California Major Risk Medical Insurance Program (MRMIP)

2022 Application and Handbook

Rates effective
January 1, 2022

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IMPORTANT INFORMATION FOR MRMIP SUBSCRIBERS REGARDING 2022 MINIMUM ESSENTIAL COVERAGE AND HEALTH INSURANCE MARKETPLACE

The Affordable Care Act included a mandate for most individuals to have health insurance or potentially pay a tax penalty for non-compliance. Individuals with insurance needed to ensure their current insurance met Minimum Essential Coverage (MEC) requirements and they are required to maintain MEC for themselves and their dependents. In February 2015, the federal government granted permanent MEC designation for any State high-risk pool in existence as of November 26, 2014.

The Major Risk Medical Insurance Program (MRMIP), California's high-risk pool, now meets the MEC requirement. MRMIP subscribers will not need to obtain additional health coverage and will not be subject to tax penalties for non-compliance. The benefit and rate structure will not change due to the MEC designation.

You now have more health insurance choices that meet the federal requirement of minimum essential coverage. The health insurance marketplace options available through Covered California **(CoveredCA.com**) and the individual insurance market also meet the federal requirement.

The annual Covered California 2022 open enrollment period is from November 1, 2021 through January 31, 2022. Covered California has announced it is giving consumers more time to sign up for healthcare coverage during the COVID-19 pandemic by extending the current special enrollment deadline. You can apply for Medi-Cal anytime during the year and you do not have to wait for Covered California's open enrollment.

For Covered California and Medi-Cal information, go to **CoveredCA.com** or call toll-free **800-300-1506** (Monday to Friday, 8 a.m. to 6 p.m.). You can review your options on your own, or you can receive 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 2022 Health Insurance Marketplace carefully and select the coverage option that provides the best value of comprehensive health benefits for your premium dollars.

Department of
Health Care Services
MCOD-MS 4703
Major Risk Medical
Insurance Program
P.O. Box 2769
Sacramento, CA
95812-2769
Fax: 855-358-3373

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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 (ADA) 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

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 copays. 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 lives in California with the intent to remain in California except when absent for transitionary or temporary purposes. A person who is absent from the state for a period of greater than 210 consecutive days is not 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 max enrollment and all other eligibility criteria are met, you will be enrolled.

If MRMIP is at max 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 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 dependents to apply for MRMIP with the purpose of separating that employee or their dependents 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 dependents to the MRMIP or to arrange for an individual employee or their dependents to apply for MRMIP with the purpose of separating that employee or their dependents 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 copay 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 doctor services. These benefits are outlined in the health plan description pages in this handbook 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 in this handbook. Please review all pages carefully to select a plan 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 which begins January 1. The only payments that count toward a deductible are those payments you make for covered services subject to the deductible. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copays or coinsurance subject to the annual out-of-pocket maximum. Payments for services provided by providers in and out of your plan network, 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. The following preventive care services with applicable copays are not subject to the calendar year deductible in any plan:

- Breast exams, pelvic exams, pap smears, and mammograms for women
- Cytology exams
- Periodic health exams
- 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

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

Copays/Coinsurance
Health Maintenance Organizations (HMOs) in MRMIP may require a fixed-dollar copay 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 copay 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 usually updated on January 1 of each year. For 2022, the subscriber contributions (premiums) were updated on January 1, 2022. In addition, your subscriber contribution may change during the year if your birthday moves you into a new age category, if you add dependents, or if you move to a new area.

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 subscriber moves from one area of the state to another or if the subscriber 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 the 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 subscriber'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 Major Risk Medical Insurance Program appeals 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 subscriber of the tribe.

Subscriber contribution checks and electronic withdrawals 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 insufficient funds. In addition, electronic withdrawals 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 $20 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 healthcare 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. 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. Subscriber contributions are paid during this period.

Post-enrollment Waiting Period
For subscribers and dependents enrolled in an 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 in total if any of the following apply:

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 number two, three, or four to waive this exclusion/waiting period, please submit appropriate documentation and check the appropriate boxes on the application (program eligibility question six).

