-to-date provider directories to choose the care they need. Western Health Advantage has partnered with BetterDoctor to keep our provider directories up-to-date and compliant with state and federal regulations.

> What You Need to Do

Every quarter, your practice will receive a fax, post letter, email or phone call from BetterDoctor asking you to update your information online. **Please respond to quarterly verification requests from BetterDoctor.** This is an easy way to update your information with WHA without any administrative burden.

> Stay Regulation Compliant

California law requires providers to verify their practice information with any health plan they contract with. Compliance with the law ensures that patients won't be misdirected to inactive practices or providers.

In California, Senate Bill 137 mandates health plans reach out twice a year to networked providers to gather updated information. Failure to update information in accordance with California law can result in plans delisting or delaying reimbursements to providers.

> For More Information

Email **validation@betterdoctor.com** to reach BetterDoctor or contact WHA's Provider Relations Department at 844.870.2178.

Dignity Health

NorthBay Healthcare

Hill Physicians

Meritage Medical Network

canopy Health

John Muir Health

SCCIPA Santa Clara County IPA

advantage

Real-time eligibility and benefits

WESTERN HEALTH ADVANTAGE has partnered with **Change Healthcare**, a leading provider of electronic solutions. By using electronic data interchange (EDI) technology, WHA communicates eligibility and benefit information in a paperless and efficient process.

As one of our provider partners, you can now check eligiblity and benefit information in real time.

GETTING STARTED IS EASY

1. Contact your practice management system vendor to initiate the process.
2. For real-time eligibility and benefits (270/271 transactions), follow the same process as other electronic commercial submissions through Change Healthcare using our **Payer ID: WSTHA**.
3. Providers can also submit directly to Change Healthcare. Change Healthcare Office Suite is a multi-payer portal.
4. For more info, call Change Healthcare at **877.363.3666** or visit **changehealthcare.com**.

Western Health Advantage

Questions? Contact WHA Provider Relations
Call 916.614.6096 or 844.870.2178 toll-free
email providerrelations@westernhealth.com

advantage you

Provider Directory Information

Western Health Advantage

Western Health Advantage and Our Providers Have New Obligations — Effective July 1, 2016

Following the passage of SB 137 in 2015, California's Health and Safety Code section 1367.27 requires that health plans update their online provider directories weekly. Western Health has therefore updated its policies and procedures for providers to keep WHA up to date on their information.

Providers are required to confirm no changes or inform WHA within five business days of any updates to the following information:

- if they are still or no longer under contract with WHA
- if they are accepting new patients or have closed their practices to new patients
- the name of each affiliated provider group currently under contract with WHA through which the provider sees enrollees

Also, the following information must be given to WHA for inclusion in the provider directory:

- provider name, practice location(s) and contact information
- type of practitioner
- National Provider Identification number
- California license number and type of license
- area of specialty, including board certifications (if any)
- provider admitting privileges, if any, at hospitals contracted with the plan
- provider languages

Effective January 1, 2018, providers are required to report their panel statuses as either:

1. Accepting new patients;
2. Accepting existing patients;
3. Available by referral only;
4. Available only through a hospital of facility; or
5. Not accepting new patients.

WHA has established policies and procedures for updating information. The process includes an online interface for providers to submit verification or changes electronically, for which they will get an acknowledgment receipt from WHA.

The public can report any inaccuracies in WHA's provider directory by emailing directory@westernhealth.com.

Providers who are not accepting new patients but are contacted by someone about being their provider must direct that person to WHA for help in finding a provider who is accepting new patients as well as report the provider directory inaccuracy to the DMHC.

To read the legislation: http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0101-0150/sb_137_bill_20151008_chaptered.pdf

Access and Availability Standards

Western Health Advantage

TIMELY ACCESS TO HEALTH CARE SERVICES – APPOINTMENT ACCESS

Visit For Primary Care

- Routine: 10 business days
- Urgent: 48 hours

Referral for visit to medical or behavioral health specialist

- Routine: 15 business days
- Urgent: 48 hours if no prior authorization required
- Urgent: 96 hours prior authorization required

Visit with non-physician behavioral health provider

- Routine: 10 business days

Ancillary services (such as lab tests and x-rays) for diagnosis or treatment of injury, illness or other health condition

- Routine: 15 business days

Telephone triage and screening services with a health professional*

- Routine/Urgent: Waiting time cannot exceed 30 minutes

Speaking with a WHA member service representative by phone during normal business hours

- Routine/Urgent: Waiting time cannot exceed 10 minutes

*WHA members can reach the Nurse24 nurse advice line 24 hours per day, 7 days per week, 365 days per year by calling 877.793.3655 toll-free or 800.877.8793 TTY.

