California
Major Risk Medical Insurance Program

Open enrollment period
November 1, 2018 through November 30, 2018

Transfer of enrollment effective date
January 1, 2019

All NEW health plan ZIP code changes effective date
January 1, 2019

All NEW subscription rates effective date
January 1, 2019

ACA-MHB-0037-18

IMPORTANT INFORMATION FOR MRMIP SUBSCRIBERS REGARDING 2019 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 (www.CoveredCA.com) and the individual insurance market also meet the federal requirement.

The Covered California 2019 open enrollment period is from November 1, 2018 through January 31, 2019 (for coverage starting as early as January 1, 2019). 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 www.CoveredCA.com or call toll free 1-800-300-1506 (M-F 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 2019 Health Insurance Marketplace carefully and select the coverage option that provides the best value of comprehensive health benefits for your premium dollars!

California Major Risk Medical Insurance Program
Major Risk Enrollment Unit 1-800-289-6574
Monday–Friday
8:30 a.m.–5 p.m. Pacific time

Department of Health Care Services
MCOD-MS 4703
Major Risk Medical Insurance Program
P.O. Box 2769
Sacramento, CA 95812-2769
FAX: 1-805-987-6084

Edmund G. Brown, Jr., Governor

Director
Jennifer Kent
Department of Health Care Services

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OPEN ENROLLMENT 2018

Your monthly subscriber contribution will change effective January 1, 2019.

Please review the rate pages for specific ZIP code changes. If you live in a ZIP code that is no longer available, you must choose another health plan or you will be disenrolled.

If you are changing your plan, we must receive your completed transfer enrollment form by November 30, 2018.

All health plan transfers will be effective January 1, 2019.

If you transfer, any enrolled dependents will also be transferred to the new plan.

ACTION IS REQUIRED

1. Review the subscriber contribution rates carefully.

2. If you are changing plans, send your transfer enrollment form and the customer satisfaction survey by November 30, 2018.

3. If you are not changing plans, complete only the Customer Satisfaction Survey and send it by November 30, 2018.

If you have any questions, please call MRMIP at 1-800-289-6574, Monday through Friday from 8:30 a.m. to 5 p.m. Pacific time.

Department of Health Care Services MRMIP open enrollment 2018 program information

The following contains important information about your health care benefits in the Major Risk Medical Insurance Program (MRMIP).

Now is the time to change plans!

- If we **do not** receive the transfer enrollment form and your current plan is still available, **you will continue to be enrolled in your current health plan at the new 2019 subscriber contribution rate**. The new subscriber contribution rates go into effect on January 1, 2019.
- If we do not receive the transfer enrollment form and your current plan is no longer available in your ZIP code, **you will be disenrolled from the MRMIP.**

Please remember that your subscriber contribution rates may also change during the year for three other reasons:

1) If you move from one area of the State to another; or,
2) If you have a birthday that moves you to a new age category; or,
3) If you add one or more dependents.

If you request a health plan change, your new MRMIP health plan will send you a health insurance identification card, an evidence of coverage and a provider directory.

Until December 31, 2018, you will continue coverage under your existing plan and you must continue to pay your current subscriber contributions.

If your December 2018 subscriber contributions are not paid by December 14, 2018, your transfer will not take place. If your subscriber contributions are past due, you will be disenrolled.

Transferring between MRMIP health plans will not change in any way your pre-existing condition/post-enrollment waiting period status.

Important information about your MRMIP coverage

The Affordable Care Act made significant changes to the health insurance market. You can now purchase more comprehensive coverage that may cost less than current MRMIP coverage.

As of January 1, 2014, health plans and health insurance companies can no longer:

- Deny coverage based on a pre-existing condition
- Charge a higher premium based on health status or gender
- Refuse to renew policies except in certain circumstances

Open Enrollment 2019 for the individual market ends on January 31, 2019. If you don’t apply for coverage by that deadline, you will not be able to obtain coverage before January 1, 2020, unless you have a triggering event that qualifies you for a special enrollment period.

MRMIP will continue to operate in 2019 and your coverage will continue, unless you disenroll or stop paying premiums.

