# Welcome to Balance

Your Path to Wellness starts here.

## 2025 Health Plans

*See how much you can save in 2025*

Balance by CCHP

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# About Balance

## 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 where we live and work.

Our plans are for companies based in San Francisco or San Mateo County. Understanding today's distributed nature of workforces around the Bay Area, we extend the coverage area to Alameda, Contra Costa and Marin counties for employees who reside there.

For large employer groups with 100+, your base can extend to all outlined counties. Be sure to inquire about how we can get you started.

## We're Focused on Wellness

We offer a range of wellness programs to suit everyone. Free preventive screenings, telehealth, health education and fitness classes, in-person and virtually. You and your teams decide how to achieve optimal health. You choose your path.

### One Medical OFFER

Ask about how you and your employees can get their sponsored One Medical membership at no cost.

# Why Balance

*“My health plan is Balance from CCHP. Over the years, I have appreciated that Balance account team offered me different options and helped me make the best possible decision. They always go the extra distance.”*
— **Mr. Hau Chung Lai, eCircle Investment, Inc.**

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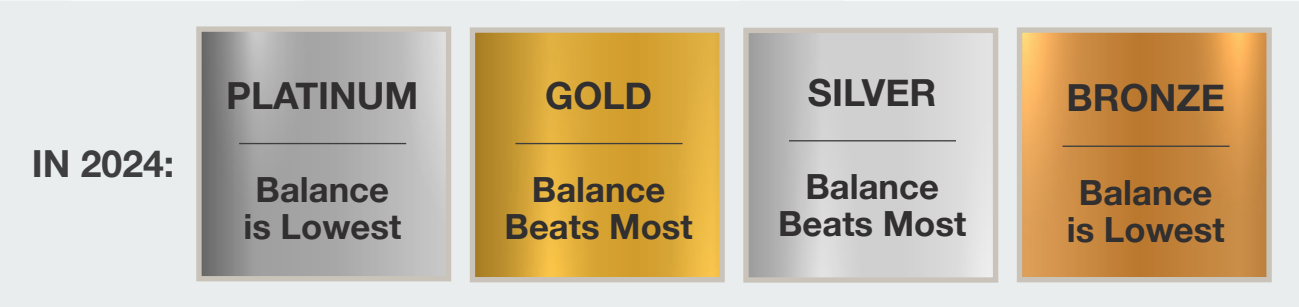
## Your Employees Deserve Balance Quality

Balance group plans enable you to provide quality, affordable health coverage for your employees. A quality health plan keeps your employees healthy and more productive. It also helps attract and retain valuable employees.

We work closely with our ever-growing provider network of over 7,000 healthcare providers and work with virtually every hospital in the area to keep our costs down for our Members.

## At Affordable Rates

For 2024 Balance offers the lowest rates in two of the four plan categories against our top rivals. In 2025, Balance will retain our price-competitiveness. See how much you could save with Balance.




Source: DMHC 2024, 2025

## Plans to Suit Your Business Needs

Balance plans are available to employers and employees who live or work in San Francisco or San Mateo counties - with extended coverage for employees who live in Alameda, Contra Costa and Marin counties.

- **We welcome groups of all sizes - as few as one employee or hundreds**
- **You choose plans with variety of copayment and premium options**
- **We offer an HSA compatible high-deductible health plans (HDHP)**
- **Dedicated, local account manager to serve you**

For many of our employer group clients who operate in San Francisco, our plans help you stay in compliance with local health ordinances, Health Care Accountability and Health Care Security Ordinances (HCAO/HCSO). These multiple regulations can lead to different coverage needs. Be sure to inquire about it.

# Access to Care

## Large Network of Doctors and Hospitals

### Access to Care

With every plan, you and your employees get an in-network choice of over 7,000 conveniently located doctors, specialists, and facilities in our service area. We are proud partners with Hill Physicians, the largest medical group in northern California.

**Our complete network includes:** Jade Health Care, Hill Physicians and nearly all the top hospitals in our service area.


Hill Physicians

Jade Health Care Medical Group

one medical

AHMC Seton Medical Center

Alameda Health System

Chinese Hospital

Dignity Health

Stanford Health Care

Sutter Health

UCSF Health

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

Now, all employees and covered dependents have Balance sponsored, no cost access to One Medical, a new kind of doctors office for busy employers and employees. 24/7 virtual or same-day appointments make it super convenient to take care of business of your health.

**Participation is simple.** Just check the One Medical box on the enrollment form and we'll take care of the rest. You are ready to start on the first of the following month.

## 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

## Get One Medical at no cost in 3 simple steps

Balance will sponsor your annual membership, including covered family members.

1. One Medical charges a yearly membership fee of $199. When employees opt-in to our sponsored One Medical program, we pay the yearly fee.
2. Complete a short Initial Health Assessment (IHA).
3. Be sure to ask our sales representative for details.

Balance by CCHP

one medical

# Our Products

**We offer several types of plan options so you can select the right level of coverage to fit your business.**

## Balance Ruby Series 10/20/40: Comprehensive Plans

Ruby Series is the right choice for groups who want the peace-of-mind of comprehensive coverage and may use medical services regularly.

- $0 copays for preventive care
- For other primary care services, you choose the copay that's best for your group ($10/$20/$40)
- Fixed copayment for most covered services so you and your employees can enjoy predictable health care costs — you'll know your out-of-pocket costs in advance.

## Balance Opal Series 25/50: Economical Plans

Opal Series is the popular option for health-conscious and budget-minded employers who don't foresee using many medical services.

- Lower monthly premiums
- Includes $0 copay for preventive services

## Balance Metal Plans: Off-Exchange Mirror Plans

For employers looking for plans like those on the Covered CA exchange but prefer to work directly with us.

- Range of cost shares
- Range of premiums to suit any company

**Ask about our large group plans tailored to your diverse needs.**

# Optional Dental & Vision Coverage

**Balance employer group plans include pediatric vision and dental coverage. For adults, we offer optional supplemental plans.**

DELTA DENTAL®

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**

vsp optics

Balance's 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: $3.54**

**Ask about our comprehensive, affordable coverage details.**

# 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

# **Balance Plan**
# Benefit Highlights & Rates

The following pages provide highlights of your plan benefits.

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

At any time you have questions, contact us. We're here to help!

