California Major Risk Medical Insurance Program (MRMIP)

2015 Application and Handbook

Rates effective January 1, 2015

IMPORTANT INFORMATION FOR MRMIP SUBSCRIBERS!
2015 MINIMUM ESSENTIAL COVERAGE AND HEALTH INSURANCE MARKETPLACE

As of January 1, 2015, **MRMIP Coverage may no longer meet federal requirements** as Minimum Essential Coverage and that means if you have only MRMIP coverage in 2015, **you may be subject to a tax penalty for the 2015 tax year.** (You may have to pay a penalty of the higher of $325 per adult or 2% of your household income).

The federal Patient Protection and Affordable Care Act (PPACA) **does not allow** health insurance companies to deny coverage or charge more for new policies because of your health condition. This means you have more health insurance choices that meet the federal requirements. The health insurance marketplace options available through Covered California (www.CoveredCA.com) meet the federal requirements. Certain coverage purchased through the individual insurance market also meets the federal requirements.

Covered California is the state's marketplace for PPACA. Covered California, in partnership with the California Department of Health Care Services, was charged with creating a new health insurance marketplace in which individuals and small businesses can get access to affordable health insurance plans. Covered California helps individuals determine whether they are eligible for premium assistance to reduce insurance costs or whether they are eligible for low-cost or no-cost Medi-Cal. Consumers can then compare health insurance plans and choose the plan that works best for their health insurance needs and budget.

The 2015 Health Insurance Marketplace at CoveredCA.com offers:

- Comprehensive coverage from doctors to medications and hospital visits
- No annual or lifetime benefit limits **(MRMIP has a $75,000 annual limit and $750,000 lifetime limit)**
- Comparable coverage choices based on price, out-of-pocket costs and other features that are important to you
- Advanced tax credits through Covered California to help individuals and families pay for the cost of new coverage options (family of two with yearly income below $62,000 may qualify for tax credits)
- Medi-Cal eligibility and enrollment for individuals and families
- Covered California open enrollment period is from **November 15, 2014 through February 15, 2015** (for coverage starting as early as January 1, 2015). You can apply for Medi-Cal anytime during the year, you do not have to wait for Covered California's open enrollment.

For Covered California and Medi-Cal information, go to www.CoveredCA.com or call toll free 1-800-300-1506 (M-F 8 a.m. to 8 p.m., Sat 8 a.m. to 6 p.m.). You can review your options on your own, or you can get in-person help from enrollment counselors and assisters, or county human service agencies. For individual insurance market information, contact an insurance agent/broker or go to insurance websites.

Please review your health coverage options in the 2015 Health Insurance Marketplace carefully and **select a coverage option that meets the federal requirements** and provides the best value of comprehensive health benefits for your premium dollars!

California Major Risk Medical Insurance Program

MRMIP Enrollment Unit
1-800-289-6574

Monday – Friday
8:30 a.m. – 7:00 p.m.

Department of Health Care Services
MCQMD-MS 4410
Major Risk Medical Insurance Program
P.O. Box 2769
Sacramento, CA 95812-2769
Fax: 1-805-987-6084

Edmund G. Brown, Jr., Governor

Director
Toby Douglas
Department of Health Care Services

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1-800-289-6574

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 Department of Health Care Services and its contractors from discriminating on the basis of disability, protects its applicants and enrollees with disabilities in program services, and requires the Department and its eligibility and enrollment contractors to make reasonable accommodations to applicants and enrollees.

