Introducing Balance

Your Path to Wellness starts here.

2024 Health Plans for Employer Groups

No Cost One Medical Offer
Look inside

Balance by CCHP

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About Balance

We are a Bay Area Original

Balance is by CCHP, a full-service health plan with 40-years of experience under our belt. So, we know a thing or two about this diverse and dynamic place where we live and work.

Our plans are for companies based in San Francisco or San Mateo County. Understanding today's distributed nature of workforces around the Bay Area, we extend the coverage area to Alameda and Contra Costa counties for employees who reside there.

We're Focused on Wellness

Free preventive screenings, telehealth, health education and fitness classes, in-person and virtually. You decide how you want to achieve your optimal health, conveniently and safely.

One Medical OFFER

Ask about how you and your employees can get One Medical membership at no cost.

Why Balance

"My health plan is Balance from CCHP. Over the years, I have appreciated that Balance account team offered me different options and helped me make the best possible decision. They always go the extra distance."
- Mr. Hau Chung Lai, eCircle Investment, Inc.

Your Employees Deserve Balance Quality

Balance group plans enable you to provide quality, affordable health coverage for your employees. A quality health plan keeps your employees healthy and more productive. It also helps attract and retain valuable employees. They can enjoy peace-of-mind by providing a way to keep themselves and their families healthy.

We work closely with our ever-growing provider network of over 7,000 healthcare providers and work with virtually every hospital in the area to keep our costs down for our Member's employers and employees.

Many of our providers offer telehealth for added convenience for busy professionals.

Plans to Suit Your Business Needs

Balance plans are available to employers and employees who live or work in San Francisco or San Mateo counties - with extended coverage for employees who live in Alameda or Contra Costa counties.

- **We welcome groups of all sizes - as few as one employee or hundreds**
- **You choose plans with variety of copayment and premium options**
- **We offer an HSA compatible high-deductible health plans (HDHP)**
- **Dedicated, local account manager to serve you**

For many of our employer group clients who operate in San Francisco, our plans help you stay in compliance with local health ordinances, Health Care Accountability and Health Care Security Ordinances (HCAO/HCSO). These multiple regulations can lead to different coverage needs.

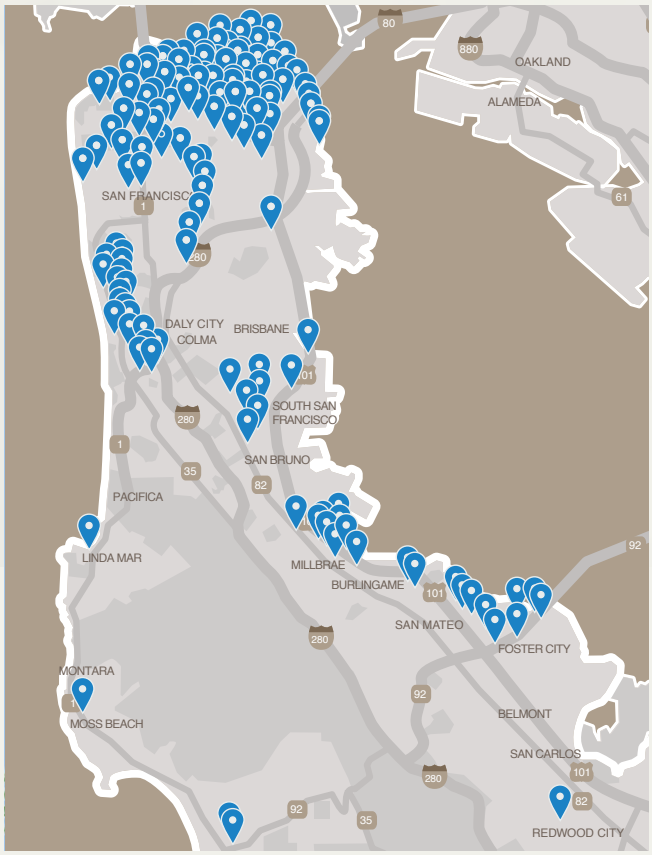
Access to Care

Large Network of Doctors and Hospitals

Access to Care

With every plan, you and your employees get an in-network choice of over 7,000 conveniently located doctors, specialists, and facilities in our San Francisco and San Mateo county service area. And more, extending into Alameda and Contra Costa counties.

Includes: Hill Physicians, One Medical, and Jade Health. You also get access to CPMC (Sutter), Chinese Hospital, Dignity, Seton, Stanford, and UCSF.



Hill Physicians

one medical

Jade HEALTH CARE MEDICAL GROUP 翡翠東華醫師協會

Dignity Health.

Sutter Health

CHINESE HOSPITAL

AHMC Seton Medical Center

Stanford HEALTH CARE

UCSF Health

One Medical at No Cost? Sounds like a plan!

Now, all employees and covered dependents have immediate, no cost access to One Medical, a concierge-like doctor's office for busy employers and employees. 24/7 virtual or same-day appointments make it super convenient to take care of business of your employee's health.

Joining is simple. Complete a brief Initial Health Assessment (IHA) questionnaire.

No Ordinary Doctor's Office

One Medical is known for welcoming neighborhood locations, the ability to see a doctor right away, and appointments that don't feel rushed. Your no-cost membership makes a great plan even better with:

- **Care for everything** from common illnesses to chronic diseases and mental health—plus lab work, vaccines, and preventative care
- **Urgent in-office visits** with expanded hours 7 days a week and 38 convenient locations throughout the Bay Area
- **24/7 virtual care** to message your care team, schedule video visits, and book same or next-day appointments

one medical

Get One Medical at no cost in 3 simple steps

We'll cover your membership for a full year - including enrolled family members.

1. Click the One Medical box on the Balance Plan enrollment application
2. Complete the Initial Health Assessment (IHA) questionnaire
3. Go to One Medical website to activate your One Medical membership

Balance by CCHP

one medical

Our Products

We offer several types of plan options so you can select the right level of coverage to fit your business.