## Call or Email

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

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**1-800-893-1598**
(TTY: 1-877-681-8898)

**Sales@BalanceByCCHP.com**

Balance by CCHP

# 2025 Plan Benefit Highlights

| Plan Name | Ruby 10 Platinum HMO | Ruby 20 Platinum HMO | Ruby 40 Platinum HMO | Opal 25 HMO |
|---|---|---|---|---|
| **Metal Level / Actuarial Value %**[1] | Platinum / 91.99% | Platinum / 91.92% | Platinum / 90.08% | Gold / 81.46% |
| **SERVICES AND FEATURES** | | | | |
| Annual Deductible | $0 | $0 | $0 | Individual $2,100<br>Family $4,200 [3] |
| Out–of–Pocket Limit on Expenses | Individual $3,100<br>Family $6,200 | Individual $3,050<br>Family $6,100 | Individual $3,000<br>Family $6,000 | Individual $5,800<br>Family $11,600 |
| **LIFETIME MAXIMUMS** | No Limit | | | |
| **PROFESSIONAL SERVICES** | **Member Cost Share** | | | |
| Preventive Care/<br>Screening/Immunization | $0 Copay | | | |
| Primary Care Physician (PCP)<br>Visit to Treat an Injury or Illness | $10 Copay | $20 Copay | $40 Copay | $30 Copay |
| Specialist Visit | $30 Copay | $20 Copay | $40 Copay | $30 Copay |
| Maternity Care - Preconception/<br>Prenatal/Postnatal Care | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| Delivery and all Inpatient Services<br>(Hospital Services) | $150 Copay/Day<br>(Up to First 5 Days) | $150 Copay/Day<br>(Up to First 5 Days) | $250 Copay/Day<br>(Up to First 5 Days) | $250 Copay/Day<br>(Up to First 5 Days)<br>(After Deductible) |
| Delivery and all Inpatient Services<br>(Professional Services) | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| **OUTPATIENT SERVICES** | | | | |
| Laboratory Tests & X-Rays | Laboratory: $15 Copay<br>X-Ray: $10 Copay | $10 Copay | $10 Copay | $25 Copay |
| Imaging (CT/PET Scans, MRIs) | $180 Copay | $160 Copay | $150 Copay | $250 Copay |
| Surgery - Facility Fee<br>(e.g., Ambulatory Surgery Center) | $100 Copay<br>(Chinese Hospital)<br>$300 Copay<br>(Other Facilities) | $100 Copay<br>(Chinese Hospital)<br>$300 Copay<br>(Other Facilities) | $150 Copay<br>(Chinese Hospital)<br>$450 Copay<br>(Other Facilities) | $250 Copay<br>(Chinese Hospital)<br>$750 Copay<br>(Other Facilities)<br>(After Deductible) |
| Physician/Surgeon Fees | $0 Copay | $0 Copay | $0 Copay | $0 Copay |

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 | Ruby 10 Platinum HMO | Ruby 20 Platinum HMO | Ruby 40 Platinum HMO | Opal 25 HMO |
|---|---|---|---|---|
| **Metal Level / Actuarial Value %**(1) | Platinum / 91.99% | Platinum / 91.92% | Platinum / 90.08% | Gold / 81.46% |
| **SERVICES AND FEATURES** | | | | |
| Annual Deductible | $0 | $0 | $0 | Individual $2,100<br>Family $4,200 (3) |
| Out–of–Pocket Limit on Expenses | Individual $3,100<br>Family $6,200 | Individual $3,050<br>Family $6,100 | Individual $3,000<br>Family $6,000 | Individual $5,800<br>Family $11,600 |
| **LIFETIME MAXIMUMS** | No Limit | | | |
| **PROFESSIONAL SERVICES** | **Member Cost Share** | | | |
| Preventive Care/<br>Screening/Immunization | $0 Copay | | | |
| Primary Care Physician (PCP)<br>Visit to Treat an Injury or Illness | $10 Copay | $20 Copay | $40 Copay | $30 Copay |
| Specialist Visit | $30 Copay | $20 Copay | $40 Copay | $30 Copay |
| Maternity Care - Preconception/<br>Prenatal/Postnatal Care | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| Delivery and all Inpatient Services<br>(Hospital Services) | $150 Copay/Day<br>(Up to First 5 Days) | $150 Copay/Day<br>(Up to First 5 Days) | $250 Copay/Day<br>(Up to First 5 Days) | $250 Copay/Day<br>(Up to First 5 Days)<br>(After Deductible) |
| Delivery and all Inpatient Services<br>(Professional Services) | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| **OUTPATIENT SERVICES** | | | | |
| Laboratory Tests & X-Rays | Laboratory: $15 Copay<br>X-Ray: $10 Copay | $10 Copay | $10 Copay | $25 Copay |
| Imaging (CT/PET Scans, MRIs) | $180 Copay | $160 Copay | $150 Copay | $250 Copay |
| Surgery - Facility Fee<br>(e.g., Ambulatory Surgery Center) | $100 Copay<br>(Chinese Hospital)<br>$300 Copay<br>(Other Facilities) | $100 Copay<br>(Chinese Hospital)<br>$300 Copay<br>(Other Facilities) | $150 Copay<br>(Chinese Hospital)<br>$450 Copay<br>(Other Facilities) | $250 Copay<br>(Chinese Hospital)<br>$750 Copay<br>(Other Facilities)<br>(After Deductible) |
| Physician/Surgeon Fees | $0 Copay | $0 Copay | $0 Copay | $0 Copay |

**NOTES:** (1) Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
(2) Medical / RX cost-sharing contributes toward annual deductible.
(3) 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 health plan benefit and coverage matrix to see when the deductible starts over (usually, but not always, January 1st).

Balance by CCHP

# 2024 Plan Benefit Highlights

| Plan Name | Ruby 10 Platinum HMO | Ruby 20 Platinum HMO | Ruby 40 Platinum HMO | Opal 25 HMO |
|---|---|---|---|---|
| **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) | $150 Copay/Day (Chinese Hospital) $450 Copay/Day (Other Facilities) (Up to First 5 Days) | $250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days) | $250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days) (After Deductible) |
| Physician/Surgeon Fees | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| **EMERGENCY HEALTH COVERAGE** | | | | |
| Emergency Room Services (waived if admitted) | $200 Copay | $230 Copay | $200 Copay | $250 Copay (After Deductible) |
| Professional Services (waived if admitted) | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| Urgent Care Center | $10 Copay | $20 Copay | $40 Copay | $25 Copay |
| **PRESCRIPTION DRUG COVERAGE** | | | | |
| Annual Rx Deductible | $0 | $0 | $0 | Individual $250 Family $500 |
| Tier 1: Generic Drugs (30-Day Supply) | $5 Copay | $5 Copay | $5 Copay | $10 Copay |
| Tier 2: Preferred Brand Drugs (30-Day Supply) | $15 Copay | $15 Copay | $15 Copay | $30 Copay (After Rx Deductible) |
| Tier 3: Non-preferred Brand Drugs (30-Day Supply) | $25 Copay | $25 Copay | $25 Copay | $60 Copay (After Rx Deductible) |
| Tier 4: Specialty Drugs (30-Day Supply) | 10% Coinsurance up to $250/Prescription | 10% Coinsurance up to $250/Prescription | 10% Coinsurance up to $250/Prescription | 20% Coinsurance up to $250/Prescription (After Rx Deductible) |
| **PEDIATRIC VISION AND DENTAL** (Included in Plan) | | | | |
| Child Needs Eye Care (Ages 0-18) | | | | |
| Eye Exam (1 Per Calendar Year) | $0 Copay | | | |
| Eyewear (Frames) (1 Pair Per Calendar Year) | $0 Copay | | | |
| Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses) | Single vision, lined bifocal, and lined trifocal lenses No Cost Share | | | |
| Eyewear (Contact Lenses) | $0 Copay | | | |
| Pediatric Dental (Ages 0-18) | Included in Plan. See Dental Summary Page. | | | |

