Balance by CCHP | 2023 Information Kit

Individual & Family Plans

Covered California Plans

Your Path To Wellness.

Balance by CCHP

COVERED CALIFORNIA™

Notes:

Hello!

At Balance by CCHP, it is our mission to improve the health of our community by providing high-quality affordable care. We are your partner on your path to health and wellness. We are here to help.

We're in Your Community
We are the only private health plan based in San Francisco offering coverage for residents in San Francisco and San Mateo counties. CCHP was founded in 1986 by healthcare professionals with unique needs of our local community in mind.

The dedicated professionals who provide your care, also live, work and play here. More of your healthcare dollars stay in the community so that everyone can live their best lives.

Access to Care
Balance gives you a convenient choice of providers and facilities. Our network includes the largest medical groups and top hospitals.

With Hill Physicians (HPMG), ONE Medical and Jade Health Care, you get a choice of over 7,000 independent, neighborhood doctors and specialists.

Hill Physicians · one medical · Jade HEALTH CARE MEDICAL GROUP

And, we work with most of the hospitals in the area.

CHINESE HOSPITAL · Dignity Health. · AHMC Seton Medical Center

Stanford HEALTH CARE · Sutter Health · UCSF Health

Focused on Wellness
We are committed to helping you achieve your optimal health. In addition to free annual preventive screenings, we offer health education and fitness classes, in-person and virtually. You decide how you want to achieve wellness, conveniently and safely.

This Information Kit is designed to help you get all the facts you need to get on Your Path to Wellness.

Thank you for considering Balance!

Questions?
1-877-256-2477
TTY 1-877-681-8898

Balance Quality & Affordable Plan Options

Balance by CCHP. We offer a range of choices for you and your family's healthcare needs. Choosing Balance means you get quality, affordable coverage that helps you stay healthy and well – your way.

Through our partnership with Covered California, we also offer financial help to pay for your coverage. Be sure to ask about it.

Balance is available exclusively to those who live or work in San Francisco and San Mateo counties. You will find us in your community.

Proof of Quality
Balance is an NCQA accredited plan. As one of a few ACA Qualified Health Plans participating in the Covered California health insurance exchange, we meet or exceed local and federal quality standards so you can rest assured knowing you and your family are in good hands.

Choosing Balance is Easy
After reviewing the information, talk to one of our friendly and knowledgeable experts who can answer questions and guide you to the right plan for your needs.

Here is what's included:
1. Overview – a quick look at our benefits and services
2. Plans we offer – plan details and rates
3. Enrollment application – if you are ready, go right ahead and fill out the form
4. Information about non-discrimination and language help
5. Ways to contact us

Get Balance for the peace-of-mind. We are your trusted local partner in your health care journey.

Your Path To Wellness.

Notes:

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TTY 1-877-681-8898

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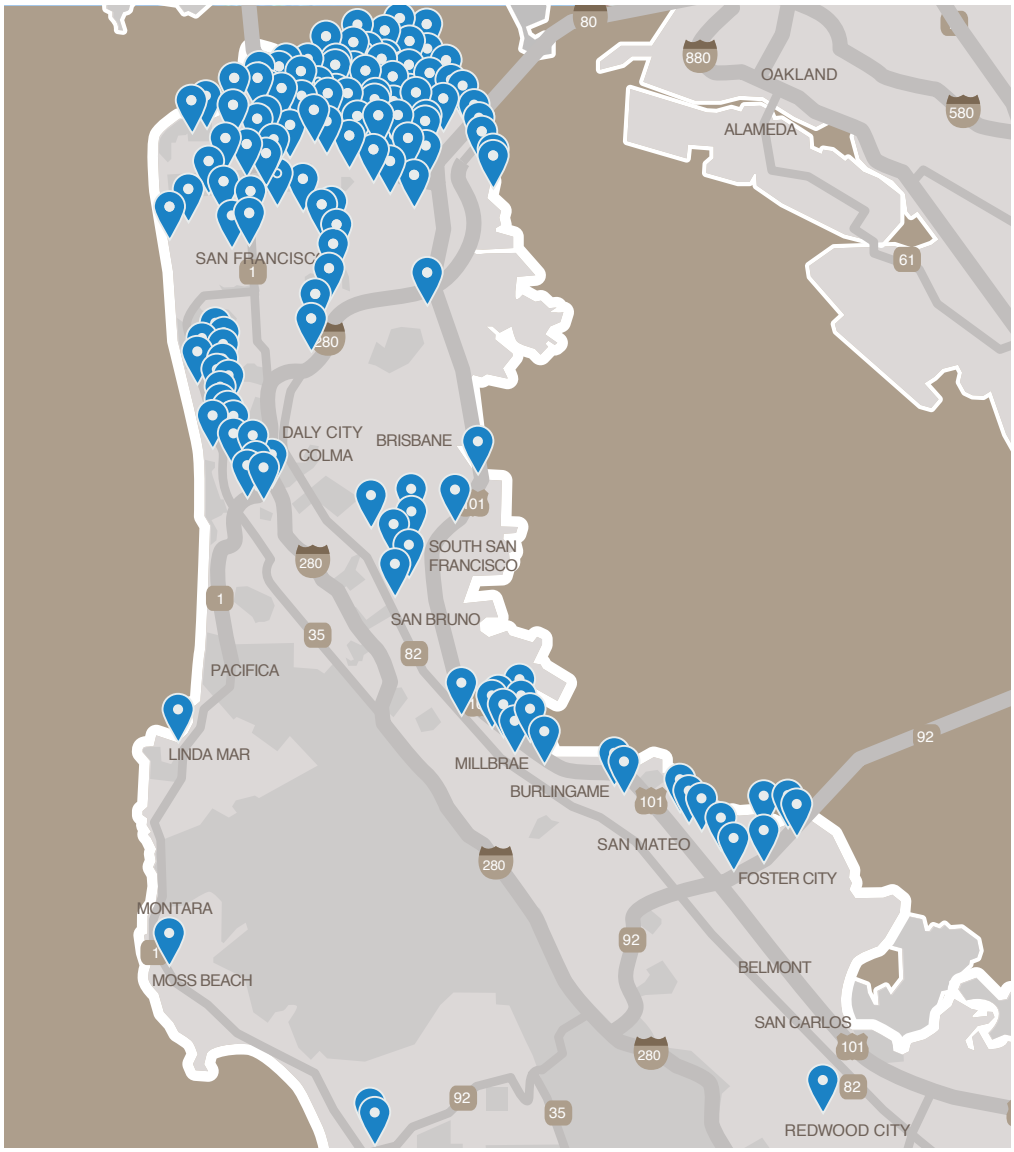
You and your family deserve CCHP quality
Balance by CCHP is a local health plan that empowers you with quality choices. We add value with extras you want so managing your health is a little easier.

