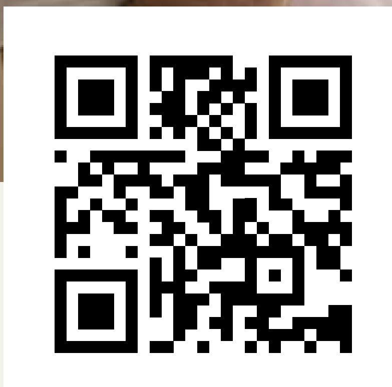
Balance

Your Path to Wellness Starts Here.

As little as

$0

a month when you qualify.



2025 Health Plans for Individuals & Family, Covered California.

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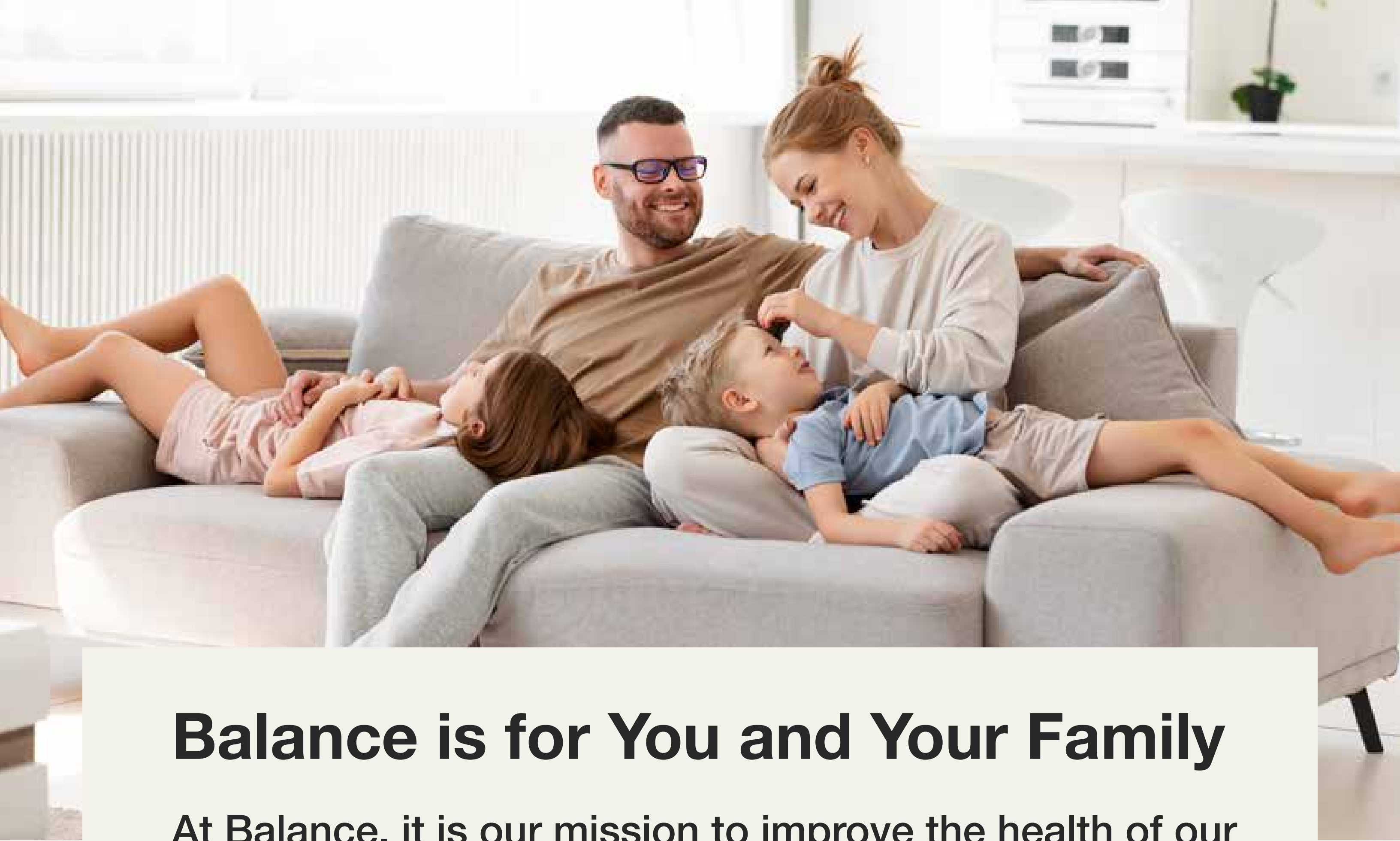


Balance is for You and Your Family

At Balance, it is our mission to improve the health of our community by delivering quality, affordable healthcare.

We are a Bay Area Original

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

Our plans are offered exclusively for San Francisco and San Mateo County residents.

We’re Focused on Wellness Your way

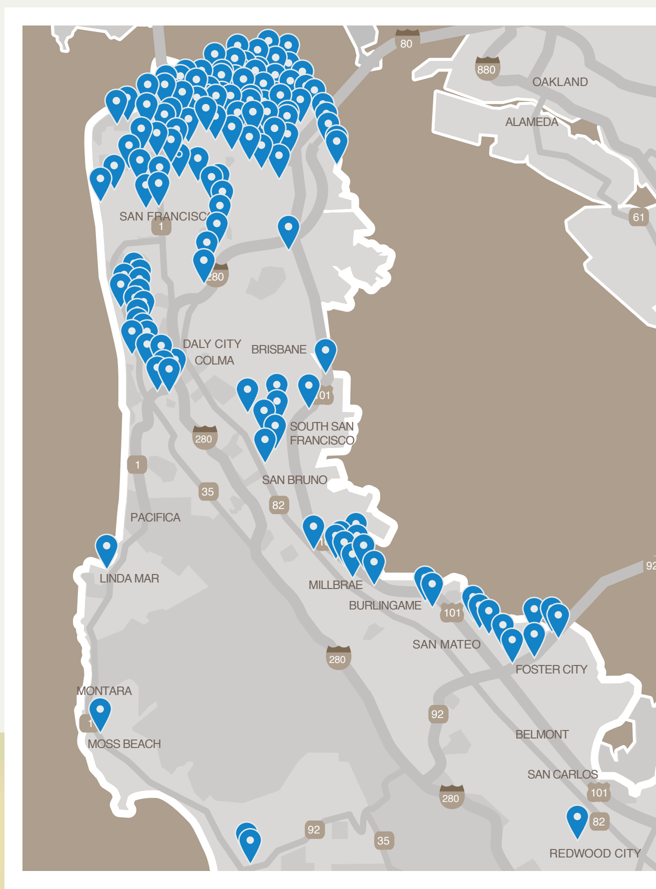
Free preventive screenings, telehealth, health education and fitness classes, in-person and virtually. You decide how you want to achieve your optimal health, conveniently and safely.

