2023
CCHP Medicare Information Kit

Choose Quality and Value from a Local Provider. Choose CCHP.

CCHP Health Plan

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Hello!

For generations, it has been our mission to improve the health of our community by providing high-quality affordable healthcare. The recent global challenges remind us healthcare is local. Our commitment to our mission is stronger than ever. Healthy, happy lives is our goal for all our neighbors.

Community Roots
Established in 1986, we are part of a healthcare system dating to 1899. We work closely with our independent community doctors and have neighborhood clinics to serve you.

Access to Care
Whatever your need, we want to make sure you have a choice in facilities. That's why our network includes many of the best hospitals: Chinese Hospital, Dignity Health, Seton Medical Center, Stanford Health Care, Sutter Health, and UCSF Health.

Always Improving
Last year – with great success – we introduced our healthy grocery card benefit to our CCHP Senior Select Program (HMO D-SNP). For 2023, we are increasing the monthly allowance and adding the grocery card as a reward incentive to our CCHP Senior Program (HMO). We have also reduced doctor visit copays on our popular Senior and Senior Value plans. There are more improvements. Be sure to ask your agent.

Focused on Wellness
Our focus on your wellness is an on-going commitment. In addition to offering free annual preventive screenings and fitness classes, we are continuing our Virtual Health Education Classes. Your health, wellness and safety is our priority.

Choosing CCHP is Easy
We want to make choosing CCHP for your Medicare needs easy. Just talk to one of our experts who can guide you to the right plan for you.

Please review the information in this booklet and be sure to let us know if you have any questions or when you are ready to join generations of happy members!

Thank you for considering CCHP!

Your CCHP Team

GREAT NEWS!

We have expanded our doctor network for 2023. You can now choose CCHP and keep your favorite doctors in Access Primary Care Medical Group.

Enjoy More, Worry Less

Thank you for your interest in CCHP Medicare Advantage plans for your health coverage needs. Choosing CCHP means you get quality care while enjoying more of the services that help you stay healthy from a company that's right here in your community.

This booklet will help you understand the benefits of enrolling in one of our three Medicare Advantage plans:

- **CCHP Senior Program (HMO)**
- **CCHP Senior Value Program (HMO)**
- **CCHP Senior Select Program (HMO D-SNP)**

Here is what's included:

1) Plan Overview gives you a quick look at our benefits and valuable services

2) Summary of Plan Benefits for an in-depth look at what's covered

3) Pre-Enrollment Checklist of items for your consideration when shopping for coverage

4) How you can contact us. Be sure to contact us with any questions. Our friendly sales representatives are waiting to help.

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

Care, in your community.

Notes:

Questions?
1-877-224-7705
TTY 1-877-681-8898

Notes:

A San Francisco Original

We are committed to helping you live your life without worry. We believe that health care is local. We know the unique health care wants and needs of Bay Area people like you because we too live, work and play right here in your community. We are available exclusively to San Francisco and San Mateo county residents, families, and businesses.

EXPANDED Choice of Physicians

You should be able to choose the doctors you want. Now, you can select from an expanded list of independent doctors, specialists and providers with offices located near you. Many of our providers are also available virtually through Telehealth for your safety and convenience.

Access to Top Local Hospitals

CCHP plans enable you access to nearly all the major hospitals including UCSF, Sutter, Dignity, Stanford, Seton, and Chinese Hospital.

No Cost Preventive Care

Maintaining your health with regular check-ups for preventive services shouldn't cost extra. That's why we cover basic services like an annual screening, labs, x-rays and vaccinations without copay.

Questions?
1-877-224-7705
TTY 1-877-681-8898

Health, Wellness and Fitness Classes

Maintaining your optimal health shouldn't be difficult. Our educational classes are practical as well as informational so you can stay on top of your health conditions. Our yoga, tai chi, and qigong classes are designed so you can choose how you stay fit.

Western Medicine with Eastern Remedies

Sometimes you want to try proven alternative therapies for certain conditions. We are committed to helping you integrate treatments for better healing and maintaining your Chi. You can choose a plan that includes acupuncture visits so you can personalize the care you receive.