For more information about Covered California, the new marketplace for health coverage, and your eligibility for subsidies, visit www.CoveredCa.com or call 1-800-300-1506.

Anthem Blue Cross Preferred Provider Organization (PPO)

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 percent of the discounted rate, depending on the service. Once you reach your yearly maximum copayment/coinsurance limit, Anthem Blue Cross pays 100 percent 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
        - 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 percent 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 5 p.m. Pacific time.

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

Summary of benefits

Type of service	Description of service	What you pay participating providers	What you pay nonparticipating providers
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)	
Copayment/ Coinsurance	Member's amount due and payable to the provider of care	$500 per family (Subscriber + 1 or more dependents on the same policy) See below	
Yearly maximum copayment/ coinsurance limit	Member's annual maximum copayment/coinsurance limit when using participating providers in one calendar year 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	$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

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**	• 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	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

	• 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
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 60-day supply for mail order	$5 for generic drugs $15 for brand drugs $5 for generic drugs through home delivery prescription drug program (Express Scripts)	All charges except 50% of drug limited fee schedule for generic or brand name drugs

		$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 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 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. 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	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	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.

	children.	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.

**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)

Kaiser Permanente Northern California

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
  - Santa Cruz
  - Solano
  - Sonoma
  - Sutter
  - Tulare
  - Yolo
  - 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 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, 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 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.

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 (0-23 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 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 your evidence of coverage for this plan.

KAISER PERMANENTE®
Southern California

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

Kaiser Permanente Southern California
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 Southern California counties:
  - Kern
  - Los Angeles
  - Orange
  - Riverside
  - San Bernardino
  - San Diego
  - Ventura
  - Tulare

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 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, 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 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.

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 $500 per household remaining cost of covered services, except for preventive care services	See specific service
Copayment	Your cost of covered services	
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 (0-23 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	$5 per visit

	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 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 $10 generic for up to a 100-day supply formulary guidelines	$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 20% of member rate providers through Kaiser Permanente	No charge during hospital stay
Prosthetic devices and braces	Prosthetic devices and braces when prescribed by a plan physician and obtained from plan.	No charge for providers through Kaiser Permanente.
Maternity care	Prenatal* and postnatal care Inpatient care, complications of pregnancy, C-section	$200 copay per inpatient day 15 copay per office visit
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	$200 copay per inpatient day $20 copay per visit

	Emotional Disturbances in children.	
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.

Rates
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	368.51	277.42
	15-29	464.12	352.90
	30-34	555.92	425.36
	35-39	585.09	447.67
	40-44	628.61	480.97
	45-49	734.27	566.11
	50-54	914.84	705.33
	55-59	1136.86	876.50
	60-64	1342.50	1035.05
	65-69	1412.94	1078.33
	70-74	1412.94	1078.33
	>74	1412.94	1078.33
Subscriber & 1 Dependent	<15	700.18	527.10
	15-29	881.82	670.52
	30-34	1056.25	808.18
	35-39	1111.66	850.58
	40-44	1194.36	913.84
	45-49	1395.11	1075.60
	50-54	1738.19	1340.13
	55-59	2160.03	1665.34
	60-64	2550.75	1966.59
	65-69	2684.59	2048.83
	70-74	2684.59	2048.83
	>74	2684.59	2048.83
Subscriber & 2 or More Dependents	<15	994.99	749.03
	15-29	1253.11	952.84
	30-34	1500.98	1148.46
	35-39	1579.73	1208.72
	40-44	1697.25	1298.62

	45-49	1982.52	1528.48
	50-54	2470.06	1904.40
	55-59	3069.51	2366.54
	60-64	3624.75	2794.63
	65-69	3814.95	2911.49
	70-74	3814.95	2911.49
	>74	3814.95	2911.49

