



**California
Major Risk
Medical Insurance
Program
(MRMIP)**

2006 Application and Handbook

Rates effective January 1, 2006

The MRMIP is a 36-month program

The Major Risk Medical Insurance Program (MRMIP) was restructured beginning September 1, 2003 pursuant to Assembly Bill 1401, which was enacted by the California Legislature and signed by the Governor in 2002.

This law change requires MRMIP subscribers to be disenrolled after 36 months of continuous enrollment in the MRMIP. However, MRMIP subscribers will have the opportunity to enroll into guaranteed coverage that health plans are required to offer in the individual insurance market.

- The guaranteed coverage is similar to what is currently offered by the four plans participating in MRMIP, with the exception of Contra Costa Health Plan, which is not available for guaranteed coverage.
- The guaranteed coverage provides individuals a \$125,000 increase in their annual benefit limit from \$75,000 to \$200,000.
- Individuals who enroll in guaranteed coverage will begin a new lifetime benefit maximum of \$750,000.
- Guaranteed coverage premiums will increase 10% above what subscribers pay for the comparable MRMIP product.
- The State and health plans will jointly subsidize the cost of the guaranteed coverage.

MRMIP has been restructured to reduce the waiting list of applicants for MRMIP and to allow more individuals to be served with the limited funding. Individuals who transition from MRMIP into the guaranteed coverage can remain with their new individual insurance until they are eligible for Medicare Part A and Part B (unless it is due to end-stage renal disease), or obtain other health insurance.

For additional information regarding the changes to MRMIP and guaranteed coverage, you may refer to the following internet websites and toll free numbers:

Managed Risk Medical Insurance Board	www.mrmib.ca.gov	Go to Post-MRMIP Information and see Frequently Asked Questions
Department of Managed Health Care	www.hmoHELP.ca.gov	1(888) HMO-2219
Department of Insurance	www.insurance.ca.gov	1(800) 927-HELP

You may also contact the MRMIP at **1-800-289-6574**, Mon. – Fri. from 8:30 a.m. to 7:00 p.m.

California Major Risk Medical Insurance Program



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

Major Risk Enrollment Unit
(800) 289-6574

Monday – Friday
8:30 a.m. – 7:00 p.m.

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

Arnold Schwarzenegger, Governor

Board Members

Clifford Allenby, Chair
Areta Crowell, Ph.D.
Richard Figueroa
Virginia Gotlieb, M.P.H.
Sandra Hernández, M.D.

Executive Director

Lesley Cummings

Table of Contents

Introduction	2
Eligibility	2
How the Program Works	3
Description of Plans and Benefit Highlights	
Blue Cross of California	8
Blue Shield of California (HMO)	10
Contra Costa Health Plan	12
Kaiser Permanente Northern California	14
Kaiser Permanente Southern California	16
Rates	18
Enrollment Application Checklist	24
Enrollment Application	25
Frequently Asked Questions about Guaranteed Coverage	29

Americans With Disabilities Act

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

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

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

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

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

Introduction

The California Major Risk Medical Insurance Program (MRMIP) is a **36 month** program developed to provide health insurance for Californians who are unable to obtain coverage in the individual insurance market. The MRMIP is administered by a five-member Board which has established a comprehensive benefit package. Services in the MRMIP are delivered through contracts with health insurance providers. Californians qualifying for the MRMIP participate in the payment for the cost of their coverage by paying premiums on their own behalf. The MRMIP supplements those premiums to cover the cost of care. The MRMIP is funded annually by \$40 million from tobacco tax funds.

After 36 consecutive months of enrollment in MRMIP, individuals will be disenrolled and offered guaranteed coverage in the individual insurance market. All health plans currently offered in MRMIP, with the exception of Contra Costa Health Plan, will be available for guaranteed coverage. Refer to page 29 for more information about guaranteed coverage.