After Hours Access

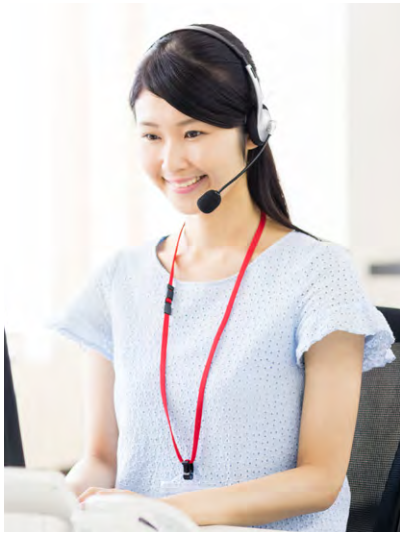
Sometimes you just have questions or need to consult a medical expert when your doctor is not available right away. You can get the help you need through our 24/7 Nurse Advice line. Should you need non-emergency care after hours you can visit one of several Urgent Care centers.

Technology Your Way

Technology should work to make your life easy, not the other way around. Our user-friendly member portal helps you get things done quickly and easily. You can review your plan and claims information, test results, and pay your premiums. And with available virtual visits, you don't need to leave your home to get the care you need.

Service with a Smile

Whether you reach us by phone, email, or in person, you will find that, first, we answer right away. You will also find a caring and listening Member Services team member on the other end. You can also visit with us in-person. With two Member Services offices to serve you (one in San Francisco and one in Daly City), you will find it comforting to know that we treat you like you would like to be treated.



	CCHP Senior Program (HMO)
SERVICE AREA:	San Francisco & San Mateo Counties
WHO QUALIFIES?:	People enrolled in Medicare parts A & B
WHAT DOES IT COST:	**$42** per month
BENEFITS INCLUDE:	

- **$0** Copay Preventive Care Services
- **$0** Medical Deductible
- **$0** Copay for Lab Tests and X-rays
- Prescription Drug Coverage
- Hearing Aid
- Acupuncture Treatments
- Over-the-Counter (OTC) Items
- NEW Grocery Flex Card
  (**$20** allowance per month)
  Available only for members meeting certain qualifications. Please check with Member Services.
- Vision Coverage + Eye Glasses
- Preventive Dental Coverage
- Optional Comprehensive Dental Coverage (additional $10/month)

CCHP Senior Value Program (HMO)	CCHP Senior Select Program (HMO D-SNP)
San Francisco & San Mateo Counties	San Francisco County
People enrolled in Medicare parts A & B	People enrolled in Medicare Parts A and B, receives Medi-Cal (Medicaid) benefits
$0 per month	**$0*** if you qualify for Extra Help or **$38.90*** per month if you don't
◥ **$0** Copay Preventive Care Services ◥ **$0** Medical Deductible ◥ Medicare Part D Drug Coverage ◥ Transportation Services for Medical Visits (12 one-way trips or 6 round-trips per year, non-ER and Plan-approved locations only) ◥ Acupuncture Treatments (15 visits per year) ◥ Routine Hearing Exam ◥ Hearing Aid ◥ Vision Coverage + Eye Glasses ◥ Optional Dental Coverage (additional $18/month)	◥ **$0** Copay Preventive Care Services ◥ **$0** Medical Deductible ◥ **$0** Copay for Lab Tests and X-rays ◥ **$0** Copay Acupuncture Treatments ◥ Prescription Drug Coverage ◥ Grocery Flex Card (**$28** allowance per month) ◥ Transportation Services for Medical Visits ◥ Hearing Aid ◥ Over-the-Counter (OTC) Items ◥ Vision Coverage + Eye Glasses ◥ Dental Coverage**

** Note: To enroll in CCHP Senior Select Prgoram (HMO D-SNP), you must receive Medi-Cal benefits. Premium may vary based on the level of Extra Help you receive.*

*** Dental Services beyond those covered by Medi-Cal Dental Program.*

CCHP Health Plan

CCHP Senior Program (HMO)
2023 Summary of Benefits
Service Area: San Francisco & San Mateo Counties

This is a summary of drug and health services covered by CCHP Senior Program (HMO) from January 1, 2023 - December 31, 2023.

