

East. West.

Balance your health.

Affordable health coverage integrating
Eastern and Western medicine



2026 Health Plans for Individuals & Family,
Covered California.

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Balance by CCHP combines the best of both worlds

With Balance, members get modern Western medicine with access to time-honored Eastern healing traditions at affordable rates.

Our Eastern and Western medicine providers collaborate to support holistic health needs. Members can access acupuncture, along with free Yoga, Tai Chi, and Qi Gong classes to enhance wellness, energy, and balance in everyday life.



amazon one medical

Balance also provides Amazon One Medical membership at no cost (\$199 value) to eligible members and covered dependents.

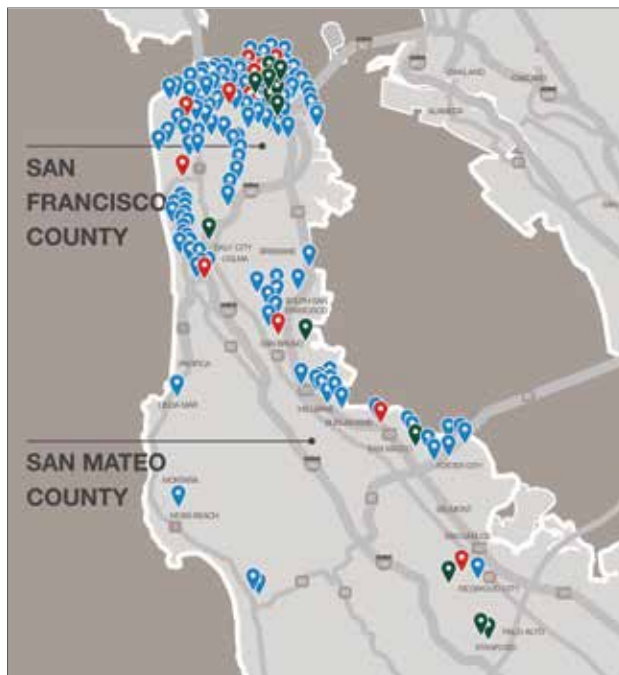
Amazon One Medical and all related logos are trademarks of Amazon.com, Inc. or its affiliates.

Access to Care

Large Network of Doctors and Hospitals

With every plan, you get an in-network choice of over 3,000 neighborhood doctors, specialists, and facilities in our San Francisco and San Mateo County service areas.

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



- PCP/Specialist
- Hospital
- Urgent Care

MEDICAL GROUPS



HOSPITALS



URGENT CARE



Balance: Amazon One Medical sponsored for you and your eligible family members

Enroll in Balance today and get an Amazon One Medical membership for you, your spouse/partner, and dependents at no cost to you.

No Ordinary Doctor's Office

Amazon 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
- **In-office visits** with expanded hours 7 days a week and many 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



amazon one medical

How to Enjoy Amazon One Medical at No Cost — For You and Your Family.

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

1. Amazon One Medical typically charges an annual membership fee of \$199. When you enroll in our Amazon One Medical program, we cover the full cost of your yearly membership.
2. Complete a short Initial Health Assessment (IHA).
3. For more details, please contact our sales representative at 1-877-256-2477.



Amazon One Medical and all related logos are trademarks of Amazon.com, Inc. or its affiliates.



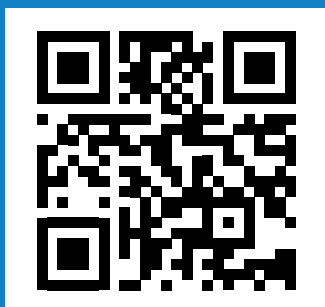
Balance Quality & Affordable Plan Options

**Every family's journey is unique —
we're here with plans that meet you where you are.**

These plans are available through the Covered California exchange, where you may qualify for financial assistance. Ask our sales team for details or visit Covered California online to see what you're eligible for.

**Get the freedom and peace-of-mind to live your
life with Balance.**

After reviewing the details, call **1-877-256-2477** to speak with one of our friendly, knowledgeable experts — they'll answer your questions and help you choose the plan that fits you best.