The Department of Health Care Services has designated the Office of Civil Rights to carry out its responsibilities under the Act. If you as a client have any questions or concerns about ADA compliance by the Department or its contractors, you may contact:

Office of Civil Rights
Department of Health Care Services
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Phone: (916) 440-7370
TTY: (916) 440-7399
Email: CivilRights@dhcs.ca.gov

للمعلومات باللغه العربيه اضغط 3	Arabic
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សម្រាប់ពត៌មានបន្ថែមជាភាសាខ្មែរ, សូមទូរស័ព្ទទៅលេខខាងលើហើយចុចលេខ 3	Cambodian/Khmer
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Introduction

The California Major Risk Medical Insurance Program (MRMIP) is a program originally developed to provide health insurance for Californians who were unable to obtain coverage in the individual insurance market. The Patient Protection and Affordable Care Act gives you new coverage choices but MRMIP will continue to provide coverage as well. MRMIP 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 or is present in California with the intent to remain in California except when absent of transitionory or temporary purposes. However, a person who is absent from the state for a period of 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 due to end-stage renal disease. Provide a Medicare eligible 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 Cal-COBRA. (COBRA or Cal-COBRA refers to the federal and state laws giving people under certain circumstances the right to continue coverage as an employee health plan for a limited time.)
4. You were denied coverage in the previous 12 months. This can be demonstrated by having a letter or a copy from a health insurance carrier, health plan or health plan maintenance organization denying individual coverage within the last 12 months, which must be submitted with your completed application.

If MRMIP is not at maximum enrollment and all other eligibility criteria are met, you will be enrolled. If 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 on which your completed application was received, not the date that you became eligible for MRMIP.

Agents/Brokers, Employers and Applicants

Under state law, it is 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.

In addition, 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 Benefit Identification Cards (BICs) cannot be used for the MRMIP.

How the Program Works

Choosing a Health Plan

The health plans participating in the MRMIP provide comprehensive health coverage 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 booklet. Subscribers may choose from any plan available to them depending on where they live, as listed on pages 14-19. **Please review all pages carefully to select a plan that is right for you.**

Deductible

The MRMIP has an annual household $500 deductible you must satisfy before the plan will begin paying for certain covered services. 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 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 may apply toward the $500 annual deductible. The $500 annual deductible applies to the annual out-of-pocket maximum.

Each plan applies the deductible differently. However, the following Preventative 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
- Newborn Blood Tests
- Prenatal Care (care during pregnancy)
- Prostate Exams for Men
- Venereal Disease 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. The 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 for a lifetime**.

Please refer to the health plan's Evidence of Coverage booklet to read more about the plan's out-of-pocket expenses. Out-of-pocket expenses are costs you may have to pay for certain services.

Subscriber Contributions

Subscriber contribution (premium) 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 or if you add dependents.

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 and 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 the 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 delinquency billing 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, and 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 written request only once in a consecutive 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 Department of Health Care Services for consideration.

Once accepted into the MRMIP, subscribers may pay by check, money order or may elect to have their monthly subscriber contribution automatically paid from their checking account. 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 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. MRMIP cashing your check does not guarantee enrollment. Qualified insurance agents and brokers may be paid a $100 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 MRMIP to pay any fee, charge or commission to a broker or agent.

Pre-Existing Condition Exclusion Period

Unlike health coverage in the individual insurance market, MRMIP has a three-month pre-existing condition exclusion or waiting period depending on the product you choose. Some applicants are eligible to have all or part of the exclusion or waiting period waived. However, if you choose coverage in the individual insurance market, your insurance will not include these limitations.

"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 PPO, there is a pre-existing condition exclusion period of three 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 HMO, there is a post-enrollment waiting period of three months. No benefits or services are provided to subscribers and enrolled dependents during this period. Subscribers will be informed 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 those circumstances, you may be granted a waiver up to three months. If the coverage was less than three months but was at least one month, the subscriber and enrolled dependents will be given credit for either one or two 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 an application for enrollment in the MRMIP was made within 180 days of termination of the previous coverage. In these circumstances, you may be granted a waiver of up to three 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 Question #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 the age 23, or a registered domestic partner's own separate child. A child under the age of 23 cannot be married nor have a registered domestic partner. If you obtain coverage in the individual insurance market, your dependent children may stay on your policy up to

age 26. 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 was executed before the child became 23.

