GET MORE

With CCHP Medicare

+ More doctors
+ More for groceries*
+ More for OTC expenses

*Must Qualify.

2024 CCHP Medicare Information Kit

CCHP Health Plan

This is an advertisement.

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TABLE OF CONTENTS

Enjoying More, Worrying Less.

Thank you for your interest in CCHP Medicare Advantage plans for your health coverage needs.

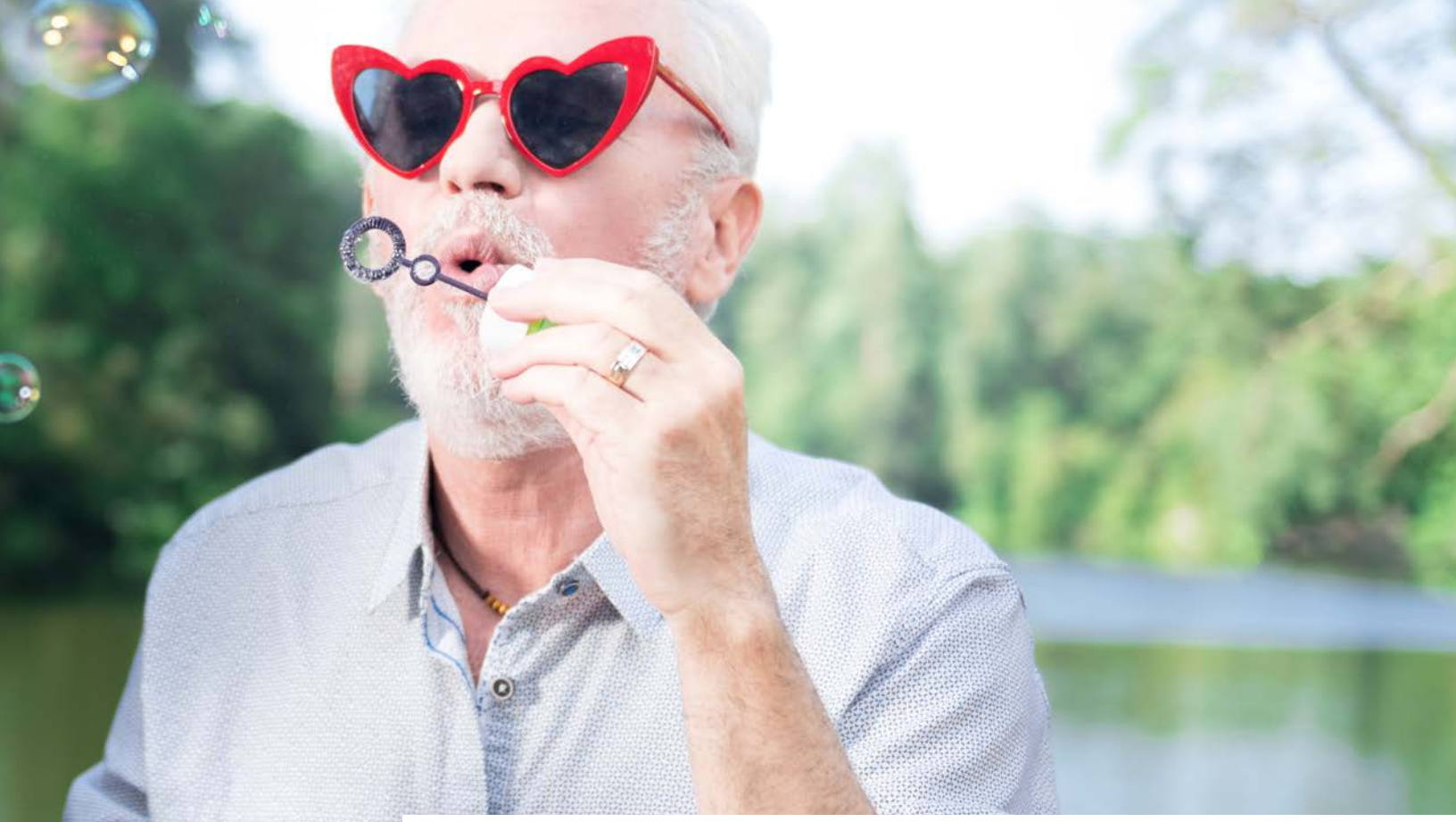
Choosing CCHP means you get quality care while enjoying more of the services that help you stay healthy from a company that's right here in your community.