| Opal 50 HMO | Platinum 90 HMO | Gold 80 HMO | Silver 70 HMO | Bronze 60 HMO | Bronze 60 HDHP HMO |
|---|---|---|---|---|---|
| | Member Cost Share | | | | |
| $250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days) (After Deductible) | $250/Day (Up to First 5 Days) | $600/Day (Up to First 5 Days) (After Deductible) | 35% Coinsurance (After Deductible) | 40% Coinsurance (After Deductible) | 0% Coinsurance (After Deductible) |
| $0 Copay | $0 Copay | $0 Copay | 35% Coinsurance | 40% Coinsurance (After Deductible) | 0% Coinsurance (After Deductible) |
| | | | | | |
| $300 Copay (After Deductible) | $150 Copay | $250 Copay (After Deductible) | 35% Coinsurance (After Deductible) | 40% Coinsurance (After Deductible) | 0% Coinsurance (After Deductible) |
| $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay | 0% Coinsurance (After Deductible) |
| $50 Copay | $20 Copay | $35 Copay | $55 Copay | $65 Copay (Deductible Applies After First (3) Non-Preventive Visits) | 0% Coinsurance (After Deductible) |
| | | | | | |
| Individual $700 Family $1,400 (3) | $0 | $0 | Individual $300 Family $600 | Individual $500 Family $1,000 | Individual $7,050 Family $14,100 (Combined Medical/ Drug Deductible) |
| $30 Copay (After Deductible) | $5 Copay | $15 Copay | $ 19 Copay | $18 Copay (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| $80 Copay (After Deductible) | $20 Copay | $40 Copay | $ 85 Copay (After Rx Deductible) | 40% Coinsurance up to $500/Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| $95 Copay (After Deductible) | $30 Copay | $70 Copay | $110 Copay (After Rx Deductible) | 40% Coinsurance up to $500/Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| 20% Coinsurance up to $250/Prescription (After Deductible) | 10% Coinsurance up to $250/Prescription | 20% Coinsurance up to $250/Prescription | 30% Coinsurance Up to $250/Prescription (After Rx Deductible) | 40% Coinsurance up to $500/Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| | | | | | |
| | | | | | |
| | $0 Copay | | | | |
| | $0 Copay | | | | |
| | Single vision, lined bifocal, and lined trifocal lenses No Cost Share | | | | |
| | $0 Copay | | | | |
| | Included in Plan. See Dental Summary Page. | | | | |

**FOR MORE INFORMATION, Call 1-877-224-7918 Or visit BalanceByCCHP.com/Shop-egp**

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# Employer Group Plans

## 2025 Monthly Rates | San Francisco County

January 1 - December 31, 2025

| | Ruby 10 HMO Platinum | Ruby 20 HMO Platinum | Ruby 40 HMO Platinum | Opal 25 HMO Gold | Opal 50 HMO Silver |
|---|---|---|---|---|---|
| AGE | RATE | RATE | RATE | RATE | RATE |
| 0-14 | 433.97 | 427.45 | 403.46 | 349.21 | 314.79 |
| 15 | 472.55 | 465.45 | 439.32 | 380.25 | 342.77 |
| 16 | 487.30 | 479.98 | 453.04 | 392.12 | 353.47 |
| 17 | 502.05 | 494.50 | 466.75 | 403.99 | 364.17 |
| 18 | 517.93 | 510.15 | 481.51 | 416.77 | 375.69 |
| 19 | 533.82 | 525.80 | 496.28 | 429.55 | 387.21 |
| 20 | 550.27 | 542.00 | 511.58 | 442.79 | 399.14 |
| 21 | 567.29 | 558.76 | 527.40 | 456.49 | 411.49 |
| 22 | 567.29 | 558.76 | 527.40 | 456.49 | 411.49 |
| 23 | 567.29 | 558.76 | 527.40 | 456.49 | 411.49 |
| 24 | 567.29 | 558.76 | 527.40 | 456.49 | 411.49 |
| 25 | 569.55 | 561.00 | 529.51 | 458.31 | 413.13 |
| 26 | 580.90 | 572.17 | 540.06 | 467.44 | 421.36 |
| 27 | 594.52 | 585.58 | 552.71 | 478.40 | 431.24 |
| 28 | 616.64 | 607.37 | 573.28 | 496.20 | 447.29 |
| 29 | 634.79 | 625.26 | 590.16 | 510.81 | 460.45 |
| 30 | 643.87 | 634.20 | 598.60 | 518.11 | 467.04 |
| 31 | 657.48 | 647.61 | 611.25 | 529.07 | 476.91 |
| 32 | 671.10 | 661.02 | 623.91 | 540.02 | 486.79 |
| 33 | 679.61 | 669.40 | 631.82 | 546.87 | 492.96 |
| 34 | 688.68 | 678.34 | 640.26 | 554.18 | 499.54 |
| 35 | 693.22 | 682.81 | 644.48 | 557.83 | 502.84 |
| 36 | 697.76 | 687.28 | 648.70 | 561.48 | 506.13 |
| 37 | 702.30 | 691.75 | 652.92 | 565.13 | 509.42 |
| 38 | 706.84 | 696.22 | 657.14 | 568.78 | 512.71 |
| 39 | 715.91 | 705.16 | 665.58 | 576.09 | 519.30 |
| 40 | 724.99 | 714.10 | 674.01 | 583.39 | 525.88 |
| 41 | 738.61 | 727.51 | 686.67 | 594.35 | 535.76 |
| 42 | 751.65 | 740.36 | 698.80 | 604.85 | 545.22 |
| 43 | 769.81 | 758.24 | 715.68 | 619.45 | 558.39 |
| 44 | 792.50 | 780.59 | 736.78 | 637.71 | 574.85 |
| 45 | 819.16 | 806.85 | 761.56 | 659.17 | 594.19 |
| 46 | 850.93 | 838.14 | 791.10 | 684.73 | 617.23 |
| 47 | 886.67 | 873.35 | 824.32 | 713.49 | 643.15 |
| 48 | 927.51 | 913.58 | 862.30 | 746.36 | 672.78 |
| 49 | 967.79 | 953.25 | 899.74 | 778.77 | 702.00 |
| 50 | 1013.17 | 997.95 | 941.93 | 815.29 | 734.91 |
| 51 | 1057.99 | 1042.09 | 983.60 | 851.35 | 767.42 |
| 52 | 1107.34 | 1090.70 | 1029.48 | 891.06 | 803.22 |
| 53 | 1157.26 | 1139.88 | 1075.89 | 931.23 | 839.43 |
| 54 | 1211.15 | 1192.96 | 1126.00 | 974.60 | 878.52 |
| 55 | 1265.05 | 1246.04 | 1176.10 | 1017.97 | 917.62 |
| 56 | 1323.48 | 1303.59 | 1230.42 | 1064.99 | 960.00 |
| 57 | 1382.47 | 1361.70 | 1285.27 | 1112.46 | 1002.79 |
| 58 | 1445.44 | 1423.73 | 1343.81 | 1163.13 | 1048.47 |
| 59 | 1476.64 | 1454.46 | 1372.82 | 1188.24 | 1071.10 |
| 60 | 1539.61 | 1516.48 | 1431.36 | 1238.91 | 1116.77 |
| 61 | 1594.07 | 1570.12 | 1481.99 | 1282.73 | 1156.28 |
| 62 | 1629.81 | 1605.32 | 1515.22 | 1311.49 | 1182.20 |
| 63 | 1674.63 | 1649.47 | 1556.88 | 1347.55 | 1214.71 |
| 64+ | 1701.85 | 1676.28 | 1582.18 | 1369.45 | 1234.45 |

