
# California Major Risk Medical Insurance Program (MRMIP)

## 2008 Application and Handbook

*Rates effective January 1, 2008*

# California Major Risk Medical Insurance Program

**Visit our website at: www.mrmib.ca.gov**

**MRMIP Enrollment Unit**
**(800) 289-6574**

**Monday – Friday**
**8:30 a.m. – 7:00 p.m.**

P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695



**Americans with Disabilities Act**
Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability be excluded from participating in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

The Americans with Disabilities Act of 1990 prohibits the Managed Risk Medical Insurance Board and its contractors from discriminating on the basis of disability, protects its applicants and enrollees with disabilities in program services, and requires the Board and its eligibility and enrollment contractors to make reasonable accommodations to applicants and enrollees.

The Managed Risk Medical Insurance Board has designated an ADA Coordinator to carry out its responsibilities under the Act. If you as a client have any questions or concerns about ADA compliance by the Board or its contractors, you may contact the Coordinator at the following address:

**ADA Coordinator**
**Managed Risk Medical Insurance Board**
**P.O. Box 2769**
**Sacramento, CA 95812-2769**
**(916) 324-4695 (Voice)**

**The hearing impaired can contact the ADA Coordinator through the California Relay Services at 1-800-735-2929.**

## Table of Contents

Introduction . . . . . 2
Eligibility . . . . . 2
How the Program Works . . . . . 3
Description of Plans and Benefit Highlights
- Anthem Blue Cross PPO . . . . . 8
- Blue Shield of California (Access + HMO) . . . . . 10
- Contra Costa Health Plan . . . . . 12
- Kaiser Permanente Northern California . . . . . 14
- Kaiser Permanente Southern California . . . . . 16

Monthly Subscriber Contributions . . . . . 18
Enrollment Application Checklist . . . . . 24
Enrollment Application . . . . . 25

**(800) 289-6574**

| | |
|---|---|
| للمعلومات باللغه العربيه اضغط 3 | Arabic |
| Հայերենով տեղեկություն ստանալու համար խնդրում ենք հեռաձայնեք վերը նշված համարով եւ սեղմեք 3 | Armenian |
| សម្រាប់ពត៌មានបន្ថែមជាភាសាខ្មែរ, សូមទូរស័ព្ទទៅលេខខាងលើហើយចុចលេខ 3 | Cambodian/Khmer |
| 对于信息用中文新闻 3 | Cantonese |
| For information in English press 1 | English |
| برای کسب اطلاعات به زبان فارسی با شماره فوق الذکر تماس بگیرید و شماره 3 را فشار دهید. | Farsi |
| Yog koj xav paub kev qhia ntxiv uas hais lus hmoob, nias tus naj npawb 3 | Hmong |
| 한국 압박안에 정보를 위해 3 | Korean |
| 对于信息在普通新闻里 3 | Mandrin |
| Для информации на русском языке, нажмите кнопку 3 | Russian |
| Si desea información en español oprima 2 | Spanish |
| dahil sa patalastas di Tagalog , daganan 3 | Tagalog |
| Muốn biết thêm tin tức, làm ơn nhấn 3 | Vietnamese |

## Introduction

The California Major Risk Medical Insurance Program (MRMIP) is a program developed to provide health insurance for Californians who are unable to obtain coverage in the individual insurance market. MRMIP is administered by a five-member Board which established a comprehensive benefit package. Services are delivered through contracts with health insurance plans. MRMIP subscribers participate in the payment for the cost of their coverage by paying subscriber contributions, an annual deductible, and copayments. MRMIP supplements subscriber contributions to cover the cost of care and is funded annually by tobacco tax funds.

## Eligibility

In order to be eligible for the MRMIP:

1. You must be a resident of the state of California. A resident is a person who is present in California with intent to remain in California except when absent for transitory or temporary purposes. However, a person who is absent from the state for a period greater than 210 consecutive days shall not be considered a resident.
2. You cannot be eligible for Medicare both **Part A** and **Part B** unless eligible solely because of end-stage renal disease. Provide a Medicare eligibility letter with the application as proof of end-stage renal disease. (Being eligible for only one part of Medicare is acceptable.)
3. You cannot be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. (COBRA and CalCOBRA refer to the federal and state laws giving people under certain circumstances the right to continue coverage in an employee health plan for a limited time.) If you have COBRA or CalCOBRA, you may apply for deferred enrollment.
4. You must be unable to secure adequate coverage within the previous 12 months. This can be demonstrated in any of three ways:
   - You have been denied individual coverage. A letter or a copy from a health insurance carrier, health plan or health maintenance organization denying individual coverage within the last 12 months must be submitted with your complete application. Insurance denial notifications received through the internet that does not provide the reason for denial and the applicant's name will not be accepted.
   - You have been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud. A letter or a copy indicating involuntary termination from a health insurance carrier, health plan, health maintenance organization or employer for reasons other than nonpayment of premium or fraud must be submitted with your complete application.
   - You have been offered an individual, not a group, health insurance premium in excess of the MRMIP subscriber contribution amount. A letter or a copy must be submitted with the complete application indicating that, within the last 12 months, you have been offered by a health insurance carrier, health plan or health maintenance organization, a premium in excess of the MRMIP subscriber contribution amount. (Based on subscribers MRMIP health plan choice.)

     Note: Letters from agents/brokers indicating that an individual is unable to secure adequate private coverage will not be accepted as documentation for eligibility.

***Applicants Who Know They Are Currently Not Eligible But Expect To Be in the Future (Deferred Enrollment)***

If you are not currently eligible for the MRMIP, but anticipate becoming eligible, you may also apply. Examples of this are: if you are currently enrolled in COBRA or CalCOBRA coverage or if your employer has informed you that you will be involuntarily terminated from insurance coverage sometime in the future.

To apply for deferred enrollment, indicate when you will become eligible and include acceptable documentation. Acceptable documentation is a letter from a health insurance carrier, health plan, health maintenance organization, or employer indicating when your coverage will end. The documentation must specify the exact date of when your current coverage will terminate. Enrollment in temporary policies does not qualify for deferred status.

If the MRMIP is not at maximum enrollment and all other eligibility criteria are met, you will be enrolled in the MRMIP the month determined you are eligible. If the MRMIP is at maximum enrollment at the time you become eligible, your application will be placed on a waiting list. Your place on the waiting list is determined by the date in which your complete application was received, not the date that you became eligible for the MRMIP.

Applicants for deferred enrollment must submit their initial subscriber contribution with their application. Payment will be refunded to you immediately if your deferred effective date is more than 60 days from the date MRMIP received your application.

***Agents/Brokers, Employers and Applicants***

Insurance Code Section 12725.5 states that it shall constitute unfair competition for an insurer, an insurance

agent or broker, or administrator to refer an individual employee or their dependent(s) to apply for MRMIP with the purpose of separating that employee or their dependent(s) from group health coverage provided in connection with the employee's employment.

Insurance Code Section 12725.5 further states that it shall constitute an unfair labor practice contrary to public policy for any employer to refer an individual employee or their dependent(s) to the MRMIP or to arrange for an individual employee or their dependent(s) to apply for MRMIP with the purpose of separating that employee or their dependent(s) from group health coverage provided in connection with the employee's employment.

***Medi-Cal Beneficiaries***

While Medi-Cal beneficiaries are not prohibited from enrolling in the MRMIP, a Medi-Cal beneficiary should carefully consider the cost before signing up for MRMIP coverage. MRMIP subscribers are responsible for their monthly subscriber contributions, annual deductible, and a copayment for services, which could be more than $5,000 per year. Medi-Cal BIC cards cannot be used for the MRMIP.

## How the Program Works

***Choosing a Health Plan***

The health plans participating in the MRMIP provide comprehensive medical benefits for inpatient and outpatient hospital and physician services. These benefits are outlined in the health plan description pages in this brochure and are also available by calling any MRMIP health plan at its toll-free number and asking for an Evidence of Coverage or Certificate of Insurance booklet. Subscribers may choose from any plan available to them depending on where they live, as listed on pages 18-23. **Please review all pages carefully to select a plan that is right for you.**

***Deductible***

The MRMIP has an annual household $450 deductible you must satisfy before the plan will begin paying for covered services. Effective February 1, 2008, you are responsible for charges for certain covered services subject to the deductible and the plans will not pay for these services until you meet the deductible in that calendar year. The only payments that count toward a deductible are those payments you make for covered services that are subject to the deductible. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayments subject to the annual out-of-pocket maximum. Payments for services provided by In-Network and Out-of-Network Providers and prescription payments may apply toward the $450 annual deductible. The $450 annual deductible is applied to the annual out-of-pocket maximum.

Each plan is applying the deductible differently. However, the following covered Preventive Care Services with applicable copayments are not subject to the calendar year deductible in any plan.

- Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women
- Cytology Examinations
- Periodic Health Examinations
- Hearing tests and eye exams for children up to age 16
- Newborn Blood Tests
- Prenatal Care (care during pregnancy)
- Prostate Exams for Men
- Venereal Diseases Tests
- Well-Baby and Well-Child Visits
- Certain Immunizations for children and adults
- Laboratory Services in connection with Periodic Health Evaluations
- Other (depends on the plan)

Please review the individual plan pages for details on which services are subject to the deductible

***Copayments / Coinsurance***

Health Maintenance Organizations (HMOs) in MRMIP may require a fixed dollar copayment for some services and up to 25% of the cost for other services. The Preferred Provider Organization (PPO) in MRMIP may also require a fixed dollar copayment for certain services and up to 25% of the cost for other services.

The out-of-pocket maximum per **calendar** year for MRMIP is $2,500 for individuals and $4,000 for an entire household covered by the MRMIP. This maximum does not apply to services received by providers that do not participate in the subscriber's chosen health plan's provider network, or to services not covered by the MRMIP. There are MRMIP benefit limits of $75,000 per calendar year and $750,000 in a lifetime.

Please refer to the health plan's Evidence of Coverage or Certificate of Insurance booklet to read more about the plan's out-of-pocket expenses.

***Subscriber Contributions***

Subscriber contribution amounts are updated on January 1 of each year. In addition, your subscriber contribution may change during the year if your birthday moves you into a new age category. For subscribers with enrolled dependents, the age category will be based on the age of the applicant. Adjustments to subscriber contributions due to age changes will occur on the first of the month following the birthdate of the applicant.

Subscriber contributions may also change when a member moves from one area of the State to another or if a member transfers to a different health plan.

Adjustments to subscriber contributions will occur on the first of the month following notification of the move or on the effective date of your transfer.

Each month you will receive a subscriber contribution notice from MRMIP. Subscriber contributions are payable in advance and are due the first day of every month. A subscriber contribution notice will be generated monthly, and will be sent out 30 days prior to the due date. Please make check payable to the **California Major Risk Medical Insurance Program**.

Subscribers now have several billing options, which include monthly, bi-monthly, and quarterly premium billing, as well as monthly electronic checking account withdrawal.

Subscribers are responsible for their monthly subscriber contributions whether or not they receive a bill, or if the premium is paid by a third party.

A delinquent bill or final notice will be sent out on the 15th day following the due date.

There is a grace period of 31 days from the due date and the member's coverage will remain in effect during this time.

Disenrollment for nonpayment of a subscriber contribution will occur on the 32nd day after the due date. The end date of coverage will be retroactive to the last day of the month in which the subscriber contribution was paid in full. A disenrollment letter will be mailed to the subscriber. Subscribers are responsible for the cost of any services received after the disenrollment date. Subscribers who are disenrolled for nonpayment of their subscriber contributions may be reinstated upon a written request only **once** in a rolling 12-month period. The subscriber must request reinstatement in writing within 60 calendar days of the date of disenrollment and bring all delinquent payments up to date. Any further reinstatements will require a written appeal to the Managed Risk Medical Insurance Board for consideration.

Subscribers may pay by check, money order or may elect to have their monthly subscriber contribution automatically paid from their checking account when accepted into the MRMIP. In addition, a federally recognized California Indian tribal government can make required subscriber contributions on behalf of a member of the tribe.

Subscriber contribution checks and electronic withdrawals that are returned by the subscriber's bank for insufficient funds may result in a retroactive disenrollment date. The subscriber will be charged a processing fee for each payment received as having non-sufficient funds. In addition, electronic withdrawals that are returned unpaid from the subscriber's bank will result in removal from electronic withdrawal and require immediate payment by check or money order. Upon written request to reinstate, the subscriber must include a check or money order of subscriber contributions to bring the account to current status with an additional $25.00 processing fee.