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 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 **800-289-6574** and talking to an MRMIP enrollment unit representative.
3. Enrolled dependents of a deceased subscriber or dependents of a subscriber who becomes eligible for Medicare (Part A and Part B) are eligible to continue coverage in MRMIP as long as program requirements are met.

Waiting List

If the MRMIP reaches max 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 not 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 requests, in writing, during the program's open enrollment period, which is usually held in November. 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 the Department of Health Care Services 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
MCOD-MS 4703
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 makes a request 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, 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's provider organization in which they are enrolled, the subscriber should first attempt to resolve the dispute with the participating plan/organization according to its established policy 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, and others do not. Some plans say 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.

Department of Health Care Services (DHCS) Appeals Process
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 DHCS 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.
4. Determination to deny a subscriber's request 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
MCOD-MS 4703
Major Risk Medical Insurance Program
Appeals
P.O. Box 2769
Sacramento, CA 95812-2769

Evidence of Coverage and Disclosure Booklets
Evidence of coverage and disclosure booklets are 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
You can view the notice of privacy practices at
dhcs.ca.gov/services/Pages/MajorRiskMedicalInsuranceProgram.aspx

For questions, please call the Major Risk Medical Insurance Program at **800-289-6574 (TTY 888-757-6034)**, Monday to Friday, 8:30 a.m. to 5 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 **800-289-6574**. "Eligible" for Part A means you are not required to pay a premium for Part A. "Eligible" for Part B simply means 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 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) at **800-434-0222** for free information and counseling about these rights.

Plan Highlights

Medical Services at Discounted Rates

Anthem has found a way to help control escalating medical expenses for subscribers. We have negotiated discounted rates with a network of doctors and hospitals across the state. These providers form the preferred provider organization (PPO) plan. They give Anthem subscribers a discount for care.

Subscribers 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, subscribers pay only a $25 copay for office visits to doctors in the Anthem network or 15% of the discounted rate, depending on the service. Once you reach your yearly maximum copay/coinsurance limit, Anthem pays 100% of the cost for covered services in your network for the rest of the calendar year. There are no claim forms to file when you use providers in your network.

Access to One of the Largest Provider Networks in California

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

- The **extensive provider network** is comprised of more than 40,000 PPO doctors and more than 400 hospitals.
- **Benefits are still available outside of your plan 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 exceeding the fee schedule.

Anthem contracts with most hospitals in California. Benefits are not provided for care given by the few hospitals without an agreement with Anthem (except care for emergencies).

How the Plan Works

The Anthem 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 subscriber or per family. The payments or incurred costs for services from providers in and out of pharmacies in your plan network 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
  - Mammograms for women

    - Human papillomavirus (HPV) screening test
    - Ovarian and cervical cancer screening
    - Cytology exams
    - Family planning services
    - Health education services
    - Periodic health exams and lab 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 visits
    - Well-child visits
    - Certain immunizations for children and adults
- Disease management programs
- $25 office visit copay when you use doctors in your plan network
- Yearly maximum copay/coinsurance limit for providers in your network per calendar year:
    - $2,500 per subscriber
    - $4,000 per family
    - $75,000 annual maximum for benefits paid per calendar year
    - $750,000 lifetime maximum for benefits paid for each subscriber in their lifetime

The Anthem PPO plan includes the Anthem prescription drug program administered by IngenioRx with these important features:

- Lower cost: Anthem 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: Pharmacies in the plan are supported by an online electronic network and will collect your copay when you pick up your prescription. There are no claim forms to file.

Important Information

If you would like more information before you enroll, please call the Anthem Customer Care Center at **877-687-0549**. Call Monday to Friday, 8:30 a.m. to 5 p.m.

Please note the information presented here is only a summary. The Anthem 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.