Balance plans for as low as $1 a month
Choose a plan that fit your needs. We have plans with a range of monthly premiums, deductibles, and copays. Be sure to talk to us to see if you qualify for financial help to bring your cost of care down to as low as $1 a month.

In-network choice of doctors & hospitals
With every plan, you get an in-network choice of over 7,000 local doctors and specialists from Hill Physicians, One Medical, and Jade Health Care. You also get access to CPMC (Sutter), Chinese Hospital, Dignity, Seton, Stanford, and UCSF.



Questions?
1-877-256-2477
TTY 1-877-681-8898

For your convenience
We want to serve you in ways that are convenient for you – not the other way around. That's why we offer multiple ways to connect with us – Member Portal, email, phone and Member Service centers you can visit. We will help you navigate your plan and get your questions answered.

Convenience and safety through telehealth
Many of our providers offer virtual care for your convenience and safety. Participating providers will 'see' you—just like an in-person visit. Of course, they are also available for safe in-office visits. As always, you are in control.

East meets west
We recognize the path to health and wellness has many roads. We complement physician care by covering Eastern therapies such as acupuncture. Giving you a choice and preference in appropriate treatment is important to us.

Sensitive to culture and language
Our members are as diverse as the Bay Area. Our providers and member services team offer language assistance and are mindful of serving you with culturally competent care.

Rewarding you for wellness
Included with every plan are no cost annual screenings, free health, fitness, and wellness classes to help you stay healthy and fit. You may even earn financial rewards for meeting health goals such as completing your annual wellness doctor visit.

Notes:

Questions?
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TTY 1-877-681-8898

Notes:

Range of Plans

At Balance we understand your healthcare needs are unique. You have the flexibility of choosing the one that's right for you.

Where to Start?

1. Identify your healthcare needs and budget

There are five levels of Balance plans by coverage and pricing: Platinum, Gold, Silver, Bronze, and Minimum Coverage.

Minimum Coverage and Bronze plans have the most affordable monthly premiums for those who want the protection of low/no cost preventive care and typically use little healthcare services or prescriptions.

Platinum, Gold, and Silver plans have higher premiums and lower medical copays. These plans are intended for those who use medical services regularly. Silver plans may be just right for many people.

2. Review your choice of in-network physicians and hospitals

Balance plans are designed for those who prefer physician and hospital choice. With every plan, you get an in-network choice of over 7,000 local doctors and specialists from Hill Physicians, One Medical, and Jade Health Care, and, access to UCSF, Sutter, Dignity, Stanford, Seton, and Chinese Hospital.

3. Talk to us to see if you qualify for financial support

Balance plans may cost as low as $1/month with financial help which is determined by your income and family size. Our certified enrollment experts will guide you through the process.

4. Ask us for exclusive plans not offered on Covered California

In addition to Covered California plans, we also offer four unique plans exclusively. For those that do not qualify for financial support, they are often a cost-effective, possibly lower cost, alternative.

5. Dental and vision coverage

All our plans include pediatric vision and dental coverage. Adults have the option to add vision and dental coverage separately for low premiums. Be sure to ask about the details and how you can get the added protection.

Questions?
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TTY 1-877-681-8898

2023 Plan Benefit Hightlights & Rates

(for San Francisco & San Mateo Counties)

The following pages provide a side-by-side comparison of the key 2023 plan benefits with rates by age.

Make sure to check the benefits that are important to you and if you don't see them listed, please be sure to ask us.

At any time you have questions, contact us.

Call or Email

7 days a week from 8 a.m. to 8 p.m.

1-877-256-2477
(TTY: 1-877-681-8898)

sales@cchphealthplan.com

Your Path To Wellness.

Balance by CCHP | COVERED CALIFORNIA™

Balance by CCHP

Plan highlights, rates, enrollment forms, etc.

Please review the highlighted benefits in this chart. You can compare between plans to find the one that fits your unique needs best. As always, please contact us with any questions.

Plan Name	Jade 15 Platinum HMO	Silver 70 Off-Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO Silver	
				In-Network	Out-of-Network
Metal Level / Actuarial Benefit Value %**	Platinum / 91.2%	Silver / 71.6%	Silver / 69.98%	Silver / 71.99 %	
SERVICES AND FEATURES					
Annual Deductible	$0	Individual $4,750 / Family $9,500 (A)	Individual $2,750 / Family $5,500 (A)	Individual $2,500 / Family $5,000 (A) Medical/ Rx(1)	
Out–of–Pocket Limit on Expenses	Individual $3,000/ Family $6,000	Individual $8,750 / Family $17,500	Individual $7,500 / Family $15,000	Individual $7,700 / Family $15,400	
LIFETIME MAXIMUMS	No Limit				
PROFESSIONAL SERVICES	**Member Cost Share**				
Preventive Care/ Screening/Immunization	Not Subject to Copay				
Primary Care Visit to Treat an Injury or Illness	$15 Copay	$45 Copay	$0 Copay for First (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	$0 Copay for First (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	50% Coinsurance (After Deductible)
Specialist Visit	$30 Copay	$85 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)
Prenatal and Preconception Visits	$0 Copay	$0 Copay	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Hospital Services)	$150 Copay Per Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	$500 Copay Per Day (Up to First 5 Days) (After Deductible)	20% Coinsurance (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	30% Coinsurance (After Deductible)	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
OUTPATIENT SERVICES					
Laboratory Tests	$5 Copay	$50 Copay	$25 Copay (After Deductible)	$10 Copay (After Deductible)	50% Coinsurance (After Deductible)
X-Rays	$5 Copay	$95 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$100 Copay	$325 Copay	$350 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$250 Copay	20% Coinsurance	$400 Copay Chinese Hospital / $1,200 Copay Other Facilities (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	20% Coinsurance	$0 Copay (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)