Balance Ruby Series 10/20/40: Comprehensive Plans

Ruby Series is the right choice for groups who want the peace-of-mind of comprehensive coverage and may use medical services regularly.

- $0 copays for preventive care
- For other primary care services, you choose the copay that's best for your group ($10/$20/$40)
- Fixed copayment for most covered services so you and your employees can enjoy predictable health care costs — you'll know your out-of-pocket costs in advance.

Balance Opal Series 25/50: Economical Plans

Opal Series is the popular option for health-conscious and budget-minded employers who don't foresee using many medical services.

- Lower monthly premiums
- Includes $0 copay for preventive services

Balance Metal Plans: Off-Exchange Mirror Plans

For employers looking for plans like those on the Covered CA exchange but prefer to work directly with us.

- Range of cost shares
- Range of premiums to suit any company

Ask about our large group plans tailored to your diverse needs.

Optional Dental & Vision Coverage

Balance employer group plans include pediatric vision and dental coverage. For adults, we offer optional supplemental plans.

DELTA DENTAL®

Balance offers dental coverage through our partner, Delta Dental, nation's leading provider of dental insurance. Having Delta Dental coverage means access to their network of dentists for professional and reliable care. You'll also get preventive care, like regular cleanings and exams, at low or no cost. Be sure to ask about this important coverage.

Monthly Rate: $18.05

vsp optics

Balance's optional vision coverage is offered through our partner, VSP, one of the leading vision insurance providers. VSP doctors provide personalized care that focuses on keeping your eyes healthy. When you see a VSP doctor, you will enjoy lower out-of-pocket costs for care and have access to hundreds of eye glass frame options from leading brands.

Monthly Rate: $3.54

Ask about our comprehensive, affordable coverage details and rates.

Value Added Services

It is our mission to help you and your family members attain optimal health. We offer a variety of ways for you to stay healthy, well and productive.

Balance Member Portal

Member Services – 2 walk-in locations
(San Francisco and Daly City)

Quarterly Community Health Newsletter

Free Fitness classes like yoga, qigong and tai chi

Wellness classes on topics like perinatal and healthy eating

Acupuncture services

Programs for managing chronic conditions like diabetes and to help quit smoking

Convenient access to Urgent Care centers for non-emergencies

24/7 Nurse Advice Line

2024 Plans
Benefit Highlights & Rates

► **For San Francisco and San Mateo Counties**

The following pages provide a side-by-side comparison of the key 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.

1-877-224-7918
(TTY: 1-877-681-8898)

Sales@BalanceByCCHP.com

Balance by CCHP

2024 Plan Benefit Highlights

Plan Name	Ruby 10 Platinum HMO	Ruby 20 Platinum HMO	Ruby 40 Platinum HMO	Opal 25 HMO
Metal Level / Actuarial Value %[1]	Platinum / 91.99%	Platinum / 91.99 %	Platinum / 89.68%	Gold / 81.59 %
SERVICES AND FEATURES				
Annual Deductible	$0	$0	$0	Individual $2,100 / Family $4,200 [3]
Out–of–Pocket Limit on Expenses	Individual $2,475 / Family $4,950	Individual $2,500 / Family $5,000	Individual $3,000 / Family $6,000	Individual $5,800 / Family $11,600
LIFETIME MAXIMUMS	No Limit			
PROFESSIONAL SERVICES	**Member Cost Share**			
Preventive Care/ Screening/Immunization	$0 Copay			
Primary Care Physician (PCP) Visit to Treat an Injury or Illness	$10 Copay	$20 Copay	$40 Copay	$30 Copay
Specialist Visit	$30 Copay	$20 Copay	$40 Copay	$30 Copay
Maternity Care - Preconception/ Prenatal/Postnatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$150 Copay Per Day (Up to First 5 Days)	$150 Copay Per Day (Up to First 5 Days)	$250 Copay Per Day (Up to First 5 Days)	$250 Copay Per Day (Up to First 5 Days) (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay	$0 Copay	$0 Copay	$0 Copay
OUTPATIENT SERVICES				
Laboratory Tests & X-Rays	Laboratory: $15 Copay X-Ray: $10 Copay	$10 Copay	$10 Copay	$25 Copay
Imaging (CT/PET Scans, MRIs)	$180 Copay	$150 Copay	$150 Copay	$250 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 Copay (Chinese Hospital) / $300 Copay (Other Facilities)	$100 Copay (Chinese Hospital) / $300 Copay (Other Facilities)	$150 Copay (Chinese Hospital) / $450 Copay (Other Facilities)	$250 Copay (Chinese Hospital) / $750 Copay (Other Facilities) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay

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.

Opal 50 HMO	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP HMO
Silver / 71.93%	Platinum / 89.38%	Gold / 80.62%	Silver / 71.99%	Bronze / 64.00%	Bronze / 64.94%
Individual $3,800 / Family $7,600 (3)	$0	Individual $250 / Family $500	Individual $2,500 / Family $5,000 (3)	Individual $6,300 / Family $12,600 (3)	Individual $7,050 / Family $14,100 (3) (Combined Medical/ Drug Deductible)
Individual $9,100 / Family $18,200	Individual $4,500 / Family $9,000	Individual $7,800/ Family $15,600	Individual $8,750/ Family $17,500	Individual $8,200 / Family $16,400	Individual $7,050 / Family $14,100
	No Limit				
	Member Cost Share				
	$0 Copay				
$50 Copay	$20 Copay	$35 Copay	$55 Copay	$65 Copay (Deductible Applies after First 3 Non-Preventive Visits)	0% Coinsurance (After Deductible)
$100 Copay	$30 Copay	$55 Copay	$110 Copay	$95 Copay (Deductible Applies after First 3 Non-Preventive Visits)	0% Coinsurance (After Deductible)
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
$250 Copay Per Day (Up to First 5 Days) (After Deductible)	$250 per day (Up to the First 5 Days)	$600 per day (Up to the First 5 Days) (After Deductible)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$0 Copay	$0 Copay	$0 Copay	40% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Laboratory: $50 Copay X-Ray: $100 Copay	Laboratory: $20 Copay X-Ray: $30 Copay	Laboratory: $35 Copay X-Ray: $55 Copay	Laboratory: $55 Copay X-Ray: $90 Copay	Laboratory: $40 Copay X-Ray: 40% Coinsurance (After Deductible for X-Ray)	0% Coinsurance (After Deductible)
$285 Copay	$100 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$300 Copay (Chinese Hospital) / $750 Copay (Other Facilities) (After Deductible)	$100 Copay	$300 Copay (After Deductible)	35% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$0 Copay	$25 Copay	$35 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)