Summary of Benefits

Type of Service	Description of Service	What You Pay Providers in the Plan	What You Pay Providers Outside the Plan
Annual Deductible	The amount you must pay for covered services except for preventive care services before the plan will cover those services at the copay or coinsurance amount	$500 per subscriber (subscriber only) $500 per family (subscriber + one or more dependents on the same policy)	
Copay/ Coinsurance	Subscriber's amount due and payable to the provider of care	See below	
Yearly Maximum Copay/ Coinsurance Limit	Subscriber's annual maximum copay/ coinsurance limit when using participating providers in one calendar year	$2,500 per subscriber (subscriber only) $4,000 per family (subscriber + one or more dependents on the same policy)	No yearly maximum copay/ coinsurance limit for nonparticipating providers. You pay unlimited coinsurance.
Annual Benefit Maximum	If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the subscriber's responsibility and do not apply to the yearly maximum copay/coinsurance limit. 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 subscriber.		
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 subscriber.	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

Preventive Care Services**	• Breast exams • Pelvic exams, pap smears, and mammograms for women • Human papillomavirus (HPV) screening test • Ovarian and cervical cancer screening • Cytology exams • Family planning services • Health education services • Periodic health exams 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 • Disease management programs		
Hospital Services	Inpatient medical services (semi-private room) Outpatient services; ambulatory surgical centers (No benefits are provided in a noncontracting hospital or noncontracting dialysis treatment center in California, except in the case of a medical emergency.)	15% of negotiated fee rate 15% of negotiated fee rate	All charges except for $650 per day All charges except for $380 per day
Doctor Office Visits	Doctor 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	Max 30-day supply per prescription when filled at a participating pharmacy 60-day supply for mail order	$5 for generic drugs $15 for brand drugs $5 for generic drugs through home delivery prescription drug program (IngenioRx) $15 for brand drugs through home delivery prescription drug program (IngenioRx)	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 doctor 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 prenatal** and postnatal care	15% of negotiated fee rate 15% of negotiated fee rate	All charges except for $650 per day for hospital services 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 Healthcare Services*	Initial treatment of an acute serious illness or accidental injury, including 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 Healthcare Services*	Inpatient basic mental healthcare services up to 10 days each calendar year Outpatient basic mental healthcare 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 and all costs for stays over 10 days except for SMI and SED services. 15% of negotiated fee rate for 15 visits per year. All costs for over 15 visits 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. 50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits except for SMI and SED services.
Home Healthcare	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 subscribers 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 recommends as a medically appropriate, more cost-effective alternative plan of treatment	

Infusion Therapy*	Therapeutic use of drugs, or other substances ordered by a doctor 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.

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

Plan Highlights
Kaiser Permanente's medical care program offers the kind of benefits you have 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 receive care in the following Northern California counties:
  - Alameda
  - Amador
  - Contra Costa
  - El Dorado
  - Fresno
  - Kings
  - Tulare
  - Madera
  - Marin
  - Mariposa
  - Napa
  - Placer
  - Sacramento
  - Yolo
  - Yuba
  - San Francisco
  - San Joaquin
  - San Mateo
  - Santa Clara
  - Santa Cruz
  - Solano
  - Sonoma
  - Sutter
- Please see the chart at the back of this handbook for the specific ZIP codes open to the MRMIP 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 is 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 copays 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 subscribers.

Plan Providers

- When you select Kaiser Permanente as your MRMIP plan provider, your medical care is provided or arranged by Kaiser Permanente doctors at Kaiser Permanente medical facilities. Our dedicated doctors 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 are proud of the caliber of our doctors. Many of them graduated from top medical schools, such as Harvard, Yale, Stanford, and UCLA.
- You can choose your own Kaiser Permanente primary care provider who will work with you to coordinate all your healthcare needs. You or your family may select a different doctor at any time — your choice is never restricted to any one doctor or facility.
- Emergency and urgent care is available from Kaiser Permanente 24 hours a day, seven 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 doctors 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 copay or coinsurance subject to the annual out-of-pocket maximum. Payments for services provided by providers in or out of your plan network 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.
- Copay — 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 Northern California Kaiser Permanente MRMIP plan program, please call our Subscriber Services Contact Center at **800-464-4000**. Please note 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.