Premiums and Benefits	CCHP Senior Program (HMO)	
Monthly Plan Premium	**$42*** You must continue to pay your Medicare Part B premium. *Premium may vary based on the level of Extra Help you receive. Please contact the plan for further details.	
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay** Other preventive services are available. There are some covered services that have a cost.	
Doctor Visits	PCP: $0 copay Specialists: $15 copay**	
Annual Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 annually Includes copays and other costs for medical services for the year.	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $200 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**	
Inpatient Hospital	Days 1-7: $100 copay per day** (at Chinese Hospital) Days 1-7: $305 copay per day** (at all other in-network hospitals) Days 8-90: $0 copay per day**	
Outpatient Hospital	$100 copay** (at Chinese Hospital) $310 copay** (at all other in-network hospitals)	
Ambulatory Surgery Center (ASC) Services	$300 copay**	
Medicare Part B Drugs	Chemotherapy: 20% coinsurance** Other Part B drugs: 20% coinsurance**	
Physical Therapy	$15 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $135 copay/day**	
Ambulance Services	$265 copay per trip	
Urgently Needed Services	$45 copay within the US $90 copay outside the US ($25,000 maximum coverage amount)	
Emergency Care	$90 copay Within the US: Copay is waived if admitted within 24 hours to hospital. Outside the US: Copay is not waived if admitted to hospital ($25,000 maximum coverage amount)	
Mental Health Services	Inpatient Hospital: Days 1-7: $250 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $15 copay**

Premiums and Benefits	CCHP Senior Program (HMO)	
Transportation	$0 copay per trip, *12 round trips (24 one-way trips)*	
Over-the-Counter (OTC) Items	$25 allowance per quarter (allowance expires at the end of the quarter)	
Grocery Flex Card	$20 allowance per month (available only for members meeting certain qualifications. Please check with Member Services.)	
Acupuncture	$5 copay**	
Vision Services	Routine eye exam: $20 copay** (one exam allowed annually) Eyeglasses: $0 copay** for one pair of glasses every two years (maximum $150 allowance)	
Hearing Services **Hearing Aids**	Routine Hearing Exam: $20 copay** (one routine hearing exam allowed annually) $600 - $2,075 copay/ear, limit two per year through NationsHearing	
Preventive Dental Services	$0 copay (limit twice per year)	
Optional Comprehensive Dental Coverage	$10 per month (in addition to monthly plan premium)	
Part D: Prescription Drug Coverage (for Drugs on CCHP's Formulary)	**30-day Supply at Retail Pharmacy**	**90-day Supply by Mail Order and Preferred Cost-Share Pharmacies***
Tier 1: Preferred Generic (no deductible)	$3 copay	$6 copay
Tier 2: Generic (no deductible)	$7 copay	$14 copay
Tier 3: Preferred Brand (no deductible)	$40 copay	$80 copay
Tier 4: Non-preferred Brand (no deductible)	$60 copay	$120 copay
Tier 5: Specialty (no deductible)	33% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.
Coverage Gap: Costs after your total yearly drug costs reach $4,660		
Generic	25% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $7,400		
Generic	You pay the greater of 5% or $4.15 copay	
Brand & Specialty	You pay the greater of 5% or 10.35 copay.	
*Premium may vary based on the level of Extra Help you receive. Please contact the plan for further details. **Prior authorization and referral rules may apply. ***Cost share for 90-day supply may differ at non-preferred cost sharing pharmacies.		

This plan is available to anyone who is enrolled in Medicare Part A and Part B and resides in our service area. Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewal. A complete list of services we cover can be found in the "Evidence of Coverage" on our website www.cchphealthplan.com/medicare or contact us for more information, 1-888-681-3888 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week. Chinese Community Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. CCHP's pharmacy network offers limited access to pharmacies with preferred cost sharing in San Francisco and San Mateo Counties. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up to date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-888-775-7888 or consult the online provider/pharmacy directory at <u>www.CCHPHealthPlan.com/medicare</u>.

CCHP Health Plan

CCHP Senior Value Program (HMO)
2023 Summary of Benefits
Service Area: San Francisco & San Mateo Counties

This is a summary of drug and health services covered by CCHP Senior Value Program (HMO) from January 1, 2023 - December 31, 2023.