2. It is the responsibility of the 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 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 **1-800-289-6574** 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 (Part A and B) are eligible to continue coverage in 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 enrolled when spaces become available in order of the date of receipt on which the completed application was received. Any time spent on the waiting list does <u>not</u> count toward the three-month pre-existing condition exclusion period or post-enrollment waiting period (once enrolled) unless the applicant has been on the waiting list at least 180 days. If the applicant has been on the waiting list 180 days or longer, the full three-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 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 failure to establish a satisfactory subscriber/plan relationship and DHCS determines 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:

Department of Health Care Services
MCQMD-MS 4410
Major Risk Medical Insurance Program
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 requirements or becomes eligible for Medicare Part A and Part B unless eligible solely due to 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 the end of the month in which the notification was received or 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 retro-active to the subscriber's originial 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.

The Department of Health Care Services (DHCS)Eligibility Appeals Process

The subscriber may file an eligibility appeal with DHCS on the following issues:

1. Determination of an applicant's or dependent's eligibility.
2. Determination to disenroll a subscriber or dependent, and
3. 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 eligibility 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:

Department of Health Care Services
MCQMD-MS 4410
Major Risk Medical Insurance
Program Appeals
P.O. Box 2769
Sacramento, CA 95812-2769

Health Plan's Dispute Resolution/Appeals

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

Grievance and Appeals Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against a health plan, you should first telephone the plan and use the plan's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency and urgent medical services. The DMHC has a toll-free telephone number, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use DMHC's TDD line (1-877-688-9891) to contact the department. The DMHC's website **(www.dmhc.ca.gov)** has complaint forms, IMR application forms and instructions online.

The health plan's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

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 and others do not. Some plans say that claims for malpractice must be decided by binding arbitration, and 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 booklet.

The Department of Health Care Services (DHCS) Benefit Appeals process

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

Subscribers may file a Benefit appeal with DHCS on any action or failure to act which has occurred in connection with a participating health plan's coverage.

Department of Health Care Services
MCQMD-MS 4410
Major Risk Medical Insurance Program
P.O. Box 2769
Sacramento, CA 95812-2769

Evidence of Coverage and Disclosure Booklet

Evidence of Coverage and Disclosure booklet 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.

MRMIP Notice of Privacy Practices

The Major Risk Medical Insurance Program (MRMIP) Notice of Privacy Practices can be viewed at www.mrmib.ca.gov/MRMIB/MRMIPPrivNotice.pdf.

For questions, please call the Major Risk Medical Insurance Program at 1-800-289-6574, Monday-Friday from 8:30 a.m.-7:00 p.m.

Reminder: Under Age 65 Disabled Medicare Beneficiaries

You are ineligible for coverage through the 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 MRMIP when you become eligible for Medicare Part A and Part B. Please contact the Major Risk Enrollment Unit at **1-800-289-6574**. "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 the 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 s**ix 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) at **1-800-434-0222** for free information and counseling about these rights.

Anthem BlueCross

1-877-687-0549
Call Monday through Friday
from 8:30 a.m. to 7:00 p.m.

Plan Highlights

Medical Services at Discounted Rates
Anthem Blue Cross has found a way to help 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 $500 calendar year deductible before the plan will begin paying for most covered services beginning each January 1st. Preventive services are not subject to the calendar year deductible. Once the deductible is met, members pay only a **$25** copayment for office visits to doctors in the Anthem Blue Cross network or 15% of the discounted rate, depending on the service. Once you reach your yearly maximum copayment/ coinsurance 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 to file 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 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 coinsurance 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 $500 calendar year deductible is met for most covered services.

- **$500 Calendar Year Deductible** per member or per family. 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, Human Papillomavirus (HPV) screening test, Ovarian and Cervical Cancer screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Disease (STD) Testing, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain immunizations for children and adults and Disease Management Programs.
- **$25 office visit** copayment when you use our in-network doctors.
- **Yearly maximum copayment/ coinsurance 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 for each Member in his/ her lifetime.

The Anthem Blue Cross PPO plan includes the **Anthem Blue Cross Prescription Drug Program administered by Express Scripts** 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 theEvidence of Coverage. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.

