

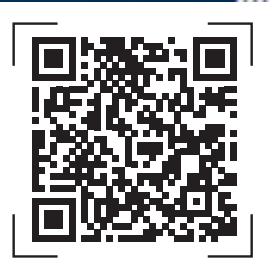
GET MORE

With CCHP
Medicare

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



**NOW,
also available
in Alameda
County!**



* Upon qualification.

2025 CCHP Medicare Information Kit



CCHP
Health Plan

This is an advertisement.

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TABLE OF CONTENTS

- 4 Introduction**
- 5 Contact Info**
- 6 Discover the CCHP Medicare Advantage**
- 8 Benefits Quick Look**
- 12 Grocery and OTC Allowances**
- 13 Dental Supplement**
- 14 Summary of Benefits**
- 24 Pre-enrollment Checklist**
- 25 Forms**



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
and age well.

We are here for you!

This booklet will help you understand the benefits of enrolling
in one of our quality 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



1-877-224-7705 (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 2025:

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



San Francisco Original. Now, also in Alameda County!

Established in 1986, we are part of a dynamic healthcare system designed with you in mind. We too live and work here to serve our neighbors. Almost 40-years in, we continue to focus on our Bay Area communities including Alameda, San Francisco, and San Mateo counties.

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 \$1,020 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 (OTC) items. We are here to help. **Depends on where you live and the program you qualify for.*

Choosing CCHP is Easy

With so many options, Medicare can be complicated. That's why we keep our choices simple. 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.

*Depends on your choice of plan and qualified participation.

ALAMEDA COUNTY

ALL-NEW BENEFITS QUICK LOOK

CCHP Senior Program (HMO)

\$31 /month

For Residents:

- In Alameda County
- Enrolled in Medicare parts A & B

Doctor Visits (PCP / Specialist)

\$0 / \$0 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

\$52 per month

Allowance for Herbal Products



Extra Grocery Allowance for Hypertensive Members

\$10 per month
(upon qualification)

Dental Coverage (Preventive)

\$0 Copay

Dental Comprehensive Coverage

\$10 additional per month

Vision Coverage (Full-Service VSP Vision Plan)

\$20 copay (once a year)
(\$150 allowance for eye glasses every 2-years)

Hearing Exam (Routine)

\$20 Copay

Hearing Aid

\$3,000 annual allowance

Acupuncture Treatments

\$5 Copay

Transportation Services

24 one way trips
(for medical appointments)

8Worldwide ER Coverage



CCHP Senior Value Program (HMO)

\$0 /month

For Residents:

- In Alameda County
- Enrolled in Medicare parts A & B

\$0 / \$15 Copays

\$0 Copay



\$0 Copay

\$0 Copay

n/a

\$65 per month



\$20 per month
(upon qualification)

\$0 Copay

\$10 additional per month

\$35 copay (once a year)
(\$100 allowance for eye glasses every 2-years)

\$20 Copay

\$3,000 annual allowance

\$10 Copay (15 visits / year)

12 one way trips
(for medical appointments)



SAN FRANCISCO & SAN MATEO COUNTIES

CCHP Senior Program (HMO)

\$21 /month

For Residents:

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

BENEFITS QUICK LOOK

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)	\$0 Copay
Dental Comprehensive Coverage	\$10 additional per month
Vision Coverage (Full-Service VSP Vision Plan)	\$20 copay (once a year) (\$150 allowance for eye glasses every 2-years)
Hearing Exam (Routine)	\$20 Copay
Hearing Aid	\$3,000 annual allowance
Acupuncture Treatments	\$5 Copay
Transportation Services	24 one way trips (for medical appointments)
¹⁰ 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-\$9.40* /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.