Eligibility

In order to be eligible for the MRMIP:

1. You must be a resident of the state of California. A resident is a person who is present in California with intent to remain in California except when absent for transitory or temporary purposes. However, a person who is absent from the state for a period greater than 210 consecutive days shall not be considered a resident.
2. You cannot be eligible for both **Part A** and **Part B** of Medicare, unless eligible solely because of end-stage

renal disease. Provide a Medicare eligibility letter with the application as proof of end-stage renal disease. (Being eligible for one part or the other is acceptable.)

3. You cannot be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. (COBRA and CalCOBRA refer to the federal and state laws giving people under certain circumstances the right to continue coverage in an employee health plan for a limited time.) If you have COBRA or CalCOBRA you may apply for deferred enrollment.
4. You must be unable to secure adequate coverage. This can be demonstrated in any of three ways:
 - If you have been denied individual coverage within the previous 12 months. A letter/copy of a letter from a health insurance carrier, health plan or health maintenance organization denying individual coverage within the last 12 months must be submitted with your complete application. Insurance denial notifications received through the internet that do not provide the reason for denial and the applicant's name will not be accepted.
 - If you have been involuntarily terminated from health insurance coverage within the previous 12 months for reasons other than nonpayment of premium or fraud. A letter/copy of a letter indicating involuntary termination from a health insurance carrier, health plan, health maintenance organization or employer for reasons other than nonpayment of premium or fraud must be submitted with your complete application.
 - If you have been offered, in the previous 12 months, an individual, not a group, health insurance

premium in excess of your Major Risk Medical Insurance Program subscriber rate. A letter/copy of a letter must be submitted with the complete application indicating that, within the last 12 months, you have been offered by a health insurance carrier, health plan or health maintenance organization, a premium for the subscriber and/or their dependents (when applicable) in excess of the MRMIP rate for the subscriber and/or their dependents.

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

Applicants Who Know They Are Currently Not Eligible But Expect To Be in the Future

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

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

If the MRMIP is not at maximum enrollment and all other eligibility criteria are met, you will be enrolled in

the MRMIP on the date that eligibility will occur. If the MRMIP is at maximum enrollment at the time you become eligible, you will be placed on a waiting list. Your place on the waiting list is determined by the date on which your complete application was received, not the date that you became eligible for the MRMIP.

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

Agents/Brokers, Employers and Applicants

Insurance Code Section 12725.5 states that it shall constitute unfair competition for an insurer, an insurance agent or broker, or administrator to refer an individual employee or their dependent(s) to apply to the MRMIP for the purpose of separating that employee or their dependent(s) from group health coverage provided in connection with the employee's employment.

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

Medi-Cal Beneficiaries

While Medi-Cal beneficiaries are not

prohibited from enrolling in the Major Risk Medical Insurance Program, a Medi-Cal beneficiary should carefully consider the cost before signing up for MRMIP coverage. MRMIP subscribers are responsible for their monthly subscriber contributions and a copayment for services, which could be more than \$5,000 per year. Medi-Cal BIC cards cannot be used for MRMIP copayments.

How the Program Works

Choosing a Health Plan

The health plans participating in the Major Risk Medical Insurance Program provide comprehensive medical benefits for inpatient and outpatient hospital and physician 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 their toll-free number and asking for an Evidence of Coverage or Certificate of Insurance booklet. Subscribers may choose from any plan available to them as listed in the enclosed subscriber contribution by county charts. **Please review all pages carefully to select a plan that is right for you.**

Benefits and Copayments

Health Maintenance Organizations (HMOs) in MRMIP require a fixed dollar copayment for some services and up to a 20% copayment for other services. The Preferred Provider Organization (PPO) in MRMIP may also require a fixed dollar copayment for certain services and up to a 15% copayment for other services.

The out-of-pocket maximum per **calendar** year for all MRMIP plans is

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

Subscriber Contributions

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

Subscriber contributions may also change when a member moves from one area of the State to another or if a member transfers to a different plan. Adjustments to subscriber contributions will occur on the first of the month following notification of the move or on the effective date of the 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 thirty (30) days prior to the due date.

Subscribers now have several billing options which include monthly, bi-monthly, and quarterly premium billing, as well as monthly checking account deduction. 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 paid to date.