Anthem Blue Cross PPO

Summary of Benefits

Type of Service	*Description of Service*	*What You Pay Participating Provider*	*What You Pay Nonparticipating 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 or coinsurance amount	$500 per member (Subscriber only) $500 per family (Subscriber + 1 or more dependents on the same policy)	
Copayment/ Coinsurance	Member's amount due and payable to the provider of care	See Below	
Yearly Maximum Copayment/ Coinsurance Limit	Member's annual maximum copayment/coinsurance limit when using participating providers in one calendar year	$2,500 per member (Subscriber only) $4,000 per family (Subscriber + 1 or more dependents on the same policy)	No yearly maximum copayment/coinsurance limit for nonparticipating providers. You pay unlimited coinsurance
	If nonparticipating 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/coinsurance limit		
Annual Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP that 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 that reaches $750,000 in a lifetime for a member		
Preventive Care Services**	Services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Human Papillomavirus (HPV) screening test, Ovarian and Cervical Cancer Screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Disease (STD) Testing, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain Immunizations for children and adults, and Disease Management Programs		
Hospital Services	Inpatient medical services (semi-private room)	15% of negotiated fee rate	All charges except for $650 per day
	Outpatient services; ambulatory surgical centers	15% of negotiated fee rate	All charges except for $380 per day
	(No benefits are provided in a non contracting hospital or noncontracting dialysis treatment center in California, except in the case of a medical emergency)		
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	$5 for generic drugs $15 for brand drugs	All charges except 50% of drug limited fee schedule for generic or brand name drugs
	60 day supply for mail order	$5 for generic drugs through home delivery prescription drug program (Express Scripts) $15 for brand drugs through home delivery prescription drug program (Express Scripts)	
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	15% of negotiated fee rate	All charges except for $650 per day for hospital services
	Prenatal ** and postnatal care	15% of negotiated fee rate	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 Care Services*	Inpatient basic mental health care services up to 10 days each calendar year	15% of negotiated fee rate and all costs for stays over 10 days except for SMI and SED services.	All charges except for $175 per day up to 10 days. In addition, all costs for stays over 10 days except for SMI and SED services.
	Outpatient basic mental health care visits up to 15 visits each calendar year *Unlimited inpatient days and outpatient visits for Severe Mental Illnesses (SMI) and Serious Emotional Disturbances (SED) in children.	15% of negotiated fee rate for 15 visits per year. All costs for over 15 visits except for SMI and SED services.	50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits except for SMI and SED services.
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.

KAISER PERMANENTE®

Northern California

1-800-464-4000
24 hours a day
(except Holidays)

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 Northern California, close to work or close to home – or both.
- MRMIP subscribers can get care in the following Northern California counties (Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Sutter, Tulare, Yolo and Yuba).
- 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 Northern 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 specialist** – 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 $500 deductible you must satisfy before the plan will begin paying for covered services. 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 $500 annual deductible. Most Preventive Care Services are covered even if you have not met your deductible and do not apply toward the $500 annual deductible.
- **Copayment** – 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 Northern California Kaiser Permanente MRMIP Plan program, please call our Member Services Contact Center at **1-800-464-4000**. 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	$500 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) $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 Allergy injections	$20 copay per office visit $3 copay per injection
Preventive Care Services*	Flexible Sigmoidoscopies Vaccines Mammograms Routine physical examinations, including hearing and vision screenings Scheduled prenatal visits Well-child preventive care visits (0-23months)	$20 copay per visit No charge $5 per visit $20 copay per office visit $15 copay per office visit $15 copay per office visit
Diagnostic X-Ray and Laboratory Tests	X-rays and ultraviolet light therapy The following Laboratory Tests: Cervical cancer screening Cholesterol tests (lipid profile) Diabetes screening (fasting blood glucose tests) Fecal occult blood tests HIV tests Prostate specific antigen tests Venereal Diseases tests	$5 per visit $5 per visit $5 per visit $5 per visit No charge $5 per visit $5 per visit $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 $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 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 Inpatient care, complications of pregnancy, C-section	$15 copay per office visit $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 Services	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Unlimited inpatient days and outpatient visits for Severe Mental Illnesses and Serious Emotional Disturbances in children.	$200 copay per inpatient day $20 copay per visit
Home Health Care/Hospice Care	Medically necessary visits by home health personnel up to 100 visits per year Hospice care	No charge 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 Inpatient	$20 copay per visit 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