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:

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

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

Pre-Enrollment Checklist
items for your consideration when shopping for coverage.

How you can contact us
our friendly sales representatives are waiting to help.

www.cchphealthplan.com/medicare-shopping
Sales@CCHPHealthPlan.com
1-888-788-2594 (TTY 1-877-681-8898)
Monday through Sunday, 8am-8pm

Discover the CCHP Medicare Advantage

For generations, it has been our mission to improve the health of our community. Healthy, happy lives is our goal for all our neighbors.

MORE for you in 2024:

+ Access to 7,000+ providers
+ Grocery allowance*
+ OTC product allowance
+ Herbal products

*Must Qualify.

San Francisco Original

Established in 1986, we are part of a dynamic healthcare system that was created before access to health insurance for individuals was common. We too live and work here to serve the community. Almost 40-years in, we continue to focus exclusively on the needs of San Francisco and San Mateo county residents.

Access to Care - Now with 7,000+ Providers

You want choice of doctors, specialists and facilities. We work with leading medical groups and networks to give you the flexibility. They are independent neighborhood doctors, clinics and nearly all the hospitals for your convenience.

Focused on Your Wellness

Our focus on wellness is an on-going commitment. In addition to offering free annual preventive screenings and fitness classes, we offer health education classes online and in-person. You also have access to a wealth of health and wellness information and resources to maintain your health.

Extra Help

We understand people have health conditions that require extra attention. Whether it be diabetes, hypertension or cholesterol, we offer programs to keep those conditions in check and even improve.

*Getting More - Up to $760 per Year**

You are not alone, things are costing more and we are all getting less for our money. We have programs where you are given cash allowances for everyday purchases like groceries and Over-the-Counter items. We are here to help. **Qualifications apply for portion of the allowance.*

Choosing CCHP is Easy

With so many options, Medicare can be complicated. We will help you sort out the best options for your specific need. Just talk to one of our experts who can guide you to the right plan for you.

BENEFITS QUICK LOOK

CCHP Senior Program (HMO)

$39.50 /month

For Residents:

- In San Francisco & San Mateo Counties
- Enrolled in Medicare parts A & B

Doctor Visits (PCP / Specialist)	**$0 / $15 Copays**
Medical Deductible	**$0 Copay**
Part D Prescription Drug (Rx) Coverage	✓
Preventive Screenings	**$0 Copay**
Preventive Lab Tests & X-rays	**$0 Copay**
Allowance for Grocery	**$20 per month** (upon completion of Annual Wellness Visit)
Allowance for Over-the-Counter (OTC) Products	**$40 per month**
Allowance for Herbal Products	✓
Extra Grocery Allowance for Hypertensive Members	**$10 per month** (upon qualification)
Dental Coverage (Preventive)	✓
Dental Comprehensive Coverage	**$10 additional per month**
Vision Coverage	**$20 copay (once a year)** ($150 allowance for eye glasses every 2-years)
Hearing Exam (Routine)	**$20 Copay**
Hearing Aid	**$600-$2,075 per year**
Acupuncture Treatments	**$5 Copay**
Transportation Services	**24 one way trips** (for medical appointments)
Worldwide ER Coverage	✓

CCHP Senior Value Program (HMO)

$0 /month

For Residents:

- In San Francisco & San Mateo Counties
- Enrolled in Medicare parts A & B

CCHP Senior Select Program (HMO D-SNP)

$0-$41★/month

For Residents:

- In San Francisco County
- Enrolled in Medicare Parts A and B, also receives Medi-Cal (Medicaid) benefits

★ Premium may vary based on the level of Extra Help you receive.