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

Disenrollment for nonpayment of a subscriber contribution will take place on the 32nd day following the due date. The disenrollment will be retroactive to the paid to date, 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 rolling 12-month period. The subscriber must request reinstatement in writing within 60 calendar days of the date of disenrollment and bring all delinquent payments up to date. Any further reinstatements will require a written appeal to the Managed Risk Medical Insurance Board.

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

Subscriber contribution checks and electronic withdrawals that are returned for non-payment by the subscriber's bank for insufficient funds may result in a disenrollment back to the paid to date. The subscriber will be charged a returned item processing fee. In

addition, electronic withdrawals that are returned unpaid from the subscriber's bank will result in removal from electronic withdrawal and require immediate payment by check or money order. Upon written request to reinstate, the subscriber must include a check or money order of subscriber contributions to bring the account to current status with an additional \$25.00 returned item processing fee. Subscribers with two checks returned for insufficient funds during a rolling 12-month period will not be reinstated.

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

Pre-Existing Condition Exclusion Period

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

For individuals enrolled in a Preferred Provider Organization (PPO), there is a pre-existing condition exclusion period of 3 months. During this period, no benefits or services related to a pre-existing condition are covered.

Subscriber contributions are paid during this period.

Post-Enrollment Waiting Period

For individuals enrolled in a Health Maintenance Organization (HMO), there is a post-enrollment waiting period of 3 months. Subscribers and enrolled dependent(s), if any, will not be eligible for health care services during this period. Subscribers will be informed of when this period begins and ends.

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

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

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

1. The subscriber and enrolled dependent(s), if any, 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 dependent(s), if any, were insured by another health insurance policy (including Medicare and Medi-Cal) and the application for enrollment in the MRMIP was made within 63 days following the termination of that coverage. In these circumstances, you may be granted a waiver up to three months. If the coverage was less than 3 months but was at least 1 month, the subscriber and enrolled dependent(s), if any, will be given credit for either 1 or 2 months toward their MRMIP exclusion/waiting period.
3. The subscriber or enrolled dependent(s), if any, were insured by another health insurance policy that ended because of a loss of

employment, or because your employer stopped offering or sponsoring health coverage, or because your employer stopped making contributions towards health coverage and application for enrollment in the MRMIP was made within 180 days following the termination of that coverage. In these circumstances you may be granted a waiver of up to 3 months.

4. The subscriber and enrolled dependent(s), if any, 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.

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

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

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

Dependent Coverage Information

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

A dependent also includes any unmarried child who is economically dependent upon the applicant. An unmarried child over 23 years old may be covered if that unmarried child is incapable of self-support because of physical or mental

disability which occurred before the age of 23. An applicant must provide documentation in the form of doctors' records which show that the dependent child cannot work for a living because of a physical or mental disability which existed before the child became 23.

2. It is the responsibility of subscribers to notify the MRMIP about changes in the number of dependents. Coverage for newborn children shall begin upon birth if the request is made within 60 days of birth. Stepchildren are eligible for MRMIP dependent coverage upon marriage by a subscriber to the stepchildren's parent or at the time the stepchild loses other health coverage. The domestic partner's children are eligible for MRMIP dependent coverage upon the parent being a registered domestic partner with the subscriber or at the time the children lose other health coverage. In all cases, the MRMIP must be notified within 60 days. If eligible, dependents are covered within 90 days of the MRMIP being notified. Dependents age 18 and under qualify for a full pre-existing or post-enrollment waiver. To add a dependent to your policy, you may request an "Add Dependent" application by calling (800) 289-6574 and talking to a MRMIP Enrollment Unit representative.
3. Enrolled dependents of a deceased subscriber or dependents of a subscriber who becomes eligible for Medicare (Parts A and B) are eligible to continue coverage in the MRMIP for 36 consecutive months 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 of a complete application. Any time spent solely on the waiting list does not count toward the 3 month pre-existing condition exclusion period or post-enrollment waiting period (once enrolled) unless the person has been on the waiting list for at least 180 days. If the person has been on the waiting list 180 days or longer, the 3 month exclusion period will be waived.