Footnotes: *Available in Covered California only.
**Actuarial Value is the Percentage of total average costs for covered benefits that a plan will cover.
Preventive care is not subject to the deductible.
(1) Medical / RX cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).

PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					
Platinum 90 HMO	**Gold 80 HMO**	**Silver 70* HMO**	**Bronze 60 HMO**	**Bronze 60 HDHP HMO**	**Minimum Coverage HMO**
Platinum / 89.8%	Gold / 80.1 %	Silver / 71.6 %	Bronze / 64.5%	Bronze / 64.2%	N/A
$0	$0	Individual $4,750 / Family $9,500 (A)	Individual $6,300 / Family $12,600(A)	Individual $7,000/ Family $14,000 (A) Medical/ Rx(1)	Individual $9,100 / Family $18,200 (A) Medical / Rx (1)
Individual $4,500 / Family $9,000	Individual $8,550/ Family $17,100	Individual $8,750/ Family $17,500	Individual $8,200/ Family $16,400	Individual $7,000/ Family $14,000	Individual $9,100 / Family $18,200
No Limit					
Member Cost Share					
Not Subject to Copay					
$15 Copay	$35 Copay	$45 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	$0 Copay for First (3) Non-Preventive Visits, then Full Cost Until Out-of-Pocket is Met
$30 Copay	$65 Copay	$85 Copay	$95 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
$250 Per day (Up to First 5 Days)	$350 Per day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$15 Copay	$40 Copay	$50 Copay	$40 Copay	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$30 Copay	$75 Copay	$95 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$75 Copay	$75 Copay	$325 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$100 Copay	$150 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$25 Copay	$40 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met

Plan Name	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO Silver	
				In-Network	Out-of-Network
HOSPITALIZATION SERVICES	**Member Cost Share**				
Facility Fee (e.g., Hospital Room)	$150 Copay Per Day Chinese Hospital / $450 Copay Per Day Other Facilities (Up to First 5 Days)	30% Coinsurance (After Deductible)	$500 Copay Per Day Chinese Hospital / $1,500 Copay Per Day Other Facilities (Up to First 5 Days) (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	30% Coinsurance	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE					
Emergency Room Services (waived if admitted)	$100 Copay	$400 Copay	$300 Copay (After Deductible)	$200 Copay (After Deductible)	$200 Copay (After Deductible)
Emergency Room Physician Fee (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Center	$50 Copay	$45 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE					
Annual Prescription Deductible	$0	Individual $85/ Family $170	Individual $275/ Family $550	Individual $2,500 / Family $5,000 [A] Medical/ Rx[1]	
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	$16 Copay (After Rx Deductible)	$15 Copay	$15 Copay (After Rx Deductible)	Not Covered
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 15 Copay	$60 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	Not Covered
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$90 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	Not Covered
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250 Per Prescription	20% Coinsurance up to $250 per Prescription (After Rx Deductible)	20% Coinsurance up to $250 Per Prescription (After Rx Deductible)	20% Coinsurance up to $250 Per Prescription (After Deductible)	Not Covered
PEDIATRIC VISION AND DENTAL (Included in Plan)					
Child Needs Eye Care (Ages 0-18)					
Eye Exam (1 Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Eyewear (Lenses) (1 Pair Per Calendar Year)	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Not Covered
Eyewear (Contact Lenses in Lieu of Glasses)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page				

PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					
Platinum 90 HMO	**Gold 80 HMO**	**Silver 70 HMO**	**Bronze 60 HMO**	**Bronze 60 HDHP HMO**	**Minimum Coverage HMO**
Member Cost Share					
$250 Per Day (Up to First 5 Days)	$350 Per Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$150 Copay	$350 Copay	$400 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met	$0 Copay
$15 Copay	$35 Copay	$45 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	$0 Copay for First (3) Non-Preventive Visits, then Full Cost until Out-of-Pocket is Met
$0	$0	Individual $85/ Family $170	Individual $500 / Family $1,000	Individual $7,000/ Family $14,000 [A] Medical/ Rx[1]	Individual $8,700 / Family $17,400 [A] Medical / Rx[1]
$5 Copay	$ 15 Copay	$16 Copay (After Rx Deductible)	$18 Copay (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$15 Copay	$60 Copay	$60 Copay (After Rx Deductible)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$25 Copay	$85 Copay	$90 Copay (After Rx Deductible)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
10% Coinsurance up to $250 per prescription	20% Coinsurance up to $250 per Prescription	20% Coinsurance up to $250 per Prescription (After Rx Deductible)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met
Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share	Single Vision / Bi-focal / Tri-focal / Lenticular Full Cost Until Out-of-Pocket is Met
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met
Included in Plan. See Dental Summary Page					

Balance by CCHP

Individual & Family Plans | 個人/家庭計劃

2023 Monthly Rates | *San Francisco County* | 三藩市縣

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

- 每位家庭成員的月費是根據年齡及居住地區計算。
- 只有前三名年齡最大的 21 歲以下子女會被計算入投保費用，額外的投保子女則免費。
- 所有 21 歲或以上的子女的月費是根據年齡計算。