Summary of Benefits

Type of Service	Description of Service	What you Pay
Annual Deductible	The amount you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services, except for preventive care services	$500 per household
Copay	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 subscriber	
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 subscriber	
Hospital Services	Room and board, anesthesia, X-rays, lab tests, and drugs	$200 copay per inpatient day
Doctor 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 (0-23 months)	$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 doctor 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 doctor and obtained from plan providers 20% of subscriber rate	No charge during hospital stays through Kaiser Permanente
Prosthetic Devices and Braces	Prosthetic devices and braces when prescribed by a plan doctor 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 Healthcare 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 Healthcare/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) doctor, or a doctor to whom a TPMG doctor has referred you for specific care. Any care received outside of the 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.

Plan Highlights
Kaiser Permanente's medical care program offers the kind of benefits you have 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 receive care in parts of seven Southern California counties:
  - Kern
  - Los Angeles
  - Orange
  - Riverside
  - San Bernardino
  - San Diego
  - Tulare
  - Ventura

Please see the chart at the back of this handbook 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 is 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 copays 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 subscribers.

Plan Providers

- When you select Kaiser Permanente as your MRMIP plan provider, your medical care is provided or arranged by Kaiser Permanente doctors at Kaiser Permanente medical facilities. Our dedicated doctors 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 doctors. Many of them graduated from top medical schools, such as Harvard, Yale, Stanford, and UCLA.
- You can choose your own Kaiser Permanente primary care provider who will work with you to coordinate all your healthcare needs. You or your family may select a different doctor at any time — your choice is never restricted to any one doctor or facility.
- Emergency and urgent care is available from Kaiser Permanente 24 hours a day, seven 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 doctors 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 copay or coinsurance subject to the annual out-of-pocket maximum. Payments for services provided by providers in or out of your plan network 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.
- Copay — 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 Subscriber Services Contact Center at **800-464-4000**. Please note 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.

Summary of Benefits

Type of Service	Description of Service	What you Pay
Annual Deductible	The amount you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services, except for preventive care services	$500 per household
Copay	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 subscriber	

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 subscriber	
Hospital Services	Room and board, anesthesia, X-rays, lab tests, and drugs	$200 copay per inpatient day
Doctor 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 (0-23 months)	$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 doctor 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 doctor and obtained from plan providers through Kaiser Permanente	20% of subscriber rate No charge during hospital stay
Prosthetic Devices and Braces	Prosthetic devices and braces when prescribed by a plan doctor 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 Healthcare Services	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year	$200 copay per inpatient day $20 copay per visit
Home Healthcare/Hospice Care	Unlimited inpatient days and outpatient visits for severe mental illnesses and serious 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) doctor, or a doctor to whom a SCPMG doctor has referred you for specific care. Any care received outside of the 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.

Rates
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, and 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
Subscriber Only	<15	297.10	260.15
	15-29	374.16	330.93
	30-34	448.18	398.88
	35-39	471.69	419.82
	40-44	506.78	451.03
	45-49	591.96	530.87
	50-54	737.53	661.43
	55-59	916.52	821.95
	60-64	1082.31	970.63
	65-69	1139.10	1011.21
	70-74	1139.10	1011.21
	>74	1139.10	1011.21
Subscriber & 1 Dependent	<15	564.48	494.29
	15-29	710.91	628.78
	30-34	851.54	757.88
	35-39	896.21	797.64
	40-44	962.88	856.96
	45-49	1124.73	1008.65
	50-54	1401.31	1256.72
	55-59	1741.39	1561.69
	60-64	2056.39	1844.19
	65-69	2164.30	1921.30
	70-74	2164.30	1921.30
	>74	2164.30	1921.30
Subscriber & 2 or More Dependents	<15	802.15	702.41
	15-29	1010.25	893.53
	30-34	1210.08	1076.99
	35-39	1273.57	1133.49
	40-44	1368.31	1217.79
	45-49	1598.29	1433.35