EXCEPTIONS TO THE APPOINTMENT AVAILABILITY STANDARDS

- **Preventive Care Services and Periodic Follow Up Care:** Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
- **Extending Appointment Waiting Time:** The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
- **Rescheduling Appointments:** When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good medical practice.

continued

- **Advanced Access:** The primary care appointment availability standard in the chart may be met if the primary care physician (PCP) office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

AVAILABILITY STANDARDS

Provider Type	Ratio to Patients	Geographic Distribution Time or Distance to Patient
Primary Care Provider	1:2000	One in 30 minutes or 15 miles
Specialty Care Provider	1:1200	One in 30 minutes or 15 miles

NURSE24

WHA also offers all members access to California-licensed, registered nurses through Nurse24. Screening, triage, and health education services are available 24 hours a day, 7 days a week. Use Nurse24 to help answer questions about a medical problem you may have, including:

- Caring for minor injuries and illnesses at home
- Seeking the most appropriate help based on the medical concern, including help for behavioral health concerns
- Identifying and addressing emergency medical concerns

CULTURAL AND LINGUISTIC SERVICES

WHA supports our member's rights to obtain accessible health care at all points of service and at no charge to the member. Providers must offer timely, qualified interpretation services when scheduling appointments and during the appointment.

WHA offers interpretation services upon request in many languages, including Spanish and American Sign Language. Call 877.793.3655 or visit mywha.org/healthsupport to chat with a nurse or to send a secure email.

Practitioner Office Site Quality Criteria

Western Health Advantage

NCQA standards for practitioner office site quality address the following areas: 1) Physical Accessibility, 2) Physical Appearance, 3) Adequacy of Waiting and Examining Room Space and 4) Adequacy of Medical/Treatment Record Keeping. The following criteria were developed to provide insight into WHA's expectations regarding the practitioner office site quality and for use in assessing practitioner office sites for credentialing purposes. The audit tool you choose to use should reflect the criteria below. The threshold for compliance for the Physical Accessibility element is 100%. The compliance thresholds for the remaining elements are 90% each. A CAP is required for those elements falling below their specific compliance threshold.

PHYSICAL ACCESSIBILITY (compliance threshold 100%)

1. Access to building is adequate, evidenced by reasonable parking and/or feasible public transportation within walking distance.
2. Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone, and/or public transportation within close proximity to the building.
3. Pedestrian ramps have a level landing at top and bottom of ramp.
4. Doorways allow for clear passage for a person in a wheelchair.
5. There is an automatic entry option or alternative access method.
6. Accessible passenger elevator, or reasonable alternative, exists in buildings with multiple floors.
7. Exit doors are clearly marked with "Exit" signs.
8. Exit doors and aisles are unobstructed and egress accessible.
9. Wheelchair accessible restroom facilities with a large stall and safety bars or reasonable alternative.
10. Wheelchair accessible hand washing facilities or reasonable alternative.

PHYSICAL APPEARANCE (compliance threshold 90%)

1. All patient areas including floor/carpets, walls and furniture are neat, clean and well maintained.
2. Exam rooms are clean and orderly and have exam tables with protective barriers.
3. Exam room equipment is in good condition.
4. Supplies are stored in areas other than the waiting room and exam rooms.
5. Restrooms are clean and contain appropriate sanitary supplies.

ADEQUACY OF WAITING AND EXAMINING ROOM SPACE (compliance threshold 90%)

1. There is adequate seating in the waiting room.
2. Waiting room is well lit.
3. Exam room work space is adequate.
4. At least (1) exam room can accommodate physically challenged patients.
5. There is clear floor space for wheelchair in waiting room.
6. Waiting room, exam rooms and dressing areas safeguard the patient's right to privacy.
7. There are at least (2) exam rooms per doctor on duty, or an alternative procedure to minimize wait time between patients.

ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING (compliance threshold 90%)

1. Medical Group/IPA practitioners must have written processes or policies/procedures addressing the management of medical record systems/documentation standards/medical record keeping practices at practitioner sites that include specifics related to the following standards. These documents are made available to the health plan, regulatory and accreditation agencies upon request.
2. Medical Group/IPA practitioners must maintain an individual hard-copy or electronic medical record (EMR) for each member. Electronic medical records or member data must:
    - Be password protected
    - Contain a list of signatures by initials
    - Include a system to incorporate electronic data into hardcopy medical records when both are used
3. The medical record keeping system must ensure:
    - The medical record is made available to the practitioner at the time of a member encounter,
    - Information can be retrieved easily and promptly,
    - Information is filed in the medical record timely (reports such as lab, x-ray, consultations, etc),
    - Hard-copy records are filed systematically either alphabetically, numerically, or color coded.
    - Hard-copy medical records and other protected health information are collected after use and stored in a secure central place accessible only to authorized personnel.
4. Hard-copy and electronic medical records that are in use, are maintained in such a manner that the contents cannot be viewed by persons unauthorized to access such records.
5. Medical Group/IPA practitioners and their staff have a documented system for tracking hard-copy medical records when a record is removed from the centralized filing system. (Mental health and substance abuse records may be filed separately from the member's main medical record.)
6. Medical Group/IPA practitioners and their staff have a documented system in place to follow-up on referrals, procedures or tests cancelled for cause by the member, and laboratory, x-ray, consultation reports or other information that hasn't been reviewed.
7. Medical Group/IPA practitioners and their staff have a documented system in place to ensure that inactive records and purged hardcopy and electronic medical data are archived in a manner that meets federal and state requirements. Medical Records should be retained in California for a minimum of 10 years after the date of last service, as recommended by the California Medical Association. It is required, additionally, for at least 1 year past the age of majority for minors.
8. Medical Group/IPA practitioners and their staff have a documented system in place to obtain Consent for Treatment given by the member, parent, or guardian at the initial office visit by signing a Consent to Treatment form filed in the member's medical record. Any special consent forms signed must be present in the member's medical record.
9. Release of hard-copy or electronic medical records are provided only by Medical Record Department or Health Information Management staff or personnel with responsibility for such release of information. There is documented evidence that staff have received periodic training regarding HIPAA Privacy Regulations and maintaining confidentiality of member information.
10. Member protected health information is released in accordance with the HIPAA Privacy regulations and any other applicable federal or state regulations. Authorization forms permitting the release of medical records specify all of the items set forth in the HIPAA regulations (including the type of information requested, name of requestor, name/ID/DOB of member, dated signature of member or authorized representative, date of request, and date of release). Release of information in response to a court order or other legal process is reported to the member when required by HIPAA.

Medical Record Management and Documentation Standards

Western Health Advantage

MEDICAL RECORD MANAGEMENT STANDARDS

1. Medical Group/IPA practitioners must have written processes or policies/procedures addressing the management of medical record systems/documentation standards/medical record keeping practices at practitioner sites that include specifics related to the following standards. These documents are made available to the health plan, regulatory and accreditation agencies upon request.
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    - Information can be retrieved easily and promptly,
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    - Hard-copy medical records and other protected health information are collected after use and stored in a secure central place accessible only to authorized personnel.
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MEDICAL RECORD DOCUMENTATION STANDARDS

1. Patient name or ID present on each page
2. Consultations are documented as appropriate
3. Medication allergies and adverse drug reactions are present
4. Clinical findings and evaluation are present every visit, including: diagnoses, appropriate history and physical findings
5. Pathology, laboratory and other reports are recorded
6. Provider is identifiable for every entry
7. Case management and/or multidisciplinary team notes are present if applicable

PROVIDER REVIEW PERFORMANCE CRITERIA

Audit scores	**Review Frequency**	**Corrective Action Plan**
90% or above	Every three years	None needed
70 – 89%	Every year	May be required as needed based on safety, security, grievances or other issues
Below 70%	Every year	Required

Provider Dispute Resolution Mechanism

Whenever a provider claim is denied, contested or adjusted (claim not paid at 100% of billed charges), Western Health Advantage (WHA), or one of its Contracted Medical Groups/IPAs (CMGs), will inform the provider in writing of the availability of the provider dispute resolution (PDR) mechanism and the procedures for obtaining forms and instructions for filing a provider dispute. This process is available for use by both contracted and non-contracted providers who disagree with the plan's or CMG's decision.

Plan Level Disputes

Provider disputes for denied, contested or adjusted claims issued by WHA should be filed with WHA and not with the CMG. For PDR inquiries or filing instructions, you can call WHA at 916.563.2250, 888.563.2250 toll-free or 888.877.5378 TTY/TDD. Or you can mail a written request, along with your denial notice, a brief description of your issue and any other relevant information, to:

Western Health Advantage
Attn: Provider Dispute Resolution
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

For your convenience, you can download and complete the attached standardized Provider Dispute Resolution Request form.

Provider disputes for claims must be received within 365 days from the most recent action on the issue. In cases of inaction, disputes must be received within 365 days after the time for contesting or denying the claim has expired. Disputes received after this deadline will be rejected and returned to the provider.