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(except Holidays)

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 $500 deductible you must satisfy before the plan will begin paying for covered services. 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 $500 annual deductible. Most Preventive Care Services are covered even if you have not met your deductible and do not apply towards the $500 annual deductible.
- **Copayment -** The maximum 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 Services Contact Center at ***1-800-464-4000****. 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 booklet.*

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	$500 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) $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 Allergy injections	$20 copay per office visit $3 copay per injection
Preventive Care Services*	Flexible Sigmoidoscopies Vaccines Mammograms Routine physical examinations, including hearing and vision screenings Scheduled prenatal visits Well-child preventive care visits (0-23months)	$20 copay per visit No charge $5 per visit $20 copay per office visit $15 copay per office visit $15 copay per office visit
Diagnostic X-Ray and Laboratory Tests	X-rays and ultraviolet light therapy The following Laboratory Tests: Cervical cancer screening Cholesterol tests (lipid profile) Diabetes screening (fasting blood glucose tests) Fecal occult blood tests HIV tests Prostate specific antigen tests Venereal Diseases tests	$5 per visit $5 per visit $5 per visit $5 per visit No charge $5 per visit $5 per visit $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 $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 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 Inpatient care, complications of pregnancy, C-section	$15 copay per office visit $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 Services	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Unlimited inpatient days and outpatient visits for Severe Mental Illnesses and Serious Emotional Disturbances in children.	$200 copay per inpatient day $20 copay per visit
Home Health Care/Hospice Care	Medically necessary visits by home health personnel up to 100 visits per year Hospice care	No charge 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 Inpatient	$20 copay per visit 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, Humbolt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPNC[1]
Subscriber Only	<15	$214.35	$192.34
	15-29	$334.81	$316.50
	30-34	$377.01	$398.73
	35-39	$408.90	$419.65
	40-44	$433.72	$450.86
	45-49	$516.78	$531.37
	50-54	$647.95	$662.04
	55-59	$819.57	$820.37
	60-64	$960.21	$908.29
	65-69	$1,004.44	$949.49
	70-74	$1,004.44	$949.49
	>74	$1,004.44	$949.49
Subscriber & 1 Dependent	<15	$407.27	$365.45
	15-29	$636.14	$601.35
	30-34	$716.33	$757.58
	35-39	$776.92	$797.33
	40-44	$824.07	$856.63
	45-49	$981.88	$1,009.60
	50-54	$1,231.10	$1,257.87
	55-59	$1,557.19	$1,558.71
	60-64	$1,824.39	$1,725.75
	65-69	$1,908.44	$1,804.03
	70-74	$1,908.44	$1,804.03
	>74	$1,908.44	$1,804.03
Subscriber & 2 or More Dependents	<15	$578.75	$519.33
	15-29	$903.99	$854.55
	30-34	$1,017.94	$1,076.56
	35-39	$1,104.04	$1,133.05
	40-44	$1,171.04	$1,217.32
	45-49	$1,395.31	$1,434.69
	50-54	$1,749.46	$1,787.51
	55-59	$2,212.85	$2,215.01
	60-64	$2,592.56	$2,452.38
	65-69	$2,711.99	$2,563.62
	70-74	$2,711.99	$2,563.62
	>74	$2,711.99	$2,563.62

1 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, 95703, 95722, 95736, 95746-47, and 95765;
Sutter–95659, 95668, 95674, and 95676;
Tulare–93261, 93618, 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 PPO
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.