**Or, Skip the Line,
Apply Online Now.**



Get extra benefits for holistic health and wellness

Balance knows that staying healthy requires more than one approach to wellness. That's why we connect plan members to the healing traditions of Eastern medicine to help you:

- Rebalance your energy with acupuncture
- Feel your best with no-cost Yoga, Tai Chi, and Qi Gong classes
- Visit in-network Chinese providers
- Access our herbal medicine pharmacy at Chinese Hospital



Value Added Services

Our mission is to help you and your family achieve optimal health. We offer many ways to help you stay healthy, well, and thriving.



Balance Member Portal



Member Services – 3 walk-in locations
(San Francisco and Daly City)



Quarterly Community Health Newsletter



Free Fitness classes like Yoga, Qi Gong 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

Optional Dental & Vision Coverage

Balance plans include pediatric vision and dental coverage. For adults, we offer options to add supplemental coverage.



Balance offers dental coverage through our partner, Delta Dental, the nation's leading provider of dental insurance. Having Delta Dental coverage means access to their large 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



Balance 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: \$3.92



2026 Plans

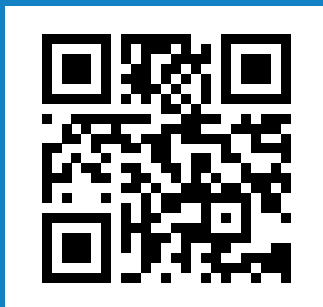
Benefit Highlights & Rates

For San Francisco and San Mateo Counties

The following pages offer a side-by-side comparison of key plan benefits. Be sure to review the benefits that matter most to you, and if you don't see something listed, feel free to ask us. If you have any questions at any time, we're here to help.

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@BalanceByCCHP.com

2026 Plan Benefit Highlights

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 / 91.97%	Silver / 79.98%	Silver / 71.29%	Silver / 71.41 %	
SERVICES AND FEATURES					
Annual Deductible	\$0	Individual \$5,200 Family \$10,400 ^(A)	Individual \$2,750 Family \$5,500 ^(A)	Individual \$3,100 / Family \$6,200 ^(A) Medical / Rx ⁽¹⁾	
Out-of-Pocket Limit on Expenses	Individual \$3,750 Family \$7,500	Individual \$9,800 Family \$19,600	Individual \$7,500 Family \$15,000	Individual \$8,000 Family \$16,000	
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	\$50 Copay	\$0 Copay for First (3) PCP Visits Then Deductible Applies, After Deductible is Met, \$50 Copay	\$0 Copay for First (3) PCP Visits Then Deductible Applies, After Deductible is Met, \$50 Copay	50% Coinsurance (After Deductible)
Specialist Visit	\$30 Copay	\$90 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/Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	\$500 Copay/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	\$0 Copay	\$0 Copay	50% Coinsurance (After Deductible)
OUTPATIENT SERVICES					
Laboratory Tests	\$10 Copay	\$50 Copay	\$25 Copay (After Deductible)	\$10 Copay (After Deductible)	50% Coinsurance (After Deductible)
X-Rays	\$20 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	30% 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	30% Coinsurance	\$0 Copay (After Deductible)	20% Coinsurance Chinese Hospital 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)

Footnotes: Preventive care services are 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 1)



2026 Plan Benefit Highlights

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.

PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA						
Plan Name	Platinum 90 HMO	Gold 80 HMO	Silver 70* HMO	Bronze 60 HMO	Bronze 60 HDHP HMO	Minimum Coverage HMO
Metal Level / Actuarial Benefit Value %**	Platinum / 91.80%	Gold / 81.70 %	Silver / 71.80 %	Bronze / 63.70%	Bronze / 64.80%	N/A
SERVICES AND FEATURES						
Annual Deductible	\$0	\$0	Individual \$5,200 Family \$10,400 ^(A)	Individual \$5,800 Family \$11,600 ^(A)	Individual \$7,200 Family \$14,400 ^(A) Medical / Rx ⁽¹⁾	Individual \$10,600 Family \$21,200 ^(A) Medical / Rx ⁽¹⁾
Out-of-Pocket Limit on Expenses	Individual \$5,000 Family \$10,000	Individual \$9,200 Family \$18,400	Individual \$9,800 Family \$19,600	Individual \$9,800 Family \$19,600	Individual \$7,200 Family \$14,400	Individual \$10,600 Family \$21,200
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	\$40 Copay	\$50 Copay	\$60 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance (Medical Deductible Applies After First 3 Non-Preventive Visits)
Specialist Visit	\$30 Copay	\$70 Copay	\$90 Copay	\$95 Copay (Deductible Applies After First (3) Non- Preventive Visits)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Prenatal and Preconception Visits	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Delivery and All Inpatient Services (Hospital Services)	\$225/day (Up to First 5 Days)	\$375/day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Delivery and All Inpatient Services (Professional Services)	\$0 Copay	\$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
OUTPATIENT SERVICES						
Laboratory Tests	\$15 Copay	\$40 Copay	\$50 Copay	\$50 Copay	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
X-Rays	\$30 Copay	\$75 Copay	\$95 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Imaging (CT/PET Scans, MRIs)	\$75 Copay	\$75 Copay	\$325 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$75 Copay	\$130 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Physician/Surgeon Fees	\$20 Copay	\$60 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance

Footnotes: Preventive care services are 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 1)

2026 Plan Benefit Highlights

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
HOSPITALIZATION SERVICES					
Member Cost Share					
Facility Fee (e.g., Hospital Room)	\$150 Copay/Day Chinese Hospital \$450 Copay/Day Other Facilities (Up to First 5 Days)	30% Coinsurance (After Deductible)	\$500 Copay/Day Chinese Hospital \$1,500 Copay/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	\$50 Copay	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE					
Annual Prescription Deductible	\$0	Individual \$50 Family \$100	Individual \$275 Family \$550	Individual \$3,100 / Family \$6,200 ^(A) Medical / Rx ⁽¹⁾	
Tier 1: Generic Drugs (30-Day Supply)	\$5 Copay	\$19 Copay	\$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/Prescription	20% Coinsurance up to \$250/Prescription (After Rx Deductible)	20% Coinsurance up to \$250/Prescription (After Rx Deductible)	20% Coinsurance up to \$250/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, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses 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				

Footnotes: Preventive care services are 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 1)



2026 Plan Benefit Highlights

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	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
HOSPITALIZATION SERVICES						
Member Cost Share						
Facility Fee (e.g., Hospital Room)	\$225/Day (Up to First 5 Days)	\$375/Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Physician/Surgeon Fees	\$0 Copay	\$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
EMERGENCY HEALTH COVERAGE						
Emergency Room Services (waived if admitted)	\$175 Copay	\$350 Copay	\$400 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Emergency Room Physician Fee (waived if admitted)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance
Urgent Care Center	\$15 Copay	\$40 Copay	\$50 Copay	\$60 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance (Medical Deductible Applies After First 3 Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE						
Annual Prescription Deductible	\$0	\$0	Individual \$50 Family \$100	Individual \$450 Family \$900	Individual \$7,200 Family \$14,400 ^(A) Medical / Rx ⁽¹⁾	Individual \$10,600 Family \$21,200 ^(A) Medical / Rx ⁽¹⁾
Tier 1: Generic Drugs (30-Day Supply)	\$9 Copay	\$18 Copay	\$19 Copay	\$20 Copay	After Combined Medical / Drug Deductible, 0% Coinsurance	After Combined Medical / Drug Deductible, 0% Coinsurance
Tier 2: Preferred Brand Drugs (30-Day Supply)	\$16 Copay	\$60 Copay	\$60 Copay (After Rx Deductible)	40% Coinsurance Up to \$500/Prescription (After Rx Deductible)	After Combined Medical / Drug Deductible, 0% Coinsurance	After Combined Medical / Drug Deductible, 0% Coinsurance
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	\$25 Copay	\$85 Copay	\$90 Copay (After Rx Deductible)	40% Coinsurance Up to \$500/Prescription (After Rx Deductible)	After Combined Medical / Drug Deductible, 0% Coinsurance	After Combined Medical / Drug Deductible, 0% Coinsurance
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to \$250/prescription	20% Coinsurance up to \$250/Prescription	20% Coinsurance up to \$250/Prescription (After Rx Deductible)	40% Coinsurance Up to \$500/Prescription (After Rx Deductible)	After Combined Medical / Drug Deductible, 0% Coinsurance	After Combined Medical / Drug Deductible, 0% Coinsurance
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	\$0 Copay	0% Coinsurance
Eyewear (Frames) (1 Pair Per Calendar Year)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	0% Coinsurance
Eyewear (Lenses) (1 Pair Per Calendar Year)	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses 0% Coinsurance
Eyewear (Contact Lenses in Lieu of Glasses)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	0% Coinsurance
Pediatric Dental (Ages 0-18)			Included in Plan. See Dental Summary Page			