**There is no application fee for applying to the MRMIP. You are required to submit your first month's subscriber contribution for MRMIP health care coverage. This payment is completely applied towards your first month of coverage if you are enrolled. Cashing your check does not guarantee enrollment. Qualified insurance agents and brokers may be paid a $50 fee by the State for explaining the MRMIP and assisting you in completing the application, if you are enrolled. The State does not require an individual applying to the MRMIP to pay any fee, charge or commission to a broker or agent.**

### *Pre-Existing Condition Exclusion Period*

"Pre-existing condition" means any condition for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding enrollment in the MRMIP.

For subscribers and dependents enrolled in a Preferred Provider Organization (PPO), there is a pre-existing condition exclusion period of 3 months. During this period, no benefits or services related to a pre-existing condition are covered. However, subscriber contributions are paid during this period.

### *Post-Enrollment Waiting Period*

For subscribers and dependents enrolled in a Health Maintenance Organization (HMO), there is a post-enrollment waiting period of 3 months. No benefits or services are provided to subscribers and enrolled dependents during this period. Subscribers will be informed of when this period begins and ends.

No subscriber contributions are paid during this waiting period. The initial one-month subscriber contribution will be applied to the first month of service.

### *How You May Waive All or Part of the Exclusion/Waiting Period*

The exclusion/waiting period requirement may be waived in part or all if:

1. The subscriber and enrolled dependents have been on the MRMIP waiting list for 180 days or longer. In this circumstance, the exclusion/waiting period will be completely waived.
2. The subscriber and enrolled dependents were previously insured by another health insurance policy (including Medicare and Medi-Cal) and the application for enrollment

in the MRMIP was made within 63 days of the termination of the previous coverage. In these circumstances, you may be granted a waiver up to 3 months. If the coverage was less than 3 months but was at least 1 month, the subscriber and enrolled dependents will be given credit for either 1 or 2 months toward their MRMIP exclusion/ waiting period.

3. The subscriber and enrolled dependents were insured by another health insurance policy that ended because of a loss of employment, or because the employer stopped offering or sponsoring health coverage, or because the employer stopped making contributions towards health coverage and application for enrollment in the MRMIP was made within 180 days of the termination of the previous coverage. In these circumstances, you may be granted a waiver of up to 3 months.

4. The subscriber and enrolled dependents were receiving coverage under a similar program in another state within the last 12 months. In this circumstance, the exclusion/waiting period will be completely waived.

   If you have met the criteria in #2, #3, or #4 to waive this exclusion/waiting period, please submit appropriate documentation and check the appropriate boxes on the application (Program Eligibility Questions #5 and/or #6).

***All documentation must be received prior to or with your first month's subscriber contribution.***

***The subscriber dependents age 18 and under are not subject to the pre-existing condition exclusion period or the post-enrollment waiting period.***

***Dependent Coverage Information***

1. Dependents may be covered under the MRMIP and are defined as a subscriber's spouse, registered domestic partner, and any unmarried child who is an adopted child, a stepchild, a recognized natural child under age 23, or a registered domestic partner's own separate child.

A dependent also includes any unmarried child who is economically dependent upon the applicant. An unmarried child over 23 years old may be covered if that unmarried child is incapable of self-support because of physical or mental disability which occurred before the age of 23. An applicant must provide documentation in the form of doctors' records which show that the dependent child cannot work for a living because of a physical or mental disability which existed before the child became 23.

2. It is the responsibility of subscribers to notify the MRMIP about changes in the number of dependents. Coverage for newborn children shall begin upon birth if the request is made within 60 days of birth. Stepchildren are eligible for MRMIP dependent coverage upon marriage by a subscriber to the stepchildren's parent or at the time the stepchildren lose other health coverage. The domestic partner's children are eligible for MRMIP dependent coverage upon the parent being a registered domestic partner with the subscriber or at the time the children lose other health coverage. In all cases, the MRMIP must be notified within 60 days. If eligible, dependents are covered within 90 days of the MRMIP being notified. Dependents age 18 and under qualify for a full pre-existing or post-enrollment waiver. To add a dependent to your policy, you may request an "Add Dependent" application by calling (800) 289-6574 and talking to a MRMIP Enrollment Unit representative.

3. Enrolled dependents of a deceased subscriber or dependents of a subscriber who becomes eligible for Medicare (Parts A and B) are eligible to continue coverage in the MRMIP as long as program requirements are met.

***Waiting List***

If the MRMIP reaches maximum enrollment, applicants and dependents will be placed on a waiting list. Applicants and dependents will be offered enrollment when spaces become available depending on the date in which the completed application was received. Any time spent solely on the waiting list does not count toward the 3 month pre-existing condition exclusion period or post-enrollment waiting period (once enrolled) unless the applicant has been on the waiting list for at least 180 days. If the applicant has been on the waiting list 180 days or longer, the full 3 month exclusion/waiting period will be waived.

***Transfer of Enrollment***

Subscribers and enrolled dependents may transfer from one participating health plan to another if any of the following occur:

1. The subscriber so requests, in writing, during the program's open enrollment period which is held in November. Subscribers will receive an open enrollment packet containing the plan choices and the new rates.

All open enrollment transfers will be effective January 1. All enrolled dependents will also be transferred to the new plan.

2. The subscriber requests a transfer in writing because the subscriber has moved and no longer resides in an area served by the health plan in which they are enrolled and there is at least one participating health plan serving the subscriber's new area.

3. The subscriber or participating health plan requests a transfer in writing because of the failure to establish a satisfactory subscriber/plan relationship and the Executive Director determines that the transfer is in the best interest of the MRMIP and there is at least one participating health plan serving the subscriber's area.

Any transfer request must be in writing to:

*Managed Risk Medical Insurance Board*
*Benefits Division*
*P.O. Box 2769*
*Sacramento, CA 95812-2769*

Subscribers who transfer enrollment are not subject to pre-existing condition/waiting period exclusions.

***Disenrollment***

A subscriber and enrolled dependents will be disenrolled from the MRMIP when any of the following occur:

1. The subscriber so requests in writing. Disenrollment will be effective at the end of the month in which the request was received or disenrollment will be effective at the end of the month for which the subscriber contribution was paid in full.
2. The subscriber fails to make subscriber contributions in accordance with the MRMIP's subscriber contribution payment and grace period policies. The effective date of disenrollment for nonpayment of a subscriber contribution will be retroactive to the last day of the month for which a subscriber contribution was paid in full.
3. The subscriber fails to meet the residency requirement or becomes eligible for Medicare Part A and Part B unless eligible solely because of end-stage renal disease. Subscribers must inform the MRMIP Enrollment Unit in writing when they become eligible for Medicare Part A and Part B. Disenrollment will be effective at the end of the month in which the notification was received or disenrollment will be effective at the end of the month in which the subscriber contribution was paid in full.
4. The subscriber or enrolled dependents have committed an act of fraud to circumvent the statutes or regulations of the MRMIP. In the event of fraud, the disenrollment could be retroactive to the subscriber's original effective date.

Subscribers and dependents who have been disenrolled for any reason may not re-enroll in the MRMIP for a period of 12 months.

***Health Plan's Dispute Resolution/Appeals***

If a subscriber is dissatisfied with any action, or inaction, of the plan/provider organization in which he/she is enrolled, the subscriber should first attempt to resolve the dispute with the participating plan/organization according to its established policies and procedures.

***Binding Arbitration***

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan and ask for an Evidence of Coverage or Certificate of Insurance booklet.

***The Managed Risk Medical Insurance Board (MRMIB) Appeals Process***

The subscriber should first attempt to resolve the dispute with the participating plan according to its established policies and procedures.

This is a State program and the subscriber's rights and obligations will be determined under Part 6.5 Division 2 of the California Insurance Code and the regulations of Title 10, Chapter 5.5.

Subscribers may file an appeal with MRMIB on the following issues:

1. Any action or failure to act which has occurred in connection with a participating health plan's coverage,
2. Determination of an applicant's or dependent's eligibility,
3. Determination to disenroll a subscriber or dependent, and
4. Determination to deny a subscriber's request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

An appeal must be filed in writing within 60 calendar days of the action, failure to act, or receipt of notice of the decision being appealed to:

*Managed Risk Medical Insurance Board*
*Attention: Eligibility Division*
*P.O. Box 2769*
*Sacramento, CA 95812-2769*

***Evidence of Coverage and Disclosure Form or Certificate of Insurance Booklets***

Evidence of Coverage and Disclosure Form or Certificate of Insurance Booklets is available from each health plan upon request. Please see each health plan description for a phone number to call to request one.

### *Coordination of Benefits*

Participating health plans will coordinate coverage of benefits with any other health insurance you may have. The MRMIP is secondary to other insurance coverage and by State law will only pay after your other insurance has paid (not including Medi-Cal and other State programs). Under the rules of the MRMIP, the benefits of this Program will not duplicate coverage you may have (whether you use it or not) under any other program or plan.

### *Post-MRMIP Guaranteed Issue Coverage*

In accordance with State law, the MRMIP has been disenrolling subscribers who have been enrolled for 36 consecutive months. As of December 31, 2007, the requirement of disenrolling subscribers after 36 months enrollment is no longer in effect. Instead, subscribers will continue to be enrolled in MRMIP for as long as they qualify for the MRMIP and are not past due on their subscriber contribution payments.

### *Privacy Notification*

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

When you apply for the MRMIP, the information you provide in the application is reviewed by a private contractor. The private contractor is hired by the State of California to assist in the administration of the MRMIP. The contractor uses your information to determine whether you are eligible for MRMIP. The contractor and the State will use your information for administration and evaluation of the Program and for necessary purposes authorized by law.

If you are determined eligible for MRMIP, the contractor will then send your information to the health insurance plan and provider that you select, so you can begin to receive health insurance coverage under that plan. Once you are enrolled, your health plan will forward to the State information regarding the health care and services that you receive.

Uses and disclosures that are not part of the operations of the Program will only be made with your written authorization or as required by law. This authorization may later be revoked at your written request.

### *Your Rights Regarding How Your Personal Information Is Used*

You have the right to request the MRMIP to restrict the use of your personal information. The Program may not agree to restrictions if it would interfere with its normal operations and administration. You also have the right to obtain a copy or request to change the personal information you provided to the MRMIP as long as the Program retains such information. You have the right to obtain an explanation about how your personal information was disclosed, other than the use of your information by MRMIP to carry out the operations of the Program.

MRMIP may revise the privacy practices described here. The Program will notify its subscribers by updating program handbooks and/or through notices mailed directly to subscribers (within 60 days) of such revisions. You may submit a complaint to the MRMIB if you believe your privacy rights have been violated by contacting:

*Managed Risk Medical Insurance Board*
*MRMIP HIPAA Coordinator*
*P.O. Box 2769*
*Sacramento, CA 95812-2769*
*(916) 324-4695*

### *Open Enrollment Period for Under Age 65 Disabled Medicare Beneficiaries*

You are ineligible for coverage through MRMIP if you are eligible for Medicare Part A and Part B, unless you are eligible for Medicare solely because you have end-stage renal disease.

**You are required to inform the Program when you become eligible for Medicare Part A and Part B.** Please contact the Major Risk Enrollment Unit at (800) 289-6574. "Eligible" for Part A means that you are not required to pay a premium for Part A. "Eligible" for Part B simply means that you have the right to purchase Part B because you are eligible for Part A. You are ineligible for MRMIP even if you choose not to pay the premium for Medicare Part B.

Most individuals who become eligible for Medicare because of **age or disability** are entitled to purchase insurance to supplement their Medicare for **six months after they first purchase Medicare Part B,** and under certain other circumstances. For individuals who become eligible for Medicare because of a **disability**, the right to buy this supplemental insurance is the result of State law. You may call the Health Insurance Counseling and Advocacy Program (HICAP) program at (800) 434-0222 for free information and counseling about these rights.

**Anthem Blue Cross Preferred Provider Organization (PPO)**
(formerly known as Prudent Buyer) **Administered by**

Anthem Blue Cross

**1-877-687-0549**

## Plan Highlights

**Quality Medical Services at Discounted Rates**

Anthem Blue Cross has found a way to control escalating medical expenses for members. We have negotiated discounted rates with a network of physicians and hospitals across the state. These providers form the Preferred Provider Organization (PPO) plan. They give Anthem Blue Cross members a discount for care.