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPNC[2]/KPSC[3]
Subscriber Only	<15	$228.57	$202.38
	15-29	$334.88	$338.54
	30-34	$379.90	$371.52
	35-39	$389.53	$419.43
	40-44	$428.76	$437.91
	45-49	$513.25	$521.33
	50-54	$663.09	$638.14
	55-59	$813.88	$791.93
	60-64	$912.62	$945.45
	65-69	$1,004.63	$1,015.62
	70-74	$1,004.63	$1,015.62
	>74	$1,004.63	$1,015.62
Subscriber & 1 Dependent	<15	$434.29	$384.52
	15-29	$636.27	$643.23
	30-34	$721.81	$705.88
	35-39	$740.10	$796.92
	40-44	$814.65	$832.03
	45-49	$975.18	$990.53
	50-54	$1,259.88	$1,212.47
	55-59	$1,546.36	$1,504.68
	60-64	$1,733.98	$1,796.35
	65-69	$1,908.80	$1,929.67
	70-74	$1,908.80	$1,929.67
	>74	$1,908.80	$1,929.67
Subscriber & 2 or More Dependents	<15	$617.15	$546.43
	15-29	$904.18	$914.06
	30-34	$1,025.72	$1,003.09
	35-39	$1,051.72	$1,132.46
	40-44	$1,157.66	$1,182.36
	45-49	$1,385.78	$1,407.60
	50-54	$1,790.35	$1,722.98
	55-59	$2,197.46	$2,138.22
	60-64	$2,464.08	$2,552.71
	65-69	$2,712.50	$2,742.17
	70-74	$2,712.50	$2,742.17
	>74	$2,712.50	$2,742.17

2 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, 93737, 93740, 93741, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 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.

3 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, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93560-61, and 93581.

Anthem = Anthem Blue Cross PPO
KPNC = Kaiser Permanente Northern California
KPSC = Kaiser Permanente Southern California

California Major Risk Medical Insurance Program
Monthly Subscriber Contributions
Area 3

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

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPNC[4]
Subscriber Only	<15	$240.97	$237.59
	15-29	$366.58	$353.11
	30-34	$434.36	$419.42
	35-39	$465.74	$434.92
	40-44	$509.09	$468.95
	45-49	$594.52	$555.37
	50-54	$727.53	$697.50
	55-59	$885.97	$855.59
	60-64	$1,077.48	$1,019.32
	65-69	$1,099.75	$1,059.33
	70-74	$1,099.75	$1,059.33
	>74	$1,099.75	$1,059.33
Subscriber & 1 Dependent	<15	$457.84	$451.43
	15-29	$696.50	$670.91
	30-34	$825.29	$796.90
	35-39	$884.90	$826.34
	40-44	$967.27	$891.01
	45-49	$1,129.59	$1,055.21
	50-54	$1,382.30	$1,325.26
	55-59	$1,683.34	$1,625.63
	60-64	$2,047.22	$1,936.71
	65-69	$2,089.52	$2,012.73
	70-74	$2,089.52	$2,012.73
	>74	$2,089.52	$2,012.73
Subscriber & 2 or More Dependents	<15	$650.61	$641.51
	15-29	$989.77	$953.40
	30-34	$1,172.78	$1,132.44
	35-39	$1,257.49	$1,174.28
	40-44	$1,374.54	$1,266.17
	45-49	$1,605.21	$1,499.51
	50-54	$1,964.32	$1,883.26
	55-59	$2,392.12	$2,310.10
	60-64	$2,909.20	$2,752.17
	65-69	$2,969.32	$2,860.20
	70-74	$2,969.32	$2,860.20
	>74	$2,969.32	$2,860.20

4 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, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, and 95196.

Anthem = Anthem Blue Cross PPO
KPNC = Kaiser Permanente Northern California

California Major Risk Medical Insurance Program
Monthly Subscriber Contributions
Area 4

Counties: Orange, Santa Barbara, Ventura.