Access to Care

Large Network of Doctors and Hospitals

With every plan, you get an in-network choice of over 7,000 neighborhood doctors, specialists, and facilities in our San Francisco, and San Mateo County service area.

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



Membership to One Medical Group for No Cost? Sounds like a plan!

Enroll in Balance and you can choose to have us cover your One Medical annual membership fee. You can include your enrolled dependents.

No Ordinary Doctor's Office

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

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

one medical

How to get One Medical at no cost to you.

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

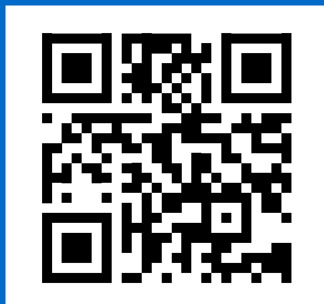
1. One Medical charges a yearly membership fee of $199. When you opt-in to our One Medical for no cost program, we pay your yearly fee.
2. Complete a short Initial Health Assessment (IHA).
3. Be sure to ask our sales representative about details.

Balance by CCHP

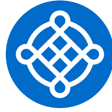
one medical

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

After reviewing the information, talk to one of our friendly and knowledgeable experts who can answer questions and guide you to the right plan for you.



Or, Skip the Line, Apply Online Now.



Balance Quality

& Affordable Plan Options

You and your family's needs are unique. That's why we offer you a range of plans for you to choose from.

This includes plans you can buy through the Covered California exchange. With this partnership, you can get financial help to pay for your coverage. Be sure to ask about it, or go online to see how much financial help you could qualify for.

Here is what's included:

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

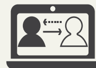
Plans We Offer
for an in-depth look at plan details and rates

Enrollment Application
submit the completed form immediately to ensure the effective time

Ways to Contact Us
our friendly sales representatives are here for you

Value Added Services

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

 Balance Member Portal

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

Quarterly Community Health Newsletter

Free Fitness classes like yoga, qigong and tai chi

Wellness classes on topics like perinatal and healthy eating

Acupuncture services

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

Convenient access to Urgent Care centers for non-emergencies

24/7 Nurse Advice Line

Optional
Dental & Vision Coverage

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

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

Monthly Rate: $18.05

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

Monthly Rate: $3.92

2025 Plans
Benefit Highlights & Rates

For San Francisco and San Mateo Counties

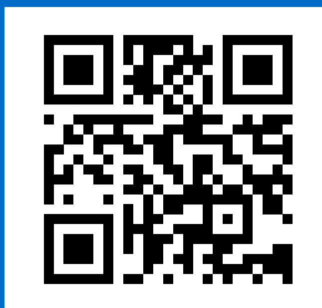
Following pages provide you with a side-by-side comparison of key plan benefits and rates by age.

Make sure to check the benefits that are important to you and if you don't see them listed, please be sure to ask us.

At any time you have questions, contact us.

Call or Email

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



1-877-256-2477
(TTY: 1-877-681-8898)

Sales@BalanceByCCHP.com

2025 Plan Benefit Highlights

Please review the highlighted benefits in this chart. You can compare between plans to find the one that fits your unique needs best. As always, please contact us with any questions.

Plan Name	Jade 15 Platinum HMO	Silver 70 Off-Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO Silver	
				In-Network	Out-of-Network
Metal Level / Actuarial Benefit Value %**	Platinum / 91.20%	Silver / 71.60%	Silver / 69.98%	Silver / 71.85 %	
SERVICES AND FEATURES					
Annual Deductible	$0	Individual $5,400 Family $10,800 (A)	Individual $2,750 Family $5,500 (A)	Individual $2,500 / Family $5,000 (A) Medical / Rx (1)	
Out–of–Pocket Limit on Expenses	Individual $3,500 Family $7,000	Individual $8,700 Family $17,400	Individual $7,500 Family $15,000	Individual $7,700 Family $15,400	
LIFETIME MAXIMUMS	No Limit				
PROFESSIONAL SERVICES	**Member Cost Share**				
Preventive Care/ Screening/Immunization	Not Subject to Copay				
Primary Care Visit to Treat an Injury or Illness	$15 Copay	$50 Copay	$0 Copay for First (3) PCP Visits Then Deductible Applies, After Deductible is Met, $50 Copay	$0 Copay for First (3) PCP Visits Then Deductible Applies, After Deductible is Met, $50 Copay	50% Coinsurance (After Deductible)
Specialist Visit	$30 Copay	$90 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)
Prenatal and Preconception Visits	$0 Copay	$0 Copay	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Hospital Services)	$150 Copay/Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	$500 Copay/Day (Up to First 5 Days) (After Deductible)	20% Coinsurance (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	30% Coinsurance	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
OUTPATIENT SERVICES					
Laboratory Tests	$5 Copay	$50 Copay	$25 Copay (After Deductible)	$10 Copay (After Deductible)	50% Coinsurance (After Deductible)
X-Rays	$5 Copay	$95 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$100 Copay	$325 Copay	$350 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$250 Copay	30% Coinsurance	$400 Copay Chinese Hospital $1,200 Copay Other Facilities (After Deductible)	20% Coinsurance Chinese Hospital 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	30% Coinsurance	$0 Copay (After Deductible)	20% Coinsurance Chinese Hospital 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)

Footnotes: Preventive care services are not subject to the deductible.
(1) Medical/Rx cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1)

2025 Plan Benefit Highlights

Please review the highlighted benefits in this chart. You can compare between plans to find the one that fits your unique needs best. As always, please contact us with any questions.