[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, 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]
Subscriber Only	<15	361.97	268.52
	15-29	449.46	339.09
	30-34	545.38	409.59
	35-39	574.01	431.09
	40-44	616.69	463.16
	45-49	722.20	543.52
	50-54	899.80	677.18
	55-59	1118.17	841.53
	60-64	1320.44	993.75
	65-69	1361.07	1029.60
	70-74	1361.07	1029.60
	>74	1361.07	1029.60
Subscriber & 1 Dependent	<15	687.74	510.20
	15-29	853.98	644.26
	30-34	1036.23	778.22
	35-39	1090.61	819.07
	40-44	1171.71	880.00
	45-49	1372.18	1032.70
	50-54	1709.62	1286.65
	55-59	2124.52	1598.91
	60-64	2508.84	1888.13
	65-69	2586.04	1956.24
	70-74	2586.04	1956.24
	>74	2586.04	1956.24
Subscriber & 2 or More Dependents	<15	977.32	725.01
	15-29	1213.55	915.53
	30-34	1472.54	1105.90
	35-39	1549.82	1163.95
	40-44	1665.07	1250.52
	45-49	1949.94	1467.52
	50-54	2429.46	1828.40

	55-59	3019.05	2272.14
	60-64	3565.19	2683.13
	65-69	3674.90	2779.91
	70-74	3674.90	2779.91
	>74	3674.90	2779.91

[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, 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

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

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[3]
Subscriber Only	<15	415.14	295.78
	15-29	522.17	380.04
	30-34	627.06	457.63
	35-39	659.95	481.65
	40-44	709.05	517.47
	45-49	844.37	610.18
	50-54	1052.02	760.23
	55-59	1307.33	944.72
	60-64	1543.82	1115.62
	65-69	1616.30	1160.89
	70-74	1616.30	1160.89
	>74	1616.30	1160.89
Subscriber & 1 Dependent	<15	788.77	561.98
	15-29	992.13	722.08
	30-34	1191.41	869.50
	35-39	1253.91	915.14
	40-44	1347.19	983.19
	45-49	1604.30	1159.33
	50-54	1998.84	1444.44
	55-59	2483.93	1794.98
	60-64	2933.26	2119.67
	65-69	3070.96	2205.70
	70-74	3070.96	2205.70
	>74	3070.96	2205.70
Subscriber & 2 or More Dependents	<15	1120.88	798.60
	15-29	1409.87	1026.11
	30-34	1693.05	1235.61
	35-39	1781.88	1300.46
	40-44	1914.43	1397.16
	45-49	2279.80	1647.47
	50-54	2840.45	2052.62
	55-59	3529.80	2550.75
	60-64	4168.32	3012.16

	65-69	4364.00	3134.41
	70-74	4364.00	3134.41
	>74	4364.00	3134.41

[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, 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[4]
Subscriber Only	<15	319.37	257.83
	15-29	407.88	329.70
	30-34	490.61	396.67
	35-39	516.35	417.49
	40-44	554.76	448.54
	45-49	656.04	529.20
	50-54	817.38	659.35
	55-59	1015.75	819.36
	60-64	1199.49	967.57
	65-69	1250.83	1010.67
	70-74	1250.83	1010.67
	>74	1250.83	1010.67
Subscriber & 1 Dependent	<15	606.81	489.88
	15-29	774.96	626.43
	30-34	932.16	753.68
	35-39	981.07	793.23
	40-44	1054.05	852.22
	45-49	1246.48	1005.48
	50-54	1553.02	1252.77
	55-59	1929.93	1556.79
	60-64	2279.03	1838.38
	65-69	2376.57	1920.28
	70-74	2376.57	1920.28
	>74	2376.57	1920.28
Subscriber & 2 or More Dependents	<15	862.31	696.15
	15-29	1101.26	890.19
	30-34	1324.65	1071.02
	35-39	1394.16	1127.22
	40-44	1497.86	1211.05
	45-49	1771.31	1428.84
	50-54	2206.92	1780.25
	55-59	2742.54	2212.28
	60-64	3238.62	2612.43