\$0-\$5 / \$20 Copays

\$0 Copay



\$0 Copay

\$0 Copay

n/a

\$40 per month



\$20 per month
(upon qualification)

\$0 Copay

\$10 additional per month

\$35 copay (once a year)
(\$100 allowance for eye glasses every 2-years)

\$20 Copay

\$3,000 annual allowance

\$10 Copay (15 visits / year)

12 one way trips
(for medical appointments)



\$0 / \$0 Copays

\$0 Copay



\$0 Copay

\$0 Copay

\$45 per month
(upon Low Income Subsidy qualification)

\$55 per quarter



\$10 per month
(upon qualification)

Through Medi-Cal

n/a

\$0 copay (once a year)
(\$150 allowance for eye glasses every 2-years)

\$0 Copay

\$3,000 annual allowance

\$0 Copay

48 one way trips
(for medical appointments)



GETTING MORE

You will get allowances for over-the-counter (OTC) purchases and groceries. Depending on the plan you choose and qualifications, you will get hundreds of dollars per year to spend on your everyday expenses.



Here is How it works:

- 1 When you enroll in a CCHP Medicare plan, you will automatically receive a pre-paid debit card.
- 2 We will deposit corresponding amount each month - depending on the plan you choose and program you participate in.
- 3 You use it like a credit card to spend at participating grocers and pharmacies. (e.g. Safeway, CVS, Walgreens, and more).
- 4 You can track your balances online or by calling customer service.

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

Plan/Allowance	Alameda County		San Francisco & San Mateo Counties		
	CCHP Senior Program	CCHP Senior Value Program	CCHP Senior Program	CCHP Senior Value Program	CCHP Senior Select Program
Monthly Grocery Allowance	\$20*	N/A	\$20*	N/A	\$45***
Monthly OTC Allowance	\$52	\$65	\$40	\$40	\$18.33
Monthly Hypertension Allowance	\$10**	\$20**	\$10**	\$20**	\$10**
Monthly Allowance Total	\$82	\$85	\$70	\$60	\$73.33
Yearly Allowance Total	\$984	\$1,020	\$840	\$720	\$880

*Senior – grocery allowance must be earned with an annual wellness visit (AWV). **Requires diagnosis
***If you qualify for Low Income Subsidy (LIS)

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 are in. 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 all 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

CCHP Senior Program
\$10/month

CCHP Senior Value Program
\$10/month

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





CCHP Senior Program (HMO) 2025 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, 2025 - December 31, 2025.

Premiums and Benefits	CCHP Senior Program (HMO)
Monthly Plan Premium	\$21* 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	\$3,000 annual allowance for hearing aids. Purchases must be made 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	Full-Service VSP Vision Plan Routine eye exam: \$20 copay** (one exam allowed annually) Eyeglasses: \$0 copay** for one pair of glasses every two years (maximum \$150 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$150 plan allowance every two years from a VSP provider.

Premiums and Benefits	CCHP Senior Program (HMO)	
Mental Health Services	Inpatient Hospital: Days 1-7: \$250 copay/day** Days 8-90: \$0 copay/day**	Group and Individual Therapy Sessions: \$15 copay**
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: \$0 copay/day** Days 21-100: \$110 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 March 31 st of the following plan year)	
Grocery Flex Card (1)	\$20 allowance per month (allowance expires at the end of March 31 st of the following plan year)	
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	
Initial Coverage		
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.
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,000		
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, San Mateo and Alameda 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 www.CCHPHealthPlan.com/medicare.



CCHP Senior Value Program (HMO) 2025 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, 2025 - December 31, 2025.

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	\$3,000 annual allowance for hearing aids. Purchases must be made 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	Full-Service VSP Vision Plan Routine eye exam: \$35 copay** (one exam allowed annually) Eyeglasses: \$0 copay for one pair of glasses every two years (maximum \$100 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$100 plan allowance every two years from a VSP provider.