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPSC[5]
Subscriber Only	<15	$197.93	$195.74
	15-29	$315.82	$308.25
	30-34	$365.25	$367.22
	35-39	$385.70	$385.29
	40-44	$410.11	$415.70
	45-49	$477.97	$489.60
	50-54	$605.17	$606.81
	55-59	$754.78	$756.05
	60-64	$906.34	$894.55
	65-69	$947.46	$924.74
	70-74	$947.46	$924.74
	>74	$947.46	$924.74
Subscriber & 1 Dependent	<15	$376.07	$371.90
	15-29	$600.06	$585.68
	30-34	$693.98	$697.71
	35-39	$732.83	$732.05
	40-44	$779.20	$789.82
	45-49	$908.15	$930.24
	50-54	$1,149.82	$1,152.94
	55-59	$1,434.09	$1,436.50
	60-64	$1,722.05	$1,699.65
	65-69	$1,800.17	$1,757.00
	70-74	$1,800.17	$1,757.00
	>74	$1,800.17	$1,757.00
Subscriber & 2 or More Dependents	<15	$534.41	$528.49
	15-29	$852.71	$832.28
	30-34	$986.18	$991.48
	35-39	$1,041.39	$1,040.29
	40-44	$1,107.29	$1,122.38
	45-49	$1,290.53	$1,321.92
	50-54	$1,633.96	$1,638.38
	55-59	$2,037.91	$2,041.35
	60-64	$2,447.13	$2,415.30
	65-69	$2,558.14	$2,496.79
	70-74	$2,558.14	$2,496.79
	>74	$2,558.14	$2,496.79

5 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, 93009-93012, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, and 93099.

Anthem = Anthem Blue Cross PPO
KPSC = Kaiser Permanente Southern California

California Major Risk Medical Insurance Program
Monthly Subscriber Contributions
Area 5

County: Los Angeles.

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPSC[6]
Subscriber Only	<15	$202.86	$181.25
	15-29	$316.46	$283.40
	30-34	$378.31	$332.67
	35-39	$399.73	$348.79
	40-44	$424.01	$375.25
	45-49	$500.57	$441.71
	50-54	$627.76	$550.97
	55-59	$769.86	$683.19
	60-64	$903.13	$804.05
	65-69	$949.37	$850.19
	70-74	$949.37	$850.19
	>74	$949.37	$850.19
Subscriber & 1 Dependent	<15	$385.44	$344.37
	15-29	$601.27	$538.46
	30-34	$718.79	$632.07
	35-39	$759.48	$662.70
	40-44	$805.62	$712.98
	45-49	$951.09	$839.25
	50-54	$1,192.75	$1,046.85
	55-59	$1,462.74	$1,298.07
	60-64	$1,715.94	$1,527.70
	65-69	$1,803.80	$1,615.35
	70-74	$1,803.80	$1,615.35
	>74	$1,803.80	$1,615.35
Subscriber & 2 or More Dependents	<15	$547.73	$489.37
	15-29	$854.44	$765.18
	30-34	$1,021.44	$898.21
	35-39	$1,079.27	$941.73
	40-44	$1,144.83	$1,013.18
	45-49	$1,351.55	$1,192.62
	50-54	$1,694.96	$1,487.63
	55-59	$2,078.63	$1,844.62
	60-64	$2,438.45	$2,170.95
	65-69	$2,563.30	$2,295.50
	70-74	$2,563.30	$2,295.50
	>74	$2,563.30	$2,295.50

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

Anthem = Anthem Blue Cross PPO
KPSC = Kaiser Permanente Southern California

California Major Risk Medical Insurance Program
Monthly Subscriber Contributions
Area 6

Counties: Riverside, San Bernardino, San Diego.

Below are available health plans listed by service area and ZIP codes. Some health plans may not be available in your area.