WHA will acknowledge a written dispute within 15 working days of receipt and make a final determination within 45 working days. If a dispute is returned for additional information, you have 30 working days to provide the information to WHA. If the information is received timely, the dispute will be processed within 45 working days from date of receipt of the additional information. If the additional information is not received or not received timely, the dispute will be closed.

Multiple claims that are substantially similar can be filed in batches as a single provider dispute in a bundled notice with individual claims numbered and identified by the original claim number. The attached Provider Dispute Resolution Request for Multiple "Like" Claims form is provided for your use.

If a dispute is submitted by a provider on behalf of an enrollee, it will be handled through WHA's grievance process, rather than the provider dispute process.

Contracted Medical Group/IPA (CMG) Level Disputes

Provider disputes involving denied, contested or adjusted claims issued by a CMG should be filed with the CMG rather than with WHA. Contact the CMG directly for information about their PDR process or for a copy of their Provider Dispute Resolution Request forms, or visit their website. Provider disputes involving issues of medical necessity or utilization management can be appealed to WHA within 60 working days after issuance of final determination by the CMG.

Provider Dispute Resolution Request

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Attention: Provider Dispute Resolution
Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

INSTRUCTIONS

Please complete the below form. Fields with an asterisk (*) are required. Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.

PROVIDER INFORMATION

*Provider NPI# _____ Provider Tax ID# _____

*Provider Name _____

Address _____ Suite # _____

City, State, Zip _____ Phone _____

Provider Type ❑ MD ❑ Mental Health Professional ❑ Mental Health Institutional ❑ Hospital ❑ ASC ❑ SNF ❑ DME ❑ Rehab
❑ Home Health ❑ Ambulance ❑ Other (please specify) _____

CLAIM INFORMATION

❑ Single ❑ Multiple "LIKE" Claims (complete attached spreadsheet) Number of Claims _____

*Patient First Name _____ *Last Name _____ MI _____

Date of Birth _____ *Health Plan ID# _____

Patient Account # _____ Original Claim ID# _____
(If multiple, use spreadsheet)

Service "From/To" Date: (*Required for Claim, Billing and Reimbursement of Overpayment Disputes) _____

Original Claim Amount Billed _____ Original Claim Amount Paid _____

Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/Utilization Management Decision
❑ Seeking Resolution of a Billing Determination ❑ Contract Dispute
❑ Disputing Request for Reimbursement or Overpayment ❑ Other _____

*Description of Dispute _____

_____

_____

Expected Outcome _____

_____

_____

Print Name _____ Title _____

Signature _____ Date _____

Phone _____ Fax _____

❑ Check here if additional information is attached (please do not staple)

OFFICE USE ONLY Tracking # _____ **Prov. ID#** _____ **Contracted ❑ Yes ❑ No**

Provider Dispute Resolution Request

TRACKING FORM for optional use by health plan/delegated provider

Western Health Advantage

INSTRUCTIONS

This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution. The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

Tracking # _____ Provider ID or NPI # _____

a. Provider Name _____ b. Contracted Provider ❑ Yes ❑ No

c. Date Dispute Received (Date Stamped) _____ d. Date of Intitial Payment or Action _____

e. Was Dispute Received Within Timeframe? (c–d) Yes No (If No, should be returned to provider without action)

f.1. Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/UM Decision ❑ Billing Determination ❑ Overpayment Dispute
❑ Contract Dispute ❑ Other (Please specify) _____

f.2. Provider Type ❑ Professional ❑ Institutional ❑ Other

g. Date Dispute Acknowledged _____ h. Turnaround Time (g–c) _____

TYPE OF LETTER SENT List the various ICE letters as applicable

If no additional information requested:

j. Date of Action _____ k. Action Turnaround Time (j–c) _____ l. Type of Action Upheld Overturned Other

If additional information requested:

m. Date Additional Info Requested _____ n. Turnaround Time (m–c) _____

o. Date Addition Info Received _____ p. Receipt Turnaround Time (o–c) _____

q. Date of Action _____ r. Action Turnaround Time (q–o) _____ s. Type of Action ❑ Upheld ❑ Overturned ❑ Other

Complete description of determination rationale _____

_____

_____

_____

_____

_____

Provider Dispute Resolution Request

FOR USE WITH MULTIPLE "LIKE" CLAIMS (Claims disputed for the same reason)

Western Health Advantage

	*Patient Last Name	*Patient First Name	Date of Birth	*Health Plan ID#	Original Claim ID#	*Service From/ To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

❑ Check here if additional information is attached (please do not staple)

WHA Provider Dispute Resolution Request: Multiple Claims | ICE Approved 10.05.07, effective 01.01.08 | Last reviewed or revised by WHA: 12.18

Member Rights and Responsibilities Statement

Western Health Advantage

GENERAL INFORMATION

WHA's Member Rights and Responsibilities outline not only the Member's rights but also the Member's responsibilities as a Member of WHA. You may request a separate copy of this Member Rights and Responsibilities by contacting our Member Services staff. It is also available on the WHA website at westernhealth.com.