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Premiums and Benefits		CCHP Senior Value Program (HMO)	
Mental Health Services	Inpatient Hospital: Days 1-7: \$250 copay/day** Days 8-90: \$0 copay/day**	Group and Individual Therapy Sessions: \$20 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: \$0 copay/day** Days 21-100: \$115 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	\$40 allowance per month (allowance expires at the end of March 31 st of the following plan year)		
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		
Initial Coverage			
Tier 1: Preferred Generic (no deductible)	\$0 copay	\$0 copay	
Tier 2: Non-preferred Generic (no deductible)	\$3 copay	\$0 copay	
Tier 3: Preferred Brand (no deductible)	\$35 copay	\$70 copay	
Tier 4: Non-preferred Brand (no deductible)	\$75 copay	\$150 copay	
Tier 5: Specialty (no deductible)	30% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,000			
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, San Mateo and Alameda 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 www.CCHPHealthPlan.com/medicare.

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CCHP Senior Select Program (HMO D-SNP) 2025 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, 2025 - December 31, 2025.

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)
Monthly Plan Premium	\$0* <i>if you qualify for Extra Help</i> or \$9.40* <i>if you don't</i> 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 8-90: \$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	\$3,000 annual allowance for hearing aids. Purchases must be made through NationsHearing.
Dental Services	\$1,000 allowance for Dental Services beyond those covered by Medi-Cal Dental Program.
Vision Services	Full-Service VSP Vision Plan Routine eye exam: \$0 copay** (one exam allowed annually) Eyeglasses: \$0 copay for one pair of glasses every two years (maximum \$150 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$150 allowance every two years from a VSP provider.

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**	
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 March 31 st of the following plan year)		
Grocery Flex Card	\$45 allowance per month if you qualify for Low Income Subsidy (LIS) (allowance expires at the end of March 31 st of the following plan year)		
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, \$590 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 copay	
	Cost-Sharing Tier 1 All Other Drugs	25% coinsurance; or with Low Income Subsidy (LIS): \$0 copay	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,000.	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.



CCHP Senior Program (HMO) 2025 Summary of Benefits

SERVICE AREA: ALAMEDA COUNTY

This is a summary of drug and health services covered by CCHP Senior Program (HMO) from January 1, 2025 - December 31, 2025.

Premiums and Benefits	CCHP Senior Program (HMO)
Monthly Plan Premium	\$31* 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)	\$3,000 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: \$200 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: \$0 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	\$110 copay within the U.S. \$90 copay outside the U.S. 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	\$20 copay within the US \$90 copay outside the US (\$25,000 maximum coverage amount)
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: \$100 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	\$3,000 annual allowance for hearing aids. Purchases must be made 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	Full-Service VSP Vision Plan Routine eye exam: \$20 copay** (one exam allowed annually) Eyeglasses: \$0 copay** for one pair of glasses every two years (maximum \$150 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$150 plan allowance every two years from a VSP provider.

Premiums and Benefits		CCHP Senior Program (HMO)	
Mental Health Services	Inpatient Hospital: Days 1-7: \$250 copay/day** Days 8-90: \$0 copay/day**	Group and Individual Therapy Sessions: \$15 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: \$0 copay/day** Days 21-100: \$75 copay/day**		
Physical Therapy	\$15 copay**		
Ambulance Services	\$180 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	\$52 allowance per month (allowance expires at the end of March 31 st of the following plan year)		
Grocery Flex Card (1)	\$20 allowance per month (allowance expires at the end of March 31 st of the following plan year)		
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		
Initial Coverage			
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)	\$30 copay	\$60 copay	
Tier 4: Non-preferred Brand (no deductible)	\$50 copay	\$100 copay	
Tier 5: Specialty (no deductible)	30% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,000			
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, San Mateo and Alameda 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 www.CCHPHealthPlan.com/medicare.



CCHP Senior Value Program (HMO) 2025 Summary of Benefits

SERVICE AREA: ALAMEDA COUNTY

This is a summary of drug and health services covered by CCHP Senior Value Program (HMO) from January 1, 2025 - December 31, 2025.