Balance by CCHP

2024 Plan Benefit Highlights

Plan Name	Ruby 10 Platinum HMO	Ruby 20 Platinum HMO	Ruby 40 Platinum HMO	Opal 25 HMO
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)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Facilities) (Up to First 5 Days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay
EMERGENCY HEALTH COVERAGE				
Emergency Room Services (waived if admitted)	$200 Copay	$200 Copay	$200 Copay	$250 Copay (After Deductible)
Professional Services (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Center	$10 Copay	$20 Copay	$40 Copay	$25 Copay
PRESCRIPTION DRUG COVERAGE				
Annual Rx Deductible	$0	$0	$0	Individual $250 / Family $500
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	$5 Copay	$5 Copay	$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$15 Copay	$15 Copay	$15 Copay	$30 Copay (After Rx Deductible)
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$25 Copay	$25 Copay	$60 Copay (After Rx Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250 Per Prescription	10% Coinsurance up to $250 Per Prescription	10% Coinsurance up to $250 Per Prescription	20% Coinsurance up to $250 Per Prescription (After Rx Deductible)
PEDIATRIC VISION AND DENTAL (Included in Plan)				
Child Needs Eye Care (Ages 0-18)				
Eye Exam (1 Per Calendar Year)	$0 Copay			
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay			
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single vision, lined bifocal, and lined trifocal lenses No Cost Share			
Eyewear (Contact Lenses)	$0 Copay			
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.			

Footnotes: (1) Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
(2) Medical / RX cost-sharing contributes toward annual deductible.
(3) 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 health plan benefit and coverage matrix to see when the deductible starts over (usually, but not always, January 1st).

Opal 50 HMO	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP HMO
	Member Cost Share				
$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days) (After Deductible)	$250 Per Day (Up to First 5 Days)	$600 Per Day (Up to First 5 Days) (After Deductible)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$0 Copay	$0 Copay	$0 Copay	40% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$300 Copay (After Deductible)	$150 Copay	$250 Copay (After Deductible)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	0% Coinsurance (After Deductible)
$50 Copay	$20 Copay	$35 Copay	$55 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	0% Coinsurance (After Deductible)
Individual $700 / Family $1,400 (3)	$0	$0	Individual $300 / Family $600	Individual $500 / Family $1,000	Individual $7,050/ Family $14,100 (Combined Medical/ Drug Deductible)
$30 Copay (After Deductible)	$5 Copay	$15 Copay	$ 19 Copay	$18 Copay (After Rx Deductible)	0% Coinsurance (After Deductible)
$80 Copay (After Deductible)	$20 Copay	$40 Copay	$ 85 Copay (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
$95 Copay (After Deductible)	$30 Copay	$70 Copay	$110 Copay (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
20% Coinsurance up to $250 Per Prescription (After Deductible)	10% Coinsurance up to $250 Per Prescription	20% Coinsurance up to $250 Per Prescription	30% Coinsurance Up to $250 Per Prescription (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
	$0 Copay				
	$0 Copay				
	Single vision, lined bifocal, and lined trifocal lenses No Cost Share				
	$0 Copay				
	Included in Plan. See Dental Summary Page.				