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					
Plan Name	**Platinum 90 HMO**	**Gold 80 HMO**	**Silver 70* HMO**	**Bronze 60 HMO**	**Bronze 60 HDHP HMO**	**Minimum Coverage HMO**
Metal Level / Actuarial Benefit Value %*	Platinum / 91.60%	Gold / 81.60 %	Silver / 71.60 %	Bronze / 63.60%	Bronze / 64.90%	N/A
SERVICES AND FEATURES						
Annual Deductible	$0	$0	Individual $5,400 Family $10,800 (A)	Individual $5,800 Family $11,600(A)	Individual $6,650 Family $13,300 (A) Medical / Rx (1)	Individual $9,200 Family $18,400 (A) Medical / Rx (1)
Out–of–Pocket Limit on Expenses	Individual $4,500 Family $9,000	Individual $8,700 Family $17,400	Individual $8,700 Family $17,400	Individual $8,850 Family $17,700	Individual $6,650 Family $13,300	Individual $9,200 Family $18,400
LIFETIME MAXIMUMS	No Limit					
PROFESSIONAL SERVICES	**Member Cost Share**					
Preventive Care/ Screening/Immunization	Not Subject to Copay					
Primary Care Visit to Treat an Injury or Illness	$15 Copay	$35 Copay	$50 Copay	$60 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance (Medical Deductible Applies After First 3 Non-Preventive Visits)
Specialist Visit	$30 Copay	$65 Copay	$90 Copay	$95 Copay (Deductible Applies After First (3) Non-Preventive Visits)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Prenatal and Preconception Visits	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	$225/day (Up to First 5 Days)	$330/day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
OUTPATIENT SERVICES						
Laboratory Tests	$15 Copay	$40 Copay	$50 Copay	$40 Copay	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
X-Rays	$30 Copay	$75 Copay	$95 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Imaging (CT/PET Scans, MRIs)	$75 Copay	$75 Copay	$325 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 Copay	$130 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Physician/Surgeon Fees	$20 Copay	$60 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance

Footnotes: Preventive care services are not subject to the deductible.
(1) Medical/Rx cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1)

Balance by CCHP | COVERED CALIFORNIA

2025 Plan Benefit Highlights

Please review the highlighted benefits in this chart. You can compare between plans to find the one that fits your unique needs best. As always, please contact us with any questions.

Plan Name	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO Silver	
				In-Network	Out-of-Network
HOSPITALIZATION SERVICES	**Member Cost Share**				
Facility Fee (e.g., Hospital Room)	$150 Copay/Day Chinese Hospital $450 Copay/Day Other Facilities (Up to First 5 Days)	30% Coinsurance (After Medical Deductible)	$500 Copay/Day Chinese Hospital $1,500 Copay/Day Other Facilities (Up to First 5 Days) (After Deductible)	20% Coinsurance Chinese Hospital 40% Coinsurance Other Facilities (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	30% Coinsurance	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE					
Emergency Room Services (waived if admitted)	$100 Copay	$400 Copay	$300 Copay (After Deductible)	$200 Copay (After Deductible)	$200 Copay (After Deductible)
Emergency Room Physician Fee (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Center	$50 Copay	$50 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE					
Annual Prescription Deductible	$0	Individual $50 Family $100	Individual $275 Family $550	Individual $2,500 / Family $5,000 [A] Medical / Rx [1]	
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	$18 Copay	$15 Copay	$15 Copay (After Rx Deductible)	Not Covered
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 15 Copay	$60 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	Not Covered
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$90 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	Not Covered
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250/Prescription	20% Coinsurance up to $250/Prescription (After Rx Deductible)	20% Coinsurance up to $250/Prescription (After Rx Deductible)	20% Coinsurance up to $250/Prescription (After Deductible)	Not Covered
PEDIATRIC VISION AND DENTAL (Included in Plan)					
Child Needs Eye Care (Ages 0-18)					
Eye Exam (1 Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Eyewear (Lenses) (1 Pair Per Calendar Year)	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Not Covered
Eyewear (Contact Lenses in Lieu of Glasses)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page				

Footnotes: Preventive care services are not subject to the deductible.
(1) Medical/Rx cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1)

2025 Plan Benefit Highlights

Please review the highlighted benefits in this chart. You can compare between plans to find the one that fits your unique needs best. As always, please contact us with any questions.

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					
Plan Name	**Platinum 90 HMO**	**Gold 80 HMO**	**Silver 70 HMO**	**Bronze 60 HMO**	**Bronze 60 HDHP HMO**	**Minimum Coverage HMO**
HOSPITALIZATION SERVICES	**Member Cost Share**					
Facility Fee (e.g., Hospital Room)	$225/Day (Up to First 5 Days)	$350/Day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Physician/Surgeon Fees	$0 Copay	$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
EMERGENCY HEALTH COVERAGE						
Emergency Room Services (waived if admitted)	$150 Copay	$330 Copay	$400 Copay	40% Coinsurance (After Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Emergency Room Physician Fee (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance
Urgent Care Center	$15 Copay	$35 Copay	$50 Copay	$60 Copay	After Medical Deductible, 0% Coinsurance	0% Coinsurance (Medical Deductible Applies After First 3 Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE						
Annual Prescription Deductible	$0	$0	Individual $50 Family $100	Individual $450 Family $900	Individual $6,650 Family $13,300 (A) Medical / Rx (1)	Individual $9,200 Family $18,400 (A) Medical / Rx (1)
Tier 1: Generic Drugs (30-Day Supply)	$7 Copay	$ 15 Copay	$18 Copay	$19 Copay	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Tier 2: Preferred Brand Drugs (30-Day Supply)	$16 Copay	$60 Copay	$60 Copay (After Rx Deductible)	40% Coinsurance Up to $500/Prescription (After Rx Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$85 Copay	$90 Copay (After Rx Deductible)	40% Coinsurance Up to $500/Prescription (After Rx Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250/prescription	20% Coinsurance up to $250/Prescription	20% Coinsurance up to $250/Prescription (After Rx Deductible)	40% Coinsurance Up to $500/Prescription (After Rx Deductible)	After Medical Deductible, 0% Coinsurance	After Medical Deductible, 0% Coinsurance
PEDIATRIC VISION AND DENTAL (Included in Plan)						
Child Needs Eye Care (Ages 0-18)						
Eye Exam (1 Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	0% Coinsurance
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	After Medical Deductible, 0% Coinsurance
Eyewear (Lenses) (1 Pair Per Calendar Year)	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses No Cost Share	Single vision, lined bifocal, and lined trifocal lenses After Medical Deductible, 0% Coinsurance
Eyewear (Contact Lenses in Lieu of Glasses)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	After Medical Deductible, 0% Coinsurance
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page					