Member Rights

Member rights may be exercised without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. Western Health Advantage member rights include the following:

- To be provided information about the WHA organization and its services, providers/practitioners, managed care requirements, processes used to measure quality and to improve member satisfaction, and their rights and responsibilities as a member.
- To be treated with respect and recognition of their dignity and right to privacy.
- To actively participate with practitioners in making decisions about their health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending physician.
- To expect candid discussion of appropriate, or medically necessary, treatment options regardless of cost or benefit coverage.
- To voice a complaint about the organization and/or appeal a decision to WHA, or the care it provides, and to expect that a process is in place to ensure timely resolution of the issue.
- To make recommendations regarding WHA's member rights and responsibilities policies.
- To know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of others who may provide services including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about their illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for them to make an informed decision to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment; medically significant risks associated with it; alternate courses of treatment or non-treatment including the risks involved with each; and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with their care, except as permitted by law or as necessary in the administration of the health plan. WHA's policies related to privacy and confidentiality are available upon request.
- To full consideration of privacy and confidentiality around the members' plan for medical care, case discussion, consultation, examination and treatment including the right to be advised of the reason an individual is present while care is being delivered.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment as well as the name of the practitioner scheduled to provide their care.
- To be advised if the physician proposes to engage in, or perform, human experimentation within the course of care or treatment, and the ability to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner's office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these member rights apply to a person with legal responsibility for making medical care decisions on their behalf. This person may be their physician.
- To have access to their personal medical records.
- To formulate advance directives for health care.

see reverse for Member Responsibilities

Member Responsibilities

It is the expectation of WHA and its providers that enrollees adhere to the following member responsibilities to facilitate the provision of a high level quality of care and service to members. These responsibilities include, but are not limited to, the following:

- To know, understand and abide by the terms, conditions and provisions set forth by WHA as their health plan. This information is contained in the Evidence of Coverage & Disclosure Form (EOC/DF) that is received at the time of enrollment and/or available online via mywha.org.
- To supply WHA and its providers and practitioners (to the extent possible) the information they need to provide care and service to WHA members. This includes informing WHA's Member Service Department when a change in residence occurs and/or when other circumstances arise that may affect entitlement to coverage or eligibility.
- To select a primary care physician (PCP) who will have primary responsibility for coordination of care, and to establish a relationship with that PCP.
- To learn about their medical condition and health problems, and to participate in developing mutually agreed upon treatment goals with their health care practitioner(s)to the degree possible.
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that the member agreed to with their health care provider(s), and provide those professionals information relevant to the members care.
- To schedule appointments, as needed or indicated, and/or to notify their health care practitioner(s) when it is necessary to cancel an appointment and to reschedule cancelled appointments, if indicated.
- To show consideration and respect to the practitioners and their staff and to other patients.
- To express grievances regarding WHA, or the care or service received through one of WHA's providers, to WHA's Member Service Department for investigation through WHA's grievance process.

Prescription Prior Authorization

Except for Specialty drugs, most oral drugs do not require prior authorization. When prior authorization is required, requests for all self-administered medications (specialty and non-specialty) should be submitted to Western Health Advantage for coverage determination. For additional details regarding pharmacy prior authorization criteria, you may create a secured account by requesting access on WHA's website (mywha.org/signup).

Specialty drug prior authorization requests should be submitted directly to WHA. State law requires that prescription prior authorization requests be made on the Prescription Drug Prior Authorization Request Form (Form No. 61-211 (12/16)), which can be obtained from:

- the provider section of the WHA website (westernhealth.com/provider),
- Express Scripts (express-scripts.com),
- Department of Managed Health Care (dmhc.ca.gov/Portals/0/HealthCareInCalifornia/ResourcesForHealthCareProviders/Prescription_Prior_Authorization_Request_Form.pdf),
- and many electronic health record (EHR) systems.

For quickest processing, ensure all information regarding the request is included on and/or with the form, including medical records and/or lab documentation if required by the guidelines. The request must be processed within twenty-four (24) hours of receipt for exigent/urgent and within seventy-two (72) hours of receipt for nonurgent requests. "Exigent" means that a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function, or that the member is undergoing a course of treatment using a non-preferred drug. If no response is received within these timeframes, it is deemed approved. Exigent requests require documentation to support the exigent circumstance or they may be determined to be routine and processed within 72 hours.