Premiums and Benefits	CCHP Senior Value Program (HMO)	
Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium.	
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay** Other preventive services are available. There are some covered services that have a cost.	
Doctor Visits	PCP: $5 copay Specialists: $20 copay**	
Annual Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$7,550 annually Includes copays and other costs for medical services for the year.	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $200 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**	
Inpatient Hospital	Days 1-7: $150 copay per day** (at Chinese Hospital) Days 1-7: $315 copay per day** (at all other in-network hospitals) Days 8-90: $0 copay per day**	
Outpatient Hospital	$230 copay** (at Chinese Hospital) $310 copay** (at all other in-network hospitals)	
Ambulatory Surgery Center (ASC) Services	$300 copay**	
Medicare Part B Drugs	Chemotherapy: 20% Coinsurance** Other Part B drugs: 20% Coinsurance**	
Physical Therapy	$20 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $135 copay/day**	
Ambulance Services	$265 copay** per trip	
Urgently Needed Services	$45 copay within the US $90 copay outside the US ($5,000 maximum coverage amount)	
Emergency Care	$90 copay Within the US: Copay is waived if admitted within 24 hours to hospital. Outside the US: Copay is not waived if admitted to hospital ($5,000 maximum coverage amount)	
Mental Health Services	Inpatient Hospital: Days 1-7: $250 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $20 copay

Premiums and Benefits	CCHP Senior Value Program (HMO)	
Transportation	$0 copay per trip, 12 one-way trips or *6 round-trips*	
Acupuncture	$10 copay (15 visits per year)	
Vision Services	Routine eye exam: $35 copay** (one exam allowed annually) Eyeglasses: $0 copay for one pair of glasses every two years (maximum $100 allowance)	
Hearing Services **Hearing Aids**	Routine Hearing Exam: $20 copay** (one routine exam allowed annually) $600 - $2,075 copay/ear, limit two per year through NationsHearing	
Optional Dental Coverage	$18/month (in addition to monthly plan premium)	
Part D: Prescription Drug Coverage (for Drugs on CCHP's Formulary)	**30-day Supply at Retail Pharmacy**	**90-day Supply by Mail Order and Preferred Cost-Share Pharmacies***
Tier 1: Preferred Generic (no deductible)	$5 copay	$10 copay
Tier 2: Non-preferred Generic (no deductible)	$12 copay	$24 copay
Tier 3: Preferred Brand (no deductible)	$47 copay	$94 copay
Tier 4: Non-preferred Brand (no deductible)	$100 copay	$200 copay
Tier 5: Specialty (no deductible)	31% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.
Coverage Gap: Costs after your total yearly drug costs reach $4,660		
Generic	25% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $7,400		
Generic	You pay the greater of 5% or $4.15 copay.	
Brand & Specialty	You pay the greater of 5% or $10.35 copay.	
*Cost share for 90-day supply may differ at non-preferred cost sharing pharmacies. **Prior authorization and referral rules may apply.		

This plan is available to anyone who is enrolled in Medicare Part A and Part B and resides in our service area. Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewal. A complete list of services we cover can be found in the "Evidence of Coverage" on our website www.cchphealthplan.com/medicare or contact us for more information, 1-888-681-3888 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week. Chinese Community Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. CCHP's pharmacy network offers limited access to pharmacies with preferred cost sharing in San Francisco and San Mateo Counties. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up to date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-888-775-7888 or consult the online provider/pharmacy directory at <u>www.CCHPHealthPlan.com/medicare</u>.

CCHP Health Plan

CCHP Senior Select Program (HMO D-SNP)
2023 Summary of Benefits
Service Area: San Francisco County

This is a summary of drug and health services covered by CCHP Senior Select Program (HMO D-SNP) from January 1, 2023 - December 31, 2023.

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)
Monthly Plan Premium	**$0*** ***if you qualify for Extra Help or*** **$38.90*** ***if you don't*** You must continue to pay your Medicare Part B premium. *Premium may vary based on the level of Extra Help you receive. Please contact the plan for further details.
Preventive Care (e.g. flu vaccine, diabetic screenings)	**$0** copay**
Doctor Visits	PCP: **$0** copay Specialists: **$0** copay**
Annual Deductible	**$0**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400 annually Includes copays AND other costs for medical services for the year.
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: **$0** copay** X-Ray and Lab Services: **$0** copay** Diagnostic Tests and Procedures: **$0** copay**
Inpatient Hospital	Days 1-7: **$0** copay per day** Days 8+: **$0** copay per day**
Outpatient Hospital	**$0** copay**
Ambulatory Surgery Center (ASC) Services	**$0** copay**
Medicare Part B Drugs	**$0** copay**
Physical Therapy	**$0** copay**
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-100: **$0** copay per day**
Ambulance Services	**$0** copay per trip
Urgently Needed Services	**$0** copay within the US **$90** copay outside the US ($25,000 maximum coverage amount)
Emergency Care	**$0** copay within the U.S. **$90** copay outside the US ($25,000 maximum coverage amount). Copay is not waived if admitted into hospital.