$5 / $20 Copays	**$0 / $0 Copays**
$0 Copay	**$0 Copay**
✓	✓
$0 Copay	**$0 Copay**
$0 Copay	**$0 Copay**
n/a	**$45 per month**
$30 per month	**$55 per quarter**
✓	✓
$20 per month (upon qualification)	**$10 per month** (upon qualification)
n/a	**Through Medi-Cal**
$18 additional per month	**n/a**
$35 copay (once a year) ($100 allowance for eye glasses every 2-years)	**$0 copay (once a year)** ($150 allowance for eye glasses every 2-years)
$20 Copay	**$0 Copay**
$600 - $2,075 per year	**$1,000 per year**
$10 Copay (15 visits / year)	**$0 Copay**
12 one way trips (for medical appointments)	**48 one way trips** (for medical appointments)
✓	✓

GETTING MORE

You will get allowances for Healthy Grocery and Over-the-Counter products like hot-cold patches and herbal supplements.

Here is How it works:

When you choose CCHP, you will receive allowances (in debit card) to help pay for everyday expenses.

For the Senior plan, you are entitled to additional allowances - when you complete an Annual Wellness Visit (AWV) with your Primary Care Physician (PCP).

Once Enrolled, you will receive the CCHP Flex Debit Card. You can use this card like a credit card. You can use the card at participating retailers like Safeway, Walgreens, and more.

We want to reward you for your taking good care of yourself.

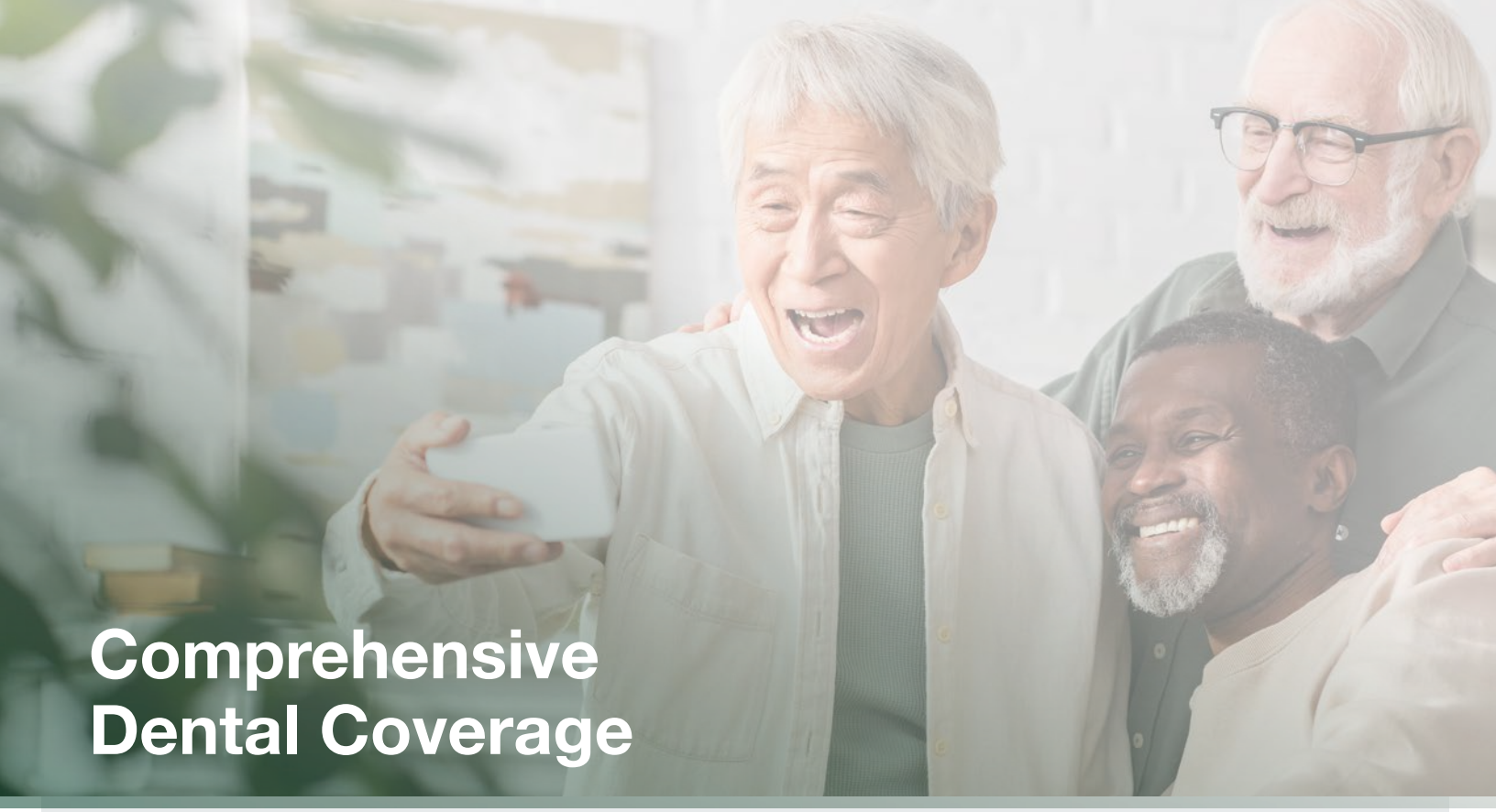
Plan/Allowance	CCHP Senior Program	CCHP Senior Value Program	CCHP Senior Select Program
Monthly Grocery Allowance	**$20***	**n/a**	**$45**
Monthly OTC Allowance	**$40**	**$30**	**$18.33**
Monthly Allowance Total	**$60**	**$30**	**$63.33**
Yearly Allowance Total	**$720**	**$360**	**$760**