All self-injectable medications, except for insulin, require prior authorization for coverage. Fax authorization requests directly to WHA at 916.568.5280 using Form No. 61-211 (12/16) described above. Prior authorization requests for physician/office administered injectable medications are covered under the medical benefit and may be covered and should be submitted directly to the medical group's UM department for review.

Disease Management Referral Form

Mail to: Western Health Advantage, Attn: HPDM Department
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0278
Email to: healthpromotions@westernhealth.com
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TYY

Sender Information **Date**_____

Contact Name (First Last) _____

Phone Number _____ Email _____

Patient Information

Name (First Middle Initial Last) _____

Phone Number _____ WHA ID # _____

❑ Is the patient a WHA subscriber? **Skip WHA Subscriber Information**

WHA Subscriber Information

Name (First Middle Initial Last) _____

Street Address _____ City State Zip _____

Physician Information

Name (First Last) _____ ❑ PCP ❑ Specialist

Office Phone _____ Other Phone _____

DISEASE MANAGEMENT PROGRAMS

Please check all that apply: ❑ Diabetes Program ❑ Coronary Artery Disease (CAD) Program ❑ Asthma Program

For members on UC 106A HMO only: ❑ High-Risk Maternity Program

Comments/Brief History

_____

_____

_____

_____

_____

_____

WHA OFFICE USE ONLY

Date Received_____ Processed by_____

Date Sent to Optum_____ Follow-up Date_____

Continuity of Care Request Form

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0278
Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

If you are currently receiving treatment and (i) a new WHA member or (ii) an existing WHA member whose physician has terminated with WHA, you may request to temporarily remain with your existing physician. Please see the back for more information about what continuity of care is and if you may be eligible. To request continuity of care, complete this form for each physician you want to retain. If you do not have a qualified continuity of care issue, you may still request assistance in changing to WHA providers by using this form. Turn this form into WHA within 30 days of enrolling (if new) or of when your physician terminated with WHA. WHA will let you know if you qualify for continuity of care.

REQUEST FOR: ❑ Continued Care With Current Specialist ❑ Assistance With Changing Specialist/Provider

Section I — EMPLOYEE AND PLAN INFORMATION

Employee First Name_____ Last Name_____ MI_____

Date of Birth_____ WHA Member ID#_____WHA Effective Date_____

Address_____ Apt./Unit#_____

City, State, Zip_____ Home Phone_____

Work Phone_____ Previous Health Insurance Carrier_____❑ HMO ❑ PPO

Employer_____

Section II — PATIENT, PHYSICIAN AND TREATMENT INFORMATION

Patient Name_____ Diagnosis_____

Relationship to Employee_____ Date of Birth_____ Phone_____

Address (if different)_____ Apt./Unit#_____

City, State, Zip_____

Primary Care Physician_____ Medical Group_____

Out-of-Network Providers

Requested Specialist_____ Specialty_____ Phone_____

Specialist Address_____ Suite#_____

City, State, Zip_____

Is patient pregnant? ❑ Yes ❑ No Due Date_____ Delivering Hospital_____

Date of initial diagnosis/treatment_____ Is patient currently receiving treatment? ❑ Yes ❑ No

Date of next scheduled treatment/appointment_____

Current treatment/need (provide details, use separate sheet if necessary)

_____

_____

Section III — SIGNATURE REQUIRED

I authorize the medical providers listed above to disclose all medical records to Western Health Advantage (WHA) for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after WHA completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and WHA are required under state and federal law to keep my medical information confidential. I understand that WHA will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

Patient Signature_____ Date_____

WHAT IS CONTINUITY OF CARE?

In certain circumstances (below), you may temporarily continue care with a physician who is not part of WHA's network (a "Non-Participating Provider"). If you are being treated by a provider who has been terminated from WHA's network, or if you are a new Member who has been receiving care from a Non-Participating Provider, you may continue care with that provider if you meet the continuity of care requirements explained below.

CONTINUITY OF CARE REQUIREMENTS

In order for you to be eligible for continued care, the Non-Participating Provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis.

- An acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition: a serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the member and the terminated provider or Non-Participating Provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled member.
- A pregnancy. Care will be continued for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness: an incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and thirty-six (36) months. Care shall be continued for up to twelve (12) months.
- Performance of surgery or other procedure that has been authorized by WHA (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

NOTE ABOUT PROVIDERS

WHA and/or the medical group may require the Non-Participating Provider to agree to WHA's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not comply with these contractual terms and conditions, you will not be eligible to continue care with that provider.