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)	
Mental Health Services	Inpatient Hospital: Days 1-90: **$0** copay per day**	Group and Individual Therapy Sessions: **$0** copay**
Transportation	**$0** copay per trip, 48 one-way trips per year**	
Over-the-Counter (OTC) Items	**$55** allowance per quarter (allowance expires at the end of the quarter)	
Grocery Flex Card	**$28** allowance per month (allowance expires at the end of the quarter)	
Acupuncture	**$0** copay**	
Vision Services	Routine eye exam: **$0** copay** (one exam allowed annually) Eyeglasses: **$0** copay for one pair of glasses every two years (maximum $150 allowance)	
Hearing Services **Hearing Aids**	Routine Hearing Exam: **$0** copay** (Up to one hearing exam each year) **$1,000** allowance/year. $1,000 annual benefit allowance may be applied towards the purchase price of up to two entry level hearing aids each year through NationsHearing.	
Dental Services	**$1,000** allowance for Dental Services beyond those covered by Medi-Cal Dental Program.	
Part D: Prescription Drug Coverage (for Drugs on CCHP's Formulary)	**Drug Tier**	**Copay*** (may vary based on the level of Extra Help eligibility)
Initial Coverage Costs for Drugs after Deductible*: • For beneficiaries receiving no Extra Help, deductible is $505. • For some beneficiaries receiving partial subsidy Extra Help, deductible is $104. • For most beneficiaries is $0.	**Generic** (including brand drugs treated as generic)	25% coinsurance; or with Low Income Subsidy (LIS): $0/$1.45/$4.15 copay or 15% coinsurance
	All Other Drugs	25% coinsurance; or with Low Income Subsidy (LIS): $0/$4.15/$10.35 copay or 15% coinsurance
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $7,400.	**Generic** (including brand drugs treated as generic)	You pay the greater of 5% or $4.15 copay.
	All Other Drugs	You pay the greater of 5% or $10.35 copay.
*Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. **Prior authorization and referral rules may apply.		

The following services are not covered by CCHP Senior Select Program (HMO D-SNP) but may be available through Medi-Cal (Medicaid):

- Long term care in a facility longer than the month of admission plus one month
- Routine foot care
- Incontinence supplies
- Certain drugs excluded by Medicare, check the Medi-Cal (Medicaid) formulary for more details
- Certain dental services

This plan is available to anyone who is enrolled in Medicare Part A and Part B, receives Medi-Cal (Medicaid) benefits, and resides in San Francisco County. Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewal. A complete list of services we cover can be found in the "Evidence of Coverage" on our website www.cchphealthplan.com/medicare or contact us for more information, 1-888-681-3888 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week. Chinese Community Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

DELTA DENTAL®

CCHP Health Plan

Keep smiling

DeltaCare® USA

provided by

Delta Dental of California

Dental benefits made easy!
When you enroll in a DeltaCare USA plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health
Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs
With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums for covered services

Convenient services
We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

CCHP Senior Program (HMO) and Senior Value Program (HMO) are HMO plan with a Medicare contract. Enrollment in CCHP Senior Program (HMO) and Senior Value Program (HMO) depend on contract renewal.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. These companies are financially responsible for their own products.

We recommend that you verify online that the dentist is your selected or assigned DeltaCare USA primary care dentist before each appointment.

Plans with an Accidental Injury Rider have a $1600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

deltadentalins.com/CCHP

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Your Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-224-7705, (TTY 1-877-681-8898). Hours are 7 days a week, 8:00 a.m. to 8:00 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.CCHPHealthPlan.com/Medicare or call 1-877-224-7705, (TTY 1-877-681-8898) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.s
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium, unless your Part B premium is covered by the State for full-dual eligible individuals. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ CCHP Senior Select Program (HMO D-SNP) is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

FORMS

CCHP Health Plan

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
請於下列選擇一項你希望代理人與你討論的醫療計劃並在方格內簽