- 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 18 and older are charged premiums based on their ages.

| | Platinum 90 HMO | Gold 80 HMO | Silver 70 HMO | Bronze 60 HMO | Bronze 60 HDHP |
|---|---|---|---|---|---|
| AGE | RATE | RATE | RATE | RATE | RATE |
| 0-14 | 426.15 | 387.55 | 310.88 | 254.80 | 258.45 |
| 15 | 464.03 | 422.00 | 338.51 | 277.45 | 281.43 |
| 16 | 478.51 | 435.17 | 349.07 | 286.11 | 290.21 |
| 17 | 493.00 | 448.34 | 359.64 | 294.77 | 299.00 |
| 18 | 508.59 | 462.53 | 371.02 | 304.10 | 308.46 |
| 19 | 524.19 | 476.71 | 382.40 | 313.42 | 317.92 |
| 20 | 540.35 | 491.40 | 394.18 | 323.08 | 327.71 |
| 21 | 557.06 | 506.60 | 406.37 | 333.08 | 337.85 |
| 22 | 557.06 | 506.60 | 406.37 | 333.08 | 337.85 |
| 23 | 557.06 | 506.60 | 406.37 | 333.08 | 337.85 |
| 24 | 557.06 | 506.60 | 406.37 | 333.08 | 337.85 |
| 25 | 559.29 | 508.63 | 408.00 | 334.41 | 339.20 |
| 26 | 570.43 | 518.76 | 416.13 | 341.07 | 345.96 |
| 27 | 583.80 | 530.92 | 425.88 | 349.06 | 354.07 |
| 28 | 605.52 | 550.68 | 441.73 | 362.05 | 367.24 |
| 29 | 623.35 | 566.89 | 454.73 | 372.71 | 378.05 |
| 30 | 632.26 | 574.99 | 461.23 | 378.04 | 383.46 |
| 31 | 645.63 | 587.15 | 470.99 | 386.03 | 391.57 |
| 32 | 659.00 | 599.31 | 480.74 | 394.03 | 399.67 |
| 33 | 667.36 | 606.91 | 486.83 | 399.02 | 404.74 |
| 34 | 676.27 | 615.02 | 493.34 | 404.35 | 410.15 |
| 35 | 680.72 | 619.07 | 496.59 | 407.02 | 412.85 |
| 36 | 685.18 | 623.12 | 499.84 | 409.68 | 415.55 |
| 37 | 689.64 | 627.17 | 503.09 | 412.35 | 418.26 |
| 38 | 694.09 | 631.23 | 506.34 | 415.01 | 420.96 |
| 39 | 703.01 | 639.33 | 512.84 | 420.34 | 426.36 |
| 40 | 711.92 | 647.44 | 519.34 | 425.67 | 431.77 |
| 41 | 725.29 | 659.60 | 529.10 | 433.66 | 439.88 |
| 42 | 738.10 | 671.25 | 538.44 | 441.33 | 447.65 |
| 43 | 755.93 | 687.46 | 551.45 | 451.98 | 458.46 |
| 44 | 778.21 | 707.72 | 567.70 | 465.31 | 471.97 |
| 45 | 804.39 | 731.53 | 586.80 | 480.96 | 487.85 |
| 46 | 835.59 | 759.90 | 609.56 | 499.61 | 506.77 |
| 47 | 870.68 | 791.82 | 635.16 | 520.60 | 528.06 |
| 48 | 910.79 | 828.29 | 664.42 | 544.58 | 552.38 |
| 49 | 950.34 | 864.26 | 693.27 | 568.23 | 576.37 |
| 50 | 994.91 | 904.79 | 725.78 | 594.87 | 603.40 |
| 51 | 1038.91 | 944.81 | 757.89 | 621.19 | 630.09 |
| 52 | 1087.38 | 988.89 | 793.24 | 650.16 | 659.48 |
| 53 | 1136.40 | 1033.47 | 829.00 | 679.47 | 689.21 |
| 54 | 1189.32 | 1081.60 | 867.61 | 711.12 | 721.31 |
| 55 | 1242.24 | 1129.72 | 906.21 | 742.76 | 753.40 |
| 56 | 1299.62 | 1181.90 | 948.07 | 777.07 | 788.20 |
| 57 | 1357.55 | 1234.59 | 990.33 | 811.71 | 823.34 |
| 58 | 1419.38 | 1290.82 | 1035.44 | 848.68 | 860.84 |
| 59 | 1450.02 | 1318.69 | 1057.79 | 867.00 | 879.42 |
| 60 | 1511.86 | 1374.92 | 1102.90 | 903.97 | 916.92 |
| 61 | 1565.33 | 1423.55 | 1141.91 | 935.94 | 949.35 |
| 62 | 1600.43 | 1455.47 | 1167.51 | 956.93 | 970.64 |
| 63 | 1644.44 | 1495.49 | 1199.61 | 983.24 | 997.33 |
| 64+ | 1671.16 | 1519.80 | 1219.11 | 999.22 | 1013.54 |