	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO
AGE / 年齡	RATE / 月費	RATE / 月費	RATE / 月費	RATE / 月費
0-14	$455.51	$349.97	$340.76	$327.97
15	$496.00	$381.08	$371.05	$357.13
16	$511.48	$392.98	$382.63	$368.27
17	$526.96	$404.87	$394.22	$379.42
18	$543.63	$417.68	$406.69	$391.42
19	$560.30	$430.49	$419.16	$403.43
20	$577.57	$443.76	$432.08	$415.86
21	$595.43	$457.48	$445.44	$428.72
22	$595.43	$457.48	$445.44	$428.72
23	$595.43	$457.48	$445.44	$428.72
24	$595.43	$457.48	$445.44	$428.72
25	$597.81	$459.31	$447.22	$430.44
26	$609.72	$468.46	$456.13	$439.01
27	$624.01	$479.44	$466.82	$449.30
28	$647.23	$497.28	$484.20	$466.02
29	$666.29	$511.92	$498.45	$479.74
30	$675.82	$519.24	$505.58	$486.60
31	$690.11	$530.22	$516.27	$496.89
32	$704.40	$541.20	$526.96	$507.18
33	$713.33	$548.06	$533.64	$513.61
34	$722.85	$555.38	$540.77	$520.47
35	$727.62	$559.04	$544.33	$523.90
36	$732.38	$562.70	$547.89	$527.33
37	$737.15	$566.36	$551.46	$530.76
38	$741.91	$570.02	$555.02	$534.19
39	$751.44	$577.34	$562.15	$541.05
40	$760.96	$584.66	$569.28	$547.91
41	$775.25	$595.64	$579.97	$558.20
42	$788.95	$606.16	$590.21	$568.06
43	$808.00	$620.80	$604.47	$581.78
44	$831.82	$639.10	$622.28	$598.92
45	$859.80	$660.61	$643.22	$619.07
46	$893.15	$686.22	$668.16	$643.08
47	$930.66	$715.05	$696.23	$670.09
48	$973.53	$747.98	$728.30	$700.96
49	$1015.81	$780.47	$759.92	$731.40
50	$1063.44	$817.06	$795.56	$765.70
51	$1110.48	$853.21	$830.75	$799.57
52	$1162.28	$893.01	$869.50	$836.86
53	$1214.68	$933.26	$908.70	$874.59
54	$1271.25	$976.73	$951.02	$915.32
55	$1327.81	$1020.19	$993.34	$956.05
56	$1389.14	$1067.31	$1039.22	$1000.21
57	$1451.07	$1114.89	$1085.54	$1044.79
58	$1517.16	$1165.67	$1134.99	$1092.38
59	$1549.91	$1190.83	$1159.49	$1115.96
60	$1616.00	$1241.61	$1208.93	$1163.55
61	$1673.16	$1285.53	$1251.69	$1204.71
62	$1710.68	$1314.35	$1279.76	$1231.72
63	$1757.72	$1350.49	$1314.95	$1265.59
64+	$1786.29	$1372.44	$1336.32	$1286.16

10.17.2022

Balance by CCHP

Individual & Family Plans | 個人/家庭計劃

2023 Monthly Rates | *San Francisco County* | 三藩市縣

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- All dependents age 21 and older are charged premiums based on their ages.

- 每位家庭成員的月費是根據年齡及居住地區計算。
- 只有前三名年齡最大的 21 歲以下子女會被計算入投保費用，額外的投保子女則免費。
- 所有 21 歲或以上的子女的月費是根據年齡計算。

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA 可通過或不通過投保加州市場選擇這些醫療計劃					*ONLY AVAILABLE INSIDE COVERED CALIFORNIA* *僅可透過 Covered CA 投保加州選擇此醫療計劃*
	Platinum[90] HMO	Gold[80] HMO	Bronze[60] HMO	Bronze[60] HDHP	Minimum Coverage HMO 最低保障 HMO	Silver[70] HMO
AGE / 年齡	RATE / 月費	RATE / 月費	RATE / 月費	RATE / 月費	RATE / 月費	RATE / 月費
0-14	$467.93	$427.31	$282.01	$281.84	$271.46	$377.97
15	$509.53	$465.29	$307.08	$306.89	$295.59	$411.57
16	$525.43	$479.82	$316.66	$316.47	$304.82	$424.42
17	$541.34	$494.34	$326.25	$326.05	$314.04	$437.26
18	$558.46	$509.98	$336.57	$336.36	$323.98	$451.10
19	$575.59	$525.62	$346.89	$346.68	$333.92	$464.93
20	$593.33	$541.82	$357.58	$357.36	$344.21	$479.26
21	$611.68	$558.58	$368.64	$368.41	$354.85	$494.08
22	$611.68	$558.58	$368.64	$368.41	$354.85	$494.08
23	$611.68	$558.58	$368.64	$368.41	$354.85	$494.08
24	$611.68	$558.58	$368.64	$368.41	$354.85	$494.08
25	$614.13	$560.81	$370.12	$369.89	$356.27	$496.06
26	$626.36	$571.98	$377.49	$377.25	$363.37	$505.94
27	$641.04	$585.39	$386.34	$386.10	$371.88	$517.80
28	$664.89	$607.17	$400.72	$400.46	$385.72	$537.07
29	$684.47	$625.05	$412.51	$412.25	$397.08	$552.88
30	$694.26	$633.98	$418.41	$418.15	$402.76	$560.78
31	$708.94	$647.39	$427.26	$426.99	$411.27	$572.64
32	$723.62	$660.80	$436.10	$435.83	$419.79	$584.50
33	$732.79	$669.17	$441.63	$441.36	$425.11	$591.91
34	$742.58	$678.11	$447.53	$447.25	$430.79	$599.81
35	$747.47	$682.58	$450.48	$450.20	$433.63	$603.77
36	$752.36	$687.05	$453.43	$453.15	$436.47	$607.72
37	$757.26	$691.52	$456.38	$456.10	$439.31	$611.67
38	$762.15	$695.99	$459.33	$459.04	$442.14	$615.63
39	$771.94	$704.92	$465.23	$464.94	$447.82	$623.53
40	$781.73	$713.86	$471.13	$470.83	$453.50	$631.44
41	$796.41	$727.27	$479.97	$479.67	$462.02	$643.29
42	$810.47	$740.11	$488.45	$488.15	$470.18	$654.66
43	$830.05	$757.99	$500.25	$499.94	$481.53	$670.47
44	$854.51	$780.33	$514.99	$514.67	$495.73	$690.23
45	$883.26	$806.58	$532.32	$531.99	$512.41	$713.45
46	$917.52	$837.86	$552.96	$552.62	$532.28	$741.12
47	$956.05	$873.05	$576.19	$575.83	$554.63	$772.25
48	$1000.09	$913.27	$602.73	$602.36	$580.18	$807.82
49	$1043.52	$952.93	$628.91	$628.51	$605.38	$842.90
50	$1092.46	$997.62	$658.40	$657.99	$633.76	$882.43
51	$1140.78	$1041.74	$687.52	$687.09	$661.80	$921.46
52	$1194.00	$1090.34	$719.59	$719.14	$692.67	$964.45
53	$1247.82	$1139.50	$752.03	$751.56	$723.90	$1007.93
54	$1305.93	$1192.56	$787.05	$786.56	$757.61	$1054.86
55	$1364.04	$1245.62	$822.07	$821.56	$791.32	$1101.80
56	$1427.05	$1303.16	$860.04	$859.51	$827.87	$1152.69
57	$1490.66	$1361.25	$898.38	$897.82	$864.77	$1204.08
58	$1558.56	$1423.25	$939.30	$938.72	$904.16	$1258.92
59	$1592.20	$1453.97	$959.58	$958.98	$923.68	$1286.09
60	$1660.10	$1515.98	$1000.50	$999.87	$963.07	$1340.94
61	$1718.82	$1569.60	$1035.89	$1035.24	$997.13	$1388.37
62	$1757.35	$1604.79	$1059.11	$1058.45	$1019.49	$1419.50
63	$1805.68	$1648.92	$1088.23	$1087.55	$1047.52	$1458.53
64+	$1835.03	$1675.72	$1105.92	$1105.23	$1064.54	$1482.23