Members must satisfy a $450 calendar year deductible before the plan will begin paying for most covered services beginning February 1, 2008. Once the deductible is met, members pay only a **$25** copayment for office visits to doctors in the Anthem Blue Cross network. Anthem Blue Cross pays the rest. For most other in-network services, Anthem Blue Cross pays **85%** of the discounted rate. Once you reach your yearly maximum copayment limit, Anthem Blue Cross pays **100%** of the cost for in network, covered services for the rest of the calendar year. There are no claim forms when you use in-network providers.

## Advantages of Plan Providers

**Access to One of the Largest Provider Networks in California**

The Anthem Blue Cross PPO plan gives you access to quality care through our network of physicians, hospitals and selected ambulatory surgical centers, infusion therapy, and durable medical equipment providers. Using network participating providers ensures maximum member savings.

- **Extensive provider network** comprised of more than 40,000 PPO physicians, 29,000 HMO physicians and more than 400 hospitals.

**Benefits Still Available Out of Network**

You can go outside the network and still receive benefits. You will pay a greater share of the cost when you use a nonparticipating provider because you will be responsible for a larger copayment and any charges that exceed the fee schedule.

Anthem Blue Cross contracts with most hospitals in California; however, benefits are not provided for care furnished by the few hospitals without an agreement with Anthem Blue Cross (except care for medical emergencies).

## How the Plan Works

The Anthem Blue Cross PPO plan covers your medical and prescription expenses after a $450 calendar year deductible is met for most covered services.

- **$450 Calendar Year Deductible** per household. The payments or incurred costs for services provided by in-network and out-of-network providers for medical and prescription services excluding preventive care services.
- **Preventive Care Services**

  These services are covered even if you have not met the calendar year deductible and do not apply towards the deductible:

  Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Cytology Examinations Family Planning Services, Health Education Services, Periodic Health Examinations, Hearing tests and eye exams for children up to age 16, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Venereal Diseases Tests, Well-Baby and Well-Child Visits, and Immunizations for children and adults.
- **$25 office visit** copayment when you use our in-network providers
- **Yearly maximum copayment limit for in network providers per calendar year:**
  - $2,500 per member
  - $4,000 per family
- **$75,000 annual maximum** for benefits paid per calendar year
- **$750,000 lifetime maximum** for benefits paid

The Anthem Blue Cross PPO plan includes the **Anthem Blue Cross Prescription Drug Program** with these important features:

- **Lower cost: Anthem Blue Cross** has negotiated discounts with almost 90% of California retail pharmacies, including all of the major chain drugstores. You may choose any pharmacy, but your costs are much lower if you stay in the network using participating providers.
- **Service:** Network pharmacies are supported by an online electronic network and will collect your copayment when you pick up your prescription. **No claim forms to file!**

## Important Information

If you would like more information before you enroll, please call **Anthem Blue Cross Customer Service at 1-877-687-0549**. Call Monday through Friday from 8:30 a.m. to 7:00 p.m.

*Please note that the information presented here is only a summary. The Anthem Blue Cross plan for MRMIP is subject to various limitations, exclusions and conditions, as fully described in the Evidence of Coverage. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.*

# Anthem Blue Cross

## Summary of Benefits

| *Type of Service* | *Description of Service* | *What You Pay Participating Provider* | *Non-Participating Provider* |
|---|---|---|---|
| **Annual Deductible** | The amount that you must pay for covered services except for Preventive Care Services before the plan will cover those services at the copayment amount | $450 Per household | $450 Per household |
| **Copayment** | Member's amount due and payable to the provider of care | See Below | See Below |
| **Yearly Maximum Copayment Limit** | Member's annual maximum copayment limit when using participating providers in one calendar year<br>If non-participating providers are used, billed charges which exceed the customary and reasonable charges are the member's responsibility and do not apply to the yearly maximum copayment limit | $2,500 per member<br>$4,000 per family | No yearly maximum copayment limit for non-participating providers. You pay unlimited copayments |
| **Annual Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year for a member | | |
| **Lifetime Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime for a member | | |
| **Preventive Care Services**** | Services<br>Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examination, Hearing tests and eye exams for children up to age 16, Newborn Blood Tests, Prenatal Care (care during pregnancy ), Prostate Exams for Men, Venereal Diseases Tests, Well-Baby and Well-Child Visits, and Immunizations for children and adults | 15% of negotiated fee rate | 50% of customary and reasonable charges and any in excess |
| **Hospital Services** | Inpatient medical services (semi-private room)<br>Outpatient services; ambulatory surgical centers<br>(No benefits are provided in a non contracting hospital or non contracting dialysis treatment center in California, except in the case of a medical emergency) | 15% of negotiated fee rate<br>15% of negotiated fee rate | All charges except for $650 per day<br>All charges except for $380 per day |
| **Physician Office Visits** | Services of a physician for medically necessary services | $25 office visit | 50% of customary and reasonable charges and any in excess |
| **Diagnostic X-Ray and Lab Services**** | Outpatient diagnostic x-ray and laboratory services | 15% of negotiated fee rate | 50% of customary and reasonable charges and any in excess |
| **Prescription Drugs** | Maximum 30 day supply per prescription when filled at a participating pharmacy<br>60 day supply for mail order | $5 for generic drugs<br>$15 for brand drugs<br>$5 for generic drugs through mail service prescription drug program (PrecisionRx)<br>$15 for brand drugs through mail service prescription drug program (PrecisionRx) | All charges except 50% of drug limited fee schedule for generic or brand name drugs |
| **Durable Medical Equipment and Supplies** | Must be certified by a physician and required for care of an illness or injury | 15% of negotiated fee rate | 50% of customary and reasonable charges and any in excess |
| **Pregnancy** and Maternity Care** | Inpatient normal delivery and complications of pregnancy<br>Prenatal ** & postnatal care | 15% of negotiated fee rate<br>15% of negotiated fee rate | All charges except for $650 per day for hospital services<br>50% of customary and reasonable charges and any in excess |
| **Ambulance Services** | Ground or air ambulance to or from a hospital for medically necessary services | 15% of negotiated fee rate | 15% of customary and reasonable charges and any in excess |
| **Emergency Health Care Services*** | Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional and supplies. | 15% of negotiated fee rate | 15% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours. |
| **Mental Health Services*** | •Inpatient nervous and mental services 10 days each calendar year<br>•Outpatient nervous and mental visits 15 visits each calendar year Except for severe mental illnesses, and serious emotional disturbances in children | 15% of negotiated fee rate and all costs for stays over 10 days<br>15% of negotiated fee rate for 15 visits per year. All costs for over 15 visits | All charges except for $175 per day up to 10 days. In addition, all costs for stays over 10 days<br>50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits |
| **Home Health Care** | Home health services through a home health agency or visiting nurse association. | 15% of negotiated fee rate | 50% of customary and reasonable charges and any in excess |
| **Hospice** | Hospice care for members who are not expected to live for more than 12 months | 15% of negotiated fee rate | 50% of customary and reasonable charges and any in excess |
| **Skilled Nursing Facilities** | Skilled nursing care | Not covered unless Anthem Blue Cross recommends as a medically appropriate more cost-effective alternative plan of treatment | |
| **Infusion Therapy*** | Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider | 15% of negotiated fee rate | You pay all charges in excess of $500 per day for all infusion therapy related administrative, professional, and drugs |
| **Physical/Occupational/ Speech Therapy** | Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis. | 15% of negotiated fee rate | You pay all charges except for $25 per visit |

* For exact terms and conditions of coverage, you should refer to your Evidence of Coverage booklet.

** These preventive care services are covered even if you have not met the calendar year deductible and do not apply towards the deductible.

Blue Shield of California has a 60-year tradition of superior member service. Our service professionals have continued to earn the trust and confidence of our more than 2 million current members.

blue of california

**1-800-424-6521**

## Plan Highlights

Blue Shield's revolutionary approach to health care coverage makes it easier than ever for you to get the care you need and the service you deserve. We offer the following special features to give you greater control over your health:

- ***Access+ Specialist*** gives you the option to go directly to a specialist in the same physician group as your Personal Physician **without** a referral for a $30 copayment per visit. Of course, you can always choose to go through your Personal Physician and pay your standard $15 copayment when you obtain a referral to a specialist.
- ***Access+ Satisfaction*** is our member feedback program that offers to refund your standard $15 copayment if you are ever dissatisfied with the service you receive during a covered office visit with one of our HMO network physicians.

With Access+ HMO, there are virtually no claim forms to file, and your dependents (spouse and unmarried children under age 23) are also eligible for coverage under the Access+ HMO Plan.

Annual maximum benefits are $75,000 per covered individual, and lifetime maximum benefits are $750,000 per covered individual.

## Plan Providers

As an Access+ HMO member, you have access to thousands of participating physicians in 22 counties. Odds are that your current doctor is a member of our HMO provider network.

You and each covered family member may choose his or her own Personal Physician from our extensive provider network. Plus, you may change Personal Physicians for any reason at any time simply by calling Blue Shield Member Services.

Blue Shield's Access+ HMO Plan is available to MRMIP subscribers in the following California counties:

| | |
|---|---|
| Alameda | San Bernardino |
| Contra Costa | San Diego |
| Fresno | San Francisco |
| Kern | San Joaquin |
| Los Angeles | San Mateo |
| Marin | Santa Barbara |
| Nevada | Santa Clara |
| Orange | Solano |
| Placer | Sonoma |
| Riverside | Stanislaus |
| Sacramento | Ventura |

Please see the chart at the back of this brochure for the specific zip codes open to MRMIP.

## How the Plan Works

Your Personal Physician will provide or coordinate all of your health care needs, except for Well-Woman exams and *Access+ Specialist* visits. (To use the *Access+ Specialist* option, your Personal Physician must belong to a physician group that has chosen to become an Access+ Provider Group and offers the *Access+ Specialist* option.)

To make an appointment with your Personal Physician or with a specialist in the same physician group using the *Access+ Specialist* option, simply call the physician's office directly and identify yourself as an Access+ HMO member. You will be asked for your Access+ HMO member identification card and your copayment at the time of your visit. (When using the *Access+ Specialist* option, you will also need to show your *Access+ Specialist* card.)

Always call your Personal Physician when you need medical care, unless you are using the *Access+ Specialist* option. Your Personal Physician or his or her designee is available 24 hours a day, seven days a week.

Your Personal Physician or Physician group will authorize any medically necessary X-ray, laboratory, emergency or hospital services. Prescription drugs can be filled at any Blue Shield participating pharmacy, including most major drugstore chains.

**Deductible**

You pay $450 for covered services each year beginning February 1, 2008 before Blue Shield makes payments toward covered services. Benefits for preventive care and outpatient prescription drugs are provided before you need to meet the deductible.

**Copayments**

The maximum amount of out-of-pocket expenses is $2,500 per individual and $4,000 per family in a calendar year.

## Important Information

**Selection of a Personal Physician from the Blue Shield HMO Physician and Hospital Directory is required when enrolling in the plan.** When you select a personal physician, you are also selecting the physician group and specialists affiliated with your personal physician. To select a Personal Physician or for more information on Blue Shield of California and the Access+ HMO Plan, call us toll-free at **(800) 424-6521**. We welcome your call.