Balance by CCHP

Employer Group Plans

2024 Monthly Rates | San Francisco County

January 1 - December 31, 2024

	Ruby 10 HMO Platinum	Ruby 20 HMO Platinum	Ruby 40 HMO Platinum	Opal 25 HMO Gold	Opal 50 HMO Silver
AGE	RATE / 月費	RATE	RATE	RATE	RATE
0-14	$406.43	$398.58	$376.01	$326.71	$294.33
15	$442.55	$434.01	$409.43	$355.75	$320.50
16	$456.37	$447.55	$422.21	$366.86	$330.50
17	$470.18	$461.10	$434.99	$377.96	$340.50
18	$485.05	$475.69	$448.76	$389.92	$351.28
19	$499.93	$490.28	$462.52	$401.88	$362.05
20	$515.34	$505.39	$476.77	$414.26	$373.21
21	$531.28	$521.02	$491.52	$427.07	$384.75
22	$531.28	$521.02	$491.52	$427.07	$384.75
23	$531.28	$521.02	$491.52	$427.07	$384.75
24	$531.28	$521.02	$491.52	$427.07	$384.75
25	$533.40	$523.10	$493.48	$428.78	$386.29
26	$544.03	$533.52	$503.31	$437.32	$393.98
27	$556.78	$546.02	$515.11	$447.57	$403.22
28	$577.50	$566.34	$534.28	$464.23	$418.22
29	$594.50	$583.02	$550.01	$477.89	$430.54
30	$603.00	$591.35	$557.87	$484.73	$436.69
31	$615.75	$603.86	$569.67	$494.98	$445.93
32	$628.50	$616.36	$581.47	$505.23	$455.16
33	$636.47	$624.18	$588.84	$511.63	$460.93
34	$644.97	$632.51	$596.70	$518.47	$467.09
35	$649.22	$636.68	$600.64	$521.88	$470.16
36	$653.47	$640.85	$604.57	$525.30	$473.24
37	$657.72	$645.02	$608.50	$528.72	$476.32
38	$661.97	$649.19	$612.43	$532.13	$479.40
39	$670.47	$657.52	$620.30	$538.97	$485.55
40	$678.97	$665.86	$628.16	$545.80	$491.71
41	$691.72	$678.36	$639.96	$556.05	$500.94
42	$703.94	$690.35	$651.26	$565.87	$509.79
43	$720.94	$707.02	$666.99	$579.54	$522.11
44	$742.19	$727.86	$686.65	$596.62	$537.50
45	$767.16	$752.35	$709.75	$616.69	$555.58
46	$796.91	$781.52	$737.28	$640.61	$577.13
47	$830.38	$814.35	$768.24	$667.51	$601.36
48	$868.64	$851.86	$803.63	$698.26	$629.07
49	$906.36	$888.85	$838.53	$728.59	$656.38
50	$948.86	$930.53	$877.85	$762.75	$687.16
51	$990.83	$971.69	$916.68	$796.49	$717.56
52	$1037.05	$1017.02	$959.44	$833.65	$751.03
53	$1083.80	$1062.87	$1002.70	$871.23	$784.89
54	$1134.27	$1112.37	$1049.39	$911.80	$821.44
55	$1184.75	$1161.87	$1096.09	$952.37	$857.99
56	$1239.47	$1215.53	$1146.71	$996.36	$897.62
57	$1294.72	$1269.72	$1197.83	$1040.78	$937.64
58	$1353.69	$1327.55	$1252.39	$1088.18	$980.34
59	$1382.91	$1356.20	$1279.42	$1111.67	$1001.50
60	$1441.88	$1414.04	$1333.98	$1159.08	$1044.21
61	$1492.89	$1464.05	$1381.17	$1200.07	$1081.15
62	$1526.36	$1496.88	$1412.13	$1226.98	$1105.39
63	$1568.33	$1538.04	$1450.96	$1260.72	$1135.78
64+	$1593.82	$1563.04	$1474.55	$1281.21	$1154.24

- 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 15 and older are charged premiums based on their ages.

	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP
AGE	RATE	RATE	RATE	RATE	RATE
0-14	$393.18	$364.48	$302.43	$242.58	$241.84
15	$428.13	$396.88	$329.31	$264.14	$263.34
16	$441.49	$409.27	$339.59	$272.39	$271.56
17	$454.86	$421.66	$349.87	$280.63	$279.78
18	$469.25	$435.00	$360.94	$289.51	$288.63
19	$483.64	$448.34	$372.01	$298.39	$297.48
20	$498.54	$462.16	$383.47	$307.59	$306.65
21	$513.96	$476.45	$395.33	$317.10	$316.14
22	$513.96	$476.45	$395.33	$317.10	$316.14
23	$513.96	$476.45	$395.33	$317.10	$316.14
24	$513.96	$476.45	$395.33	$317.10	$316.14
25	$516.02	$478.35	$396.91	$318.37	$317.40
26	$526.30	$487.88	$404.82	$324.71	$323.72
27	$538.63	$499.32	$414.31	$332.32	$331.31
28	$558.68	$517.90	$429.72	$344.69	$343.64
29	$575.12	$533.15	$442.38	$354.83	$353.76
30	$583.35	$540.77	$448.70	$359.91	$358.81
31	$595.68	$552.20	$458.19	$367.52	$366.40
32	$608.02	$563.64	$467.68	$375.13	$373.99
33	$615.73	$570.79	$473.61	$379.88	$378.73
34	$623.95	$578.41	$479.93	$384.96	$383.79
35	$628.06	$582.22	$483.09	$387.49	$386.32
36	$632.17	$586.03	$486.26	$390.03	$388.85
37	$636.29	$589.84	$489.42	$392.57	$391.38
38	$640.40	$593.66	$492.58	$395.10	$393.91
39	$648.62	$601.28	$498.91	$400.18	$398.96
40	$656.84	$608.90	$505.23	$405.25	$404.02
41	$669.18	$620.34	$514.72	$412.86	$411.61
42	$681.00	$631.29	$523.81	$420.16	$418.88
43	$697.45	$646.54	$536.46	$430.30	$429.00
44	$718.01	$665.60	$552.28	$442.99	$441.64
45	$742.16	$687.99	$570.86	$457.89	$456.50
46	$770.94	$714.67	$593.00	$475.65	$474.20
47	$803.32	$744.69	$617.90	$495.62	$494.12
48	$840.33	$778.99	$646.37	$518.46	$516.88
49	$876.82	$812.82	$674.43	$540.97	$539.33
50	$917.94	$850.94	$706.06	$566.34	$564.62
51	$958.54	$888.58	$737.29	$591.39	$589.59
52	$1003.25	$930.03	$771.69	$618.98	$617.10
53	$1048.48	$971.96	$806.47	$646.88	$644.92
54	$1097.31	$1017.22	$844.03	$677.00	$674.95
55	$1146.14	$1062.48	$881.59	$707.13	$704.98
56	$1199.07	$1111.56	$922.31	$739.79	$737.55
57	$1252.53	$1161.11	$963.42	$772.77	$770.42
58	$1309.58	$1213.99	$1007.30	$807.97	$805.52
59	$1337.84	$1240.20	$1029.05	$825.41	$822.90
60	$1394.89	$1293.08	$1072.93	$860.60	$857.99
61	$1444.23	$1338.82	$1110.88	$891.05	$888.34
62	$1476.61	$1368.84	$1135.79	$911.02	$908.26
63	$1517.22	$1406.48	$1167.02	$936.07	$933.23
64+	$1541.88	$1429.34	$1185.98	$951.28	$948.40