Balance by CCHP

# Employer Group Plans

## 2025 Monthly Rates | San Mateo County

January 1 - December 31, 2025

| | Ruby 10 HMO Platinum | Ruby 20 HMO Platinum | Ruby 40 HMO Platinum | Opal 25 HMO Gold | Opal 50 HMO Silver |
|---|---|---|---|---|---|
| AGE | RATE | RATE | RATE | RATE | RATE |
| 0-14 | 468.68 | 461.63 | 435.72 | 377.14 | 339.96 |
| 15 | 510.34 | 502.67 | 474.45 | 410.66 | 370.18 |
| 16 | 526.26 | 518.36 | 489.26 | 423.48 | 381.73 |
| 17 | 542.19 | 534.05 | 504.07 | 436.30 | 393.29 |
| 18 | 559.35 | 550.94 | 520.02 | 450.10 | 405.73 |
| 19 | 576.50 | 567.84 | 535.97 | 463.90 | 418.17 |
| 20 | 594.27 | 585.34 | 552.48 | 478.20 | 431.06 |
| 21 | 612.65 | 603.44 | 569.57 | 492.99 | 444.39 |
| 22 | 612.65 | 603.44 | 569.57 | 492.99 | 444.39 |
| 23 | 612.65 | 603.44 | 569.57 | 492.99 | 444.39 |
| 24 | 612.65 | 603.44 | 569.57 | 492.99 | 444.39 |
| 25 | 615.10 | 605.86 | 571.85 | 494.96 | 446.17 |
| 26 | 627.35 | 617.93 | 583.24 | 504.82 | 455.06 |
| 27 | 642.05 | 632.41 | 596.91 | 516.65 | 465.72 |
| 28 | 665.95 | 655.94 | 619.12 | 535.88 | 483.05 |
| 29 | 685.55 | 675.25 | 637.35 | 551.66 | 497.27 |
| 30 | 695.35 | 684.91 | 646.46 | 559.54 | 504.38 |
| 31 | 710.06 | 699.39 | 660.13 | 571.38 | 515.05 |
| 32 | 724.76 | 713.87 | 673.80 | 583.21 | 525.71 |
| 33 | 733.95 | 722.92 | 682.35 | 590.60 | 532.38 |
| 34 | 743.75 | 732.58 | 691.46 | 598.49 | 539.49 |
| 35 | 748.66 | 737.41 | 696.02 | 602.43 | 543.05 |
| 36 | 753.56 | 742.24 | 700.57 | 606.38 | 546.60 |
| 37 | 758.46 | 747.06 | 705.13 | 610.32 | 550.16 |
| 38 | 763.36 | 751.89 | 709.69 | 614.27 | 553.71 |
| 39 | 773.16 | 761.55 | 718.80 | 622.15 | 560.82 |
| 40 | 782.96 | 771.20 | 727.91 | 630.04 | 567.93 |
| 41 | 797.67 | 785.68 | 741.58 | 641.87 | 578.60 |
| 42 | 811.76 | 799.56 | 754.68 | 653.21 | 588.82 |
| 43 | 831.36 | 818.87 | 772.91 | 668.99 | 603.04 |
| 44 | 855.87 | 843.01 | 795.69 | 688.71 | 620.81 |
| 45 | 884.66 | 871.37 | 822.46 | 711.88 | 641.70 |
| 46 | 918.97 | 905.16 | 854.36 | 739.48 | 666.59 |
| 47 | 957.57 | 943.18 | 890.24 | 770.54 | 694.58 |
| 48 | 1001.68 | 986.63 | 931.25 | 806.04 | 726.58 |
| 49 | 1045.18 | 1029.47 | 971.69 | 841.04 | 758.13 |
| 50 | 1094.19 | 1077.75 | 1017.25 | 880.48 | 793.68 |
| 51 | 1142.59 | 1125.42 | 1062.25 | 919.43 | 828.79 |
| 52 | 1195.89 | 1177.92 | 1111.80 | 962.32 | 867.45 |
| 53 | 1249.80 | 1231.02 | 1161.92 | 1005.70 | 906.56 |
| 54 | 1308.00 | 1288.35 | 1216.03 | 1052.53 | 948.77 |
| 55 | 1366.20 | 1345.68 | 1270.14 | 1099.37 | 990.99 |
| 56 | 1429.31 | 1407.83 | 1328.81 | 1150.15 | 1036.76 |
| 57 | 1493.02 | 1470.59 | 1388.04 | 1201.42 | 1082.98 |
| 58 | 1561.03 | 1537.57 | 1451.27 | 1256.14 | 1132.31 |
| 59 | 1594.72 | 1570.76 | 1482.59 | 1283.25 | 1156.75 |
| 60 | 1662.73 | 1637.74 | 1545.82 | 1337.97 | 1206.08 |
| 61 | 1721.54 | 1695.68 | 1600.49 | 1385.30 | 1248.74 |
| 62 | 1760.14 | 1733.69 | 1636.38 | 1416.36 | 1276.73 |
| 63 | 1808.54 | 1781.36 | 1681.37 | 1455.31 | 1311.84 |
| 64+ | 1837.93 | 1810.32 | 1708.70 | 1478.96 | 1333.16 |

- 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 15 and older are charged premiums based on their ages.