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)	\$3,500 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: \$250 copay per day** (at all other in-network hospitals) Days 8-90: \$0 copay per day**
Outpatient Hospital	\$150 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	\$125 copay within the U.S. \$90 copay outside the U.S. 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	\$25 copay within the US \$90 copay outside the US (\$5,000 maximum coverage amount)
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: \$150 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	\$3,000 annual allowance for hearing aids. Purchases must be made 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	Full-Service VSP Vision Plan Routine eye exam: \$35 copay** (one exam allowed annually) Eyeglasses: \$0 copay for one pair of glasses every two years (maximum \$100 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$100 plan allowance every two years from a VSP provider.

Premiums and Benefits		CCHP Senior Value Program (HMO)	
Mental Health Services	Inpatient Hospital: Days 1-7: \$250 copay/day** Days 8-90: \$0 copay/day**	Group and Individual Therapy Sessions: \$20 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: \$0 copay/day** Days 21-100: \$100 copay/day**		
Physical Therapy	\$20 copay**		
Ambulance Services	\$200 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	\$65 allowance per month (allowance expires at the end of March 31 st of the following plan year)		
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		
Initial Coverage			
Tier 1: Preferred Generic (no deductible)	\$0 copay	\$0 copay	
Tier 2: Non-preferred Generic (no deductible)	\$3 copay	\$0 copay	
Tier 3: Preferred Brand (no deductible)	\$35 copay	\$70 copay	
Tier 4: Non-preferred Brand (no deductible)	\$75 copay	\$150 copay	
Tier 5: Specialty (no deductible)	30% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,000			
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, San Mateo and Alameda 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 www.CCHPHealthPlan.com/medicare.

H0571_2025SOB011_M

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, 2025.
- 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.



FORMS



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.

<input type="checkbox"/>	Medicare Advantage Plan (Part C)
<p>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).</p>	
<input type="checkbox"/>	Medicare Special Needs Plan (SNP)
<p>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.</p>	

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:

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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).

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.

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 January 1)
- 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 8 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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. the plan. See "What happens next?" on this page to send your completed form to the plan.

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 in this section 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.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | |
| <input type="checkbox"/> I choose not to answer | |

What is your race? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian: | Native Hawaiian or Other Pacific Islander: |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Korean | <input type="checkbox"/> White |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Other Asian | |

What is your ethnicity? Select all that apply.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> American | <input type="checkbox"/> European | <input type="checkbox"/> Latin American | |
| <input type="checkbox"/> Arab | <input type="checkbox"/> Filipino | <input type="checkbox"/> Mexican | |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Russian | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Black | <input type="checkbox"/> Iranian | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> I choose not to answer |

What is your preferred language for health care?

- | WRITTEN | SPOKEN | WRITTEN | SPOKEN | WRITTEN | SPOKEN |
|--------------------------|---|--------------------------|----------------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> American Sign Language (ASL) | <input type="checkbox"/> | <input type="checkbox"/> Khmer | <input type="checkbox"/> | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> | <input type="checkbox"/> Arabic | <input type="checkbox"/> | <input type="checkbox"/> Laotian | <input type="checkbox"/> | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> | <input type="checkbox"/> Bulgarian | <input type="checkbox"/> | <input type="checkbox"/> Persian | <input type="checkbox"/> | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Chinese (Written) / Cantonese (Spoken) | <input type="checkbox"/> | <input type="checkbox"/> Polish | | |
| <input type="checkbox"/> | <input type="checkbox"/> Chinese (Written / Mandarin (Spoken) | <input type="checkbox"/> | <input type="checkbox"/> Punjabi | <input type="checkbox"/> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> English | <input type="checkbox"/> | <input type="checkbox"/> Russian | <input type="checkbox"/> | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> | <input type="checkbox"/> Korean | <input type="checkbox"/> | <input type="checkbox"/> Spanish | | |

What is your assigned sex at birth?

- Female Male Unknown **I choose not to answer**

What is your preferred pronoun?

- | | |
|---|--|
| <input type="checkbox"/> He/Him/His | <input type="checkbox"/> No Pronoun |
| <input type="checkbox"/> She/Her/Hers | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> They/Them/Theirs | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Ze/Zir/Zirs | |

What is your gender? Select one.