☐	**Medicare Advantage Plan (Part C) 聯邦保健優勢計劃 (Part C)**
	Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies). 這是一項聯邦保健優勢計劃，提供所有聯邦保健 A 及 B 部份的保障或會提供 Part D 藥物保障。大多數的 HMO， 你只可以使用計劃醫療網內的醫生或醫院，急症除外。
☐	**Medicare Special Needs Plan (SNP) 聯邦保健特殊需要計劃 (SNP)**
	Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions. 這是一項為有特別醫療需要人仕而設的聯邦保健優勢計劃。特別醫療需要是指同時持有聯邦保健及加州醫療補助咭人仕，居住在療養院人仕和有某些慢性疾病人仕。

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

通過簽署這表格， 表示同意華人保健計劃的代理人向你講解閣下在表格上簡簽的有關計劃。與你討論計劃的代理人可能是受薪的僱員或和本公司簽有合約，他們並不直接為聯邦政府服務。當你參加後，這代理人可能得到報酬。

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.
簽署這表格不代表你要參加本計劃，亦將不會影響你現時已加入的計劃，及不會把你加入聯邦保健計劃。

Beneficiary or Authorized Representative Signature and Signature Date:
受益人或授權代表簽署和簽署日期

_____
Signature 簽署:

_____
Signature Date 簽署日期:

If you are the authorized representative, please sign above and print below: 如你是授權代表 ，請在上欄簽署及以正楷填寫下面有關資料

Representative's Name 授權代表姓名: _____

Your Relationship to the Beneficiary 與受益人的關係: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
[Plan Use Only:]	

Scope of Appointment documentation is subject to CMS record retention requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO Plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewals. CCHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
華人保健計劃（CCHP）是一個與聯邦保健簽有合約的聯邦保健優惠 HMO 計劃（Medicare Advantage HMO plan）及與加州醫療補助計劃（Medicaid）簽有合約提供東華智選計劃 (HMO D-SNP)。能否接收會員取決於這合約是否獲得續約。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。

CCHP Health Plan

Attestation of Eligibility for an Enrollment Period

Name: _____

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan 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 an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.

☐ I recently was released from incarceration. I was released on (insert date)_____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statement applies to you or you're not sure, please contact Chinese Community Health Plan at 1-888-775-7888 (TTY users should call 1-877-681-8898) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., seven days a week.

Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO Plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewals.CCHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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CCHP Health Plan

OMB No. 0938-1378
Expires: 7/31/2024

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Attn: Sales Department
Chinese Community Health Plan
445 Grant Avenue
San Francisco, CA 94108

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Chinese Community Health Plan at 1-888-681-3888. TTY users can call 1-877-681-8898.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Chinese Community Health Plan al 1-888-681-3888 (TTY: 1-877-681-8898) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

CCHP Health Plan

MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT REQUEST FORM

SECTION 1 – All Fields on this Page are Required (unless marked optional)

Select the plan you want to join:

☐ **CCHP Senior Program (HMO): $42 per month**
☐ **CCHP Senior Value Program (HMO): $0 per month**
☐ **CCHP Senior Select Program (HMO D-SNP): $0 if you qualify for Extra Help or $38.90* if you don't**

**Note: To enroll in CCHP Senior Select Program (HMO D-SNP), you must receive Medi-Cal benefits. Monthly premium depends on your level of Low-Income Subsidy.*

FIRST Name:	LAST Name:	Middle Initial:

Date of Birth (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	Home Phone Number:

Permanent Residence street address (Don't enter a PO Box):

City:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare Information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these Important Questions:

1) Will you have other prescription drug coverage (like VA, TRICARE) in addition to CCHP Medicare coverage? ☐ Yes ☐ No

   Name of other coverage: _____

   Member # for this coverage: _____

   Group # for this coverage: _____

2) Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

3) Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If yes, please provide the following information:

   Name of Institution: _____

   Address and Phone number of Institution (Number and Street):_____

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this CCHP Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that CCHP Medicare Advantage plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my CCHP Medicare Advantage plan coverage begins, I must get all of my medical and prescription drug benefits from CCHP Medicare Advantage plan. Benefits and services provided by CCHP Medicare Advantage plan and contained in my CCHP Medicare Advantage Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCHP Medicare Advantage plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

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SECTION 2 – All Fields on this Page are Optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English.