If you have questions about Western Health Advantage's continuity of care policy, please call our Member Services Department.

FILING A GRIEVANCE

Western Health Advantage

advantage you

PUBLISHED JUNE 2018

Western Health Advantage's goal is to provide its members with the optimum quality and member service experience. To this end, WHA has established a formal process for addressing member concerns, complaints, grievances and appeals.

What is a Grievance?

A grievance is any written or oral expression of dissatisfaction made by you, your representative or your provider regarding your experience with WHA, your medical group or any WHA participating provider.

A "standard" or routine grievance is usually investigated and resolved within 30 calendar days. A "fast track" or expedited grievance is completed within 72 hours from receipt of the formal complaint.

What is an Appeal?

An appeal is a verbal or written formal request to re-review or reconsider a decision that has been made. The appeal can be related to a payment issue, an administrative action, quality of care or service issue or utilization recommendation. Your appeal will be reviewed by a doctor who was not involved in the initial review of the issue. This doctor will make an independent second decision after reviewing all available information. The second decision may agree or disagree with the first decision.

Standard or routine appeals are completed within 30 calendar days. A delay in a final decision may occur if additional information is needed for the reviewer to make an informed decision. Expedited or "fast track" appeals are completed within 72 hours upon request if delaying the appeal decision risks jeopardizing your health. You have the right to request a "fast track" or expedited appeal if your doctor agrees there are health risks in delaying the decision. WHA's Medical Director will make the decision as to whether the appeal will be handled as an expedited or standard appeal.

What is WHA's Grievance and Appeal Procedure?

If you have a complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other complaint, please call Member Services for immediate assistance.

If your complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written grievance or appeal may be submitted to:

Mail:	Western Health Advantage Attn: Member Relations 2349 Gateway Oaks, Suite 100 Sacramento, CA 95833
Secure fax:	916.563.2207
Call:	916.563.2250 or 888.563.2250 888.877.5378 TDD/TTY
Email:	appeal.grievance@westernhealth.com
Online form:	mywha.org/grievance

Please complete the attached form. Be sure to include a discussion of your questions or situation and your reasons for dissatisfaction. Submit the grievance or appeal to WHA Member Services, Grievances and Appeals Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you may request a review by WHA or go directly to the Department of Managed Health Care. If your coverage is still in effect when you submit your grievance, your coverage will be continued while your grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the grievance, including any appeal to the California Department of Managed Health Care, if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All premiums must be up to date and paid timely.

WHA will send an acknowledgment letter to you within five (5) calendar days of receipt of your grievance or appeal. A determination is rendered within thirty (30) calendar days. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the grievance or appeal will be provided to the Member and will include an explanation of the contractual or clinical rationale for the decision.

A grievance form and a description of the grievance procedures are available at every Medical Group and Plan facility. In addition, a grievance form will be promptly mailed to you if you request one by calling Member Services. If you would like assistance in filing a grievance or an appeal, please call Member Services and a representative will assist you in completing the form or explain how to write your letter. We will also be happy to take the information over the phone verbally or through a secure message on myWHA.

For detailed information about the grievance and appeal procedure visit **mywha.org/grievance** or call WHA Member Services at 916.563.2250 or 888.563.2250.

Terminal Illness Conference

If WHA has denied treatment, services or supplies deemed experimental and you have a terminal illness (a condition that has a high probability of causing death within one year or less), you can request a conference as part of the grievance system. Please indicate on the grievance form your request for a conference.

Plan Partner Grievances

If you have a grievance about your dental, vision or mental health services, visit **mywha.org/grievance** for special instructions.

Language Assistance

WHA wants to ensure all Members have access to the grievance and appeal system. WHA provides free-of-charge verbal and written translation services to those with limited English proficiency or with visual or other communicative impairments. Please contact WHA's Member Services Department for more information or visit **mywha.org/grievance** for more information.

GRIEVANCE/APPEAL REQUEST FORM

Mail to: Western Health Advantage, Attn: Member Relations
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.563.2207
Email to: appeal.grievance@westernhealth.com
Questions 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TYY
This form is also available online mywha.org/grievance

Member Name_____ Member ID Number_____ Birth Date_____

Street Address_____ City, State, Zip Code_____

Daytime Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Alternate Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Name of Person Filing _____
(If Different Than Above, Please Complete the Attached Authorized Assistance Form)

Relationship_____ Daytime Telephone Number_____

Department/Location or Medical Facility Where Issue Occurred_____

Date(s) Issue(s) Occurred_____

Please Describe the Nature of the Issue(s) — Attach Additional Sheets if Needed

_____

_____

_____

Please Explain How You Have Tried to Resolve the Issue(s)

_____

_____

_____

What Would You Consider a Proper Solution to the Issue(s)?