Balance by CCHP

Individual & Family Plans | 個人/家庭計劃

2023 Monthly Rates | *San Mateo County* | 聖馬刁縣

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

- 每位家庭成員的月費是根據年齡及居住地區計算。
- 只有前三名年齡最大的 21 歲以下子女會被計算入投保費用，額外的投保子女則免費。
- 所有 21 歲或以上的子女的月費是根據年齡計算。

	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO
AGE / 年齡	RATE / 月費	RATE / 月費	RATE / 月費	RATE / 月費
0-14	$491.94	$377.97	$368.02	$354.21
15	$535.67	$411.57	$400.73	$385.69
16	$552.39	$424.41	$413.24	$397.73
17	$569.11	$437.26	$425.75	$409.77
18	$587.12	$451.09	$439.22	$422.73
19	$605.12	$464.93	$452.69	$435.70
20	$623.77	$479.26	$466.64	$449.13
21	$643.06	$494.08	$481.07	$463.02
22	$643.06	$494.08	$481.07	$463.02
23	$643.06	$494.08	$481.07	$463.02
24	$643.06	$494.08	$481.07	$463.02
25	$645.63	$496.05	$483.00	$464.87
26	$658.50	$505.94	$492.62	$474.13
27	$673.93	$517.79	$504.17	$485.24
28	$699.01	$537.06	$522.93	$503.30
29	$719.59	$552.87	$538.32	$518.11
30	$729.88	$560.78	$546.02	$525.52
31	$745.31	$572.64	$557.56	$536.64
32	$760.74	$584.49	$569.11	$547.75
33	$770.39	$591.91	$576.33	$554.69
34	$780.68	$599.81	$584.02	$562.10
35	$785.82	$603.76	$587.87	$565.81
36	$790.97	$607.72	$591.72	$569.51
37	$796.11	$611.67	$595.57	$573.21
38	$801.26	$615.62	$599.42	$576.92
39	$811.54	$623.53	$607.12	$584.33
40	$821.83	$631.43	$614.81	$591.73
41	$837.27	$643.29	$626.36	$602.85
42	$852.06	$654.65	$637.42	$613.50
43	$872.64	$670.46	$652.82	$628.31
44	$898.36	$690.23	$672.06	$646.83
45	$928.58	$713.45	$694.67	$668.60
46	$964.59	$741.12	$721.61	$694.52
47	$1005.11	$772.24	$751.92	$723.69
48	$1051.41	$807.82	$786.56	$757.03
49	$1097.06	$842.90	$820.71	$789.91
50	$1148.51	$882.42	$859.20	$826.95
51	$1199.31	$921.45	$897.20	$863.52
52	$1255.26	$964.44	$939.06	$903.81
53	$1311.85	$1007.92	$981.39	$944.55
54	$1372.94	$1054.86	$1027.09	$988.54
55	$1434.03	$1101.79	$1072.79	$1032.53
56	$1500.26	$1152.68	$1122.35	$1080.22
57	$1567.14	$1204.07	$1172.38	$1128.37
58	$1638.52	$1258.91	$1225.78	$1179.76
59	$1673.89	$1286.08	$1252.24	$1205.23
60	$1745.27	$1340.93	$1305.63	$1256.63
61	$1807.00	$1388.36	$1351.82	$1301.07
62	$1847.52	$1419.49	$1382.13	$1330.24
63	$1898.32	$1458.52	$1420.13	$1366.82
64+	$1929.18	$1482.22	$1443.21	$1389.04