Balance by CCHP

Employer Group Plans

2024 Monthly Rates | San Mateo County

January 1 - December 31, 2024

	Ruby 10 HMO Platinum	Ruby 20 HMO Platinum	Ruby 40 HMO Platinum	Opal 25 HMO Gold	Opal 50 HMO Silver
AGE	RATE	RATE	RATE	RATE	RATE
0-14	$438.96	$430.48	$406.11	$352.86	$317.90
15	$477.98	$468.75	$442.21	$384.23	$346.15
16	$492.90	$483.38	$456.01	$396.22	$356.96
17	$507.82	$498.01	$469.82	$408.22	$367.76
18	$523.89	$513.77	$484.68	$421.13	$379.40
19	$539.95	$529.52	$499.55	$434.05	$391.03
20	$556.59	$545.84	$514.94	$447.42	$403.08
21	$573.81	$562.72	$530.87	$461.26	$415.55
22	$573.81	$562.72	$530.87	$461.26	$415.55
23	$573.81	$562.72	$530.87	$461.26	$415.55
24	$573.81	$562.72	$530.87	$461.26	$415.55
25	$576.10	$564.98	$532.99	$463.11	$417.21
26	$587.58	$576.23	$543.61	$472.33	$425.52
27	$601.35	$589.74	$556.35	$483.40	$435.50
28	$623.73	$611.68	$577.05	$501.39	$451.70
29	$642.09	$629.69	$594.04	$516.15	$465.00
30	$651.27	$638.69	$602.53	$523.53	$471.65
31	$665.04	$652.20	$615.27	$534.60	$481.62
32	$678.81	$665.70	$628.01	$545.67	$491.60
33	$687.42	$674.14	$635.98	$552.59	$497.83
34	$696.60	$683.15	$644.47	$559.97	$504.48
35	$701.19	$687.65	$648.72	$563.66	$507.80
36	$705.78	$692.15	$652.97	$567.35	$511.13
37	$710.37	$696.65	$657.21	$571.04	$514.45
38	$714.96	$701.16	$661.46	$574.73	$517.78
39	$724.14	$710.16	$669.95	$582.11	$524.43
40	$733.32	$719.16	$678.45	$589.49	$531.07
41	$747.10	$732.67	$691.19	$600.56	$541.05
42	$760.29	$745.61	$703.40	$611.17	$550.60
43	$778.66	$763.62	$720.39	$625.93	$563.90
44	$801.61	$786.13	$741.62	$644.38	$580.52
45	$828.58	$812.57	$766.57	$666.06	$600.06
46	$860.71	$844.09	$796.30	$691.89	$623.33
47	$896.86	$879.54	$829.74	$720.95	$649.51
48	$938.17	$920.06	$867.97	$754.16	$679.43
49	$978.91	$960.01	$905.66	$786.91	$708.93
50	$1024.82	$1005.03	$948.13	$823.81	$742.17
51	$1070.15	$1049.48	$990.07	$860.25	$775.00
52	$1120.07	$1098.44	$1036.25	$900.38	$811.16
53	$1170.56	$1147.96	$1082.97	$940.97	$847.72
54	$1225.08	$1201.42	$1133.40	$984.79	$887.20
55	$1279.59	$1254.88	$1183.83	$1028.61	$926.68
56	$1338.69	$1312.84	$1238.51	$1076.12	$969.48
57	$1398.37	$1371.36	$1293.72	$1124.09	$1012.70
58	$1462.06	$1433.82	$1352.65	$1175.29	$1058.82
59	$1493.62	$1464.77	$1381.84	$1200.66	$1081.68
60	$1557.31	$1527.24	$1440.77	$1251.86	$1127.80
61	$1612.40	$1581.26	$1491.73	$1296.14	$1167.70
62	$1648.55	$1616.71	$1525.18	$1325.20	$1193.88
63	$1693.88	$1661.16	$1567.12	$1361.64	$1226.71
64+	$1721.41	$1688.16	$1592.59	$1383.77	$1246.64

- 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 15 and older are charged premiums based on their ages.