Footnotes: Preventive care services are 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 1)

Discrimination is against the law. Balance by CCHP follows State and Federal civil rights laws. Balance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Balance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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, call our Member Service at 1-888-775-7888 between

- ❖ 8am – 8pm, 7 days a week (October 1- March 31)
- ❖ 8am – 8pm, Monday - Friday (April 1 – September 30)

If you cannot hear or speak well, call 1-877-681-8898. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write or visit:

Balance Member Services
445 Grant Avenue, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-8898

How to file a grievance

If you believe Balance failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance by phone, in writing, in person, by fax or electronically:

- **By phone:** Member Services at 1-888-775-7888 between
 - ❖ 8am – 8pm, 7 days a week (October 1- March 31)
 - ❖ 8am – 8pm, Monday - Friday (April 1 – September 30)Or, if you cannot hear or speak well, please call 1-877-681-8898.
 - **In writing:** Fill out a complaint form or write a letter and send it to:
Member Services
445 Grant Avenue, San Francisco, CA 94108
 - **In person:** Visit your doctor's office or Balance Member Service (address above) and say you want to file a grievance.
 - **By Fax:** 1-415-397-2129
 - **Electronically:** Visit www.balancebycchp.com/grievances-and-appeals
-

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services Office of Civil Rights
P.O. Box 997413, MS 0009 Sacramento, CA 95899-7413
Complaint forms are available at www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Electronically:** Send an email to CivilRights@dhcs.ca.gov

OFFICE FOR CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- **By phone:** Call 1-800-368-1019.
If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697
- **In writing:** Fill out a complaint form or send a letter to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf

ANNUAL NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS

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

- Free language assistance services to individuals with limited English proficiency, including qualified interpreters and translation of written materials.
- Free auxiliary aids and services to individuals with disabilities, such as qualified sign language interpreters, written information in accessible formats, and other aids.

These services are available to you at no cost and in a timely manner. We are committed to ensuring your privacy and independence when accessing these services. To request language assistance or auxiliary aids, please contact:

Balance Member Services
445 Grant Avenue, San Francisco, CA 94108
1-888-775-7888, TTY 1-877-681-8898

You can also visit our website at www.balancebycchp.com/contact-us/ for more information.

Taglines in the top 15 non-English languages spoken in California are available below to inform individuals of the availability of free language assistance services.

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 दः 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: ՈՒՇԱՂԴՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք 1-888-775-7888 (TTY (հեռախոս)՝ 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 ដោយមិនគិតល្អៗ 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: 注意: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-775 7888 (TTY: 1-877-681-8898).