Transfer of Enrollment

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

1. The subscriber so requests, in writing, during the program's open enrollment period which is held in November. Subscribers will receive an open enrollment packet containing the plan choices and the new rates.
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.
3. The subscriber or participating health plan requests a transfer in writing because of the failure to establish a satisfactory subscriber/plan relationship and the Executive Director determines that the transfer is in the best interest of the MRMIP.

Any transfer request must be in writing and mailed to:

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

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

Disenrollment

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

1. The subscriber and/or enrolled dependent(s) has been enrolled in MRMIP for 36 consecutive months. The disenrollment will be effective at the end of the 36th month of enrollment.
2. The subscriber so requests in writing. Disenrollment will be effective at the end of the month in which the request was received or as of the last paid date.
3. The subscriber fails to make subscriber contributions in accordance with the MRMIP's existing subscriber contribution payment and grace period practices. 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.
4. The subscriber fails to meet the residency requirement or becomes eligible for Part A and B of Medicare unless eligible solely because of end-stage renal disease. Subscribers must inform the MRMIP Enrollment Unit in writing when eligible for both Part A and Part B of Medicare. Disenrollment will be effective at the end of the month in which the notification was received or as of the last paid date.
5. The subscriber or enrolled dependent(s) has committed an act of fraud to circumvent the statutes or regulations of the MRMIP. In the event of fraud, the disenrollment

could be retroactive to the original effective date.

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

Health Plan's Dispute Resolution/Appeals

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

Binding Arbitration

Binding arbitration is an agreement between some insurance plans and subscribers to have health care disputes reviewed by a neutral person. After reviewing all the facts and hearing both sides, the neutral person makes a decision. Both parties agree to accept the decision.

Does the plan require its members to use Binding Arbitration to resolve disputes?

Blue Cross of California: Yes

Blue Shield HMO: No

Contra Costa Health Plan: No

Kaiser Permanente: Yes (includes medical and hospital malpractice)

The Managed Risk Medical Insurance Board (MRMIB) Appeals Process

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

This is a state program and the subscriber's rights and obligations will be determined under Part 6.5 Division 2 of the California Insurance Code and the regulation of Title 10, Chapter 5.5. Subscribers may file an appeal with the Board over (1) any action or failure to act

which has occurred in connection with participating health plan/organization coverage, (2) determination of an applicant's or dependent's eligibility, (3) determination to disenroll a subscriber or dependent, and (4) determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan. An appeal must be filed in writing and mailed within sixty (60) calendar days of the action or failure to act or receipt of notice of the decision being appealed to:

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

Evidence of Coverage and Disclosure Forms

Evidence of Coverage and Disclosure Forms 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.

Guaranteed Coverage after MRMIP

After 36 consecutive months of enrollment subscribers and enrolled dependents will be disenrolled from MRMIP and may enroll into guaranteed coverage that health plans will be required to offer in the individual insurance market. MRMIP will provide individuals with additional information approximately 3 months before their 36th month of enrollment.

The health plan benefit coverage will be similar to what is currently offered by the four plans participating in MRMIP, with the exception of Contra Costa Health Plan which will not be available for guaranteed coverage. The guaranteed coverage will provide individuals a \$125,000 increase in their annual benefit limit from \$75,000 to \$200,000. Individuals will begin a new lifetime benefit of \$750,000.

Premiums will increase 10% above what subscribers pay for the comparable MRMIP product. The State and health plans will jointly subsidize the cost of the guaranteed coverage.

Privacy Notification

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

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

program and for necessary purposes authorized by law.

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

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

Your Rights Regarding How Your Personal Information Is Used

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

MRMIP may revise the privacy practices described here. The Program will notify its subscribers in updated program handbooks or through direct mailed notices (within 60 days) of such revisions. You may complain to the MRMIP if you believe your privacy rights have been violated by contacting:

*Privacy Officer
MRMIP*

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

Open Enrollment Period for Under Age 65 Disabled Medicare Beneficiaries

You are ineligible for coverage through the Major Risk Medical Insurance Program (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 obligated to inform the program 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 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 a recent state law. You may call the HICAP program at 1-800-434-0222 for free information and counseling about these rights.