	65-69	3377.23	2728.81
	70-74	3377.23	2728.81
	>74	3377.23	2728.81

[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[5]
Subscriber Only	<15	321.93	228.16
	15-29	411.92	291.95
	30-34	495.64	351.28
	35-39	521.65	369.71
	40-44	560.44	397.21
	45-49	660.52	468.13
	50-54	822.95	583.26
	55-59	1022.67	724.80
	60-64	1207.66	855.92
	65-69	1262.46	894.75
	70-74	1262.46	894.75
	>74	1262.46	894.75
Subscriber & 1 Dependent	<15	611.66	433.50
	15-29	782.65	554.70
	30-34	941.71	667.43
	35-39	991.13	702.45
	40-44	1064.84	754.70
	45-49	1254.99	889.46
	50-54	1563.60	1108.19
	55-59	1943.08	1377.13
	60-64	2294.56	1626.25
	65-69	2398.67	1700.03
	70-74	2398.67	1700.03
	>74	2398.67	1700.03
Subscriber & 2 or More Dependents	<15	869.20	616.03
	15-29	1112.18	788.25
	30-34	1338.21	948.45
	35-39	1408.45	998.22
	40-44	1513.20	1072.46
	45-49	1783.41	1263.96
	50-54	2221.96	1574.79
	55-59	2761.21	1956.97
	60-64	3260.69	2310.99
	65-69	3408.64	2415.83
	70-74	3408.64	2415.83
	>74	3408.64	2415.83

[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, 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[6]
Subscriber Only	<15	354.50	241.08
	15-29	450.53	307.91
	30-34	543.17	370.69
	35-39	571.68	390.14
	40-44	614.20	419.16
	45-49	718.12	492.94
	50-54	894.72	614.17
	55-59	1111.86	763.22
	60-64	1312.98	901.28
	65-69	1397.45	946.74
	70-74	1397.45	946.74
	>74	1397.45	946.74
Subscriber & 1 Dependent	<15	673.54	458.05
	15-29	856.01	585.02
	30-34	1032.03	704.31
	35-39	1086.20	741.27
	40-44	1166.97	796.40
	45-49	1364.43	936.59
	50-54	1699.97	1166.92
	55-59	2112.54	1450.12
	60-64	2494.66	1712.44
	65-69	2655.16	1798.81
	70-74	2655.16	1798.81
	>74	2655.16	1798.81
Subscriber & 2 or More Dependents	<15	957.14	650.91
	15-29	1216.44	831.35
	30-34	1466.57	1000.86
	35-39	1543.54	1053.38
	40-44	1658.33	1131.73
	45-49	1938.92	1330.94
	50-54	2415.74	1658.25
	55-59	3002.03	2060.70
	60-64	3545.05	2433.47
	65-69	3773.13	2556.20
	70-74	3773.13	2556.20
	>74	3773.13	2556.20

[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, 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, 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

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. Subscribers may choose from any plan available to them depending on where they live. **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 which begins January 1. 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 percent 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 percent 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 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 amounts for 2019 will be updated January 1, 2019. In addition, your subscriber contribution may change during the year if your birthday moves you into a new 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 birth date 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 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 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 nonsufficient 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.

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 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 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 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 February 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 the Department of Health Care Services determines that the transfer is in the best interest of the MRMIP and there is at least one participating health plan serving the subscriber's area.

Any transfer request must be in writing to:

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 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 because of end-stage renal disease. Subscribers must inform the MRMIP Enrollment Unit in writing when they become eligible for Medicare Part A and Part B. Disenrollment will be effective 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 statues or regulations of the MRMIP. In the event of fraud, the disenrollment could be retroactive to the subscriber's original effective date. Subscribers and dependents who have been disenrolled for any reason may not re-enroll in the MRMIP for a period of 12 months.

Health plan's dispute resolution/appeals

If a subscriber is dissatisfied with any action or inaction, of the plan'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.

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.

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 or a subscriber or dependent and
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 form
An evidence of coverage and disclosure form 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.

Updated MRMIP notice of privacy practices
MRMIP updated its notice of privacy practices. You can view the updated notice of privacy practices on the MRMIP website at https://www.dhcs.ca.gov/services/Documents/MRMIP/MRMIP_Privacy_Notice.pdf. For questions, please call MRMIP at 1-800-289-6574, Monday through Friday from 8:30 a.m. to 5 p.m. Pacific time.

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 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 1-800-434-0222 for free information and counseling about these rights.