	50-54	1991.34	1785.87
	55-59	2474.61	2219.25
	60-64	2922.23	2620.69
	65-69	3075.58	2730.28
	70-74	3075.58	2730.28
	>74	3075.58	2730.28

[1]Kaiser Permanente Northern California is 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 — 93618, 93666, and 93673
Yolo — 95605, 95607, 95612, 9561518, 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

Area 2
Counties: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis, Obispo, Santa Cruz, Solano, Sonoma, and 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 and KPSC
Subscriber Only	<15	291.82	251.81
	15-29	362.35	317.99
	30-34	439.68	384.09
	35-39	462.76	404.26
	40-44	497.18	434.33
	45-49	582.23	509.69
	50-54	725.41	635.04
	55-59	901.46	789.16
	60-64	1064.53	931.90
	65-69	1097.29	965.52
	70-74	1097.29	965.52
	>74	1097.29	965.52
Subscriber & 1 Dependent	<15	554.45	478.44
	15-29	688.48	604.17
	30-34	835.39	729.79
	35-39	879.24	768.09
	40-44	944.62	825.23
	45-49	1106.24	968.42
	50-54	1378.28	1206.57
	55-59	1712.76	1499.39
	60-64	2022.61	1770.61
	65-69	2084.84	1834.48
	70-74	2084.84	1834.48
	>74	2084.84	1834.48
Subscriber & 2 or More Dependents	<15	787.90	679.89
	15-29	978.35	858.55
	30-34	1187.14	1037.07
	35-39	1249.45	1091.50
	40-44	1342.36	1172.69
	45-49	1572.03	1376.17
	50-54	1958.61	1714.60

	55-59	2433.93	2130.72
	60-64	2874.22	2516.13
	65-69	2962.67	2606.89
	70-74	2962.67	2606.89
	>74	2962.67	2606.89

[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 except 95640
Santa Cruz — 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, and 95076-77
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
Solano — 94503 and 95618

[2]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

Area 3
Counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, and 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
Subscriber Only	<15	334.68	277.37
	15-29	420.97	356.39
	30-34	505.52	429.15
	35-39	532.05	451.68
	40-44	571.63	485.26
	45-49	680.72	572.20
	50-54	848.12	712.91
	55-59	1053.96	885.93
	60-64	1244.62	1046.18
	65-69	1303.04	1088.64
	70-74	1303.04	1088.64
	>74	1303.04	1088.64
Subscriber & 1 Dependent	<15	635.90	527.00
	15-29	799.85	677.14
	30-34	960.50	815.38
	35-39	1010.89	858.18
	40-44	1086.09	922.00
	45-49	1293.38	1087.18
	50-54	1611.44	1354.53
	55-59	2002.52	1683.25
	60-64	2364.77	1987.74
	65-69	2475.78	2068.42
	70-74	2475.78	2068.42
	>74	2475.78	2068.42
Subscriber & 2 or More Dependents	<15	903.65	748.90
	15-29	1136.63	962.25
	30-34	1364.92	1158.70
	35-39	1436.53	1219.52
	40-44	1543.39	1310.20
	45-49	1837.95	1544.93
	50-54	2289.94	1924.87
	55-59	2845.69	2391.99
	60-64	3360.46	2824.69
	65-69	3518.22	2939.33