	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP
AGE	**RATE**	**RATE**	**RATE**	**RATE**	**RATE**
0-14	$424.66	$393.66	$326.64	$262.00	$261.20
15	$462.40	$428.65	$355.67	$285.29	$284.42
16	$476.84	$442.03	$366.77	$294.19	$293.30
17	$491.27	$455.41	$377.88	$303.10	$302.18
18	$506.81	$469.82	$389.83	$312.69	$311.74
19	$522.36	$484.23	$401.79	$322.28	$321.30
20	$538.45	$499.15	$414.17	$332.21	$331.20
21	$555.11	$514.59	$426.98	$342.48	$341.44
22	$555.11	$514.59	$426.98	$342.48	$341.44
23	$555.11	$514.59	$426.98	$342.48	$341.44
24	$555.11	$514.59	$426.98	$342.48	$341.44
25	$557.33	$516.65	$428.69	$343.85	$342.81
26	$568.43	$526.94	$437.23	$350.70	$349.64
27	$581.75	$539.29	$447.47	$358.92	$357.83
28	$603.40	$559.36	$464.13	$372.28	$371.15
29	$621.16	$575.83	$477.79	$383.24	$382.08
30	$630.05	$584.06	$484.62	$388.72	$387.54
31	$643.37	$596.41	$494.87	$396.94	$395.73
32	$656.69	$608.76	$505.12	$405.16	$403.93
33	$665.02	$616.48	$511.52	$410.29	$409.05
34	$673.90	$624.71	$518.35	$415.77	$414.51
35	$678.34	$628.83	$521.77	$418.51	$417.24
36	$682.78	$632.95	$525.18	$421.25	$419.98
37	$687.22	$637.06	$528.60	$423.99	$422.71
38	$691.66	$641.18	$532.02	$426.73	$425.44
39	$700.54	$649.41	$538.85	$432.21	$430.90
40	$709.43	$657.65	$545.68	$437.69	$436.37
41	$722.75	$670.00	$555.93	$445.91	$444.56
42	$735.52	$681.83	$565.75	$453.79	$452.41
43	$753.28	$698.30	$579.41	$464.75	$463.34
44	$775.48	$718.88	$596.49	$478.45	$477.00
45	$801.57	$743.07	$616.56	$494.55	$493.05
46	$832.66	$771.89	$640.47	$513.72	$512.17
47	$867.63	$804.30	$667.37	$535.30	$533.68
48	$907.60	$841.36	$698.11	$559.96	$558.26
49	$947.01	$877.89	$728.43	$584.28	$582.50
50	$991.42	$919.06	$762.58	$611.67	$609.82
51	$1035.27	$959.71	$796.31	$638.73	$636.79
52	$1083.57	$1004.48	$833.46	$668.53	$666.50
53	$1132.42	$1049.76	$871.04	$698.67	$696.55
54	$1185.15	$1098.65	$911.60	$731.20	$728.98
55	$1237.89	$1147.54	$952.16	$763.74	$761.42
56	$1295.06	$1200.54	$996.14	$799.01	$796.59
57	$1352.79	$1254.06	$1040.55	$834.63	$832.10
58	$1414.41	$1311.18	$1087.94	$872.65	$870.00
59	$1444.94	$1339.48	$1111.42	$891.48	$888.78
60	$1506.56	$1396.60	$1158.82	$929.50	$926.68
61	$1559.85	$1446.00	$1199.81	$962.38	$959.46
62	$1594.82	$1478.42	$1226.71	$983.95	$980.97
63	$1638.67	$1519.07	$1260.44	$1011.01	$1007.94
64+	$1665.31	$1543.76	$1280.93	$1027.44	$1024.32

Employer Group Plan
Application Submission Checklist

Thank you for choosing Balance by CCHP for your group coverage. This checklist will help you gather and submit all required documents to start coverage. All new group applications must provide information supporting its qualification for employer group coverage. A new group must demonstrate it has been in business for a minimum of six (6) weeks, with a least one (1) employee working an average of thirty (30) hours or more per week. An employer with 1-100 full-time employees qualifies for Small Group plans and groups with 100+ employees are considered large groups. A Small Group is eligible for guaranteed issue and renewability when they meet and continue to satisfy the Small Group definition under California state regulations.

Please use this checklist to include the following documents when submitting the Master Group Application to ensure prompt processing.

- ☐ A signed original Employer Master Group Application
- ☐ If a Broker is involved, please complete Section 10 of the Master Group Application.
- ☐ A copy (all pages) of the most recent state Quarterly Wage and Tax Report (DE9C).
  - ○ Please indicate each employee's status on the DE9C using the following codes:

T	Terminated (including termination date)	**PT**	Part Time
E	Eligible and enrolling	**WP**	Waiting Period (include date of hire for those in waiting period)
W	Eligible and waving coverage	**TEMP**	Temporary Employees
S	Seasonal		

  - ○ For all employees that do not appear on the current DE9C, a copy of the most recent payroll is required.
  - ○ Proof of Worker's Compensation.
  - ○ If the group has not been in business long enough to have a DE9C, six weeks of payroll, including withholdings, may be submitted.
- ☐ A copy of the current carrier's most recent billing statement (all pages) if applicable.

  Employees appearing on the current bill with a reported termination date of 90 days or greater will be required a COBRA application or waiver form to be completed as verification of their eligibility to continue or decline coverage.
- ☐ Enrollment forms completed and signed by all eligible employee(s) enrolling / waiving coverage.
- ☐ If Medicare is primary, a copy of each employee's Medicare card is required to verify enrollment in parts A and B. A copy of the Medicare card is also required to confirm participation requirements.
- ☐ **First month premium check made payable to CCHP.**

Submit the completed forms with first month premium check:

Mail
CCHP Sales Department
445 Grant Avenue
San Francisco, CA 94108

OR

Submit to your Agent/Broker

Please call Sales Department at 1-888-371-3060 if you need assistance.

Please Retain a Copy of the Application for Your Records

Revised 1/16/20

Proof of Ownership/Company Structure:

Required for groups of any size. This documentation is used to verify that the prospective client is a legitimate, active Small Group eligible for coverage. The information is also used to verify that an owner, officer or partner is actively engaged in the business for eligible for coverage. CCHP may conduct online searches to validate filings and other documentation. CCHP may decline a group for coverage if a search is not successful.

☐ **Sole Proprietorship:**
- ○ Most recent IRS Schedule C (Form 1040), or
- ○ California Business License, or
- ○ Fictitious Business Name Statement, if any

Partnership and Sole Proprietorship (Individual & Husband/Wife)

Business must have a minimum of one (1) DE9C/employee on the payroll.
- Partnerships where the only employees are the partners themselves **do not** qualify for small group coverage
- Partnerships where the only employees are the partners and/or the spouse of the partners **do not** qualify for small group coverage
- Sole proprietors where the only employee is the sole proprietor **do not** qualify for small group coverage
- Sole proprietors where the only employee(s) is the sole proprietor and/or its spouse **do not** qualify for small group coverage

☐ **Partnership:**
- ○ IRS Schedule K-1 (Form 1065) for all enrolling partners, or
- ○ Partnership Agreement signed by each partner plus a federal EIN assignment letter

☐ **Corporation:**
- ☐ S-Corps: IRS Schedule K-1 (Form1120S) for all enrolling owners/officers.
- ☐ C-Corps: IRS Form 1120 (pages 1 & 2) which includes “Schedule E”
- ☐ Statement of Information (Form LLC-12)