- Woman I use a different term: _____
 Man I choose not to answer
 Non-binary

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay or homosexual I use a different term: _____
 Straight, that is, not gay or lesbian I don't know
 Bisexual I choose not to answer

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 Data 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 Compliance 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 having it automatically taken out of 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.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only):

Office Use Only

Name of staff member/agent/broker

(if assisted in enrollment): _____

Plan ID: 001 005 007

Effective Date of Coverage: _____

010 011

ICEP AEP MAOEP SEP (type): _____

Not Eligible: _____

RECEIVED DATE STAMP

Broker assisted enrollments:

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

Note: _____

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.

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. 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.

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 **\$18.50 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 **\$18.50 per month**, which is in addition to my Medicare Part B and CCHP Senior Program (HMO) premiums.

CCHP	Group No. 76609	Effective Date
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Applicant Information

Last Name		First Name		Middle Name		CCHP ID No.	
Permanent Residence (Street Address ONLY - No P.O. Box)						Apt. #	
City		State	Zip		County		
Gender <input type="checkbox"/> Male <input type="checkbox"/> 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.

Delta Dental is a registered trademark of Delta Dental Plans Association.

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 reenter 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.

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



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

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

Please complete the information below	
Name of Applicant:	Effective Date Requested (MM/DD/YY):
Premium Amount: \$	
Card Number:	Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> 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

Internal 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.**

⑆ 122105278⑆	6724301068⑈	2400⑈
Routing Number	Account Number	Check Number

NOTE: If you select automatic withdrawal as your payment option for your plan premium, you will not 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
 October 1 - March 31 | 7 days a week 8:00 a.m. to 8:00 p.m.
 April 1 - September 30 | Monday - Friday 8:00 a.m. to 8:00 p.m.

Other Payment Methods:

Location/Payment Types	Credit Card Debit Card	Personal Check Cashier Check Money Order	Cash	Pay Online Walkthrough
CCHP 445 Grant Ave. San Francisco, CA 94108		○ By Mail		
Member Services Center 445 Grant Ave. San Francisco, CA 94108	○ 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 www.cchphealthplan.com/how-to-pay	○ Electronic			



**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. CCHP (Chinese Community Health Plan) follows State and Federal civil rights laws. CCHP does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

CCHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call our Member Service at 1-888-775-7888 between

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

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

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

How to file a grievance

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

- **By phone:** Member Services at 1-888-775-7888 between
 - ❖ 8am – 8pm, 7 days a week (October 1- March 31)
 - ❖ 8am – 8pm, Monday - Friday (April 1 – September 30)

Or, if you cannot hear or speak well, please call 1-877-681-8898.

- **In writing:** Fill out a complaint form or write a letter and send it to:
Member Services
445 Grant Avenue, San Francisco, CA 94108
 - **In person:** Visit your doctor's office or CCHP Member Service (address above) and say you want to file a grievance.
 - **By Fax:** 1-415-397-2129
 - **Electronically:** Visit www.cchphealthplan.com/grievances-and-appeals
-

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

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

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

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

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

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 दः यद आप हद्दी 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: Ուշադրութեամբ խոսելու դեպքում, մեր լեզուների օգնությունը կազմակերպվում է անվճար կարգով և անհատապես ձեր լեզվի համար: Ձանգահարեք 1-888-775-7888 (TTY (հեռախոս)՝ 1-877-681-8898):

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-775 7888 (TTY: 1-877-681-8898) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-888-775-7888 (TTY: 1-877-681-8898)។

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

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

Persian (Farsi):

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

Lao (Laotian):

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



For more

Information

please contact CCHP Sales Department.

In Person

San Francisco Office
445 Grant Avenue
San Francisco, CA 94108

Daly City Office
386 Gellert Boulevard
Daly City, CA 94015

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

Call or Email

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



1-877-224-7705 (TTY: 1-877-681-8898)
Monday through Sunday, 8am-8pm



Sales@CCHPHealthPlan.com



cchphealthplan.com/medicare-shopping

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