Rating Group	Age	Anthem	KPSC[7]
Subscriber Only	<15	$199.86	$183.99
	15-29	$324.52	$291.91
	30-34	$367.43	$341.67
	35-39	$388.12	$362.26
	40-44	$420.89	$389.28
	45-49	$498.70	$458.50
	50-54	$618.23	$572.45
	55-59	$772.69	$710.59
	60-64	$903.60	$840.53
	65-69	$973.55	$875.73
	70-74	$973.55	$875.73
	>74	$973.55	$875.73
Subscriber & 1 Dependent	<15	$379.74	$349.58
	15-29	$616.59	$554.63
	30-34	$698.11	$649.17
	35-39	$737.44	$688.29
	40-44	$799.70	$739.64
	45-49	$947.52	$871.15
	50-54	$1,174.64	$1,087.65
	55-59	$1,468.11	$1,350.12
	60-64	$1,716.84	$1,597.01
	65-69	$1,849.75	$1,663.89
	70-74	$1,849.75	$1,663.89
	>74	$1,849.75	$1,663.89
Subscriber & 2 or More Dependents	<15	$539.63	$496.78
	15-29	$876.20	$788.16
	30-34	$992.05	$922.50
	35-39	$1,047.94	$978.09
	40-44	$1,136.42	$1,051.06
	45-49	$1,346.48	$1,237.95
	50-54	$1,669.23	$1,545.61
	55-59	$2,086.26	$1,918.59
	60-64	$2,439.72	$2,269.43
	65-69	$2,628.59	$2,364.47
	70-74	$2,628.59	$2,364.47
	>74	$2,628.59	$2,364.47

7 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, 91759, 91761-64, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 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, 92410-13, 92415, 92418, 92423, and 92427.
San Diego–91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 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, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92186-87, 92190-93, and 92195-99.
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

Anthem = Anthem Blue Cross PPO
KPSC = Kaiser Permanente Southern California

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 21-24 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 24.
- ❑ **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
    - If you are eligible for Medicare Part A and Part B, copy of a Medicare letter explaining that you are eligible solely due to end-stage renal disease.
  - ❑ 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 14-19 of this handbook). Payments that **do not equal the exact amount due** will delay the processing of your application. **MRMIP cashing your check does not guarantee enrollment.**
  - ❑ **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 page 4 of this handbook for more information.)
  - ❑ **Insurance Agents or Brokers:** You must complete all boxes at the bottom of page 21 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
1-800-289-6574
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.

Permission to Share Information

I give permission for MRMIP to give information over the telephone about my application status and final eligibility to the person listed below.

Person's name: Bruce Jugan

CA Agent/Broker License Number (if applicable): OB10919

Applicant's signature: _____ Date: _____

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 page 2 of the handbook.) **Use blue or black ink only**.

Agent Name	CA Agent/Broker License No.	Tax I.D. No./Soc. Sec. No.
Bruce Jugan	0B10919	20-1199501

Street Address: 280 N. Montebello Blvd. Ste. 102

City: Montebello | State: CA | ZIP Code: 90640

Phone No.: (800) 746-0045 | FAX No: (if available): (323) 721-7343

I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program.

Signature: Bruce Jugan

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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	(For internal use 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	Family Size (Optional)	Annual Household Income (Optional)	Home Phone ( )	County

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

Billing Name, if different

Billing Address, if different	City	State	ZIP Code

Employer, if employed	Occupation	Business Phone ( )

Employer Street Address	City	State	ZIP Code

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 ☐

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

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

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 ☐

12/09

6. Program Eligibility: To be eligible for the Program, you must answer "yes" to the first question. 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. Have you and your dependent(s), if any, met the requirements to waive all or part of the exclusion/waiting period? (See page 4 under "How You May Waive All or Part of the Exclusion/Waiting Period.") Please provide a copy of supporting documentation.	☐	☐	☐	☐

Name of prior insurance company: _____

Effective date of prior coverage: _____

Termination date of prior insurance: _____

3. 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 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.		
7. 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.		

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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 the 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 requires 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. This means we may share your information with other agencies and health plans. 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.

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 can be contacted at Department of Health Care Services, Major Risk Medical Insurance Program, MCQMD-MS 4410, Sacramento, CA 95812-2769. DHCS may charge a small fee to cover the cost of duplicating this information.

You can view the MRMIP Notice of Privacy Practices at: www.mrmib.ca.gov/MRMIB/MRMIPPRIVNOTICE.pdf.

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.

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

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 completed application to:

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

STAPLE CHECK HERE
payable to California Major Risk Medical Insurance Program

12/13

ACA-MHB-0007-14 11.14