Footnotes: Preventive care services are not subject to the deductible.
(1) Medical/Rx cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1)

Individual & Family Plans

2025 Monthly Rates | *San Francisco County*

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

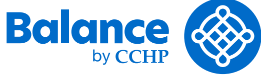
	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO
AGE	**RATE**	**RATE**	**RATE**	**RATE**
0-14	495.18	383.27	364.56	351.99
15	539.20	417.33	396.97	383.28
16	556.03	430.36	409.36	395.24
17	572.85	443.39	421.75	407.21
18	590.98	457.41	435.09	420.09
19	609.10	471.44	448.44	432.97
20	627.87	485.97	462.26	446.32
21	647.29	501.00	476.55	460.12
22	647.29	501.00	476.55	460.12
23	647.29	501.00	476.55	460.12
24	647.29	501.00	476.55	460.12
25	649.88	503.01	478.46	461.96
26	662.83	513.03	487.99	471.16
27	678.36	525.05	499.43	482.21
28	703.61	544.59	518.01	500.15
29	724.32	560.62	533.26	514.87
30	734.68	568.64	540.89	522.24
31	750.21	580.66	552.32	533.28
32	765.75	592.68	563.76	544.32
33	775.46	600.20	570.91	551.22
34	785.81	608.22	578.53	558.59
35	790.99	612.22	582.35	562.27
36	796.17	616.23	586.16	565.95
37	801.35	620.24	589.97	569.63
38	806.53	624.25	593.78	573.31
39	816.88	632.26	601.41	580.67
40	827.24	640.28	609.03	588.03
41	842.78	652.30	620.47	599.08
42	857.66	663.83	631.43	609.66
43	878.38	679.86	646.68	624.38
44	904.27	699.90	665.74	642.79
45	934.69	723.45	688.14	664.41
46	970.94	751.50	714.83	690.18
47	1011.72	783.07	744.85	719.17
48	1058.33	819.14	779.16	752.30
49	1104.28	854.71	813.00	784.96
50	1156.07	894.79	851.12	821.77
51	1207.20	934.37	888.77	858.12
52	1263.52	977.95	930.23	898.15
53	1320.48	1022.04	972.17	938.64
54	1381.97	1069.64	1017.44	982.36
55	1443.46	1117.23	1062.71	1026.07
56	1510.14	1168.84	1111.80	1073.46
57	1577.45	1220.94	1161.36	1121.31
58	1649.30	1276.55	1214.26	1172.38
59	1684.91	1304.11	1240.47	1197.69
60	1756.76	1359.72	1293.36	1248.76
61	1818.90	1407.81	1339.11	1292.94
62	1859.67	1439.38	1369.14	1321.92
63	1910.81	1478.96	1406.78	1358.27
64+	1941.87	1502.99	1429.65	1380.35

Individual & Family Plans

2025 Monthly Rates | *San Francisco County*

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					*ONLY AVAILABLE INSIDE COVERED CALIFORNIA*
	Platinum90 HMO	**Gold80 HMO**	**Bronze60 HMO**	**Bronze60 HDHP**	**Minimum Coverage HMO**	**Silver70 HMO**
AGE	**RATE**	**RATE**	**RATE**	**RATE**	**RATE**	**RATE**
0-14	513.77	467.91	307.35	309.65	296.19	413.93
15	559.44	509.50	334.67	337.17	322.52	450.72
16	576.90	525.40	345.12	347.69	332.58	464.79
17	594.36	541.30	355.56	358.22	342.65	478.86
18	613.16	558.43	366.81	369.55	353.49	494.01
19	631.97	575.56	378.06	380.88	364.33	509.16
20	651.45	593.29	389.71	392.62	375.56	524.85
21	671.59	611.64	401.77	404.77	387.17	541.08
22	671.59	611.64	401.77	404.77	387.17	541.08
23	671.59	611.64	401.77	404.77	387.17	541.08
24	671.59	611.64	401.77	404.77	387.17	541.08
25	674.28	614.09	403.37	406.39	388.72	543.25
26	687.71	626.32	411.41	414.48	396.47	554.07
27	703.83	641.00	421.05	424.19	405.76	567.05
28	730.02	664.86	436.72	439.98	420.86	588.16
29	751.51	684.43	449.58	452.93	433.25	605.47
30	762.26	694.22	456.01	459.41	439.44	614.13
31	778.38	708.89	465.65	469.12	448.73	627.11
32	794.49	723.57	475.29	478.84	458.03	640.10
33	804.57	732.75	481.32	484.91	463.83	648.22
34	815.31	742.54	487.75	491.39	470.03	656.87
35	820.69	747.43	490.96	494.62	473.13	661.20
36	826.06	752.32	494.17	497.86	476.22	665.53
37	831.43	757.21	497.39	501.10	479.32	669.86
38	836.80	762.11	500.60	504.34	482.42	674.19
39	847.55	771.89	507.03	510.81	488.61	682.84
40	858.30	781.68	513.46	517.29	494.81	691.50
41	874.41	796.36	523.10	527.01	504.10	704.49
42	889.86	810.43	532.34	536.31	513.01	716.93
43	911.35	830.00	545.20	549.27	525.39	734.25
44	938.22	854.47	561.27	565.46	540.88	755.89
45	969.78	883.21	580.15	584.48	559.08	781.32
46	1007.39	917.47	602.65	607.15	580.76	811.62
47	1049.70	956.00	627.96	632.65	605.15	845.71
48	1098.05	1000.04	656.89	661.79	633.03	884.67
49	1145.74	1043.46	685.42	690.53	660.52	923.08
50	1199.47	1092.40	717.56	722.91	691.49	966.37
51	1252.52	1140.71	749.30	754.89	722.08	1009.12
52	1310.95	1193.93	784.25	790.10	755.76	1056.19
53	1370.05	1247.75	819.61	825.72	789.83	1103.81
54	1433.85	1305.86	857.77	864.18	826.62	1155.21
55	1497.65	1363.96	895.94	902.63	863.40	1206.61
56	1566.83	1426.96	937.32	944.32	903.28	1262.34
57	1636.67	1490.57	979.11	986.41	943.54	1318.62
58	1711.22	1558.47	1023.70	1031.34	986.52	1378.68
59	1748.16	1592.11	1045.80	1053.61	1007.81	1408.43
60	1822.70	1660.00	1090.40	1098.53	1050.79	1468.49
61	1887.18	1718.72	1128.97	1137.39	1087.96	1520.44
62	1929.49	1757.25	1154.28	1162.89	1112.35	1554.53
63	1982.54	1805.57	1186.02	1194.87	1142.94	1597.27
64+	2014.77	1834.92	1205.29	1214.29	1161.51	1623.23