☐ Chinese ☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact CCHP at 1-888-775-7888 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week. TTY users can call 1-877-681-8898.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

- ☐ All
- ☐ Evidence of Coverage (EOC)
- ☐ Formulary
- ☐ Provider/Pharmacy Directory
- ☐ Annual Notice of Change (ANOC)

E-mail address:

Paying your Plan Premiums

You can pay your monthly plan premium (if applicable), (including any late enrollment penalty you have or may owe) by mail, "Electronic Funds Transfer (EFT)" or by "credit card" each month. You can also choose to pay your premium (if applicable) by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay CCHP the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment):_____

Effective Date of Coverage: _____ Plan ID: □001 □005 □007

□ ICEP □ AEP □ MAOEP □ SEP (type): _____

□ Not Eligible: _____

Broker assisted enrollments:
Please fax completed application to CCHP: 1-415-955-8819

RECEIVED DATE STAMP

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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CCHP Health Plan

DeltaCare® USA

Dental Enrollment Form

Complete this form if you want to enroll in the Optional Dental Plan offered by Delta Dental of California. Please print clearly when completing this form and return to CCHP.

☐ Yes, I would like to enroll in the **CCHP Senior Program (HMO)** Optional Comprehensive Dental Plan for **$10 per month**, which is in addition to my Medicare Part B and CCHP Senior Program (HMO) premiums.

☐ Yes, I would like to enroll in the **CCHP Senior Value Program (HMO)** Optional Supplemental Dental Plan for **$18 per month**, which is in addition to my Medicare Part B and CCHP Senior Program (HMO) premiums.

CCHP	Group No.: 76609	Effective Date:

Applicant Information

Last Name	First Name	Middle	CCHP ID No.
Permanent Residence (*Street Address **ONLY** – No P.O. Box*)			Apt. #
City	State	Zip	County

Gender Male Female	Date of Birth (mm/dd/yyyy)	Home Phone ( ) -	Work Phone ( ) -

Note: I will be auto-assigned to a Contract Dentist by Delta Dental. I can change contract dentist by contacting Delta Dental Customer Service at 1-866-247-2486 Monday through Friday from 5:00 a.m. to 6:00 p.m. Pacific time (TTY/TDD: 1-800-735-2929) after I receive member ID card from Delta Dental.

#78954 FM_DCUSA_Enroll_CA_6609 (07-07-14)

Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our SNP. Enrollment in CCHP depends on contract renewal.

The CCHP Senior Program (HMO) Optional Comprehensive Dental Plan is only available to individuals enrolled in or applying for coverage in CCHP Senior Program (HMO).

The CCHP Senior Value Program (HMO) Optional Supplemental Dental Plan is only available to individuals enrolled in or applying for coverage in CCHP Senior Value Program (HMO).

I acknowledge that I must pay an additional premium if I enroll in the Optional Dental Coverage provided by Delta Dental of California. This premium is paid to CCHP. I must continue to pay my Medicare Part B premium. I will receive a monthly bill, which is separate from my monthly plan premium. This program is voluntary. All dental care must be received within the DeltaCare USA network. I may choose to drop coverage at any time. If I choose to drop the program, I may not re-enter the program until the next Annual Election Period. I understand that the dental coverage is provided by Delta Dental of California as described in the Evidence of Coverage.

I understand that a Contract Dentist will be auto-assigned by Delta Dental, I can change contract dentist by contacting Delta Dental Customer Service at 1-866-247-2486 Monday through Friday from 5:00 a.m. to 6:00 p.m. Pacific time (TTY/TDD: 1-800-735-2929) after I received my member ID card.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by CCHP or by Medicare.

Applicant Signature: _____ Today's Date: _____

If you are the authorized representative, you must sign above and complete the following information:

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

Return signed form to:

Attn: Enrollment and Eligibility Department
Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

CCHP Senior Program (HMO) is an HMO plan with a Medicare contract. Enrollment in CCHP Senior Program (HMO) depends on contract renewal. Chinese Community Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

CCHP Health Plan
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.