| | Platinum 90 HMO | Gold 80 HMO | Silver 70 HMO | Bronze 60 HMO | Bronze 60 HDHP |
|---|---|---|---|---|---|
| **AGE** | **RATE** | **RATE** | **RATE** | **RATE** | **RATE** |
| **0-14** | 460.23 | 418.54 | 335.73 | 275.18 | 279.12 |
| **15** | 501.13 | 455.74 | 365.58 | 299.64 | 303.93 |
| **16** | 516.78 | 469.97 | 376.99 | 308.99 | 313.42 |
| **17** | 532.42 | 484.19 | 388.40 | 318.34 | 322.90 |
| **18** | 549.26 | 499.51 | 400.69 | 328.41 | 333.12 |
| **19** | 566.11 | 514.83 | 412.97 | 338.49 | 343.34 |
| **20** | 583.55 | 530.70 | 425.70 | 348.92 | 353.92 |
| **21** | 601.60 | 547.11 | 438.87 | 359.71 | 364.86 |
| **22** | 601.60 | 547.11 | 438.87 | 359.71 | 364.86 |
| **23** | 601.60 | 547.11 | 438.87 | 359.71 | 364.86 |
| **24** | 601.60 | 547.11 | 438.87 | 359.71 | 364.86 |
| **25** | 604.01 | 549.30 | 440.62 | 361.15 | 366.32 |
| **26** | 616.04 | 560.24 | 449.40 | 368.34 | 373.62 |
| **27** | 630.48 | 573.37 | 459.93 | 376.98 | 382.38 |
| **28** | 653.94 | 594.71 | 477.05 | 391.00 | 396.61 |
| **29** | 673.19 | 612.22 | 491.09 | 402.51 | 408.28 |
| **30** | 682.82 | 620.97 | 498.11 | 408.27 | 414.12 |
| **31** | 697.26 | 634.10 | 508.65 | 416.90 | 422.88 |
| **32** | 711.70 | 647.23 | 519.18 | 425.54 | 431.63 |
| **33** | 720.72 | 655.44 | 525.76 | 430.93 | 437.11 |
| **34** | 730.35 | 664.19 | 532.79 | 436.69 | 442.94 |
| **35** | 735.16 | 668.57 | 536.30 | 439.57 | 445.86 |
| **36** | 739.97 | 672.95 | 539.81 | 442.44 | 448.78 |
| **37** | 744.78 | 677.32 | 543.32 | 445.32 | 451.70 |
| **38** | 749.60 | 681.70 | 546.83 | 448.20 | 454.62 |
| **39** | 759.22 | 690.46 | 553.85 | 453.95 | 460.46 |
| **40** | 768.85 | 699.21 | 560.87 | 459.71 | 466.30 |
| **41** | 783.29 | 712.34 | 571.41 | 468.34 | 475.05 |
| **42** | 797.12 | 724.92 | 581.50 | 476.62 | 483.44 |
| **43** | 816.37 | 742.43 | 595.54 | 488.13 | 495.12 |
| **44** | 840.44 | 764.32 | 613.10 | 502.51 | 509.72 |
| **45** | 868.71 | 790.03 | 633.73 | 519.42 | 526.86 |
| **46** | 902.40 | 820.67 | 658.30 | 539.56 | 547.30 |
| **47** | 940.30 | 855.14 | 685.95 | 562.23 | 570.28 |
| **48** | 983.62 | 894.53 | 717.55 | 588.13 | 596.55 |
| **49** | 1026.33 | 933.37 | 748.71 | 613.66 | 622.46 |
| **50** | 1074.46 | 977.14 | 783.82 | 642.44 | 651.65 |
| **51** | 1121.99 | 1020.36 | 818.49 | 670.86 | 680.47 |
| **52** | 1174.33 | 1067.96 | 856.67 | 702.15 | 712.21 |
| **53** | 1227.27 | 1116.11 | 895.29 | 733.81 | 744.32 |
| **54** | 1284.42 | 1168.08 | 936.98 | 767.98 | 778.98 |
| **55** | 1341.57 | 1220.06 | 978.68 | 802.15 | 813.65 |
| **56** | 1403.54 | 1276.41 | 1023.88 | 839.20 | 851.23 |
| **57** | 1466.10 | 1333.31 | 1069.52 | 876.61 | 889.17 |
| **58** | 1532.88 | 1394.04 | 1118.23 | 916.54 | 929.67 |
| **59** | 1565.97 | 1424.13 | 1142.37 | 936.32 | 949.74 |
| **60** | 1632.75 | 1484.86 | 1191.09 | 976.25 | 990.24 |
| **61** | 1690.50 | 1537.38 | 1233.22 | 1010.78 | 1025.27 |
| **62** | 1728.40 | 1571.85 | 1260.87 | 1033.45 | 1048.25 |
| **63** | 1775.93 | 1615.07 | 1295.54 | 1061.86 | 1077.08 |
| **64+** | 1804.80 | 1641.33 | 1316.59 | 1079.12 | 1094.58 |

Balance by CCHP

# Employer Group
## Application Submission Checklist

Thank you for choosing Balance by CCHP for your group coverage. This checklist will help you gather and submit all required documents to start coverage. All new group applications must provide information supporting their qualification for employer group coverage. A new group must demonstrate it has been in business for a minimum of six (6) weeks, with at least one (1) employee working an average of thirty (30) hours or more per week. An employer with 1-100 full-time employees qualifies for Small Group plans and employers with 100+ employees are considered Large Groups. A Small Group is eligible for guaranteed issue and renewability when it meets and continues to satisfy the Small Group definition under California state regulations.

Please use this checklist to gather the following documents when submitting the Master Group Application to ensure prompt processing.

☐ A signed original Employer Master Group Application

☐ If a Broker is involved, please complete Section 10 of the Master Group Application.

☐ A copy (all pages) of the most recent state Quarterly Wage and Tax Report (DE9C).

- ○ Please indicate each employee's status on the DE9C using the following codes:

| | | | |
|---|---|---|---|
| **T** | Terminated (include Termination Date) | **PT** | Part-Time |
| **E** | Eligible and enrolling | **WP** | Waiting Period (include Date of Hire) |
| **W** | Eligible and waving coverage | **TEMP** | Temporary Employee |
| **S** | Seasonal | | |

- ○ For all employees who do not appear on the current DE9C, a copy of the most recent payroll is required.
- ○ Proof of Worker's Compensation.
- ○ If the group has not been in business long enough to have a DE9C, six weeks of payroll, including withholdings, may be submitted.

☐ A copy of the current carrier's most recent billing statement (all pages). If applicable,

Employees appearing on the current bill with a reported termination date of 90 days or greater will be required a COBRA application or waiver form to be completed as verification of their eligibility to continue or decline coverage.

☐ Enrollment forms completed and signed by all eligible employee(s) enrolling or waiving coverage.

☐ If Medicare is primary, a copy of each employee's Medicare card is required to verify enrollment in parts A and B. A copy of the Medicare card is also required to confirm participation requirements.

☐ First-month premium check made payable to: **Balance by CCHP**.

Submit the completed forms with the first month's premium check:

**By mail to:**

Balance Sales Department
445 Grant Avenue
San Francisco, CA 94108

OR
**Submit via your Agent/Broker**

For assistance, call our Sales Department at 1-888-681-3888.

**Please keep a copy of your application for your records.**

**Proof of Ownership/Company Structure:**

Required for groups of any size. This document is used to verify the prospective client is a legitimate, active Small Group eligible for coverage. The information is also used to verify an Owner, Officer, or Partner is actively engaged in the business eligible for coverage. Balance may conduct online searches to validate filings and other documentation. Balance may decline a group for coverage if a search is not successful.

**Sole Proprietorship:**

- Most recent IRS Schedule C (Form 1040), or
- California Business License, or
- Fictitious Business Name Statement, if any

**Partnership and Sole Proprietorship (Individual & Husband/Wife)**

Businesses must have a minimum of one (1) DE9C/employee on the payroll.

- Partnerships where the only employees are the partners themselves do not qualify for small group coverage
- Partnerships where the only employees are the partners and/or the spouse of the partners do not qualify for small group coverage
- Sole proprietors where the only employee is the sole proprietor do not qualify for small group coverage
- Sole proprietors where the only employee(s) is the sole proprietor and/or its spouse do not qualify for small group coverage

**Partnership:**

- IRS Schedule K-1 (Form 1065) for all enrolling partners, or
- Partnership Agreement signed by each partner plus a federal EIN assignment letter

**Corporation:**

- S-Corps: IRS Schedule K-1 (Form1120S) for all enrolling owners/officers.
- C-Corps: IRS Form 1120 (pages 1 & 2) which includes “Schedule E”
- Statement of Information (Form LLC-12)

**LLC:**

- LLC Agreement signed by all managers/members/parties or copies of appropriate tax returns (follow the guidelines for an S-Corp, Partnership or Sole Proprietorship based on how the LLC was formed), or
- Statement of Information (Form LLC-12)

**New/Start-up Businesses**

New/Start-up Businesses typically may meet all the underwriting requirements with the exception of the length of time they have been in business. Balance will consider groups that have been in business for at least six (6) weeks but retain the right to defer the group until the California Small Group requirements have been met. To obtain approval for a New/Start-up Business, the following may be required:

- Payroll records or applicable filings indicating the length of time the group has been in business. These documents must span the twelve (12) weeks preceding the effective date and demonstrate one or more eligible employees for the entire period. Payroll records must include all pages for all pay periods and list the following:
  - Company Name
  - Type of Company (see above)
  - Date of pay periods
  - Employee Names, wages paid, withholdings, and grand totals
- Individual payroll/pay stubs, estimated payroll, payroll summaries, or handwritten journals are not deemed acceptable.