*Please note that the information presented here is only a summary of Blue Shield's Access+ HMO Plan. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.*

# Blue Shield Access + HMO

## Summary of Benefits

| *Type of Service* | *Description of Service* | *What You Pay* |
|---|---|---|
| **Annual Deductible** | The amount that you must pay before Blue Shield assumes liability for the remaining cost of covered services. Benefits for preventive care and outpatient prescription drugs are provided before you need to meet the deductible. | $450 (per covered family) |
| **Copayment** | Your cost of covered services | See specific service |
| **Out-of-Pocket Maximum** | The amount you are responsible for paying per calendar year | $2,500 (per covered person)<br>$4,000 (per covered family) |
| **Annual Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year for a member | |
| **Lifetime Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime for a member | |
| **Hospital Services** | • Inpatient services, including semi-private room & board, general nursing care, and drugs | $200 copay per inpatient day |
| **Preventive Services*** | • Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women<br>• Cytology Examinations<br>• Health Education Services<br>• Periodic Health Examinations<br>• Hearing tests and eye exams for children up to age 16<br>• Newborn Blood Tests<br>• Prostate Exams for Men<br>• Venereal Diseases Tests<br>• Well-Baby and Well-Child Visits<br>• Immunizations for children and adults<br>• Family Planning Services<br>• Prenatal Care (care during pregnancy) | No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>No charge<br>$15 per visit<br>$15 per visit |
| **Professional (Physician) Services** | • Office visits, specialist visits<br>• Home visits by Plan Physicians<br>• Allergy testing | $15 copay per office visit<br>Access+ $30 copay per office visit<br>$25 per visit<br>No charge |
| **Diagnostic X-Ray and Laboratory Tests** | Diagnostic tests and X-rays, ultraviolet light therapy and Laboratory tests* | |
| **Outpatient Prescription Drugs* (Closed Formulary)** | Medically necessary drugs prescribed by physician and obtained at a Plan pharmacy, according to Formulary guidelines | $10 generic/$10 generic mail order $15 brand/$20 brand mail order |
| **Durable Medical Equipment, Supplies, Prosthetic Devices and Braces** | Home medical equipment, oxygen and its administration, and home colostomy and ostomy supplies that meet the member's medical needs and are cost effective, prostheses, and orthoses. (Routine maintenance and repair due to damage are not covered, and HMO rental charges in excess of purchase price are not covered.) | 20% copay of allowed charges |
| **Maternity Care** | Prenatal* & postnatal care<br>Normal delivery, complications of pregnancy, C-section | $15 copay per office visit<br>$200 copay per inpatient day |
| **Ambulance** | Ground transportation as medically necessary | No charge |
| **Emergency Care Services** | Plan and non-plan emergency room visits | $25 copay per visit, waived if directly admitted (Hospitalization copays apply) |
| **Mental Health Care** | Mental health services<br>• Inpatient nervous and mental services 10 days each calendar year<br>• Outpatient nervous and mental services up to 15 visits per calendar year<br>Except for severe mental illnesses, and serious emotional disturbances in children | <br>$200 copay per inpatient day<br>$15 copay per visit |
| **Home Health Care** | Medically necessary visits by home health personnel | $10 per visit |
| **Hospice Care** | Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less | $50 per day |
| **Skilled Nursing Services** | As medically necessary in lieu of hospitalization. Up to 100 days per calendar year<br>Custodial care is not covered | $50 per day |
| **Speech/Physical/ Occupational Therapy** | Rehabilitative therapy services by a physical, occupational, respiratory or speech therapist in the following settings:<br>• In the rehabilitation unit of a hospital or skilled nursing facility for medically necessary days<br>• For services in the office | <br>$50 per day<br>$15 copay per visit |
| **Other** | Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing and in-hospital blood processing) | No charge |

*These services are not subject to the annual deductible.

Access + HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access + HMO specialist, and must be received while the patient is a current member. All care must be prescribed by and received from a Blue Shield

Access + HMO physician or a physician to whom a Blue Shield HMO physician has referred you to for specific care. Payments for care that is not covered do not count toward your out-of-pocket maximum. Please read the Evidence of Coverage booklet for complete details of coverage.

CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Contra Costa County's own HMO, serving residents since 1973.

**Member Call Center**
**1-877-661-6230 (Press 2)**

## Plan Highlights

Contra Costa Health Plan (CCHP), founded in 1973, is stable and secure. CCHP is sponsored by the County of Contra Costa, is licensed by the California State Department of Managed Health Care, and is a federally qualified Health Maintenance Organization. Our over 65,000 members, therefore, have the assurance of knowing that CCHP must conform to the highest standards of care.

Our members appreciate

- Affordable, quality care, plus excellent service
- A comprehensive benefit package
- Neighborhood Health Centers with extended hours for primary and urgent care services, and access to Contra Costa Regional Medical Center
- An extensive network of community primary care and specialty physicians, and contracted community hospitals
- A 24-hour Advice Nurse service available 365 days a year
- Emergency services covered worldwide

## Plan Providers

When you select CCHP for yourself and your family, you are gaining access to over 150 primary care providers and over 300 specialists. CCHP offers a choice of two "provider networks": One, our Regional Medical Center Network, offers primary care and access to specialty care through eight Health Centers and at the newest hospital in the East Bay, the Contra Costa Regional Medical Center in Martinez. You would simply select the Health Center most conveniently located for you, and your doctor there will make sure you get all the preventive care, routine care, and referrals for specialty care that you need.

CCHP's other "provider network" is the Community Provider Network. With offices throughout Contra Costa County, you will easily be able to select a Primary Care Provider (PCP) near you. These community providers are affiliated with one or more of six hospitals in the area. The Contra Costa Regional Medical Center's specialty services are also available to providers and members of this network.

## How the Plan Works

CCHP is available to MRMIP subscribers who live in Contra Costa County.

When you join CCHP, we encourage you to call our Member Services Department. Our friendly Member Services Representatives will take as much time as you need to help with selecting your PCP and with any other questions you may have about how to access your plan services. You can change your PCP at any time by calling Member Services and choosing another provider from either provider network.

The 24-hour Advice Nurse service is available to members every day of the year. Advice Nurses offer confidential and professional health advice and important information about preventive care services.

All new members will receive Informational Materials, which include a Member Handbook, Provider Directory, Combined Evidence of Coverage and Disclosure document, and a Health Plan membership ID card. Call CCHP Member Services at 1-877-661-6230 (Press 2) with any questions about your membership.

## Deductible

There will be an annual $450 deductible that accrues on a calendar year basis beginning February 1, 2008. Only payments or incurred costs for Inpatient Hospital services provided by In-Network and Out-of-Network Providers apply toward the $450 annual deductible. You do not have to meet a deductible before receiving coverage for any other benefits. Please refer to the "Benefits and Cost Sharing" section of your Evidence of Coverage booklet for more information.

**Your Copayments and Prescription Coverage**

You will be responsible for paying a copayment for some services, such as doctor visits and hospital stays. You will be charged 20% of the cost of your prescriptions, which must be obtained at Plan-authorized pharmacies.

The maximum amount of out-of-pocket expenses is $2,500 per person, or $4,000 per family, in any calendar year.

**Maximum Benefits**

Annual maximum benefits are $75,000 per covered person, with a maximum lifetime benefit of $750,000.

## Important Information

To learn more about Contra Costa Health Plan's MRMIP, call our Marketing Department at 1-800-221-8040 (Press 6).

*The information presented on this page is only a summary. For exact terms and conditions please refer to the Evidence of Coverage booklet.*

# Contra Costa Health Plan

## Summary of Benefits

| *Type of Service* | *Description of Service* | *What You Pay*<br>*Contra Costa Health Plan Provider* |
|---|---|---|
| **Annual Deductible** | The amount you must pay for Inpatient Hospital services before the plan will cover those services at the copayment amount within that calendar year. | $450 per household |
| **Copayment** | Your out-of-pocket expense for the cost of authorized and covered expenses | Inpatient medical $200/day<br>Inpatient psychiatric $200/day<br>Inpatient maternity $200/day<br>Outpatient ER $25/visit<br>Outpatient visits $15/visit |
| **Out-of-pocket Maximum** | The annual maximum out-of-pocket expense you're responsible for (excluding unauthorized or non-covered services) | $2,500 (per covered person)<br>$4,000 (per family) |
| **Annual Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year for a member | |
| **Lifetime Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime for a member | |
| **Hospital Services** | Semi-private room & board, and all medically necessary inpatient services and supplies including inpatient visits by physicians | $200/day |
| **Physician Care** | Medical and surgical outpatient services performed or authorized by Contra Costa Health Plan provider | Office visits $15/visit<br>Well baby $15/visit<br>Physical exams $15/visit |
| **Preventive Services** | • Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women<br>• Cytology Examinations<br>• Family Planning Services<br>• Health Education Services<br>• Periodic Health Examinations<br>• Hearing tests and eye exams for children up to age 16<br>• Newborn Blood Tests<br>• Prenatal Care (care during pregnancy)<br>• Prostate Exams for Men<br>• Venereal Diseases Tests<br>• Well-Baby and Well-Child Visits<br>• Immunizations for Children and Adults | $15/visit |
| **Diagnostic X-ray and Lab Tests** | Inpatient and outpatient diagnostic X-ray and laboratory tests | -0- |
| **Prescription Drugs** | Drugs prescribed by a physician | 20% of the cost of prescription obtained at Plan-authorized pharmacies |
| **Durable Medical Equipment & Supplies** | Purchase or rental as authorized by Contra Costa Health Plan and required for care of an illness or injury | -0- |
| **Maternity Care** | Treated as any other medical condition:<br>Inpatient<br>Outpatient | <br>$200/day<br>$15/visit |
| **Ambulance** | Ambulance service when required for an emergency or approved by a Contra Costa Health Plan physician | $15 copay |
| **Emergency Care Services** | Services in an emergency room for emergency care only – non-emergency care not covered | $25/visit |
| **Mental Health Care** | Inpatient visits up to 10 days per calendar year<br>Outpatient visits up to 15 visits per calendar year<br>Limitations do not apply to severe mental illnesses or serious emotional disturbances in children | $200/day<br>$15/visit |
| **Home Health Care/ Home Hospice Care** | Medically necessary visits when authorized for diagnostic and treatment service and nursing care | -0- |
| **Skilled Nursing Services** | Provided only when Contra Costa Health Plan authorizes as medically necessary and more cost effective | -0- |
| **Speech/Physical/ Occupational Therapy** | Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis | $15/visit |
| **Other** | Blood and blood plasma, 24-hour Advice<br>Nurse, member services, health education, and case management | -0- |

**Note:** All benefits are covered by Contra Costa Health Plan only if they are prescribed or directed by a Contra Costa Health Plan physician. Other Plan limitations and exclusions apply. Please refer to the Evidence of Coverage for disclosure of Plan limitations and exclusions.
**Contra Costa Health Plan is available only to residents in Contra Costa County.**

KAISER PERMANENTE®

Northern California

**1-800-464-4000**

## Plan Highlights

For over 50 years, Kaiser Permanente has provided quality care for the people of Northern California. You can receive care at any of our locations in Northern California, close to work or close to home - or both.

Your family (spouse and unmarried children under age 23) are also eligible for coverage under Kaiser Permanente's MRMIP Plan. Annual maximum benefits are $75,000 per covered individual, lifetime maximum benefits are $750,000 per covered individual.

You do not need to file claim forms for the services you receive at Kaiser Permanente facilities.

## Plan Providers

Representing virtually all major medical and surgical specialties, our physicians work together in one of the nation's largest medical groups to care for you and your family.

We're proud of the caliber of our physicians. Many of them graduated from the top medical schools, such as: Harvard, Yale, Stanford, and UCLA.

You can choose your own Kaiser Permanente primary care physician who will work with you to coordinate all your health care needs. Of course, you and your family are not restricted to only one of our physicians or facilities. You may receive care at any of our locations in Northern California.

Kaiser Permanente is available in the following Northern California counties:

| | |
|---|---|
| Alameda | Sacramento |
| Amador | San Francisco |
| Contra Costa | San Joaquin |
| El Dorado | San Mateo |
| Fresno | Santa Clara |
| Kings | Solano |
| Madera | Sonoma |
| Marin | Sutter |
| Mariposa | Tulare |
| Napa | Yolo |
| Placer | Yuba |

Please see the chart at the back of this brochure for the specific zip codes open to MRMIP Plan enrollment.

## How the Plan Works

**Always carry your Kaiser Permanente ID Card.** You can make an appointment by calling the appointment desk at the Kaiser Permanente facility that is most convenient for you.

Laboratories, X-ray services, and pharmacies are located at most medical facilities. Urgent care is available on a same-day basis at many facilities. Medical advice by phone and emergency services are available 24 hours a day.

As a group practice, our physicians can easily refer you to a specialist within your medical center or another Kaiser Permanente facility.

**Deductible**

Kaiser Permanente has an annual $450 deductible you must satisfy before the plan will begin paying for covered services. Effective February 1, 2008 you are responsible for charges for certain covered services subject to the deductible and Kaiser Permanente will not cover these services until you meet the deductible. The only payments that count toward a deductible are those you make for covered services that are subject to the deductible. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayment or coinsurance subject to the annual out-of-pocket maximum. Payments for services provided by In-Network and Out-of-Network Providers and prescription payments apply toward the $450 annual deductible. Most Preventive Care Services are covered even if you have not met your deductible and do not apply towards the $450 annual deductible.