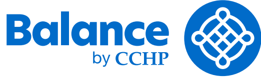


Individual & Family Plans

2025 Monthly Rates | *San Mateo County*

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

	Jade 15 Platinum HMO	Silver 70 Off Exchange HMO	Amber 50 Silver HMO	*ActiveChoice* PPO
AGE	**RATE**	**RATE**	**RATE**	**RATE**
0-14	534.82	413.95	393.75	380.17
15	582.36	450.74	428.75	413.96
16	600.54	464.81	442.13	426.88
17	618.71	478.88	455.51	439.80
18	638.29	494.03	469.92	453.72
19	657.86	509.18	484.33	467.63
20	678.14	524.87	499.26	482.04
21	699.11	541.11	514.70	496.95
22	699.11	541.11	514.70	496.95
23	699.11	541.11	514.70	496.95
24	699.11	541.11	514.70	496.95
25	701.91	543.27	516.76	498.94
26	715.89	554.09	527.05	508.88
27	732.67	567.08	539.41	520.81
28	759.93	588.18	559.48	540.19
29	782.31	605.50	575.95	556.09
30	793.49	614.16	584.19	564.04
31	810.27	627.14	596.54	575.97
32	827.05	640.13	608.89	587.90
33	837.54	648.25	616.61	595.35
34	848.72	656.90	624.85	603.30
35	854.31	661.23	628.97	607.28
36	859.91	665.56	633.08	611.25
37	865.50	669.89	637.20	615.23
38	871.09	674.22	641.32	619.20
39	882.28	682.88	649.55	627.16
40	893.46	691.54	657.79	635.11
41	910.24	704.52	670.14	647.03
42	926.32	716.97	681.98	658.46
43	948.69	734.28	698.45	674.37
44	976.66	755.93	719.04	694.24
45	1009.52	781.36	743.23	717.60
46	1048.67	811.66	772.05	745.43
47	1092.71	845.75	804.48	776.74
48	1143.05	884.71	841.54	812.52
49	1192.68	923.13	878.08	847.80
50	1248.61	966.42	919.26	887.56
51	1303.84	1009.17	959.92	926.82
52	1364.67	1056.24	1004.70	970.05
53	1426.19	1103.86	1049.99	1013.79
54	1492.60	1155.27	1098.89	1061.00
55	1559.02	1206.67	1147.79	1108.21
56	1631.03	1262.40	1200.80	1159.39
57	1703.73	1318.68	1254.33	1211.08
58	1781.34	1378.74	1311.46	1266.24
59	1819.79	1408.50	1339.77	1293.57
60	1897.39	1468.57	1396.90	1348.73
61	1964.50	1520.51	1446.31	1396.44
62	2008.55	1554.60	1478.74	1427.75
63	2063.78	1597.35	1519.40	1467.01
64+	2097.32	1623.31	1544.10	1490.85



Individual & Family Plans

2025 Monthly Rates | *San Mateo County*

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 21 and older are charged premiums based on their ages.

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					*ONLY AVAILABLE INSIDE COVERED CALIFORNIA*
	Platinum90 HMO	**Gold80 HMO**	**Bronze60 HMO**	**Bronze60 HDHP**	**Minimum Coverage HMO**	**Silver70 HMO**
AGE	**RATE**	**RATE**	**RATE**	**RATE**	**RATE**	**RATE**
0-14	554.90	505.36	331.96	334.43	319.90	447.06
15	604.22	550.29	361.46	364.16	348.33	486.80
16	623.08	567.46	372.75	375.53	359.21	502.00
17	641.94	584.64	384.03	386.89	370.08	517.19
18	662.25	603.13	396.18	399.13	381.79	533.55
19	682.56	621.63	408.33	411.38	393.50	549.92
20	703.60	640.79	420.91	424.05	405.62	566.86
21	725.36	660.61	433.93	437.17	418.17	584.40
22	725.36	660.61	433.93	437.17	418.17	584.40
23	725.36	660.61	433.93	437.17	418.17	584.40
24	725.36	660.61	433.93	437.17	418.17	584.40
25	728.26	663.25	435.67	438.92	419.84	586.73
26	742.76	676.46	444.34	447.66	428.20	598.42
27	760.17	692.32	454.76	458.15	438.24	612.45
28	788.46	718.08	471.68	475.20	454.55	635.24
29	811.67	739.22	485.57	489.19	467.93	653.94
30	823.28	749.79	492.51	496.19	474.62	663.29
31	840.69	765.64	502.92	506.68	484.66	677.32
32	858.10	781.50	513.34	517.17	494.69	691.34
33	868.98	791.41	519.85	523.73	500.97	700.11
34	880.58	801.98	526.79	530.72	507.66	709.46
35	886.39	807.26	530.26	534.22	511.00	714.13
36	892.19	812.55	533.73	537.72	514.35	718.81
37	897.99	817.83	537.21	541.21	517.69	723.48
38	903.79	823.12	540.68	544.71	521.04	728.16
39	915.40	833.69	547.62	551.71	527.73	737.51
40	927.00	844.26	554.56	558.70	534.42	746.86
41	944.41	860.11	564.98	569.19	544.45	760.88
42	961.10	875.30	574.96	579.25	554.07	774.33
43	984.31	896.44	588.84	593.24	567.45	793.03
44	1013.32	922.87	606.20	610.72	584.18	816.40
45	1047.41	953.92	626.59	631.27	603.83	843.87
46	1088.03	990.91	650.89	655.75	627.25	876.59
47	1133.73	1032.53	678.23	683.29	653.60	913.41
48	1185.96	1080.09	709.48	714.77	683.70	955.49
49	1237.46	1127.00	740.28	745.81	713.39	996.98
50	1295.49	1179.84	775.00	780.78	746.85	1043.73
51	1352.79	1232.03	809.28	815.32	779.88	1089.90
52	1415.89	1289.51	847.03	853.35	816.26	1140.74
53	1479.73	1347.64	885.22	891.82	853.06	1192.17
54	1548.64	1410.40	926.44	933.36	892.79	1247.69
55	1617.54	1473.15	967.66	974.89	932.52	1303.20
56	1692.26	1541.20	1012.36	1019.91	975.59	1363.40
57	1767.69	1609.90	1057.49	1065.38	1019.08	1424.17
58	1848.21	1683.23	1105.65	1113.91	1065.49	1489.04
59	1888.10	1719.56	1129.52	1137.95	1088.49	1521.18
60	1968.62	1792.89	1177.69	1186.48	1134.91	1586.05
61	2038.25	1856.31	1219.34	1228.44	1175.05	1642.15
62	2083.95	1897.92	1246.68	1255.99	1201.40	1678.97
63	2141.25	1950.11	1280.96	1290.52	1234.43	1725.14
64+	2176.06	1981.81	1301.78	1311.50	1254.49	1753.18