# Master Group Application

**Group Sales: Tel: 1-888-371-3060 | Fax: 1-415-955-8819**

Balance by CCHP

*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.*

## 1. Employer Group Information

| | | | |
|---|---|---|---|
| Full Legal Business Name: | How Long in Business: | Type of Business (Be Specific): | Effective Date: (MM/DD/YY) / / |
| Primary Group Administrator Contact: | Title: | Phone: | Email: |
| Secondary Group Administrator Contact | Title: | Phone: | Email: |
| Federal Employer ID #: | State Employer ID #: | Fax: | Send administrative kit to: ☐ Employer ☐ Agent/Broker |
| Business Physical Address, City, State, ZIP (No P.O. Box): | | | |
| Billing Contact: | Title: | Phone: | Email: |
| Billing Address, City, State, ZIP (if different from above): | | | |

Type of Entity: ☐ Corporation ☐ Sole Proprietorship ☐ S-Corporation ☐ Partnership ☐ Other (explain) _____

## 2. Employer Group Plan Coverage Selection

**Medical Plans** ☐ Ruby$^{10}$ HMO Platinum ☐ Ruby$^{20}$ HMO Platinum ☐ Ruby$^{40}$ HMO Platinum ☐ Opal$^{25}$ HMO Gold ☐ Opal$^{50}$ HMO Silver
☐ Platinum$^{90}$ HMO ☐ Gold$^{80}$ HMO ☐ Silver$^{70}$ HMO ☐ Bronze$^{60}$ HMO ☐ Bronze$^{60}$ HDHP HMO

**Optional Riders (Applies to all Balance Enrollees)** ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (Balance Use Only):

## 3. Employer Premium Contribution

Employee (min. 50%): $ / %

Dependent: $ / %

## 4. Employees Will Be Eligible for Benefits Upon

1st of the month following: ☐ Date of Hire ☐ 30 days ☐ 60 days
Other _____

## 5. Number of Employees (Employer is responsible for collecting refusal of coverage forms)

| | | |
|---|---|---|
| Total # of employees: | Total # of eligible employees (30+hrs/week): | |
| Total # of eligible employees enrolled in Balance: | Total # of employees who wavie coverage: | Annual average # of employees: |

## 6. Current Carrier Information

Name of your current group medical insurance carrier(s):

Are you intending to replace your existing group coverage? ☐ No ☐ Yes, Termination Date (MM/DD/YY): / /

| | |
|---|---|
| Current Workers' Compensation Carrier: | Next Renewal Date (MM/DD/YY): / / |

## 7. COBRA / CAL-COBRA Information

Is your group currently subject to COBRA or CAL-COBRA? ☐ No ☐ Yes, please complete the following for each person

| | | | | | |
|---|---|---|---|---|---|
| 1 | Name: | Date of Birth (MM/DD/YY): / / | SSN: | Tel: | Date Continuation Begin (MM/DD/YY): / / |
| | Qualifying event description: | | | | Date (MM/DD/YY): / / |
| 2 | Name: | Date of Birth (MM/DD/YY): / / | SSN: | Tel: | Date Continuation Begin (MM/DD/YY): / / |
| | Qualifying event description: | | | | Date (MM/DD/YY): / / |

## 8. Form of Member *Evidence of Coverage and Notices*

Employer are responsible for the distribution of the Evidence of Coverage and Notices to your covered employees. Electronic versions will be distributed to you upon request. Employer is responsible for distributing the documents using one of the following methods; 1.) posting on the employer's intranet for employee access or, 2) emailing these documents directly to their employees. Printed versions will only be mailed to the employer directly upon request.

☐ I elect to receive printed, not electronic, Evidence of Coverage and Notices. I understand that I am responsible for distributing the documents to my covered employees.

## 9. Signature and Conditional Receipt

This is an application for coverage only. The group understands that no contract for coverage will exist Balance has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service/group policy will be issued. The group's representative certifies to the best of his or her knowledge and belief, all of the responses given are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, Balance may pursue one of the following remedies: coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the Health Service Contract/Insurance policy may be rescinded.

We, the employer, warrant that all information in this application is true and complete, and that Balance may rely on this application in deciding whether to provide coverage. If the application is not complete, Balance reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Balance and only if we have paid our first month's contribution and this application is accepted, and that we should keep prior coverage in force until notified of acceptance by Balance. If this application is accepted, it becomes a part of our contract with Balance.

We 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 us and Balance and any of this 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 and Notice.

| Signature of Employer/Authorized Representative: X | Print Name: | Title: | Date (MM/DD/YY): / / |
|---|---|---|---|

## 10. Agent/Broker Certification (To be completed by your agent or broker after completion of this application)

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by applicant. 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.

**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.

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

**Balance Use Only**

| | | |
|---|---|---|
| Sales Representtive / Sales Executive [ ] | Sales Manager [ ] | COO [ ] |
| Payment [ CC / Bill / Check # ] | Amount [ ] | Date [ ] |
| Rec'd Enrollment [ ] | Packet Sent Date [ ] | |

# Employee Enrollment Form

**Group Sales: 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.

## Employer Group Information

| Employer (Group) Name: | | Group Number: |
|---|---|---|
| Requested Effective Date (MM/DD/YY): / / | Date of Hire (MM/DD/YY): / / | Employment Status: ☐ Full-time ☐ Part-time |

Reason for Application:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Add Dependent(s)

☐ Employee Status Change, Reason _____ ☐ Other Enrollment, Reason _____

## Employer Group Plan Coverage Selection

**Medical Plans** ☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver

☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

**Optional Riders (Applies to all Balance Enrollees)** ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (Balance Use Only):

## 1. Employee Information

| Last Name: | First Name: | M.I.: |
|---|---|---|
| Marital Status ☐ Single ☐ Married ☐ Domestic Partner | Date of Birth (MM/DD/YY): / / | SSN: |
| Email: | Cell Phone: | Home Telephone: |

Home Address, City, State, ZIP (No P.O. Box):

Mailing Address, City, State, ZIP (if different than home address):

| Primary Care Physician (PCP): | Medical Group: *(Leave blank if not known)* | Existing Patient? ☐ Yes ☐ No |
|---|---|---|

**One Medical** ☐ YES, I want to JOIN One Medical. **If 'YES' we will assign you a PCP. You are free to change if you decide later.**