**Copayments**

The maximum amount of out-of-pocket expenses is $2,500 per individual and $4,000 per family in a calendar year.

## Important Information

*For more information about the Northern California Kaiser Permanente MRMIP Plan, please call our Member Service Call Center at (800) 464-4000. Please note that the information presented on these pages is only a summary of the Kaiser Permanente MRMIP Plan for Northern California. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.*

# Kaiser Permanente Northern California

## Summary of Benefits

| *Type of Service* | *Description of Service* | *What You Pay* |
|---|---|---|
| **Annual Deductible** | The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services, except for Preventive Care Services | $450 per household |
| **Copayment** | Your cost of covered services | See specific service |
| **Out-of-Pocket Maximum** | The maximum amount you're responsible for paying for covered services per calendar year | $2,500 (per covered person)<br>$4,000 (per covered family) |
| **Annual Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year for a member | |
| **Lifetime Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime for a member | |
| **Hospital Services** | Room and board, anesthesia, X-rays, lab tests, and drugs | $200 copay per inpatient day |
| **Physician Care** | Primary and specialty care visits<br>Allergy injections | $20 copay per office visit<br>$3 copay per injection |
| **Preventive Care Services*** | Flexible Sigmoidoscopies<br>Vaccines<br>Mammograms<br>Routine physical examinations, including well-woman visits and hearing and vision tests<br>Scheduled prenatal visits<br>Tuberculosis tests<br>Well child preventive care visits (0-23months) | $20 copay per visit<br>No charge<br>$5 per visit<br>$20 copay per office visit<br>$15 copay per office visit<br>$5 per visit<br>$15 copay per office visit |
| **Diagnostic X-Ray and Laboratory Tests** | X-rays and ultraviolet light therapy<br>The following Laboratory Tests:<br>Cervical cancer screening<br>Cholesterol tests (lipid profile)<br>Diabetes screening (fasting blood glucose tests)<br>Fecal occult blood tests<br>HIV tests<br>Prostate specific antigen tests<br>Venereal Diseases tests | $5 per visit<br><br>$5 per visit<br>$5 per visit<br>$5 per visit<br>No charge<br>$5 per visit<br>$5 per visit<br>$5 per visit |
| **Prescription Drugs** | Drugs prescribed by a plan physician and obtained at a plan pharmacy in accord with formulary guidelines | $10 generic for up to a 100-day supply<br>$35 brand for up to a 100-day supply |
| **Durable Medical Equipment, Supplies** | Durable medical equipment when prescribed by a plan physician and obtained from plan providers through Kaiser Permanente | 20% of member rate<br>No charge during hospital stay |
| **Prosthetic Devices and Braces** | Prosthetic devices and braces when prescribed by a plan physician and obtained from plan providers through Kaiser Permanente | No charge |
| **Maternity Care** | Prenatal* and postnatal care<br>Inpatient care, complications of pregnancy, C-section | $15 copay per office visit<br>$200 copay per inpatient day |
| **Ambulance** | Ambulance services | $75 per trip |
| **Emergency Care Services** | Emergency department visits | $100 copay per incident (waived if admitted and hospitalization copays apply) |
| **Mental Health Care** | Inpatient visits up to 10 days per calendar year<br>Outpatient visits up to 15 visits per calendar year<br>Day and visit limits do not apply to severe mental illnesses and serious emotional disturbances in children | $200 copay per inpatient day<br>$20 copay per visit |
| **Home Health Care/Hospice Care** | Medically necessary visits by home health personnel up to 100 visits per year<br>Hospice care | No charge<br>No charge |
| **Skilled Nursing Services** | Up to 100 days per benefit period | No charge up to 100 days per benefit period |
| **Speech/Physical/ Occupational Therapy** | Outpatient medical rehabilitation and the services of an occupational therapist, physical therapists, and speech therapists<br>Inpatient | $20 copay per visit<br><br>No charge |

*Covered Preventive Care Services described above are not subject to the annual deductible.

**Note:** All care must be prescribed by and received from the Permanente Medical Group (TPMG) physician, or a physician to whom a TPMG physician has referred you for specific care. Any care received outside of Kaiser Permanente Northern California Region is not covered, with the exception of emergencies.

This chart does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations) and additional benefits not included in this summary, please refer to the Evidence of Coverage for this plan.

KAISER PERMANENTE®

Southern California

**1-800-464-4000**

## Plan Highlights

Kaiser Permanente's medical care program offers the kind of benefits you've been looking for:

**Convenient Care**

- You can receive care at any of our locations in Southern California, close to work or close to home - or both.
- MRMIP subscribers can get care in parts of seven Southern California counties (Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura).
- Please see the chart at the back of this brochure for the specific zip codes open to MRMIP Plan enrollment.

**Broad-based Care**

- Your family (including spouse and unmarried children under age 23) are also eligible for coverage under the MRMIP Plan. Your annual maximum benefit total is $75,000 per covered individual, and the lifetime maximum benefit is $750,000 per covered individual.
- In addition to primary care visits, your MRMIP Plan includes specialty care services, lab tests, X-rays and health education classes.

**A Plan That's Easy to Use**

- You do not need to file claim forms for services received at Kaiser Permanente facilities.
- When you present your Kaiser card at one of our Health Plan facilities, our computerized registration system will identify your benefits and copayments as described on the next page.
- Upon enrollment in the MRMIP Plan, you will receive *The Guidebook to Kaiser Permanente Services*. This publication is a directory of all Southern California facilities and services available to our members.

## Plan Providers

- When you select Kaiser Permanente as your MRMIP Plan provider, your medical care is provided or arranged by Kaiser Permanente physicians at Kaiser Permanente medical facilities. Our dedicated physicians represent virtually all major medical and surgical specialties, and work together in one of the nation's largest medical groups to care for you and your family.
- We're proud of the caliber of our physicians. Many of them graduated from top medical schools, such as: Harvard, Yale, Stanford, and UCLA.
- You can choose your own Kaiser Permanente primary care physician who will work with you to coordinate all your health care needs. You or your family may select a different physician at any time - your choice is never restricted to any one physician or facility.
- Emergency and urgent care is available from Kaiser Permanente 24 hours a day, 7 days a week.

## How the Plan Works

- **Always carry your Kaiser Permanente ID Card.** It has important information which will assist you in making appointments and utilizing services. You can make an appointment by calling one of our convenient appointment centers.
- **Laboratories, X-ray services, and pharmacies -** These are located at each medical center (many pharmacies are open 24 hours).
- **Urgent care** is available on a walk-in basis at each Medical Center. Medical advice by phone and emergency services are available 24 hours a day, seven days a week.
- **Referrals to specialists -** As a group practice, our physicians can easily refer you to a specialist within your service area, at another Kaiser Permanente service area.
- **Deductible -** Kaiser Permanente has an annual $450 deductible you must satisfy before the plan will begin paying for covered services. Effective February 1, 2008 you are responsible for charges for certain covered services subject to the deductible and Kaiser Permanente will not cover these services until you meet the deductible. The only payments that count toward a deductible are those you make for covered services that are subject to the deductible.

  After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayment or coinsurance subject to the annual out-of-pocket maximum. Payments for services provided by In-Network and Out-of-Network Providers and prescription payments apply toward the $450 annual deductible. Preventive Care Services are covered even if you have not met your deductible and do not apply towards the $450 annual deductible.
- **Copayments -** The maximum of out-of-pocket expenses you pay in a calendar year are $2,500 per individual and/or $4,000 per family.

## Important Information

*For more information about the Southern California Kaiser Permanente MRMIP Plan program, please call our Member Service Call Center at (800) 464-4000. Please note that the information presented on these pages is only a summary of the Kaiser Permanente MRMIP Plan for Southern California. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage.*

# Kaiser Permanente Southern California

## Summary of Benefits

| *Type of Service* | *Description of Service* | *What You Pay* |
|---|---|---|
| **Annual Deductible** | The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services, except for Preventive Care Services | $450 per household |
| **Copayment** | Your cost of covered services | See specific service |
| **Out-of-Pocket Maximum** | The maximum amount you're responsible for paying for covered services per calendar year | $2,500 (per covered person)<br>$4,000 (per covered family) |
| **Annual Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year for a member | |
| **Lifetime Benefit Maximum** | You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime for a member | |
| **Hospital Services** | Room and board, anesthesia, X-rays, lab tests and drugs | $200 copay per inpatient day |
| **Physician Care** | Primary and specialty care visits<br>Allergy injections | $20 copay per office visit<br>$3 copay per injection |
| **Preventive Care Services*** | Flexible Sigmoidoscopies<br>Vaccines<br>Mammograms<br>Routine physical examinations, including well-woman visits and hearing and vision tests<br>Scheduled prenatal visits<br>Tuberculosis tests<br>Well child preventive care visits (0-23months) | $20 copay per visit<br>No charge<br>$5 per visit<br>$20 copay per office visit<br>$15 copay per office visit<br>$5 per visit<br>$15 copay per office visit |
| **Diagnostic X-Ray and Laboratory Tests** | X-rays and ultraviolet light therapy<br>The following Laboratory Tests:<br>Cervical cancer screening<br>Cholesterol tests (lipid profile)<br>Diabetes screening (fasting blood glucose tests)<br>Fecal occult blood tests<br>HIV tests<br>Prostate specific antigen tests<br>Venereal Diseases tests | $5 per visit<br><br>$5 per visit<br>$5 per visit<br>$5 per visit<br>No charge<br>$5 per visit<br>$5 per visit<br>$5 per visit |
| **Prescription Drugs** | Drugs prescribed by a plan physician and obtained at a plan pharmacy in accord with formulary guidelines | $10 generic for up to a 100-day supply<br>$35 brand for up to a 100-day supply |
| **Durable Medical Equipment, Supplies** | Durable medical equipment when prescribed by a plan physician and obtained from plan providers through Kaiser Permanente | 20% of member rate<br>No charge during hospital stay |
| **Prosthetic Devices and Braces** | Prosthetic devices and braces when prescribed by a plan physician and obtained from plan providers through Kaiser Permanente | No charge |
| **Maternity Care** | Prenatal* and postnatal care<br>Inpatient care, complications of pregnancy, C-section | $15 copay per office visit<br>$200 copay per inpatient day |
| **Ambulance** | Ambulance Services | $75 per trip |
| **Emergency Care Services** | Emergency department visits | $100 copay per incident (waived if admitted and hospitalization copays apply) |
| **Mental Health Care** | Inpatient visits up to 10 days per calendar year<br>Outpatient visits up to 15 visits per calendar year<br>Day and visit limits do not apply to severe mental illnesses and serious emotional disturbances in children | $200 copay per inpatient day<br>$20 copay per visit |
| **Home Health Care/Hospice Care** | Medically necessary visits by home health personnel up to 100 visits per year<br>Hospice care | No charge<br>No charge |
| **Skilled Nursing Services** | Up to 100 days per benefit period | No charge up to 100 days per benefit period |
| **Speech/Physical/ Occupational Therapy** | Outpatient medical rehabilitation and the services of an occupational therapist, physical therapists, and speech therapists<br>Inpatient | $20 copay per visit<br><br>No charge |

*Covered Preventive Care Services described above are not subject to the annual deductible.

Note: All care must be prescribed by and received from the Permanente Medical Group (SCPMG) physician, or a physician to whom a SCPMG physician has referred you for specific care. Any care received outside of Kaiser Permanente Southern California Region is not covered, with the exception of emergencies.

This chart does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations) and additional benefits not included in this summary, please refer to the Evidence of Coverage for this plan.