10.17.2022

Balance by CCHP

Individual & Family Plans | 個人/家庭計劃

2023 Monthly Rates | *San Mateo County* | 聖馬刁縣

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- 只有前三名年齡最大的 21 歲以下子女會被計算入投保費用，額外的投保子女則免費。
- 所有 21 歲或以上的子女的月費是根據年齡計算。

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA 可通過或不通過投保加州市場選擇這些醫療計劃					*ONLY AVAILABLE INSIDE COVERED CALIFORNIA* *僅可透過 Covered CA 投保加州選擇此醫療計劃*
	Platinum[90] HMO	Gold[80] HMO	Bronze[60] HMO	Bronze[60] HDHP	Minimum Coverage HMO 最低保障 HMO	Silver[70] HMO
AGE / 年齡	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**
0-14	$505.37	$461.49	$304.57	$304.38	$293.18	$408.21
15	$550.29	$502.51	$331.64	$331.44	$319.24	$444.49
16	$567.46	$518.20	$342.00	$341.78	$329.20	$458.37
17	$584.64	$533.88	$352.35	$352.13	$339.16	$472.24
18	$603.13	$550.77	$363.49	$363.27	$349.89	$487.18
19	$621.63	$567.67	$374.64	$374.41	$360.63	$502.12
20	$640.79	$585.16	$386.19	$385.95	$371.74	$517.60
21	$660.61	$603.26	$398.13	$397.88	$383.24	$533.60
22	$660.61	$603.26	$398.13	$397.88	$383.24	$533.60
23	$660.61	$603.26	$398.13	$397.88	$383.24	$533.60
24	$660.61	$603.26	$398.13	$397.88	$383.24	$533.60
25	$663.25	$605.67	$399.72	$399.47	$384.77	$535.74
26	$676.46	$617.74	$407.69	$407.43	$392.43	$546.41
27	$692.32	$632.21	$417.24	$416.98	$401.63	$559.22
28	$718.08	$655.74	$432.77	$432.50	$416.58	$580.03
29	$739.22	$675.05	$445.51	$445.23	$428.84	$597.10
30	$749.79	$684.70	$451.88	$451.60	$434.97	$605.64
31	$765.64	$699.18	$461.43	$461.15	$444.17	$618.45
32	$781.50	$713.65	$470.99	$470.70	$453.37	$631.25
33	$791.41	$722.70	$476.96	$476.66	$459.12	$639.26
34	$801.98	$732.35	$483.33	$483.03	$465.25	$647.80
35	$807.26	$737.18	$486.52	$486.21	$468.32	$652.06
36	$812.55	$742.01	$489.70	$489.40	$471.38	$656.33
37	$817.83	$746.83	$492.89	$492.58	$474.45	$660.60
38	$823.12	$751.66	$496.07	$495.76	$477.51	$664.87
39	$833.69	$761.31	$502.44	$502.13	$483.64	$673.41
40	$844.26	$770.96	$508.81	$508.49	$489.78	$681.95
41	$860.11	$785.44	$518.37	$518.04	$498.97	$694.75
42	$875.31	$799.32	$527.52	$527.19	$507.79	$707.03
43	$896.44	$818.62	$540.26	$539.93	$520.05	$724.10
44	$922.87	$842.75	$556.19	$555.84	$535.38	$745.44
45	$953.92	$871.10	$574.90	$574.54	$553.39	$770.52
46	$990.91	$904.89	$597.20	$596.82	$574.85	$800.41
47	$1032.53	$942.89	$622.28	$621.89	$599.00	$834.02
48	$1080.09	$986.33	$650.95	$650.54	$626.59	$872.44
49	$1127.00	$1029.16	$679.21	$678.79	$653.80	$910.33
50	$1179.85	$1077.42	$711.06	$710.62	$684.46	$953.02
51	$1232.03	$1125.08	$742.52	$742.05	$714.74	$995.17
52	$1289.51	$1177.56	$777.15	$776.67	$748.08	$1041.59
53	$1347.64	$1230.65	$812.19	$811.68	$781.80	$1088.55
54	$1410.40	$1287.95	$850.01	$849.48	$818.21	$1139.24
55	$1473.16	$1345.26	$887.83	$887.28	$854.62	$1189.94
56	$1541.20	$1407.40	$928.84	$928.26	$894.09	$1244.90
57	$1609.90	$1470.14	$970.25	$969.64	$933.95	$1300.39
58	$1683.23	$1537.10	$1014.44	$1013.81	$976.49	$1359.62
59	$1719.56	$1570.28	$1036.34	$1035.69	$997.56	$1388.97
60	$1792.89	$1637.24	$1080.53	$1079.85	$1040.10	$1448.20
61	$1856.31	$1695.15	$1118.75	$1118.05	$1076.89	$1499.43
62	$1897.93	$1733.16	$1143.83	$1143.12	$1101.04	$1533.04
63	$1950.11	$1780.82	$1175.28	$1174.55	$1131.31	$1575.20
64+	$1981.81	$1809.76	$1194.39	$1193.64	$1149.70	$1600.80

Individual and Family Plan Enrollment Application – Off Exchange

T: 1-888-371-3060
F: 1-415-955-8819

Chinese Community Health Plan (CCHP) will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

Reason for application

Please select one	☐ New Application (during open enrollment period November 1, 2022 – January 31, 2023)
	☐ Special Enrollment (during February 1, 2023 – October 31, 2023, please attach attestation & proof of the qualifying event)
	☐ Adding Spouse/Domestic Partner ☐ Adding Child(ren) Current Member ID#_____ Current Plan: _____

Proposed Effective Date (MM/DD/YY) / /

Please select a plan

Medical Plan Options: ☐ Jade[15] HMO Platinum ☐ Amber[50] HMO Silver ☐ ActiveChoice PPO Silver ☐ Platinum[90] HMO ☐ Gold[80] HMO
☐ Silver[70] Off Exchange HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO ☐ Minimum Coverage HMO

Optional Riders: ☐ Adult Vision (VSP) ☐ Adult Dental (Delta Dental)

A. Primary applicant's information

Last Name:	First Name:	MI:	SS#:
Date of Birth (MM/DD/YY) : / /	Age:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Email:		Cell Phone:	Home Phone:
Home Address (No P.O. Box)		City:	State: / Zip:

We will send all correspondence to your home address. If you have concerns about receiving confidential and private medical information at your home address, designate an address below where you want to receive such notices. You may be able to have medical information sent to you in an alternate format. Please contact CCHP for more information.