Blue Cross of California Preferred Provider Organization (PPO) (formerly known as Prudent Buyer) Administered by



(800) 289-6574

Plan Highlights

No annual deductibles!

Just your co-payment up front with no paperwork for medical and prescription expenses!

*Customer service hours for faster service.
8:30 am – 7:00 pm (pacific time)
Monday – Friday*

Blue Cross of California offers you our Preferred Provider Organization (PPO) Plan. It covers your medical and prescription expenses from your initial visit so you never have to pay a deductible. Our PPO plan offers you **more freedom than an HMO in choosing doctors, hospitals, and other medical providers.** It provides comprehensive health care coverage that is convenient and in tune with your needs, such as:

- **No annual deductible!**
- **Extensive provider network** comprising more than 40,000 PPO physicians, 29,000 HMO physicians and over 400 hospitals.
- **\$25 office visit** co-payment in-network.
- **Prescription drug coverage** including pharmacy and mail order service—with no deductible.
- **30–60% savings** when you use our in-network providers.
- **No claim forms** when you use our in-network providers.
- **Yearly maximum co-payment limit** in-network:
 - \$2,500 per subscriber.
 - \$4,000 per family.
- **\$75,000 annual maximum** for benefits paid.
- **\$750,000 lifetime maximum** for benefits paid.

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

- **No annual drug deductible!**
- **Lower cost:** Blue Cross has negotiated discounts with almost 90% of California retail pharmacies, including all of the major chain drugstores. You may choose any pharmacy, but your costs are much lower if you stay in the network.
- **Service:** Network pharmacies are supported by an on-line electronic network and will collect your co-payment when you pick up your prescription. **No claim forms to file!**
- **High value mail order program:** For many maintenance drugs, you can order up to a 60-day supply. There are no claim forms and **only a \$5 co-payment** per generic prescription.

Advantages of Plan Providers

Access to one of the largest provider networks in California.

The Blue Cross Preferred Provider Organization (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 providers ensures maximum member savings.

Benefits are still available out-of-network.

You can go outside the network and still receive benefits. You will pay a much greater share of the cost when you use a non-participating provider as you will be responsible for a larger co-payment and any charges which exceed the fee schedule.

Blue Cross contracts with most hospitals in California. However, benefits are not provided for care furnished by the few hospitals without any Blue Cross agreement except in a medical emergency.

How the Plan Works

Quality Medical Service at Discounted Rates

Blue Cross has found a way to control escalating medical expenses for subscribers. 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 Blue Cross members a discount for care.

With no deductibles, members pay only a \$25 co-payment for office visits to the in-network doctor of their choice. Blue Cross pays the rest. For most other in-network services, Blue Cross pays 85% of the discounted rate. Once you reach your yearly maximum co-payment limit, Blue Cross pays 100% of the cost for in-network covered services for the rest of the year.

Blue Cross has been helping Californians get healthy and stay healthy for over 65 years.

Important Information

If you would like more information prior to enrollment, please call **Blue Cross Customer Service at (800) 289-6574.**