	70-74	3518.22	2939.33
	>74	3518.22	2939.33

[3]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

Area 4
Counties: Orange, Santa Barbara, and 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
Subscriber Only	<15	257.47	241.79
	15-29	328.83	309.17
	30-34	395.53	371.98
	35-39	416.28	391.51
	40-44	447.24	420.62
	45-49	528.90	496.26
	50-54	658.96	618.32
	55-59	818.89	768.36
	60-64	967.02	907.34
	65-69	1008.41	947.76
	70-74	1008.41	947.76
	>74	1008.41	947.76
Subscriber & 1 Dependent	<15	489.21	459.39
	15-29	624.77	587.44
	30-34	751.50	706.77
	35-39	790.93	743.86
	40-44	849.76	799.17
	45-49	1004.90	942.90
	50-54	1252.03	1174.79
	55-59	1555.89	1459.89
	60-64	1837.33	1723.95
	65-69	1915.96	1800.76
	70-74	1915.96	1800.76
	>74	1915.96	1800.76
Subscriber & 2 or More Dependents	<15	695.19	652.82
	15-29	887.82	834.78
	30-34	1067.92	1004.36
	35-39	1123.96	1057.07
	40-44	1207.56	1135.67
	45-49	1428.02	1339.90
	50-54	1779.20	1669.45
	55-59	2211.01	2074.58
	60-64	2610.94	2449.83

	65-69	2722.69	2558.97
	70-74	2722.69	2558.97
	>74	2722.69	2558.97

[4]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

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
Subscriber Only	<15	259.53	213.96
	15-29	332.08	273.78
	30-34	399.57	329.42
	35-39	420.55	346.70
	40-44	451.83	372.48
	45-49	532.51	439.00
	50-54	663.46	546.95
	55-59	824.47	679.69
	60-64	973.60	802.65
	65-69	1017.78	839.06
	70-74	1017.78	839.06
	>74	1017.78	839.06
Subscriber & 1 Dependent	<15	493.12	406.52
	15-29	630.96	520.17
	30-34	759.19	625.89
	35-39	799.04	658.74
	40-44	858.46	707.72
	45-49	1011.76	834.10
	50-54	1260.56	1039.22
	55-59	1566.49	1291.42
	60-64	1849.86	1525.03
	65-69	1933.78	1594.22
	70-74	1933.78	1594.22
	>74	1933.78	1594.22
Subscriber & 2 or More Dependents	<15	700.75	577.69
	15-29	896.63	739.19
	30-34	1078.85	889.42
	35-39	1135.48	936.10
	40-44	1219.93	1005.71
	45-49	1437.77	1185.29
	50-54	1791.32	1476.77
	55-59	2226.06	1835.17
	60-64	2628.74	2167.16
	65-69	2748.01	2265.46
	70-74	2748.01	2265.46
	>74	2748.01	2265.46

[5]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

Area 6
Counties: Riverside, San Bernardino, and 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
Subscriber Only	<15	285.79	226.07
	15-29	363.22	288.74
	30-34	437.90	347.61
	35-39	460.89	365.86
	40-44	495.16	393.07
	45-49	578.95	462.26
	50-54	721.32	575.94
	55-59	896.37	715.72
	60-64	1058.51	845.18
	65-69	1126.62	887.82
	70-74	1126.62	887.82
	>74	1126.62	887.82
Subscriber & 1 Dependent	<15	543.00	429.54
	15-29	690.10	548.61
	30-34	832.01	660.47
	35-39	875.68	695.13
	40-44	940.80	746.83
	45-49	1099.99	878.30
	50-54	1370.49	1094.29
	55-59	1703.11	1359.87
	60-64	2011.17	1605.86
	65-69	2140.56	1686.84
	70-74	2140.56	1686.84
	>74	2140.56	1686.84
Subscriber & 2 or More Dependents	<15	771.64	610.40
	15-29	980.68	779.61
	30-34	1182.33	938.57
	35-39	1244.39	987.82
	40-44	1336.93	1061.29
	45-49	1563.14	1248.10
	50-54	1947.55	1555.04
	55-59	2420.21	1932.44
	60-64	2857.98	2282.00
	65-69	3041.86	2397.10
	70-74	3041.86	2397.10
	>74	3041.86	2397.10

[6]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, 92020-27, 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, 92028, 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 your application is complete:

- ✓ Review the handbook to learn about the eligibility requirements for the MRMIP and choose your health plan before completing the **enrollment application**.
- ✓ Complete the **enrollment application** in 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**.
- ✓ Attach the following items (your entire application may be returned to you if you do not provide the following):
    - Your supporting documentation indicating your eligibility for the MRMIP. (The **introduction** section in 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 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 the check payable to: *California Major Risk Medical Insurance Program*. (Monthly subscriber and/or dependent contribution amounts in the **rates** section 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 the **Introduction** section of this handbook for more information.)
- ✓ Insurance agents or brokers: You must complete all boxes at the bottom 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

California Major Risk Medical Insurance Program
Enrollment Application

Instructions

Thank you for applying for the California Major Risk Medical Insurance Program (MRMIP). 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 answered fully. 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: _____

CA agent/broker license number (if applicable): _____

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 two of the handbook.) Use blue or black ink only for completing a printed version.