Individual and Family Plan – Off Exchange Enrollment Application Form

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

Balance by CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

Reason for application

Please Select One	☐ New Application (during open enrollment period November 1, 2024 – January 31, 2025)
	☐ Special Enrollment (during February 1, 2025 – October 31, 2025, please attach attestation & proof of the qualifying event)
	☐ Adding Spouse/Domestic Partner ☐ Adding Child(ren) Current Member ID#________________ Current Plan______________
Proposed Effective Date (MM/DD/YY): / /	

Please select a plan

Medical Plans Options	☐ Jade^{15} HMO Platinum	☐ Amber^{50} HMO Silver	☐ ActiveChoice PPO Silver	☐ Platinum^{90} HMO	☐ Gold^{80} HMO
	☐ Silver^{70} Off Exchange HMO	☐ Bronze^{60} HMO	☐ Bronze^{60} HDHP HMO	☐ Minimum Coverage HMO	
Optional Riders	☐ Adult Vision (VSP)	☐ Adult Dental (Delta Dental)			

A. Primary applicant's information

Last Name:	First Name:	M.I.:	SSN:
Date of Birth (MM/DD/YY): / /	Age:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Email:	Cell Phone:		Home Telephone:
Home Address, City, State, ZIP (No P.O. Box):			
We will send all correspondence to your home address. If you have concerns about receiving confidential and private medical information at your home address, designate an address below where you want to receive such notices. You may be able to have medical information sent to you in an alternate format. Please contact Balance for more information.			
Mailing Address, City, State, ZIP (if different than home address):			
Primary Care Physician (PCP):	Medical Group: (*Leave blank if not known)*	Are you a current patient of this PCP? ☐ Yes ☐ No	
One Medical	☐ YES, I want the No-Cost One Medical program. **If PCP is known indicate. If not, we will assign.**		
Name of Employer:		Work Phone:	
Work Address, City, State, ZIP			

Optional Questions

What is your race? (Check all that apply)

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

What is your ethnicity? (Check all that apply)

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

What is your preferred language for health care?

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

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Their
- ☐ Ze/Zir/Zirs
- ☐ No pronoun
- ☐ Other, please specify: ________________
- ☐ 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

B. List all family member(s) to be covered

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

What is your race? (Check all that apply)

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

What is your ethnicity? (Check all that apply)

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

What is your preferred language for health care?

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

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Their
- ☐ Ze/Zir/Zirs
- ☐ No pronoun
- ☐ Other, please specify: ________________
- ☐ Decline to state

What is your current gender identity?

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

What is your sexual orientation?

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

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

What is your race? (Check all that apply)

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

What is your ethnicity? (Check all that apply)			
☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: ______ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?					
WRITTEN	SPOKEN	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 preferred pronoun?

☐ He/Him/His ☐ They/Them/Theirs ☐ No pronoun ☐ Decline to state
☐ She/Her/Hers ☐ Ze/Zir/Zirs ☐ Othe, please specify: ______

What is your current gender identity?	
☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: ______ ☐ Decline to state

What is your sexual orientation?	
☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: ______ ☐ Do not know ☐ Decline to state

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

What is your race? (Check all that apply)	
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: ______ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)			
☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: ______ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

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

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His
☐ She/Her/Hers
☐ They/Them/Theirs
☐ Ze/Zir/Zirs
☐ No pronoun
☐ Othe, please specify: ____________________
☐ Decline to state

What is your current gender identity?

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

What is your sexual orientation?

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

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

What is your race? (Check all that apply)

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

What is your ethnicity? (Check all that apply)

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

What is your preferred language for health care?

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

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His
☐ She/Her/Hers
☐ They/Them/Theirs
☐ Ze/Zir/Zirs
☐ No pronoun
☐ Othe, please specify: ____________________
☐ Decline to state

What is your current gender identity?

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

What is your sexual orientation?

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

Dependent # 4	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

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

What is your ethnicity? (Check all that apply)

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

What is your preferred language for health care?		
WRITTEN SPOKEN ☐ American Sign Language (ASL) ☐ ☐ Arabic ☐ ☐ Bulgarian ☐ ☐ Chinese (Written) / Cantonese (Spoken) ☐ ☐ Chinese (Written / Mandarin (Spoken) ☐ ☐ English ☐ ☐ Korean	WRITTEN SPOKEN ☐ ☐ Khmer ☐ ☐ Laotian ☐ ☐ Persian ☐ ☐ Polish ☐ ☐ Punjabi ☐ ☐ Russian ☐ ☐ Spanish	WRITTEN SPOKEN ☐ ☐ Tagalog ☐ ☐ Vietnamese ☐ ☐ Other, please specify: ____________________ ☐ ☐ Unknown ☐ ☐ Decline to state

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ They/Them/Theirs ☐ No pronoun ☐ Decline to state
☐ She/Her/Hers ☐ Ze/Zir/Zirs ☐ Othe, please specify: ____________________

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

C. Fill out this section if applicant is using an insurance Agent or Broker

I understand that the broker of record may receive monetary and/or non-monetary payments from Balance in connection with the purchase of this coverage.
I understand my premiums are the same whether or not I use an agent or broker.