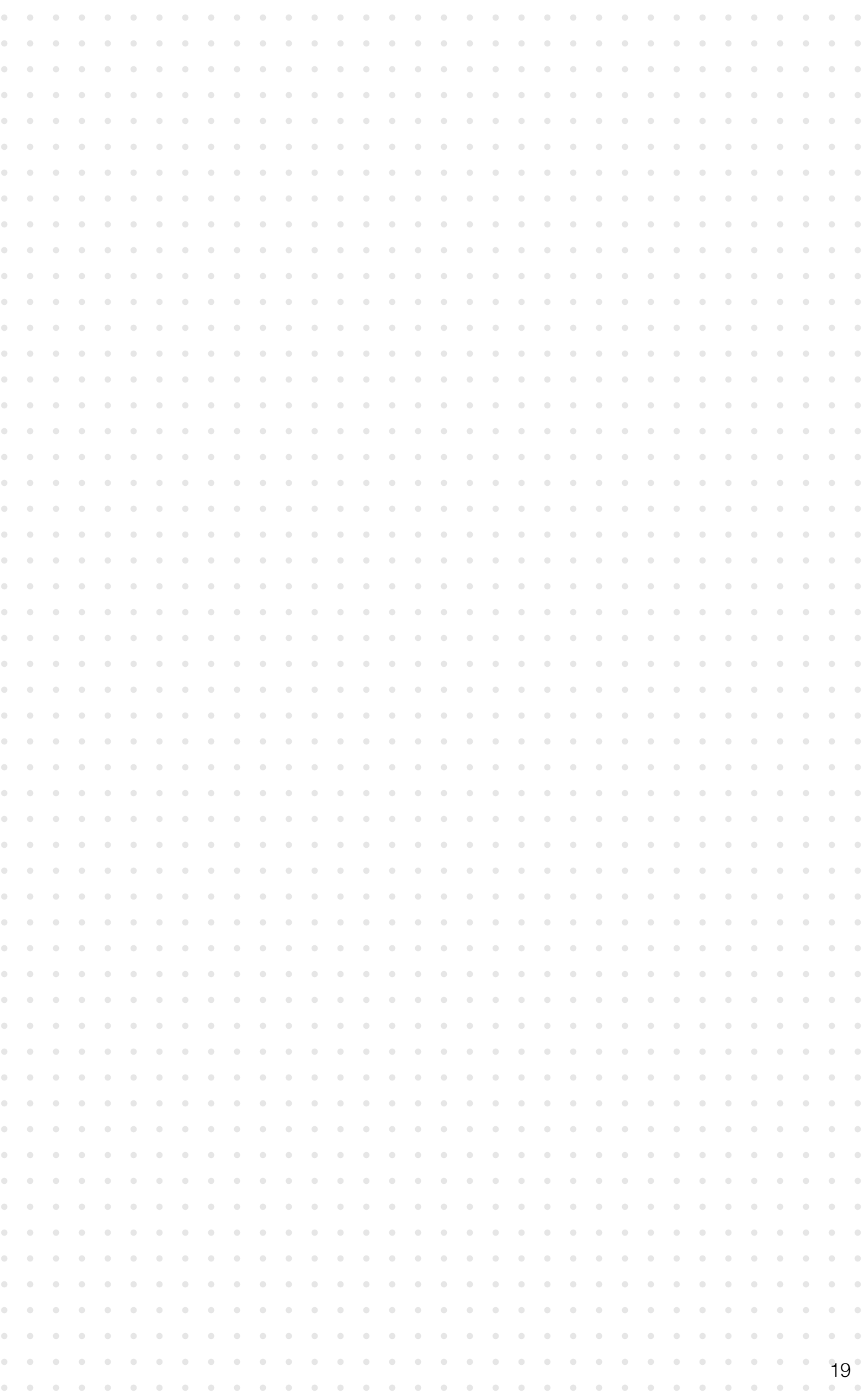
Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شماست. تماس بگیرید.

Lao (Laotian):

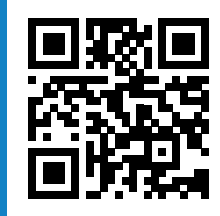
ຄວາມສົນໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດຕິດຕໍ່ເບີຂ້າງລຸ່ມນີ້ ເພື່ອຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໄດ້. ໂທຫາເບີ 1-888-775-7888 (TTY: 1-877-681-8898).

Notes





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