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions
## Area 1

**Counties:** Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO | KPNC |
|---|---|---|---|---|
| **Subscriber Only** | <15 | $243.75 | $740.92 | $206.43 |
| | 15-29 | $351.25 | $740.92 | $257.13 |
| | 30-34 | $460.00 | $929.19 | $303.83 |
| | 35-39 | $506.25 | $986.63 | $326.23 |
| | 40-44 | $573.75 | $1,069.41 | $366.08 |
| | 45-49 | $615.00 | $1,170.77 | $402.20 |
| | 50-54 | $776.25 | $1,282.28 | $464.45 |
| | 55-59 | $943.75 | $1,584.68 | $531.69 |
| | 60-64 | $1,112.50 | $2,037.45 | $588.98 |
| | 65-69 | $1,245.00 | $2,510.14 | $821.18 |
| | 70-74 | $1,312.50 | $3,021.54 | $866.91 |
| | >74 | $1,390.00 | $3,573.69 | $919.74 |
| **Subscriber & 1 Dependent** | <15 | $497.50 | $1,442.77 | $412.85 |
| | 15-29 | $857.50 | $1,442.77 | $542.90 |
| | 30-34 | $975.00 | $1,809.38 | $617.61 |
| | 35-39 | $1,048.75 | $1,929.33 | $681.11 |
| | 40-44 | $1,086.25 | $2,088.13 | $747.10 |
| | 45-49 | $1,210.00 | $2,285.80 | $783.23 |
| | 50-54 | $1,476.25 | $2,500.36 | $933.88 |
| | 55-59 | $1,752.50 | $3,088.28 | $1,034.75 |
| | 60-64 | $1,963.75 | $3,973.54 | $1,177.94 |
| | 65-69 | $2,198.75 | $4,895.40 | $1,456.34 |
| | 70-74 | $2,316.25 | $5,892.76 | $1,536.58 |
| | >74 | $2,453.75 | $6,969.59 | $1,625.06 |
| **Subscriber & 2 or More Dependents** | <15 | $758.75 | $2,241.87 | $700.05 |
| | 15-29 | $1,205.00 | $2,241.87 | $889.06 |
| | 30-34 | $1,371.25 | $2,738.57 | $1,075.83 |
| | 35-39 | $1,477.50 | $2,948.05 | $1,075.83 |
| | 40-44 | $1,586.25 | $3,110.24 | $1,092.03 |
| | 45-49 | $1,711.25 | $3,211.61 | $1,092.03 |
| | 50-54 | $1,967.50 | $3,258.91 | $1,207.83 |
| | 55-59 | $2,302.50 | $3,664.37 | $1,207.83 |
| | 60-64 | $2,590.00 | $4,466.85 | $1,364.73 |
| | 65-69 | $2,901.25 | $5,503.16 | $1,892.40 |
| | 70-74 | $3,056.25 | $6,624.34 | $2,000.53 |
| | >74 | $3,237.50 | $7,834.86 | $2,116.43 |

1 Blue Shield Access+ HMO available **only** to residents in these zip codes in these counties:
**Nevada**–95712, 95924, 95945-46, 95949, 95959-60, 95975, and 95986.
**Placer**–95602-04, 95631, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95701, 95703, 95713-15, 95717, 95722, 95736, 95746-7, and 95765.

2 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
**Amador**–95640 and 95669;
**El Dorado**–95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, and 95762;
**Kings**–93230 and 93232;
**Placer**–95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, and 95765;
**Sutter**–95626, 95648, 95659, 95668, 95674, and 95676;
**Tulare**–93238, 93261, 93618, 93631, 93666, and 93673;
**Yolo**–95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, and 95798-99;
**Yuba**–95692, 95903, and 95961.

Anthem = Anthem Blue Cross
BS HMO = Blue Shield Access+ HMO
KPNC = Kaiser Permanente Northern California

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions

## Area 2

**Counties:** Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO[3] | KPNC[4]/KPSC[5] |
|---|---|---|---|---|
| **Subscriber Only** | <15 | $232.50 | $707.03 | $206.43 |
| | 15-29 | $337.50 | $707.03 | $257.13 |
| | 30-34 | $440.00 | $883.57 | $303.83 |
| | 35-39 | $487.50 | $939.32 | $326.23 |
| | 40-44 | $546.25 | $1,015.35 | $366.08 |
| | 45-49 | $586.25 | $1,111.64 | $402.20 |
| | 50-54 | $732.50 | $1,218.08 | $464.45 |
| | 55-59 | $893.75 | $1,503.59 | $531.69 |
| | 60-64 | $1,048.75 | $1,932.71 | $588.98 |
| | 65-69 | $1,175.00 | $2,381.10 | $821.18 |
| | 70-74 | $1,237.50 | $2,866.21 | $866.91 |
| | >74 | $1,311.25 | $3,389.97 | $919.74 |
| **Subscriber & 1 Dependent** | <15 | $478.75 | $1,373.51 | $412.85 |
| | 15-29 | $822.50 | $1,373.51 | $542.90 |
| | 30-34 | $931.25 | $1,716.46 | $617.61 |
| | 35-39 | $1,000.00 | $1,831.34 | $681.11 |
| | 40-44 | $1,036.25 | $1,983.39 | $747.10 |
| | 45-49 | $1,152.50 | $2,165.85 | $783.23 |
| | 50-54 | $1,402.50 | $2,373.65 | $933.88 |
| | 55-59 | $1,665.00 | $2,931.16 | $1,034.75 |
| | 60-64 | $1,857.50 | $3,770.81 | $1,177.94 |
| | 65-69 | $2,080.00 | $4,645.63 | $1,456.34 |
| | 70-74 | $2,191.25 | $5,592.11 | $1,536.58 |
| | >74 | $2,321.25 | $6,614.00 | $1,625.06 |
| **Subscriber & 2 or More Dependents** | <15 | $725.00 | $2,130.37 | $700.05 |
| | 15-29 | $1,150.00 | $2,130.37 | $889.06 |
| | 30-34 | $1,308.75 | $2,596.65 | $1,075.83 |
| | 35-39 | $1,401.25 | $2,797.70 | $1,075.83 |
| | 40-44 | $1,502.50 | $2,949.74 | $1,092.03 |
| | 45-49 | $1,625.00 | $3,054.49 | $1,092.03 |
| | 50-54 | $1,883.75 | $3,093.35 | $1,207.83 |
| | 55-59 | $2,205.00 | $3,481.91 | $1,207.83 |
| | 60-64 | $2,440.00 | $4,243.85 | $1,364.73 |
| | 65-69 | $2,733.75 | $5,228.42 | $1,892.40 |
| | 70-74 | $2,880.00 | $6,293.63 | $2,000.53 |
| | >74 | $3,050.00 | $7,443.71 | $2,116.43 |

3 Blue Shield Access+ HMO available **only** to residents in these zip codes in these counties:
**Fresno**–All zip codes;
**Kern**–93203, 93205-6, 93215-6, 93220, 93222, 93224-6, 93238, 93240-1, 93243, 93249-52, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301-9, 93311-4, 93380-90, 93501-2, 93504-5, 93516, 93518, 93519, 93524, 93531, 93560-1, 93570, 93581, 93596.
**Sacramento, San Joaquin, Solano, Sonoma and Stanislaus**–All zip codes.

Anthem = Anthem Blue Cross
BS HMO = Blue Shield Access+ HMO
KPNC = Kaiser Permanente Northern California
KPSC = Kaiser Permanente Southern California

4 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
**Fresno**–93242, 93602, 93606-07, 93609, 93611-13, 93616, 93619, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, and 93888;
**Madera**–93601-02, 93604, 93614, 93636-39, 93643-45, 93653, and 93669;
**Mariposa**–93623;
**Napa**–94503, 94508, 94515, 94558-59, 94562, 94567 (except the community of Knoxville), 94573-74, 94576, 94581, and 94599;
**Sacramento, San Joaquin, and Solano**–All zip codes;
**Sonoma**–94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999,95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, and 95492.

5 Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
**Kern**–93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93560-61, and 93581.

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions

## Area 3

**Counties:** Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO | CC[6] | KPNC[7] |
|---|---|---|---|---|---|
| **Subscriber Only** | <15 | $228.75 | $690.53 | $184.58 | $206.43 |
| | 15-29 | $335.00 | $690.53 | $234.79 | $257.13 |
| | 30-34 | $437.50 | $868.37 | $341.13 | $303.83 |
| | 35-39 | $481.25 | $925.81 | $341.13 | $326.23 |
| | 40-44 | $540.00 | $1,001.83 | $392.96 | $366.08 |
| | 45-49 | $576.25 | $1,093.06 | $392.96 | $402.20 |
| | 50-54 | $718.75 | $1,196.12 | $524.68 | $464.45 |
| | 55-59 | $876.25 | $1,481.63 | $524.68 | $531.69 |
| | 60-64 | $1,052.50 | $1,902.30 | $662.85 | $588.98 |
| | 65-69 | $1,178.75 | $2,343.63 | $889.54 | $821.18 |
| | 70-74 | $1,242.50 | $2,821.11 | $889.54 | $866.91 |
| | >74 | $1,315.00 | $3,336.63 | $889.54 | $919.74 |
| **Subscriber & 1 Dependent** | <15 | $476.25 | $1,344.79 | $455.57 | $412.85 |
| | 15-29 | $818.75 | $1,344.79 | $455.57 | $542.90 |
| | 30-34 | $923.75 | $1,691.12 | $604.56 | $617.61 |
| | 35-39 | $987.50 | $1,800.93 | $604.56 | $681.11 |
| | 40-44 | $1,023.75 | $1,952.98 | $747.05 | $747.10 |
| | 45-49 | $1,151.25 | $2,132.06 | $747.05 | $783.23 |
| | 50-54 | $1,382.50 | $2,339.86 | $1,023.43 | $933.88 |
| | 55-59 | $1,645.00 | $2,887.24 | $1,023.43 | $1,034.75 |
| | 60-64 | $1,867.50 | $3,715.06 | $1,321.38 | $1,177.94 |
| | 65-69 | $2,091.25 | $4,576.95 | $1,733.78 | $1,456.34 |
| | 70-74 | $2,203.75 | $5,509.43 | $1,733.78 | $1,536.58 |
| | >74 | $2,335.00 | $6,516.21 | $1,733.78 | $1,625.06 |
| **Subscriber & 2 or More Dependents** | <15 | $716.25 | $2,094.89 | $839.90 | $700.05 |
| | 15-29 | $1,148.75 | $2,094.89 | $839.90 | $889.06 |
| | 30-34 | $1,295.00 | $2,557.80 | $928.42 | $1,075.83 |
| | 35-39 | $1,406.25 | $2,755.46 | $928.42 | $1,075.83 |
| | 40-44 | $1,500.00 | $2,907.51 | $1,105.47 | $1,092.03 |
| | 45-49 | $1,620.00 | $3,003.81 | $1,105.47 | $1,092.03 |
| | 50-54 | $1,886.25 | $3,046.04 | $1,265.25 | $1,207.83 |
| | 55-59 | $2,202.50 | $3,431.23 | $1,265.25 | $1,207.83 |
| | 60-64 | $2,446.25 | $4,176.27 | $1,535.14 | $1,364.73 |
| | 65-69 | $2,740.00 | $5,145.16 | $2,055.49 | $1,892.40 |
| | 70-74 | $2,886.25 | $6,193.41 | $2,055.49 | $2,000.53 |
| | >74 | $3,057.50 | $7,325.18 | $2,055.49 | $2,116.43 |

6 Contra Costa Health Plan available **only** in Contra Costa County.

7 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
**Alameda**–All zip codes;
**Contra Costa**–All zip codes;
**Marin**–All zip codes;
**San Francisco**–All zip codes;
**San Mateo**–All zip codes;
**Santa Clara**–94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, and 95196.