*Upon completing Annual Wellness Visit (AWV) per calendar year.

Getting a Little Extra Help with Your Health Condition

We know some people struggle with certain health conditions like high blood pressure (hypertension). We want to help.

If you are diagnosed by your Primary Care Physician (PCP), we will send you medical devices to keep your condition in check. We will also add $10 or $20 more per month in grocery allowance depending on the plan you choose. It's that easy.



Comprehensive Dental Coverage

Dental care is an important part of your overall health. That's why we include preventive dental coverage in some of our plans.

If you want a more comprehensive dental coverage, we offer supplemental coverage through our partner DeltaCare USA.

A partner in oral health

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

Convenient services

Delta makes 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

Affordable - Be sure to ask about it or fill-out the application in this booklet

CCHP Senior Program
$10/month

CCHP Senior Value Program
$18/month

(The premiums are in addition to your monthly premiums.)

CCHP Health Plan

CCHP Senior Program (HMO)
2024 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, 2024 - December 31, 2024.

Premiums and Benefits	CCHP Senior Program (HMO)	
Monthly Plan Premium	**$39.50*** 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.	
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.	
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**	
Doctor Visits	PCP: $0 copay, Specialists: $15 copay**	
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay** Other preventive services are available. There are some covered services that have a cost.	
Emergency / Worldwide ER 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)	
Urgently Needed Services	$45 copay within the US $90 copay outside the US ($25,000 maximum coverage amount)	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $200 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**	
Hearing Services	Routine Hearing Exam: $20 copay** (one routine hearing exam allowed annually)	
Hearing Aids	$600 - $2,075 copay per hearing aid, 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)	
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)	
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)	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $135 copay/day**	
Physical Therapy	$15 copay**	
Ambulance Services	$265 copay per trip	
Transportation	$0 copay per trip, *12 round trips (24 one-way trips)*	
Medicare Part B Drugs	Medicare Part B Insulin Drugs: $35 copay Chemotherapy: 20% coinsurance** Other Part B drugs: 20% coinsurance**	
Acupuncture	$5 copay**	
Over-the-Counter (OTC) Items	$40 allowance per month (allowance expires at the end of the quarter)	
Grocery Flex Card (1)	$20 allowance per month (allowance expires at the end of the quarter)	
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*** **
Yearly Deductible	$0	
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 $5,030		
Generic	25% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $8,000		
Generic	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.	
Brand & Specialty		
*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. (1) Must qualify by completing Annual Wellness Visit.		

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., Monday to Friday. 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>.

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CCHP Senior Value Program (HMO)
2024 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, 2024 - December 31, 2024.