_____

_____

_____

Signature_____ Date_____

❑ Check Here If You Are Requesting A Terminal Illness Conference

For Internal Use Only: Member Services Representative Name_____ Date Received_____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-563-2250 (TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Western Health Advantage

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

If you have any questions, please call Member Services at 916.563.2250, 888.563.2250 toll-free or 888.877.5378 TDD/TTY.

A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

1. Person (the "Member") whose information is to be disclosed

Member name and address:_____

Member ID number:_____ Date of birth:_____

2. Person (the "Recipient") authorized to receive the Member's information

Recipient's name:_____

Recipient's address:_____

Recipient's relationship to the Member:_____

3. Information to be disclosed to the Recipient

check one: ❑ Any or all information that WHA maintains. This may include information relating to the Member's medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. This does not include Sensitive Information unless specifically approved below.

OR Only the following information, or types of information, WHA maintains (check all that apply):

❑ Claims status ❑ Authorization status ❑ Referral status ❑ Other_____

4. Is the Recipient authorized to receive Sensitive Information as described below?

check one: ❑ NO – PROCEED TO SECTION 5

OR ❑ YES – SELECT ONE (a or b) OF THE FOLLOWING

I specifically authorize the Recipient to receive:

a. ❑ Psychotherapy notes: If you check this box, you may not check any of the other boxes in section b. below. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information. PROCEED TO SECTION 5.

OR b. ❑ Complete this section ONLY IF you did not check box 4(a) above and you wish to authorize disclosure of any of the following types of Sensitive Information* (check all that apply):

❑ All sensitive information OR

❑ Abortion	❑ Alcohol/substance abuse**	❑ Genetic information
❑ HIV/AIDS	❑ Mental health	❑ Pregnancy
❑ Sexual, physical, or mental abuse		❑ Sexually transmitted illness

*Note to parents/legal guardians of minors 12 years of age or older: You may be unable to obtain or authorize the use or disclosure of certain types of Sensitive Information about the minor without the minor's own written authorization. This may include the types of Sensitive Information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is 17 years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

**For Recipient of Substance Abuse Information: This information has been disclosed to you from records protected by the Federal Confidentiality of Alcohol or Drug Abuse Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical information or other information is not sufficient for this purpose.

5. Reason for this authorization

check one: ❑ The information is about me and is to be used or disclosed at my request.

❑ Other (please specify):_____

B. Expiration and revocation

This authorization will remain in effect for one year from the date of your signature below UNLESS a different date is specified here: Month_____Day_____Year_____

You have the right to revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information we use or disclose before we receive your revocation request. If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

C. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the Recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996. I also understand that signing this form is of my own free will.

I understand that WHA may not condition payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this form.

Signature_____ Date_____

Print name_____

D. Personal or legal representatives or guardians

If this form is signed by someone other than the Member or the parent of a minor, such as a personal/legal representative, guardian or executor, you must also submit legal documentation showing your authority to act on behalf of the Member (or the Member's estate) to authorize the use or disclosure of the Member's health information. Such documentation may include, for example: 1) Durable Health Care Power of Attorney; 2) current, valid documentation of court-ordered guardianship; or 3) other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate).

Please also complete the following:

Representative's name (print):_____

Relationship to Member:_____

Type of documentation submitted:_____

Keep a copy of this Authorization for your records.

Mail completed form to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks, Suite 100, Sacramento, CA 95833

Fax to: 916.568.0126

Email to: memberservices@westernhealth.com

Questions? Call: 916.563.2250 | 888.563.2250 toll-free | 888.877.5378 TDD/TTY

FOR INTERNAL USE ONLY Initials_____ Date Entered_____

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, 888.877.5378 (TTY), 916.568.0126 (fax), 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.

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 888.877.5378.

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 888.877.5378 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) 888.877.5378**。**

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 888.877.5378.

TAGALOG

Kung ikaw, o ang iyong tinutulangan, 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 888.877.5378.

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 888.877.5378로 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 888.877.5378՝ 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 ادونتیج) 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 888.877.5378 پیام تایپ 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 TTY для лиц с нарушениями слуха по номеру 888.877.5378.

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、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعد أو تقوم برعايته 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 888.877.5378.

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। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

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 888.877.5378.

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 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378