Mailing address if different from above:		City:	State: / Zip:
Primary Care Physician (PCP) :		Medical Group:	Are you a current patient of this PCP? ☐ Yes ☐ No
Name of Employer:			Work Phone:
Work Address:		City:	State: / Zip:

Preferred Written Language: ☐ Chinese ☐ English ☐ Spanish ☐ Other ____

Optional Questions

Your ethnic origin

☐ Asian Indian	☐ Black or African American	☐ Cambodian	☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Hmong	☐ Hispanic, Latino or Spanish Origin	☐ Japanese	☐ Korean	☐ Laotian	☐ Native Hawaiian
☐ Samoan	☐ White	☐ Vietnamese	☐ Other ____		

B. List all family member(s) to be covered

☐ **Spouse** ☐ **Domestic Partner**	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 1	Last Name	First Name	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 2	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 3	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No

C. Fill out this section if applicant is using an insurance Agent or Broker

I understand that the broker of record may receive monetary and/or non-monetary payments from CCHP in connection with the purchase of this coverage. I understand my premiums are the same whether or not I use an agent or broker.

Applicant's Signature X	Broker Name:	Date (MM/DD/YY): / /

D. Insurance agent/broker attestation (AB2569, Cal H&S §1389.8)

To be completed by your agent or broker after completion of this application

Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand ($10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I,_____, assisted the applicant in submitting this application. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future.

To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Agent/Broker Signature X		Agent/Broker Name:	Date (MM/DD/YY) : / /
Phone:	Fax:	Email:	CA License Number:
Agent/Broker Company Name:			Note(s) (CCHP Use Only):
Agent/Broker Address:			

E. Conditions of application – Please carefully read the following:

I. General Conditions

Chinese Community Health Plan (CCHP) reserves the right to reject any application for enrollment.

1. I understand that I have no coverage under this application until notified by CCHP that I am accepted.
2. If I am accepted, this application will become part of the agreement between CCHP and myself. Enrolled family members and I agree to be bound by the arbitration clause in the CCHP contract instead of trial by a court or jury.
3. I understand that willful misrepresentation can result in rescission of my coverage. CCHP can only rescind for a material misrepresentation or omission if the misrepresentation or omission is willful.

II. Acknowledgment and Agreement:

I hereby subscribe for myself and any enrolled dependents to the health plan designated here and agree to abide by all terms, conditions and provision of this Individual Membership Contract. I have read and understand the terms on this application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. I agree to notify CCHP promptly of any facts or circumstances which arise before the effective date of coverage under CCHP which make any of the statements supplied herein incorrect. I understand that coverage may be cancelled if CCHP demonstrates I have been fraudulent or intentionally misrepresented material fact in my application.

III. Disclosure of Personal and Health Information

CCHP understand the importance of keeping your and your dependents' personal and health information private. CCHP protects this information in electronic, written, and oral forms when used throughout our company. CCHP will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your CCHP coverage, CCHP is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, CCHP is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of CCHP policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing CCHP's website.

IV. Arbitration Agreement:

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and my dependents enrolled in the plan and CCHP and any of its affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

Applicant Signature X	Print Your Name:	Date (MM/DD/YY): / /
Spouse or Domestic Partner Signature X	Print Your Name:	Date (MM/DD/YY): / /
Signature Required for Dependents Age 18 or over		
Dependent #1 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #2 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #3 Signature X	Print Your Name:	Date (MM/DD/YY): / /

Marketing Source

☐ TV ☐ DM ☐ Email Ad ☐ Mobile Ad ☐ Radio ☐ Sing Tao Newspaper ☐ Journal Newspaper ☐ Other Newspaper

☐ Referrals ☐ Street Fair/Event ☐ Other _____

CCHP Use Only

Sales [ ] Manager [ ] Payment Type [CC / Bill / Check#] Amount [ ] Date [ ]

Rec'd by Enrollment [ ] Packet Sent Date [ ]

DMHC Approval: 11/9/2017 Rev. JAN2020

Special Enrollment Attestation Form

You may enroll in an individual health plan only during the open enrollment period from Nov. 1st to Jan. 31st. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for Special Enrollment Period privileges. If you later determine that this information is incorrect, you may be disenrolled.

Name of Applicant:	Effective Date Requested (MM/DD/YY): / /

Completing this form does not guarantee acceptance of the exception request, please provide the required documentation.

I am certifying I qualify for Special Enrollment due to (check box the reason that best applies):

- ☐ Got married or entered into domestic partnership
- ☐ Divorce, legal separation, dissolution of domestic partnership, or death
- ☐ A child is born, adopted or received into foster care
- ☐ Dependent turns 26 years old
- ☐ Attainment of citizenship
- ☐ Loss of Medi-Cal
- ☐ Loss of Group Coverage (e.g. death of an employee, termination of employment, deduction of hours)
- ☐ Loss of CORBA
- ☐ Loss of Student Health Insurance
- ☐ Ineligible for tax credits or cost-sharing reductions under Covered California
- ☐ Permanently moved into CCHP Service Area
- ☐ Misconduct or misinformation occurred during your enrollment
- ☐ Released from jail or prison
- ☐ Returned from active duty military service
- ☐ Received a certificate of exemption for hardship exception from Health & Human Services
- ☐ Court ordered provision of health insurance
- ☐ Federally Recognized American Indian/Alaska Native
- ☐ Other (Please provide an explanation): _____

Required Documentation for Special Enrollment Periods

A person enrolling as the result of a qualifying life event **should** provide the proof that the triggering event occurred and the date the event occurred. Most special enrollment periods last **60 days** from the date of the qualifying life event.