CCHP Health Plan
445 Grant Ave., Suite 700, San Francisco, CA 94108
Tel: (415) 955-8800 • Fax: (415) 955-8817

CCHP use only
Finance: Entry date _____
Member Services or Sales: Recv'd date _____
DST entry date _____

Chinese Community Health Plan
Medicare Advantage Plans Automatic Bank Withdrawal Authorization Form
(Please complete all of the information in this form)

Member Information

Subscriber Name: _____
(as shown on your Member ID card)

Member ID: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email : _____

Financial Institution Information

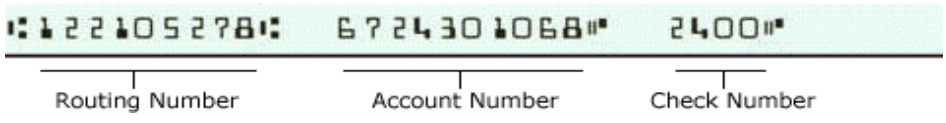
Name of Financial Institution: _____

Account Holder Name: _____ Account Type: □Checking □Savings

Bank Routing Number: _____ Bank Account Number: _____

Premium Amount: $_____ per month beginning _____

Please attach a voided check or deposit slip here.
We will use this information to withdraw your monthly plan premium from the account that you specify on the form.



NOTE: If you select automatic withdrawal as your payment option for your plan premium, you will receive monthly premium billing and **you do not need to send your payment to us**. The plan premium amount will be automatically withdrawn from the account. Your bank confirmation will be the proof of payment. If there are insufficient funds in the account or if the account is frozen/closed on the date of the withdrawal, you will be charged a $15 fee separately by CCHP.

Please Read and Sign Below

This agreement is between Chinese Community Health Plan ("CCHP") and the CCHP member for the automatic withdrawal of funds. The funds will be transferred between the 10th and the 15th day of each month and will be used to pay the plan premium.

I authorize Chinese Community Health Plan to instruct my financial institution to make plan premium payments from the account indicated above. I understand that if I decide to discontinue this method of payment at any time, I will notify CCHP in writing and make the plan premium payment using an alternative method.

Signature:_____ Date:_____

Please submit form by fax: 415-955-8817 or mail to CCHP, 445 Grant Ave, Suite 700, San Francisco, CA 94108 by the 20th of the month for changes to be effective the first day of the following month. If you have any questions or if you need help completing the form, please contact the CCHP Member Services Center at 1-888-775-7888 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week.

Other Payment Methods:

Location/Payment Types	Credit Card Debit Card	Personal Check Cashier Check Money Order	Cash	Pay Online Walkthrough
Chinese Community Health Plan 445 Grant Ave, #700, San Francisco, CA 94108	○ In person	○ In person ○ By Mail		○ In person
Member Services Center 445 Grant Ave, San Francisco, CA 94108		○ In person		○ In person
Gellert Health Services 386 Gellert Blvd, Daly City, CA 94015				○ In person
Bank of the Orient 1023 Stockton St, San Francisco, CA 94108			○ In person with Billing Payment Stub	
CCHP Website http://cchphealthplan.com/how-to-pay	○ Electronic			

CCHP Health Plan

BROKER-OF-RECORD ATTESTATION
For MEDICARE ADVANTAGE

I _____ attest that I have been represented by a broker/agent. Now, working directly with a CCHP's representative, I choose not to be represented by my current broker-of-record name: _____.

經紀記錄證明
聯邦保健優惠計劃

本人 _____ 證明我已委任一位新的經紀 / 代理人，立即與 **CCHP** 的代表直接合作， 我選擇不再使用我目前記錄的經紀： _____.

CERTIFICACIÓN DE AGENTE REGISTRADO
Para MEDICARE ADVANTAGE

Yo _____ doy fe de que he sido representado por un coagente. Ahora, trabajando directamente con un representante de CCHP, elijo no ser representado por mi actual agente registrado llamado: _____.

NAME/姓名/NOMBRE: _____

SIGNATURE/簽名/FIRMA: _____ DATE/日期/FECHA: _____

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 1-877-681-8898
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).

CCHP
Health Plan

CALL

1-877-224-7705 (TTY 1-877-681-8898)

EMAIL

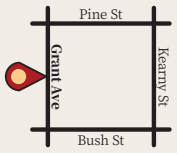
sales@cchphealthplan.com

GO ONLINE

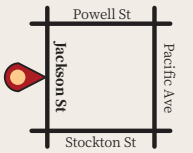
CCHPHealthPlan.com/Medicare-Shopping

VISIT

San Francisco
445 Grant Avenue
San Francisco, CA 94108



845 Jackson Street
San Francisco, CA 94133



Daly City
386 Gellert Boulevard
Daly City, CA 94015

Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewal. CCHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.