Anthem = Anthem Blue Cross
BS HMO = Blue Shield Access+ HMO
CC = Contra Costa Health Plan
KPNC = Kaiser Permanente Northern California

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions

## Area 4

**Counties:** Orange, Santa Barbara, Ventura.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO | KPSC[8] |
|---|---|---|---|---|
| **Subscriber Only** | <15 | $252.50 | $502.43 | $186.39 |
| | 15-29 | $348.75 | $502.43 | $232.64 |
| | 30-34 | $452.50 | $628.47 | $274.78 |
| | 35-39 | $502.50 | $674.08 | $295.54 |
| | 40-44 | $583.75 | $728.14 | $332.18 |
| | 45-49 | $648.75 | $799.10 | $363.93 |
| | 50-54 | $836.25 | $875.12 | $420.11 |
| | 55-59 | $1,013.75 | $1,076.17 | $481.18 |
| | 60-64 | $1,105.00 | $1,385.33 | $533.68 |
| | 65-69 | $1,237.50 | $1,706.73 | $762.85 |
| | 70-74 | $1,303.75 | $2,054.45 | $804.01 |
| | >74 | $1,381.25 | $2,429.87 | $851.78 |
| **Subscriber &** | <15 | $513.75 | $983.25 | $372.79 |
| **1 Dependent** | 15-29 | $862.50 | $983.25 | $490.94 |
| | 30-34 | $980.00 | $1,229.90 | $558.11 |
| | 35-39 | $1,055.00 | $1,312.69 | $616.73 |
| | 40-44 | $1,146.25 | $1,422.50 | $676.58 |
| | 45-49 | $1,263.75 | $1,550.90 | $708.31 |
| | 50-54 | $1,571.25 | $1,697.88 | $845.10 |
| | 55-59 | $1,865.00 | $2,098.27 | $936.69 |
| | 60-64 | $1,956.25 | $2,701.40 | $1,066.14 |
| | 65-69 | $2,190.00 | $3,328.12 | $1,357.29 |
| | 70-74 | $2,307.50 | $4,006.17 | $1,431.85 |
| | >74 | $2,445.00 | $4,738.25 | $1,521.78 |
| **Subscriber &** | <15 | $773.75 | $1,522.18 | $632.61 |
| **2 or More Dependents** | 15-29 | $1,211.25 | $1,522.18 | $871.98 |
| | 30-34 | $1,415.00 | $1,860.06 | $973.33 |
| | 35-39 | $1,446.25 | $2,005.35 | $973.33 |
| | 40-44 | $1,583.75 | $2,111.79 | $989.20 |
| | 45-49 | $1,738.75 | $2,182.74 | $989.20 |
| | 50-54 | $2,053.75 | $2,214.84 | $1,093.01 |
| | 55-59 | $2,415.00 | $2,491.91 | $1,093.01 |
| | 60-64 | $2,570.00 | $3,035.90 | $1,235.90 |
| | 65-69 | $2,878.75 | $3,740.23 | $1,718.99 |
| | 70-74 | $3,032.50 | $4,502.25 | $1,814.00 |
| | >74 | $3,212.50 | $5,324.98 | $1,927.69 |

8 Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
**Orange**–All zip codes;
**Ventura**–91319-20, 91358-62, 91377, 93001-07, 93009, 93010-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93093-94, 93099, and 93252.

Anthem = Anthem Blue Cross
BS HMO = Blue Shield Access+ HMO
KPSC = Kaiser Permanente Southern California

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions

## Area 5

**County:** Los Angeles.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO[9] | KPSC[10] |
|---|---|---|---|---|
| **Subscriber Only** | <15 | $260.00 | $421.51 | $186.39 |
| | 15-29 | $365.00 | $421.51 | $232.64 |
| | 30-34 | $476.25 | $527.10 | $274.78 |
| | 35-39 | $535.00 | $560.89 | $295.54 |
| | 40-44 | $615.00 | $609.88 | $332.18 |
| | 45-49 | $652.50 | $667.32 | $363.93 |
| | 50-54 | $840.00 | $733.21 | $420.11 |
| | 55-59 | $1,030.00 | $900.47 | $481.18 |
| | 60-64 | $1,191.25 | $1,158.95 | $533.68 |
| | 65-69 | $1,335.00 | $1,427.82 | $762.85 |
| | 70-74 | $1,406.25 | $1,718.72 | $804.01 |
| | >74 | $1,490.00 | $2,032.80 | $851.78 |
| **Subscriber & 1 Dependent** | <15 | $525.00 | $822.75 | $372.79 |
| | 15-29 | $908.75 | $822.75 | $490.94 |
| | 30-34 | $1,033.75 | $1,028.86 | $558.11 |
| | 35-39 | $1,116.25 | $1,101.51 | $616.73 |
| | 40-44 | $1,177.50 | $1,189.36 | $676.58 |
| | 45-49 | $1,317.50 | $1,297.48 | $708.31 |
| | 50-54 | $1,615.00 | $1,422.50 | $845.10 |
| | 55-59 | $1,922.50 | $1,758.70 | $936.69 |
| | 60-64 | $2,095.00 | $2,260.46 | $1,066.14 |
| | 65-69 | $2,346.25 | $2,784.88 | $1,357.29 |
| | 70-74 | $2,471.25 | $3,352.26 | $1,431.85 |
| | >74 | $2,618.75 | $3,964.84 | $1,521.78 |
| **Subscriber & 2 or More Dependents** | <15 | $815.00 | $1,277.21 | $632.61 |
| | 15-29 | $1,285.00 | $1,277.21 | $871.98 |
| | 30-34 | $1,471.25 | $1,557.65 | $973.33 |
| | 35-39 | $1,566.25 | $1,677.60 | $973.33 |
| | 40-44 | $1,693.75 | $1,770.52 | $989.20 |
| | 45-49 | $1,840.00 | $1,826.27 | $989.20 |
| | 50-54 | $2,187.50 | $1,851.61 | $1,093.01 |
| | 55-59 | $2,562.50 | $2,088.13 | $1,093.01 |
| | 60-64 | $2,780.00 | $2,545.97 | $1,235.90 |
| | 65-69 | $3,113.75 | $3,136.64 | $1,718.99 |
| | 70-74 | $3,281.25 | $3,775.67 | $1,814.00 |
| | >74 | $3,476.25 | $4,465.63 | $1,927.69 |

9 Blue Shield Access+ HMO is available to residents in all zip codes in Los Angeles County **except** 90704 (Catalina Island).

10 Kaiser Permanente Southern California available to residents in all zip codes in Los Angeles County **except** 90704 (Catalina Island).

Anthem = Anthem Blue Cross
BS HMO = Blue Shield Access+ HMO
KPSC = Kaiser Permanente Southern California

# California Major Risk Medical Insurance Program
# Monthly Subscriber Contributions

## Area 6

**Counties:** Riverside, San Bernardino, San Diego.

See below for service areas and available zip codes.

| Rating Group | Age | Anthem | BS HMO[11] | KPSC[12] |
|---|---|---|---|---|
| **Subscriber Only** | <15 | $232.50 | $553.23 | $186.39 |
| | 15-29 | $325.00 | $553.23 | $232.64 |
| | 30-34 | $423.75 | $694.36 | $274.78 |
| | 35-39 | $475.00 | $738.28 | $295.54 |
| | 40-44 | $532.50 | $800.79 | $332.18 |
| | 45-49 | $583.75 | $873.44 | $363.93 |
| | 50-54 | $753.75 | $961.29 | $420.11 |
| | 55-59 | $911.25 | $1,184.29 | $481.18 |
| | 60-64 | $1,040.00 | $1,523.87 | $533.68 |
| | 65-69 | $1,165.00 | $1,877.40 | $762.85 |
| | 70-74 | $1,227.50 | $2,259.89 | $804.01 |
| | >74 | $1,300.00 | $2,672.86 | $851.78 |
| **Subscriber & 1 Dependent** | <15 | $476.25 | $1,079.55 | $372.79 |
| | 15-29 | $801.25 | $1,079.55 | $490.94 |
| | 30-34 | $911.25 | $1,354.92 | $558.11 |
| | 35-39 | $993.75 | $1,444.46 | $616.73 |
| | 40-44 | $1,032.50 | $1,561.03 | $676.58 |
| | 45-49 | $1,136.25 | $1,702.94 | $708.31 |
| | 50-54 | $1,415.00 | $1,870.20 | $845.10 |
| | 55-59 | $1,677.50 | $2,312.83 | $936.69 |
| | 60-64 | $1,822.50 | $2,968.33 | $1,066.14 |
| | 65-69 | $2,041.25 | $3,656.98 | $1,357.29 |
| | 70-74 | $2,150.00 | $4,402.03 | $1,431.85 |
| | >74 | $2,277.50 | $5,206.45 | $1,521.78 |
| **Subscriber & 2 or More Dependents** | <15 | $713.75 | $1,677.60 | $632.61 |
| | 15-29 | $1,130.00 | $1,677.60 | $871.98 |
| | 30-34 | $1,281.25 | $2,047.59 | $973.33 |
| | 35-39 | $1,370.00 | $2,206.40 | $973.33 |
| | 40-44 | $1,475.00 | $2,326.34 | $989.20 |
| | 45-49 | $1,595.00 | $2,402.37 | $989.20 |
| | 50-54 | $1,845.00 | $2,439.54 | $1,093.01 |
| | 55-59 | $2,172.50 | $2,741.94 | $1,093.01 |
| | 60-64 | $2,428.75 | $3,343.38 | $1,235.90 |
| | 65-69 | $2,720.00 | $4,119.05 | $1,718.99 |
| | 70-74 | $2,865.00 | $4,958.23 | $1,814.00 |
| | >74 | $3,035.00 | $5,864.29 | $1,927.69 |

11 Blue Shield Access+ HMO available **only** in the following zip codes:
**Riverside**–all zip codes;
**San Bernardino**–91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-9, 91761-4, 91784-6, 91798, 92252, 92256, 92267-8, 92277-8, 92284-6, 92301, 92304-5, 92307-18, 92321-7, 92329, 92332-42, 92344-47, 92350, 92352, 92354, 92356-9, 92364-6, 92368-9, 92371-8, 92382, 92385-6, 92391-4, 92397-9, 92401-8, 92410-16, 92418, 92420, 92423-4, 92427, 93523, 93558, 93562, and 93592.
**San Diego**–91901-3, 91905-6, 91908-17, 91921, 91931-5, 91941-48, 91950-51, 91962-3, 91976-80, 91987, 91990, 92003-4, 92007-11, 92013-4, 92018-30, 92033, 92036-40, 92046, 92049, 92051-2, 92054-61, 92064-72, 92074-5, 92078-9, 92081-6, 92088, 92090-3, 92096, 92101-24, 92126-40, 92142-3, 92145, 92147, 92149-50, 92152-5, 92158-79, 92182, 92184, 92186-7, and 92190-9.

12 Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
**San Bernardino**–91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91792, 91798, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-15, 92418, 92423-24, and 92427.
**San Diego**–91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-92011, 92013-14, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, and 92190-99.
**Riverside**–91752, 92220, 92223, 92320, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, and 92877-83

# MRMIP Enrollment Application Checklist

Please use the following checklist to ensure that your application is complete:

- ❑ **Review** the handbook to learn about the eligibility requirements for the California Major Risk Medical Insurance Program (MRMIP) and choose your health plan before completing the Enrollment Application.
- ❑ **Complete** the Enrollment Application on pages 25-28 of this handbook. All questions must be fully answered. If you do not provide all necessary information (including the required documentation, signatures, and payments), your application will be incomplete, which will delay the processing of your application.
- ❑ **Sign and date** the completed Enrollment Application on page 28.
- ❑ **Attach** the following items (your entire application may be returned to you if you do not provide the following):
  - ❑ Your **supporting documentation** that indicates your eligibility for the MRMIP. (Page 2 of this handbook describes how eligibility can be demonstrated.)
    - Copy of denial for individual insurance within the previous 12 months; or
    - Copy of letter indicating involuntary termination of health insurance within the previous 12 months for reasons other than nonpayment of premium or fraud; or
    - Copy of letter indicating individual health insurance premium in excess of the MRMIP subscriber contribution amount.
    - If you are eligible for Medicare Part A and B, copy of a Medicare letter explaining that you are eligible solely because of end-stage renal disease.
    - If you are applying for deferred enrollment, copy of letter indicating when coverage ends.
  - ❑ A **check** for one month's contribution for subscriber and/or dependent for your chosen health plan. Make check payable to **California Major Risk Medical Insurance Program**. (Monthly subscriber and/or dependent contribution amounts are listed on pages 18-23 of this handbook). Payments that **do not equal the exact amount that is due** will delay the processing of your application.
  - ❑ **Proof of Qualifying Prior Coverage** (if applicable) to waive all or part of your Exclusion/Waiting Period must be received prior to or with your first month's contribution for credit to be given. (Please see pages 4-5 of this handbook for more information.)
  - ❑ **Insurance Agents or Brokers:** You must complete all boxes at the bottom of page 25 of the Enrollment Application to request reimbursement.
  - ❑ **Mail** the completed Enrollment Application with your check and all necessary attachments to:

**California Major Risk**
**Medical Insurance Program**
**P.O. Box 9044**
**Oxnard, CA 93031-9044**

MRMIP Enrollment Unit
(800) 289-6574
Mon. – Fri. from 8:30 a.m. to 7:00 p.m.

**California Major Risk Medical Insurance Program**

# Enrollment Application

**Instructions:**

Thank you for applying for the California Major Risk Medical Insurance Program. Please follow these instructions to allow us to better process your application.