Event	Supporting Documentation
Marriage	*Marriage certificate*
Divorce	*Divorce decree document*
Birth/Adoption/Legal Guardianship of Child	*Birth certificate or hospital discharge paperwork*
Dependent Child reaches age 26	*Proof of previous health insurance*
Death of policyholder	*Death certificate*
Eligible Immigration Status or US Citizenship	*Valid US passport, Green Card, or legal supporting documentation*
Loss of Employer Coverage	*Proof of previous group health insurance*
Loss of Coverage Through Spouse's Employer	*Proof of previous group health insurance*
Loss of COBRA	*Loss of COBRA letter*
Loss of Medi-Cal	*Loss of Medi-Cal document*
Ineligible for cost-sharing reductions under Covered CA	*Covered CA letter*
Relocation / Move into CCHP Service Area	*Proof of old and new address, such as utility bill, credit card statement, insurance statement, bank statement, driver's license or education institution document. Both document must indicate permanent move occurred within 60 days of application.*

Applicant Signature X	Date (MM/DD/YY) / /

One-Time Credit Card Payment Authorization Form (New Enrollment Only)

T:1-888-371-3060
F:1-415-955-8819

I authorize CCHP to charge the debit/credit card indicated in this authorization form according to the terms outlined below. This payment authorization is for the goods/services described below, for the amount indicated below only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Please complete the information below	
Name of Applicant:	Effective Date Requested (MM/DD/YY):
Premium Amount: $	
Card Number:	Card Type: ☐ Visa ☐ MasterCard
Expiration Date:	Security Code:
Cardholder Name:	
Billing Address:	City:
State:	Zip:
Email:	Phone:
Cardholder Signature X	Date (MM/DD/YY):

Important Notice

Any submissions or payments made do not constitute a binding agreement to your policy or coverages. Changes and payments to policies are not effective or binding until you, or any party involved, receive official notice from either your insurance agent or CCHP. If you have any questions, please contact CCHP Sales Department 415-955-8831.

Balance by CCHP

Discrimination is Against the Law

Chinese Community Health Plan (CCHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CCHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Chinese Community Health Plan:

- 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 CCHP Member Services.

If you believe that CCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with us in person, by phone, by mail, or by fax at:

CCHP Member Services
445 Grant Ave, Suite 700, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-8898
Fax 1-415-397-2129

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 *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

華人保健計劃（CCHP 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。華人保健計劃（CCHP） 不因種族、膚色、民族血統、年齡、殘障或性別而排斥任何人或以不同的方式對待他們。

華人保健計劃（CCHP）：

- 向殘障人士免費提供各種援助和服務，以幫助他們與我們進行有效溝通，如：
  - 合格的手語翻譯員
  - 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）
- 向母語非英語的人員免費提供各種語言服務，如：
  - 合格的翻譯員
  - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡華人保健計劃（CCHP）

如果您認為華人保健計劃（CCHP） 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以親自提交投訴，或者以郵寄、傳真或電郵的方式向我們提交投訴：

CCHP Member Services
445 Grant Ave, Suite 700, San Francisco, CA 94108
1-888-775-7888, 聽力殘障人仕電話 1-877-681-8898
傳真 1-415-397-2129

您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過 Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf，或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C.20201
1-800-368-1019，800-537-7697 (TDD)（聾人用電信設備）

登入 http://www.hhs.gov/ocr/office/file/index.html 可獲得投訴表格。

Chinese Community Health Plan (CCHP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Chinese Community Health Plan no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Chinese Community Health Plan:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con CCHP Member Services.

Si considera que CCHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona:

CCHP Member Services
445 Grant Ave, Suite 700, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-889
Fax 1-415-397-2129.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-775-7888 (TTY: 1-877-681-8898).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-775-7888 (TTY: 1-877-681-8898).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-775-7888

(TTY: 1-877-681-8898)。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-775-7888 (TTY: 1-877-681-8898).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-775-7888

(TTY: 1-877-681-8898).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-888-775-7888 (TTY: 1-877-681-8898) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-775-7888 (телетайп: 1-877-681-8898)

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

1-888-775-7888 (TTY:1-877-681-8898) .

Hindi: ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।

1-888-775-7888 (TTY: 1-877-681-8898) पर कॉल कर।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1-888-775 7888 (TTY: 1-877-681-8898) まで、お電話にてご連絡ください。

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-775-7888

(TTY (հեռատիպ)՝ 1-877-681-8898):

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-888-775 7888 (TTY: 1-877-681-8898) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-775-7888 (TTY: 1-877-681-8898)។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-775 7888 (TTY: 1-877-681-8898).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-775 7888 (TTY: 1-877-681-8898).

Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-775-7888 (TTY: 1-877-681-8898) تماس بگیرید.

Lao (Laotian):

ຄວາມສົນໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດຕິດຕໍ່ເບີຂ້າງລຸ່ມນີ້ ເພື່ອຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໄດ້.

ໂທຫາເບີ 1-888-775-7888 (TTY: 1-877-681-8898).

Balance by CCHP

CALL

1-877-256-2477

VISIT ONLINE

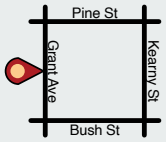
www.CCHPHealthPlan.com/family-shopping

VIRTUAL MEETING

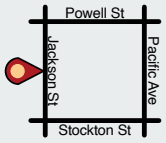
Call or email our sales team for an appointment.
(Sales@CCHPHealthPlan.com)

VISIT

San Francisco Office:
445 Grant Avenue, San Francisco, CA 94108



San Francisco Chinatown (Chinese Hospital):
845 Jackson Street, San Francisco, CA 94133



Daly City Office:
386 Gellert Boulevard, Daly City, CA 94015