**What is your race? (Check all that apply)**

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

**What is your ethnicity? (Check all that apply)**

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

**What is your preferred language for health care?**

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

**What is your assigned sex at birth?**

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

**What is your current gender identity?**

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____

☐ Decline to state

**What is your sexual orientation?**

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

## 2. Dependent(s) to be covered or added

| ☐ **Spouse** ☐ **Domestic Partner** | Last Name: | First Name: | M.I.: |
|---|---|---|---|
| Date of Birth (MM/DD/YY): / / | | SSN: | |
| Primary Care Physician (PCP) (*Required for HMO Plans Only*): | | 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 | |
| ☐ 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 | | | |
| ☐ | ☐ | Chinese (Written /Mandarin (Spoken) | ☐ | ☐ | Punjabi | ☐ | ☐ | Unknown |
| ☐ | ☐ | English | ☐ | ☐ | Russian | ☐ | ☐ | Decline to state |
| ☐ | ☐ | Korean | ☐ | ☐ | Spanish | | | |

**What is your assigned sex at birth?**

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

**What is your current gender identity?**

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

**What is your sexual orientation?**

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

**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 | |
|---|---|---|
| | ☐ | 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 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):<br>/ / | | SSN: | |
| Primary Care Physician (PCP): | | Medical Group: *(Leave blank if not known)* | Existing Patient?<br>☐ Yes ☐ No |

**What is your race? (Check all that apply)**

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

**What is your ethnicity? (Check all that apply)**

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

**What is your preferred language for health care?**

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

**What is your assigned sex at birth?**

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

**What is your current gender identity?**

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

**What is your sexual orientation?**

| | |
|---|---|
| ☐ Lesbian or gay or homosexual<br>☐ Straight or heterosexual<br>☐ Bisexual | ☐ Something else, please describe: _____<br>☐ Do not know<br>☐ Decline to state |

| **Dependent # 3** | Last Name: | First Name: | M.I.: |
|---|---|---|---|
| Date of Birth (MM/DD/YY):<br>/ / | | SSN: | |
| Primary Care Physician (PCP): | | Medical Group: *(Leave blank if not known)* | Existing Patient?<br>☐ 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 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
- ☐ 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 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

## 3. Medicare Information

Is any person applying for coverage currently enrolled with Medicare?

☐ No ☐ Yes, please attach a copy of your Medicare card(s) & Name: _____

## 4. Disclosure of Personal and Health Information

Balance understands 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.

## 5. 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 Balance and any of this 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.

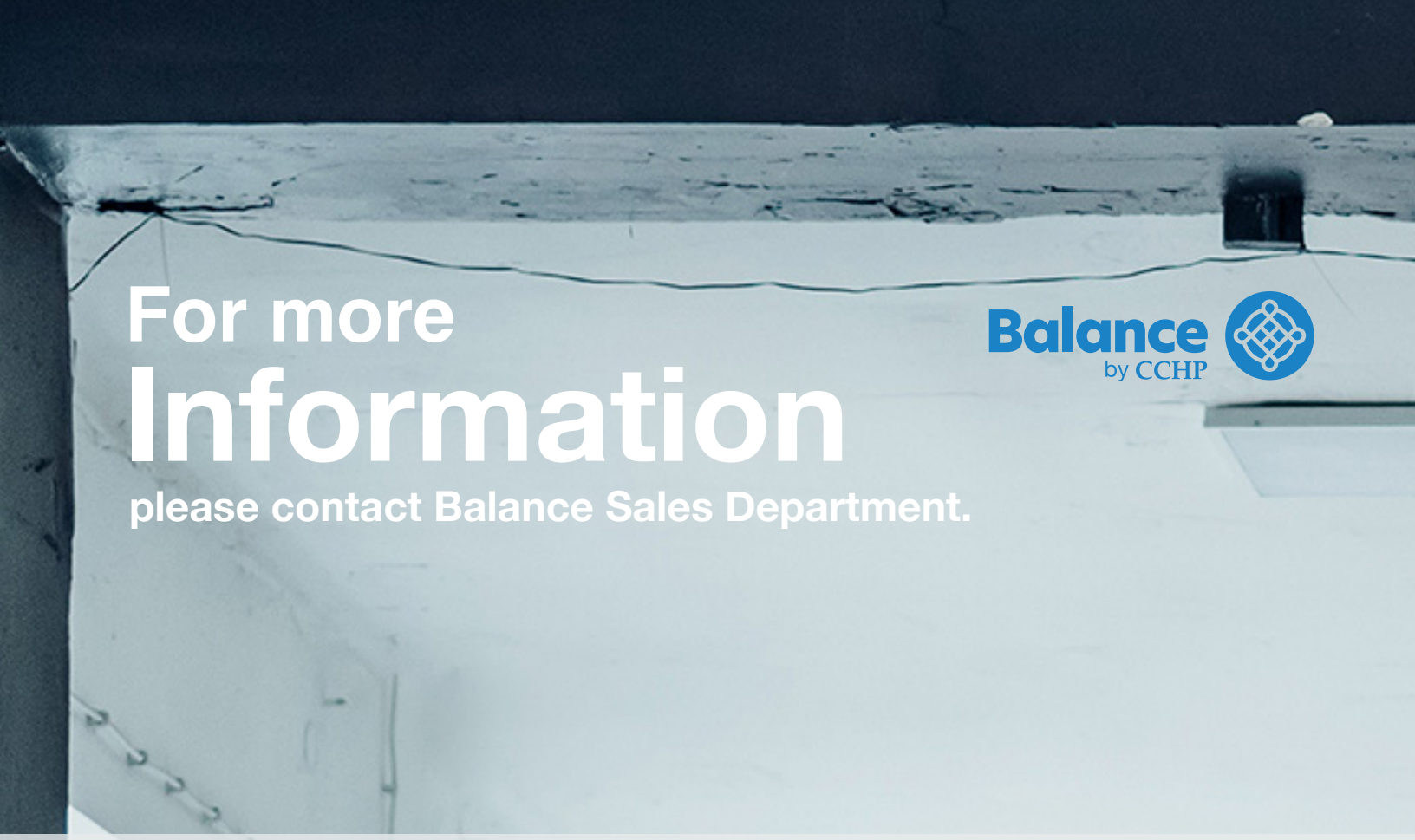
| Employee Signature<br>X | Employee Name: | Date (MM/DD/YY):<br>/ / |
|---|---|---|
| Signature of Employer/Authorized Representative:<br>X | Employer/Authorized Representative Name & Title: | Date (MM/DD/YY):<br>/ / |

## 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). 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 CCHPComplianceDept@cchphealthplan.com.

# NOTES



# For more Information

**please contact Balance Sales Department.**

Balance by CCHP

## Call or Email

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

**1-800-893-1598**
(TTY: 1-877-681-8898)

**Sales@BalanceByCCHP.com**

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.

REV 10.29.24