Agent name		
CA agent/broker license number	Tax ID number or Social Security number	
Street address		
City	State	ZIP code
Phone number	Fax number (if available)	

☐ I understand no agent payment will be made unless and until this applicant is enrolled in the MRMIP.
Signature:

1. Choice of Health Plan:
Make the check payable to California Major Risk Medical Insurance Program. Use blue or black ink only.

2. Check One: ☐ New enrollment ☐ Add dependents

(For internal use only.) Health plan name:

3. Applicant Information: Applicant must complete this section.

☐ Check here if parent or legal guardian is completing this application for the applicant

Last name	First name	Middle initial	☐ Male ☐ Female
Social Security Number	Birthdate (MM/DD/YYYY)	Age	

Check one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered domestic partner

Home phone	Family size (optional)	Annual household income (optional) $	
Street address (Must be completed. P.O. box is not acceptable.)		Suite or unit number	
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.

☐ Aleut
☐ American Indian, Native American
☐ Black/African American
☐ Eskimo
☐ White

Hispanic
☐ Cuban
☐ Mexican, Mexican American, Chicano
☐ Puerto Rican

Asian
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese

Pacific Islander
☐ Filipino
☐ Guamanian
☐ Samoan
☐ Other:

5. **Family Information: List all additional family subscribers to be enrolled**			
☐ Husband ☐ Wife ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age
☐ Son ☐ Daughter ☐ Single ☐ Married ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age
☐ Son ☐ Daughter ☐ Single ☐ Married ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age
☐ Son ☐ Daughter ☐ Single ☐ Married ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age
☐ Son ☐ Daughter ☐ Single ☐ Married ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age
☐ Son ☐ Daughter ☐ Single ☐ Married ☐ Registered domestic partner	Last name	First name	Middle initial
	Social Security Number	Birthdate (MM/DD/YYYY)	Age

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

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

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.

	Applicant		Dependent	
	Yes	**No**	**Yes**	**No**
A. Within the past 12 months, have you been denied individual health insurance?	☐	☐	☐	☐
B. Have you and your dependents, if any, met the requirements to waive all or part of the exclusion/waiting period? (See page 8 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, or end date, of prior insurance				
C. 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 and initial each one. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions.

	Applicant	Dependent
	Initials	**Initials**
A. 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.)		
B. I declare that all individuals listed on this application are residents of the state of California. (See page 4 under "Eligibility" for the definition of California resident.)		
C. 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 4.)		
D. 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.		
E. I declare that I have reviewed the benefits offered by the MRMIP and the subscriber contribution amounts.		
F. 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.		
G. 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.		

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, doctor, hospital, clinic, or healthcare 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.

9. 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 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 their personal information maintained by the Major Risk Medical Insurance Program. The official who maintains the information can be contacted at Department of

Health Care Services, Major Risk Medical Insurance Program, MCOD-MS 4703, Sacramento, CA 95812-2769. The DHCS may charge a small fee to cover the cost of duplicating this information.

You can view the MRMIP Notice of Privacy Practices at:
dhcs.ca.gov/services/Pages/MajorRiskMedicalInsuranceProgram.aspx
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.

Signature of applicant/parent or legal guardian required

Signature of applicant's spouse/registered domestic partner required (if listed on this application)

Signature of applicant's dependent, age 18 or over required (if listed on this application)

Signature of applicant's dependent, age 18 or over required (if listed on this application)

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