☐ **LLC:**
- ☐ LLC Agreement signed by all managers/members/parties or copies of appropriate tax returns(follow the guidelines for an S-Corp, Partnership or Sole Proprietorship based on how the LLC was formed), or
- ☐ Statement of Information (Form LLC-12)

New/Start-up Businesses

New/Start-up Businesses typically may meet all the underwriting requirements with the exception of the length of time they have been in business. CCHP will consider groups that have been in business for at least six (6) weeks, but retains the right to defer the group until the California Small Group requirements have been met. To obtain approval for a New/Start-up Business, the following may be required:

- Payroll records or applicable filings indicating the length of time the group has been in business. These documents must span the twelve (12) weeks preceding the effective date and demonstrate one or more eligible employees for the entire period. Payroll records must include all pages for all pay periods and list the following:
  - Company name;
  - Type of Company (see above)
  - Date of pay periods; and
  - Employee names, wages paid, withholdings and grand totals
- Individual payroll/pay stubs, estimated payroll, payroll summaries or handwritten journals are not deemed acceptable.

Master Group Application

Group Sales: Tel: 1-888-371-3060 | Fax: 1-415-955-8819

Balance by 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.

1. Employer Group Information

Full Legal Business Name:	How Long in Business:	Type of Business (Be Specific):	Effective Date: (MM/DD/YY) / /
Primary Group Administrator Contact:	Title:	Phone:	Email:
Secondary Group Administrator Contact	Title:	Phone:	Email:
Federal Employer ID #:	State Employer ID #:	Fax:	Send administrative kit to: ☐ Employer ☐ Agent/Broker
Business Physical Address, City, State, ZIP (No P.O. Box):			
Billing Contact:	Title:	Phone:	Email:
Billing Address, City, State, ZIP (if different from above):			

Type of Entity: ☐ Corporation ☐ Sole Proprietorship ☐ S-Corporation ☐ Partnership ☐ Other (explain) _____

2. Employer Group Plan Coverage Selection

Medical Plans ☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver
☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

Optional Riders (Applies to all Balance Enrollees) ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (CCHP Use Only):

3. Employer Premium Contribution

Employee (min. 50%): $ / %

Dependent: $ / %

4. Employees Will Be Eligible for Benefits Upon

1st of the month following: ☐ Date of Hire ☐ 30 days ☐ 60 days

Other _____

5. Number of Employees (Employer is responsible for collecting refusal of coverage forms)

Total # of employees:	Total # of eligible employees (30+hrs/week):	
Total # of eligible employees enrolled in Balance:	Total # of employees who wavie coverage:	Annual average # of employees:

6. Current Carrier Information

Name of your current group medical insurance carrier(s):

Are you intending to replace your existing group coverage? ☐ No ☐ Yes, Termination Date / /

Current Workers' Compensation Carrier:	Next Renewal Date (MM/DD/YY): / /

DMHC Approval:11/09/17 REV 11/14/2022

7. COBRA / CAL-COBRA Information

Is your group currently subject to COBRA or CAL-COBRA? ☐ No ☐ Yes, please complete the following for each person

1	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /
2	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /

8. Form of Member *Evidence of Coverage and Notices*

Employer are responsible for the distribution of the Evidence of Coverage and Notices to your covered employees. Electronic versions will be distributed to you upon request. Employer is responsible for distributing the documents using one of the following methods; 1.) posting on the employer's intranet for employee access or, 2) emailing these documents directly to their employees. Printed versions will only be mailed to the employer directly upon request.

☐ I elect to receive printed, not electronic, Evidence of Coverage and Notices. I understand that I am responsible for distributing the documents to my covered employees.

9. Signature and Conditional Receipt

This is an application for coverage only. The group understands that no contract for coverage will exist until CCHP has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service/group policy will be issued. The group's representative certifies to the best of his or her knowledge and belief, all of the responses given are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, CCHP may pursue one of the following remedies: coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the Health Service Contract/Insurance policy may be rescinded.

We, the employer, warrant that all information in this application is true and complete, and that CCHP may rely on this application in deciding whether to provide coverage. If the application is not complete, CCHP reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by CCHP and only if we have paid our first month's contribution and this application is accepted, and that we should keep prior coverage in force until notified of acceptance by CCHP. If this application is accepted, it becomes a part of our contract with CCHP.

We 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 us and CCHP and any of this 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 and Notice.

Signature of Employer/Authorized Representative: X	Print Name:	Title:	Date (MM/DD/YY): / /

10. Agent/Broker Certification (To be completed by your agent or broker after completion of this application)

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by applicant. 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.

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.

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

CCHP Use Only

Sales Representative / Sales Executive [ ]	Sales Manager [ ]	COO [ ]
Payment [CC / Bill / Check #]	Amount [ ]	Date [ ]
Rec'd by Enrollment [ ]	Packet Sent Date [ ]	

Employee Enrollment Form

Group Sales: Tel: 1-888-371-3060 I Fax: 1-415-955-8819

Balance by 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.

Employer Group Information

Employer (Group) Name:		Group Number:
Requested Effective Date (MM/DD/YY): / /	Date of Hire (MM/DD/YY): / /	Employment Status: ☐ Full-time ☐ Part-time

Reason for Application:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Add Dependent(s)

☐ Employee Status Change, Reason _____ ☐ Other Enrollment, Reason _____

Employer Group Plan Coverage Selection

Medical Plans ☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver

☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

Optional Riders (Applies to all CCHP Enrollees) ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

One Medical ☐ YES, I want to JOIN One Medical. **If 'YES' we will assign you a PCP. You are free to change if you decide later.**

Note(s) (Balance Use Only):

1. Employee Information

Last Name:	First Name:	M.I.:
Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Date of Birth (MM/DD/YY): / /	SSN:
Email:	Cell Phone:	Home Telephone:

Home Address, City, State, ZIP (No P.O. Box):