Premiums and Benefits	CCHP Senior Value Program (HMO)	
Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium.	
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.	
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**	
Doctor Visits	PCP: $0 - $5 copay Specialists: $20 copay**	
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay** Other preventive services are available. There are some covered services that have a cost.	
Emergency / Worldwide ER 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)	
Urgently Needed Services	$45 copay within the US $90 copay outside the US ($5,000 maximum coverage amount)	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $200 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**	
Hearing Services	Routine Hearing Exam: $20 copay** (one routine exam allowed annually)	
Hearing Aids	$600 - $2,075 copay per hearing aid, limit two per year through NationsHearing	
Optional Dental Coverage	$18/month (in addition to monthly plan premium)	
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)	
Mental Health Services	Inpatient Hospital: Days 1-7: $250 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $20 copay**

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Premiums and Benefits	CCHP Senior Value Program (HMO)	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $135 copay/day**	
Physical Therapy	$20 copay**	
Ambulance Services	$265 copay** per trip	
Transportation	$0 copay per trip, 12 one-way trips or *6 round-trips*	
Medicare Part B Drugs	Medicare Part B Insulin Drugs: $35 copay Chemotherapy: 20% Coinsurance** Other Part B drugs: 20% Coinsurance**	
Acupuncture	$10 copay (15 visits per year)	
Over-the-Counter (OTC) Items	$30 allowance per month (allowance expires at the end of the quarter)	
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***
Yearly Deductible	$0	
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 $5,030		
Generic	25% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $8,000		
Generic	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.	
Brand & Specialty		
*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., Monday to Friday. 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>.

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CCHP Health Plan

CCHP Senior Select Program (HMO D-SNP)
2024 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, 2024 - December 31, 2024.

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)	
Monthly Plan Premium	**$0*** ***if you qualify for Extra Help or*** **$41*** ***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.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400 annually Includes copays AND other costs for medical services for the year.	
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**	
Doctor Visits	PCP: **$0** copay Specialists: **$0** copay**	
Preventive Care (e.g. flu vaccine, diabetic screenings)	**$0** copay**	
Emergency / Worldwide ER 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.	
Urgently Needed Services	**$0** copay within the US **$90** copay outside the US ($25,000 maximum coverage amount)	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: **$0** copay** X-Ray and Lab Services: **$0** copay** Diagnostic Tests and Procedures: **$0** copay**	
Hearing Services	Routine Hearing Exam: **$0** copay** (Up to one hearing exam each year)	
Hearing Aids	**$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.	
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)	
Mental Health Services	Inpatient Hospital: Days 1-90: **$0** copay per day**	Group and Individual Therapy Sessions: **$0** copay**

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-100: **$0** copay per day**	
Physical Therapy	**$0** copay**	
Ambulance Services	**$0** copay per trip	
Transportation	**$0** copay per trip, 48 one-way trips per year**	
Medicare Part B Drugs	**$0** copay**	
Acupuncture	**$0** copay**	
Over-the-Counter (OTC) Items	**$55** allowance per quarter (allowance expires at the end of the quarter)	
Grocery Flex Card	**$45** allowance per month (allowance expires at the end of the quarter)	
Part D: Prescription Drug Coverage (for Drugs on CCHP's Formulary)	**Drug Tier**	**Copay*** (may vary based on the level of Extra Help eligibility)
Yearly Deductible	**$0** if you receive Extra Help, $545 if you receive no Extra Help	
Initial Coverage	**Cost-Sharing Tier 1 Generic** (including brand drugs treated as generic)	25% coinsurance; or with Low Income Subsidy (LIS): $0/$1.55/$4.50 copay
	Cost-Sharing Tier 1 All Other Drugs	25% coinsurance; or with Low Income Subsidy (LIS): $0/$4.60/$11.20 copay
Coverage Gap (after you pay $5,030)	During this phase you will pay 25% for generic or brand-name drugs.	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $8,000.	**Generic** (including brand drugs treated as generic)	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.
	All Other Drugs	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.
*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., Monday to Friday. 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.

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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.
- ☐ 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, 2024.
- ☐ 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.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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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.

☐ **Medicare Advantage Plan (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).

☐ **Medicare Special Needs Plan (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.

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.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

_____

Signature:

_____

Signature Date:

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

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.

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 (October 1 - March 31). Mondays – Fridays 8:00 a.m. to 8:00 p.m. (April 1 - September 30).

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CCHP Health Plan

445 Grant Avenue, San Francisco, CA 94108
Tel 1-415-955-8800 | Fax 1-415-955-8818
www.cchphealthplan.com

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.