Applicant's Signature X	Broker Name:	Date (MM/DD/YY): / /

D. Insurance agent/broker attestation (AB2569, Cal H&S §1389.8)

To be completed by your agent or broker after completion of this application.
Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand ($10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I ______________________________, assisted the applicant in submitting this application. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future.

To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

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

E. Conditions of application – Please carefully read the following:

I. General Conditions

Balance by CCHP reserves the right to reject any application for enrollment.

1. I understand that I have no coverage under this application until notified by Balance that I am accepted.
2. If I am accepted, this application will become part of the agreement between Balance and myself. Enrolled family members and I agree to be bound by the arbitration clause in the Balance contract instead of trial by a court or jury.
3. I understand that willful misrepresentation can result in rescission of my coverage. Balance can only rescind for a material misrepresentation or omission if the misrepresentation or omission is willful.

II. Acknowledgment and Agreement:

I hereby subscribe for myself and any enrolled dependents to the health plan designated here and agree to abide by all terms, conditions and provision of this Individual Membership Contract. I have read and understand the terms on this application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. I agree to notify Balance promptly of any facts or circumstances which arise before the effective date of coverage under Balance which make any of the statements supplied herein incorrect. I understand that coverage may be cancelled if Balance demonstrates I have been fraudulent or intentionally misrepresented material fact in my application.

III. Disclosure of Personal and Health Information

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

For the purpose of administering your Balance coverage, Balance is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Balance is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Balance policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Balance's website.

IV. Arbitration Agreement:

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and my dependents enrolled in the plan and Balance and any of its affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

Applicant Signature X	Print Your Name:	Date (MM/DD/YY): / /
Spouse or Domestic Partner Signature X	Print Your Name:	Date (MM/DD/YY): / /
Signature Required for Dependents Age 18 or over		
Dependent #1 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #2 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #3 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #4 Signature X	Print Your Name:	Date (MM/DD/YY): / /

Marketing Source:

☐ TV ☐ DM ☐ Email Ad ☐ Mobile Ad ☐ Radio ☐ Newspaper ☐ Referrals ☐ Street Fair/Event

☐ Others ______________________________

Balance by CCHP Use Only:

Sales ___________ Manager _________ Payment Type: CC / Bill / Check#______________ Amount ______________ Date ________________

Rec'd by Enrollment ____ Packet Sent Date ____

Privacy Protection of Data

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

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

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

Special Enrollment Attestation Form

You may enroll in an individual health plan only during the open enrollment period from Nov. 1st to Jan. 31st. There are exceptions that may allow you to enroll 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 Special Enrollment Period privileges. If you later determine that this information is incorrect, you may be disenrolled.

Name of Applicant:	**Effective Date Requested (MM/DD/YY):** / /

Completing this form does not guarantee acceptance of the exception request, please provide the required documentation.
I am certifying I qualify for Special Enrollment due to (check box the reason that best applies):

- ☐ Got married or entered into domestic partnership
- ☐ Divorce, legal separation, dissolution of domestic partnership, or death
- ☐ A child is born, adopted or received into foster care
- ☐ Dependent turns 26 years old
- ☐ Attainment of citizenship
- ☐ Loss of Medi-Cal
- ☐ Loss of Group Coverage (e.g. death of an employee, termination of employment, deduction of hours) Loss of CORBA
- ☐ Loss of Student Health Insurance
- ☐ Ineligible for tax credits or cost-sharing reductions under Covered California
- ☐ Permanently moved into Balance Service Area
- ☐ Misconduct or misinformation occurred during your enrollment
- ☐ Released from jail or prison
- ☐ Returned from active duty military service
- ☐ Received a certificate of exemption for hardship exception from Health & Human Services
- ☐ Court ordered provision of health insurance
- ☐ Federally Recognized American Indian/Alaska Native
- ☐ Other (Please provide an explanation):______________________________

Required Documentation for Special Enrollment Periods

A person enrolling as the result of a qualifying life event should provide the proof that the triggering event occurred and the date the event occurred. Most special enrollment periods last **60 days** from the date of the qualifying life event.

Event	Supporting Documentation
Marriage	Marriage certificate
Divorce	Divorce decree document
Birth/Adoption/Legal Guardianship of Child	Birth certificate or hospital discharge paperwork
Dependent Child reaches age 26	Proof of previous health insurance
Death of policyholder	Death certificate
Eligible Immigration Status or US Citizenship	Valid US passport, Green Card, or legal supporting documentation
Loss of Employer Coverage	Proof of previous group health insurance
Loss of Coverage Through Spouse's Employer	Proof of previous group health insurance
Loss of COBRA	Loss of COBRA letter
Loss of Medi-Cal	Loss of Medi-Cal document
Ineligible for cost-sharing reductions under Covered CA	Covered CA letter
Relocation / Move into Balance Service Area	Proof of old and new address, such as utility bill, credit card statement, insurance statement, bank statement, driver's license or education institution document. Both document must indicate permanent move occurred within 60 days of application.

Applicant Signature	**Date (MM/DD/YY):**
X	/ /

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 __________

Balance by CCHP

Commercial 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 Address: ___________________________

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 receive monthly premium billing and **you do not need to send your payment to us**. The premium amount will be automatically withdrawn from the account according to the "Total Amount Due" on the premium billing. 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 Balance CCHP.

Please Read and Sign Below
This agreement is between Balance by CCHP ("Balance") and the Balance member for the automatic withdrawal of funds. The funds will be transferred on or around the 25th day of each month and will be used to pay monthly 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 Balance by CCHP 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 Balance in writing and make the plan premium payment using an alternative method. Signature:____________________Date:________________
Please submit form by fax: 415-955-8817 mail to Balance by CCHP, 445 Grant Ave, San Francisco, CA 94108 before 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 Balance 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 | Mondays - Friday 8:00 a.m. to 8 p.m.