Mailing Address, City, State, ZIP (if different than home address):

Primary Care Physician (PCP):	Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

2. Dependent(s) to be covered or added

☐ **Spouse** ☐ **Domestic Partner**	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP) (*Required for HMO Plans Only*):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander

☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American	☐ Chinese	☐ Korean	☐ Other, please specify:
☐ American	☐ European	☐ Latin American	
☐ Arab	☐ Filipino	☐ Mexican	☐ Unknown
☐ Asian Indian	☐ Hispanic/Latino	☐ Russian	☐ Decline to state
☐ Black	☐ Iranian	☐ Vietnamese	

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify:
_____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 1	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander

☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American
☐ American
☐ Arab
☐ Asian Indian
☐ Black

☐ Chinese
☐ European
☐ Filipino
☐ Hispanic/Latino
☐ Iranian

☐ Korean
☐ Latin American
☐ Mexican
☐ Russian
☐ Vietnamese

☐ Other, please specify:
_____
☐ Unknown
☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)
☐	☐	Arabic
☐	☐	Bulgarian
☐	☐	Chinese (Written)/Cantonese (Spoken)
☐	☐	Chinese (Written /Mandarin (Spoken)
☐	☐	English
☐	☐	Korean

WRITTEN	SPOKEN	
☐	☐	Khmer
☐	☐	Laotian
☐	☐	Persian
☐	☐	Polish
☐	☐	Punjabi
☐	☐	Russian
☐	☐	Spanish

WRITTEN	SPOKEN	
☐	☐	Tagalog
☐	☐	Vietnamese
☐	☐	Other, please specify:
		_____
☐	☐	Unknown
☐	☐	Decline to state

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify:
_____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 2	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify: _____
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish	☐	☐	Unknown
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Decline to state
☐	☐	English	☐	☐	Russian			
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

Dependent # 3	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your ethnicity? (Check all that apply)

- ☐ African American
- ☐ American
- ☐ Arab
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Iranian
- ☐ Korean
- ☐ Latin American
- ☐ Mexican
- ☐ Russian
- ☐ Vietnamese
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)
☐	☐	Arabic
☐	☐	Bulgarian
☐	☐	Chinese (Written)/Cantonese (Spoken)
☐	☐	Chinese (Written /Mandarin (Spoken)
☐	☐	English
☐	☐	Korean
☐	☐	Khmer
☐	☐	Laotian
☐	☐	Persian
☐	☐	Polish
☐	☐	Punjabi
☐	☐	Russian
☐	☐	Spanish
☐	☐	Tagalog
☐	☐	Vietnamese
☐	☐	Other, please specify: _____
☐	☐	Unknown
☐	☐	Decline to state

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Transgender male/ trans man/ female-to-male (FTM)
- ☐ Transgender female/ trans woman/ male-to-female (MTF)
- ☐ Genderqueer (neither exclusively male nor female)
- ☐ Additional gender category or other, please specify: _____
- ☐ Decline to state

What is your sexual orientation?

- ☐ Lesbian or gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please describe: _____
- ☐ Do not know
- ☐ Decline to state

Dependent # 4

Last Name:	First Name:	M.I.:

Date of Birth (MM/DD/YY):
/ /

SSN:

Primary Care Physician (PCP):

Medical Group: *(Leave blank if not known)*

Existing Patient?
☐ Yes ☐ No

What is your race? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your ethnicity? (Check all that apply)

- ☐ African American
- ☐ American
- ☐ Arab
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Iranian
- ☐ Korean
- ☐ Latin American
- ☐ Mexican
- ☐ Russian
- ☐ Vietnamese
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify:

_____

☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe:

_____

☐ Do not know
☐ Decline to state

3. Medicare Information

Is any person applying for coverage currently enrolled with Medicare?

☐ No ☐ Yes, please attach a copy of your Medicare card(s) & Name: _____

4. Disclosure of Personal and Health Information

Balance understands the importance of keeping your and your dependents' personal and health information private. Balance protects this information in electronic, written, and oral forms when used throughout our company. Balance will not disclose this information without your authorization except as permitted by law.
For the purpose of administering your Balance coverage, Balance 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, Balance 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 Balance 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 Balance's website.

5. 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 Balance and any of this 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.

Employee Signature	Employee Name:	Date (MM/DD/YY):
X		/ /
Signature of Employer/Authorized Representative:	**Employer/Authorized Representative Name & Title:**	**Date (MM/DD/YY):**
X		/ /

Privacy Protection of Data

CCHP and Balance by CCHP are required to comply with various State and Federal laws to protect, secure, retain, and maintain confidentiality of your sensitive and personal information. These laws include**, but not limited to**, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare and Medicaid Services (CMS), and the California Consumer Privacy Act (CCPA). Balance has put in place policies and procedures to ensure that access to or use of your personal information is secure.

Policies and processes include standards on how Balance manages access to and the utilization of identified race, ethnicity, preferred language, gender identity and sexual orientation information collected for current or prospective health plan members. Balance discloses its procedures for managing access to and the use of collected race, ethnicity, preferred language, gender identity and sexual information at a minimum, at the time of data collection and on Balance's website Compliance Privacy page at balancebycchp.com/confidentiality-and-compliance-notice/. For questions on these policies, please call the Balance Compliant Hotline at 415-955-8810 or email to CCHPComplianceDept@cchphealthplan.com.

NOTES

For more Information

please contact Balance Sales Department.

Balance by CCHP

In Person

San Francisco Office
445 Grant Avenue
San Francisco, CA 94108

Daly City Office
386 Gellert Boulevard
Daly City, CA 94015

Monday - Friday I 9 a.m. - 5 p.m.

Call or Email

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

1-877-224-7918
(TTY: 1-877-681-8898)

Sales@BalanceByCCHP.com

Balance by CCHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.