- Read the handbook to learn about eligibility and choose your health plan before completing this application.
- You (the applicant/parent/legal guardian) must complete this application. You are solely responsible for its accuracy and completeness.
- All questions must be fully answered. **If you do not provide all necessary information (including the required supporting documentation, signatures, and payments), your application will be incomplete, which will delay the processing of your application or may result in a denial.**
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

Attach check to page 28 where indicated.
Please submit one month's subscriber contribution for your chosen health plan (refer to pages 18-23).
Regardless of which plan you choose, **make your check payable to California Major Risk Medical Insurance Program**.

Submit check, application and all necessary documentation to:

*California Major Risk*
*Medical Insurance Program*
*P.O. Box 9044*
*Oxnard, CA 93031-9044*

**INSURANCE AGENT and BROKER:** If you assisted your client in completing this application, please complete this section. You must complete all boxes. You will not be paid if you do not complete this section prior to submission. Missing information cannot be submitted at a later date for payment. (Please see note to Agents on pages 2-3 of the handbook.) **Use blue or black ink only.**

| Agent Name | | | CA Agent/Broker License No. | Tax I.D. No:/Soc. Sec. No. |
|---|---|---|---|---|
| Street Address | | | I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program. | |
| City | State | Zip | | |
| Phone No. | FAX No: (if available) | | Signature | |

12/07

## 1. Check One:

☐ New Enrollment ☐ Add Dependents **Use blue or black ink only.**

## 2. Choice of Health Plan:

**(Remember: Regardless of your choice of health plan, make check payable to California Major Risk Medical Insurance Program.)**

| Health Plan Name | Name of Primary Care Physician (for Blue Shield Access+ HMO only) |
|---|---|
| | |

## 3. Applicant Information: Applicant must complete this section.

**(If parent or legal guardian is completing this application for the applicant, please mark this box. ☐ )**

| Last Name | First Name | M.I. | Social Security Number (optional) | Age | Birthdate Mo Day Yr | 10 ☐ Male 20 ☐ Female |
|---|---|---|---|---|---|---|
| | | | | | | |

| Check One 1 ☐ Single 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 5 ☐ Registered Domestic Partner | Home Phone ( ) | County |
|---|---|---|
| | | |

| Street Address (must be completed; P.O. Box not acceptable) | Suite or Unit # | City | State | Zip |
|---|---|---|---|---|
| | | | | |

| Billing Name, if different |
|---|
| |

| Billing Address, if different | City | State | Zip |
|---|---|---|---|
| | | | |

| Employer, if employed | Occupation | Business Phone ( ) |
|---|---|---|
| | | |

| Employer Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

## 4. Race/Ethnicity (Optional): Check box which best applies.

10 ☐ Aleut
11 ☐ American Indian, Native American
12 ☐ Black/African American
13 ☐ Eskimo
14 ☐ White

Hispanic
21 ☐ Cuban
22 ☐ Mexican, Mexican-American, Chicano
23 ☐ Puerto Rican
92 ☐ Other; please specify:

Asian
41 ☐ Asian Indian
42 ☐ Cambodian
43 ☐ Chinese
44 ☐ Japanese
45 ☐ Korean
46 ☐ Laotian
47 ☐ Vietnamese
94 ☐ Other; please specify:

Pacific Islander
61 ☐ Filipino
62 ☐ Guamanian
63 ☐ Samoan

Other not listed; please specify:
99 ☐

**STAPLE CHECK HERE**
**payable to California Major Risk Medical Insurance Program**

## 5. Family Information: List all additional family members to be enrolled.

| | Last Name | First Name | | M.I. | Social Security Number (optional) | Age | Birthdate Mo Day Year |
|---|---|---|---|---|---|---|---|
| 30 ☐ Husband 40 ☐ Wife | | | | | | | |
| 30 ☐ Registered 40 Domestic Partner | | | | | | | |
| 50 ☐ Son 70 ☐ Daughter | | | Marital Status ☐ S ☐ M | | | | |
| 51 ☐ Son 71 ☐ Daughter | | | Marital Status ☐ S ☐ M | | | | |
| 52 ☐ Son 72 ☐ Daughter | | | Marital Status ☐ S ☐ M | | | | |
| 53 ☐ Son 73 ☐ Daughter | | | Marital Status ☐ S ☐ M | | | | |
| 54 ☐ Son 74 ☐ Daughter | | | Marital Status ☐ S ☐ M | | | | |

**If a dependent child is over 23 years of age, send doctor's record showing that the dependent child cannot work for a living because of a physical or mental disability which existed before becoming 23 years old with the application.**

Is this dependent child covered by Medicare? Yes ☐ No ☐

12/07

## 6. Program Eligibility: To be eligible for the Program you must answer "yes" to one of the first four questions. Provide a copy of a letter or formal written communication documenting all "yes" answers. (See page 2.)

| | Applicant | | Dependent | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 1. Within the past 12 months, have you been denied individual health insurance? | ☐ | ☐ | ☐ | ☐ |
| 2. Within the past 12 months, have you been involuntarily terminated from health insurance coverage for reasons other than fraud or non-payment of premium? | ☐ | ☐ | ☐ | ☐ |
| 3. Within the past 12 months, have you been offered an individual premium higher than the rate for the first choice health plan listed on this application? | ☐ | ☐ | ☐ | ☐ |
| 4. Are you currently ineligible, but anticipate becoming eligible, and want to apply for a deferred enrollment? (See page 2.) | ☐ | ☐ | ☐ | ☐ |
| 5. Have you and your dependent(s), if any, met the requirements to waive all or part of the exclusion/waiting period? (See pages 4-5) under "How You May Waive All or Part of the Exclusion/Waiting Period.") Please provide a copy of supporting documantation. | ☐ | ☐ | ☐ | ☐ |
| Name of prior insurance company: _____ | | | | |
| Effective date of prior coverage: _____ | | | | |
| Termination date of prior insurance: _____ | | | | |
| 6. Within the past 12 months, were you covered in a similar high risk pool sponsored by another state before becoming a California resident? | ☐ | ☐ | ☐ | ☐ |

## 7. Declarations: Please read each of the following statements carefully and initial each statement. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions.

| | Applicant Initials | Dependent Initials |
|---|---|---|
| 1. I declare that no individual listed on this application is eligible for **both** Part A (hospital) and Part B (professional) of Medicare. If you **are** eligible solely because of end-stage renal disease, leave blank and provide Medicare eligibility letter as proof of end-stage renal disease. (Medicare is a federal program that provides health services to older Americans and disabled persons.) | | |
| 2. I declare that all individuals listed on this application are residents of the state of California. (See page 2 under "Eligibility" for the definition of California resident.) | | |
| 3. I declare that I am not currently eligible to purchase any health insurance for continuation of benefits from my employer under the provisions of 29 U.S. Code 1161 et seq. (COBRA), or under the provisions of Insurance Code Sections 10128.50 et seq. and Health and Safety Code Sections 1366.20 et seq. (Cal-COBRA). These are the laws which allow people to buy into their employer's health insurance for at least 36 months after they leave their employer. (If you **are** currently on COBRA, leave blank and refer to page 2.) | | |
| 4. I declare that all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating health plan in which the individual is enrolled. A dispute resolution process may include binding arbitration rather than a court trial to resolve any claim, including a claim for malpractice, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the participating health plan, or against the employees, partners, or agents, of the participating health plan. | | |
| 5. I declare that I have reviewed the benefits offered by the MRMIP and the subscriber contribution amounts. | | |
| 6. I declare that no individual listed on this application was excluded from group health coverage solely for the purpose of being made eligible for the MRMIP. | | |
| 7. I declare that I understand and will follow the rules and regulations of the MRMIP. I understand that depositing a subscriber contribution check shall not constitute acceptance on the part of the MRMIP, or any of its subcontractors, if the application is not approved or if the member has already been disenrolled for nonpayment of subscriber contribution, fails to meet program eligibility requirements, commits program fraud, or because the dependent ceases to be a dependent, upon request by the member, or for any other reason. | | |
| 8. I declare that I have not been terminated within the last 12 months from a Post-MRMIP Graduate health plan, which became available through guaranteed coverage after my eligibility for MRMIP ended (Health and Safety Code Section 1373.62 or Insurance Code Section 10127.15) due to nonpayment of premiums, as a result of my request to voluntarily disenroll, or as a result of fraud. | | |

12/07

## 8. Authorization and Conditions of Enrollment

Required by the Confidentiality of Medical Information Act of 1/1/80, Sect 56 et seq. of the California Civil Code for all applicants of 18 years and over. I authorize any insurance company, physician, hospital, clinic or health care provider to give Major Risk Medical Insurance Program Administrator any and all records pertaining to any medical history, services or treatment provided to anyone listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as Administrator requires. A photocopy of this Authorization is as valid as the original.

**Privacy Notification**
The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Major Risk Medical Insurance Program (established by Part 6.5 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal and medical information is for subscriber identification and program administration. Program regulations (Chapter 5.5 of Title 10 of the California Code of Regulations, Sections 2698.100 et seq.) require every individual to furnish appropriate information for application to the Major Risk Medical Insurance Program. Failure to furnish this information may result in the return of the application as incomplete. The following information on the application is voluntary: social security number, race/ethnicity information and health history.

Personal information provided on this form will not be furnished to any other governmental agency.

An individual has a right of access to records containing his/her personal information that are maintained by the Major Risk Medical Insurance Program. The official responsible for maintaining the information is: Deputy Director, Eligibility, Enrollment and Marketing, Managed Risk Medical Insurance Board, PO Box 2769, Sacramento, CA 95812-2769. The Board may charge a small fee to cover the cost of duplicating this information.

**I understand that this is a state program and my rights and obligations under it will be determined under Part 6.5 Division 2 of the California Insurance Code and at the regulation of Title 10, Chapter 5.5**

**I understand that if this application is approved, the effective date of coverage will be determined according to applicable laws and regulations and I will be informed in writing of the effective date. (Do not cancel any current coverage until you hear from MRMIP.)**

**I understand that there may be waiting periods for pre-existing conditions.**

**Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan and request an Evidence of Coverage or Certificate of Insurance booklet.**

**These plans DO NOT require binding arbitration: Blue Shield Access+ HMO and Contra Costa Health Plan.**

**These plans DO require binding arbitration of disputes: INCLUDING malpractice, so long as the disputes are beyond the jurisdictional limit of the small claims court: Anthem Blue Cross and Kaiser Permanente.**

**I, the applicant, declare that I have read and understand the information on this form and agree to the Authorizations and Conditions of Enrollment. I certify that the information provided on this application is true and correct.**

| | | | |
|---|---|---|---|
| **X** | | **X** | |
| Signature of Applicant/Parent or Legal Guardian Required | Date | Signature of Applicant's Spouse/Registered Domestic Partner Required (If listed on this application) | Date |
| **X** | | **X** | |
| Signature of Applicant's Dependent Age 18 or over Required (If listed on this application) | Date | Signature of Applicant's Dependent Age 18 or over Required (If listed on this application) | Date |

After filling out the application, signing and securing all necessary documentation, submit a check for one month's contribution for your chosen health plan.

**Make your check payable to California Major Risk Medical Insurance Program**.

Mail your complete application to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044

12/07

Flex Your

# Power

## California's Energy Challenge

*California is facing an energy challenge.* To reduce the risk of power outages, everyone can help by reducing the demand for electricity by using less energy.

California has the power of the world's sixth largest economy. Your efforts, times 35 million Californians, will make a real difference.

**All you have to do is**
**FLEX YOUR POWER**

Simple things you can do right now to cut your energy costs are:

- Keep energy use low during peak demand hours from 5 a.m. to 9 a.m. and 4 p.m. to 7 p.m.
- Turn off unneeded lights and appliances. Unplug that spare refrigerator out in the garage if you don't really need it.
- Avoid using dishwashers, clothes washers, dryers and ovens during the peak demand periods. Wash full loads of clothes/or dishes. Use the cold setting on your washer if you can.
- In cool weather, turn your thermostats down to 68º degrees or below. Set it at 55º degrees before going to sleep or when away for the day. **For every 1 degree reduction, you will save up to 5% on your heating costs.** Close your shades and blinds at night to keep heat from being lost through windows.
- In warm weather, set your air conditioner to 78º degrees or higher. When away from home set the thermostat to 85º degrees. **These tips can save you up to 20% on your air conditioner costs.**
- Buy Energy Star appliances, products and lights.
- For more on saving energy and money, go to **www.my.ca.gov** on the Web and click the California's Energy Challenge site next to the **FLEX YOUR POWER** logo.

0408 CA0014932 5/08