Other Payment Methods:

Location/Payment Types	Credit Card Debit Card	Personal Check Cashier Check Money Order	Cash	Pay Online Walkthrough
Balance by 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	
Balance Website www.balancebycchp.com/how-to-pay	○ Electronic			

Balance by CCHP

NONDISCRIMINATION NOTICE

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

Balance provides:

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

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

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

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

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

How to file a grievance

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

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

  Or, if you cannot hear or speak well, please call 1-877-681-8898.
- In writing: Fill out a complaint form or write a letter and send it to:

  Balance Member Services
  445 Grant Avenue, San Francisco, CA 94108
- In person: Visit your doctor's office or Balance Member Service (address above) and say you want to file a grievance.
- By Fax: 1-415-397-2129
- Electronically: Visit www.balancebycchp.com/grievances-and-appeals

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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

Important Information about Language Assistance Services

Interpreter Services

You can get an interpreter at no cost to you if you need an interpreter to communicate with your doctor or to arrange health care services. To get an interpreter, please call 1-888-775-7888 (TTY 1-877-681-8898) October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

Translation of Written Information to Plan Enrollees

The language most frequently spoken among the Plan's membership is Chinese. Upon your request, the Plan will translate written information that impacts your healthcare coverage. To request a free translation, please call 1-888-775-7888 (TTY 1-877-681-8898)
October 1 - March 31: 7 days a week from 8:00 a.m. to 8:00 p.m.
April 1 - September 30: Mondays – Fridays 8:00 a.m. to 8:00 p.m.

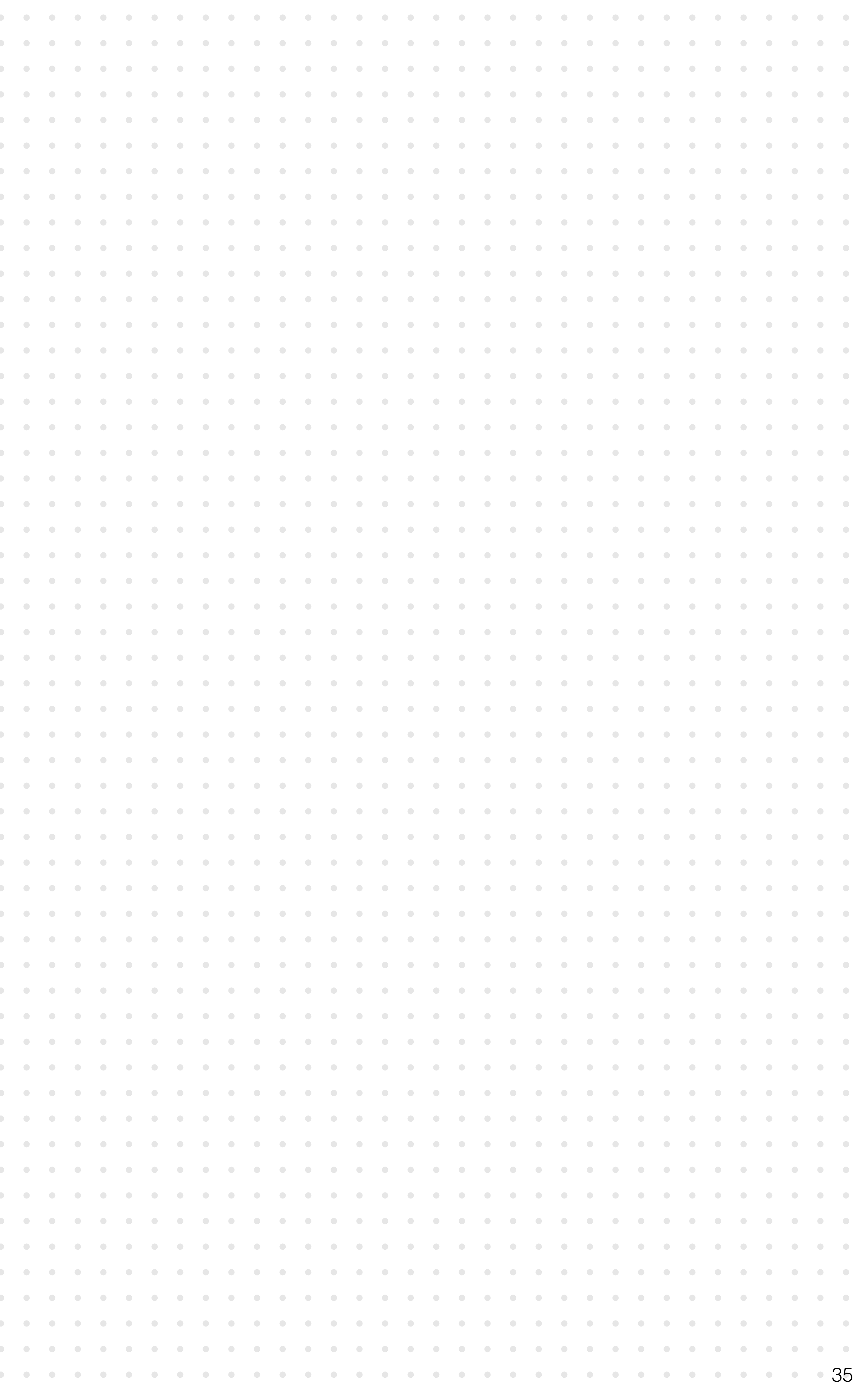
If unable to reach us, please contact the Department of Managed Health Care's Help Center at 1-888-466-2219 (TTY 1-877-688-9891). It provides telephone translation services in over 100 languages. The Help Center also provides a written translation of the Independent Medical Review and Complaint Forms in Spanish and Chinese.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language.
For free help, please call 1-888-775-7888 right away.

重要通知：您是否能夠閱讀此文件？如果您無法閱讀，我們有專員為您提供協助。此外，我們也可以將此文件翻譯成您使用的語言。如需要免費服務，請立即致電 1-888-775-7888。

IMPORTANTE: ¿Puede leer este documento? Si no es así, podemos ayudarle a leerla. También es posible que usted pueda recibir este documento en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-888-775-7888.

NOTES



Contact Information

Call or Email

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

1-877-256-2477
(TTY: 1-877-681-8898)

Sales@BalanceByCCHP.com

In Person

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

San Francisco Office
445 Grant Avenue
San Francisco, CA 94108

Daly City Office
386 Gellert Boulevard
Daly City, CA 94015

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