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): $39.50 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 $41* 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:

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.

What is your race? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Black or African American
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Hispanic or Latino
- ☐ Korean
- ☐ Japanese
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ 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**

Are you Hispanic, Latino/a, or Spanish origin? (Check all that apply)

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

Select one if you would prefer us to send you information in a language other than English or in an accessible format.

☐ Chinese ☐ Spanish ☐ 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:

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). CCHP 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 CCHP 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. CCHP 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 CCHP's website Compliance Privacy page at CCHPHealthPlan.com/yourconfidentialmedicalinfo. For questions on these policies, please call the CCHP Compliant Hotline at 415-955-8810 or email to CCHPComplianceDept@cchphealthplan.com.

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 1-855-245-1120, 8 a.m. - 8 p.m. 7 days a week October 1st through March 31st; Monday through Friday from 8 a.m. - 8 p.m. (TTY:711) after I receive member ID card from Delta Dental.

#78954 FM_DCUSA_Enroll_CA_6609 (07-07-14)

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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 1-855-245-1120, 8 a.m.-8 p.m. 7 days a week October 1st through March 31st; Monday through Friday from 8 a.m.-8 p.m. (TTY:711) 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
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.

H0571_2024DEF000_C

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., 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

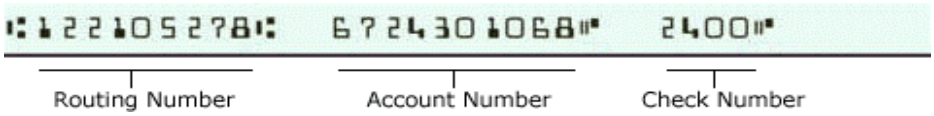
Name of Financial Institution: _____

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 on or around the 15th day of each month and will be used to pay the plan premium. If the transferred day of the month falls on a weekend or a holiday, the Automatic Payment will be debited from your account on the following business day.

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, San Francisco, CA 94108 by the 10th 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., Monday to Friday.

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		○ By Mail		
Member Services Center 890 Jackson St, San Francisco, CA 94133	○ In person	○ In person		○ In person
Gellert Health Services 386 Gellert Blvd, Daly City, CA 94015	○ In person			○ 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			

REV 10/5/23

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 (including limited English proficiency and primary language), age, disability, or sex (including sexual orientation, gender identity, and sex characteristics.

Chinese Community Health Plan:

- Provides free aids and services to people with disabilities, including appropriate auxiliary aids and other services, 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, including electronic and translated documents and oral interpretation, 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
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, TTY 1-877-681-8898
Fax 1-415-397-2129
https://cchphealthplan.com/

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)

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（包括有限的英語水平及主要語言）、年齡、殘障或性別（包括性取向、性別認同及性別特徵）而歧視任何人。

華人保健計劃（CCHP）：

- 向殘障人士免費提供各種援助和服務，包括適合的輔助設備及其他服務，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，包括電子文件、翻譯文件、口譯，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
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, 聽力殘障人仕電話 1-877-681-8898
傳真 1-415-397-2129
https://cchphealthplan.com/

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）

Chinese Community Health Plan (CCHP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, (incluido el dominio limitado del inglés y el idioma materno edad, discapacidad o sexo (incluida la orientación sexual, la identidad de género y las características sexuales).

Chinese Community Health Plan:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades incluidas las ayudas auxiliares apropiadas y otros servicios, para comunicarse de manera efectiva con nosotros, tales como:
  - 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
890 Jackson Street, San Francisco, CA 94133
1-888-775-7888, TTY 1-877-681-8898
Fax 1-415-397-2129.
https://cchphealthplan.com/

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)

Multi-language Interpreter Services

English: ATTENTION: If you speak another language, language assistance services, and appropriate auxiliary aids and 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, y las ayudas y servicios auxiliares apropiados. 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).

NOTES

Daly City Office

San Francisco Offices

1-888-788-2594 (TTY 1-877-681-8898)
Monday through Sunday, 8am-8pm

Sales@CCHPHealthPlan.com

www.cchphealthplan.com/medicare-shopping

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. 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.