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

Blue Cross of California

Summary of Benefits

Type of Service	Description of Service	What You Pay	
		Participating Provider	Non-Participating Provider
Calendar Year Deductible	There is no deductible	0	0
Co-payment	Member's amount due and payable to the provider of care	See Below	See Below
Yearly Maximum Co-Payment Limit	Member's annual maximum co-payment limit when using participating providers If non-participating providers are used, billed charges which exceed the customary and reasonable charges are the member's responsibility and do not apply to the yearly maximum co-payment limit	\$2,500 per member \$4,000 per family	No yearly maximum co-payment limit for non-participating providers. You pay unlimited co-payments
Annual Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$75,000 in one calendar year for a member		
Lifetime Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$750,000 in a lifetime for a member		
Hospital Services	Inpatient medical services (semi-private room) Outpatient services; ambulatory surgical centers (No benefits are provided in a non contracting hospital or non contracting dialysis treatment center in California, except in the case of a medical emergency)	15% of negotiated fee rate 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
Inpatient Professional Services	Services of a physician for medically necessary services	15% of negotiated fee rate	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 mail service prescription drug program (PrecisionRx) \$15 for brand drugs through mail service prescription drug program (PrecisionRx)	All charges except 50% of drug limited fee schedule for generic or brand name drugs
Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy and Maternity Care	Inpatient normal delivery and complications of pregnancy Prenatal & 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 Services*	<ul style="list-style-type: none"> Inpatient nervous and mental services 10 days each calendar year Outpatient nervous and mental visits 15 visits each calendar year Except for severe mental illnesses, and serious emotional disturbances in children 	15% of negotiated fee rate and all costs for stays over 10 days 15% of negotiated fee rate for 15 visits per year. All costs for over 15 visits	All charges except for \$175 per day up to 10 days. In addition, all costs for stays over 10 days 50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits
Home Health Care	Home health services through a home health agency or visiting nurse association.	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for members who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	Skilled nursing care	Not covered unless Blue Cross recommends as a medically appropriate more cost-effective alternative plan of treatment	
Infusion Therapy*	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	You pay all charges in excess of \$500 per day for all infusion therapy related administrative, professional, and drugs
Physical/Occupational/Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis.	15% of negotiated fee rate	You pay all charges except for \$25 per visit

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

With more than 60 years of health care experience and a history of financial stability, Blue Shield has earned a reputation of trust and dependability throughout California.

Access + HMO



(800) 424-6521

Plan Highlights

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

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

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

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

Plan Providers

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

You and each covered family member may choose his or her own Personal Physician from our extensive provider

network. Plus, you may change Personal Physicians for any reason at any time simply by calling Blue Shield Member Services.

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

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

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

How the Plan Works

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

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

Always call your Personal Physician when you need medical care, unless you

are using the *Access + Specialist* option. Your Personal Physician or his or her designee is available 24 hours a day, seven days a week.

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

Copayments

The maximum amount you pay in co-payments is \$2,500 per individual and \$4,000 per family in a calendar year.

Important Information

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

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

Blue Shield Access + HMO

Summary of Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What You Pay</i>
Calendar Year Deductible	The amount that you must pay before Blue Shield assumes liability for the remaining cost of covered services	No deductible
Co-payment	Your cost of covered services	See specific service
Out-of-Pocket Maximum	The amount you are responsible for paying per calendar year	\$2,500 (per covered person) \$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	<ul style="list-style-type: none"> Inpatient services, including semi-private room & board, general nursing care, and drugs 	\$200 co-pay per inpatient day
Physician Care	<ul style="list-style-type: none"> Office visits, specialist visits Home visits by Plan Physicians Allergy testing Routine physical examinations, hearing and vision tests Immunizations 	\$15 co-pay per office visit Access + \$30 co-pay per office visit \$25 per visit No charge No charge No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	No charge
Outpatient Prescription Drugs (Closed Formulary)	Medically necessary drugs prescribed by physician and obtained at a Plan pharmacy, according to Formulary guidelines	\$10 generic/\$10 generic mail order \$15 brand/\$20 brand mail order
Durable Medical Equipment, Supplies, Prosthetic Devices and Braces	Home medical equipment, oxygen and its administration, and home colostomy and ostomy supplies that meet the member's medical needs and are cost effective, prostheses, and orthoses. (Routine maintenance and repair due to damage are not covered, and HMO rental charges in excess of purchase price are not covered.)	20% co-pay of allowed charges
Maternity Care	Prenatal & postnatal care Normal delivery, complications of pregnancy, C-section	\$15 co-pay per office visit \$200 co-pay per inpatient day
Ambulance	Ground transportation as medically necessary	No charge
Emergency Care Services	Plan and non-plan emergency room visits	\$25 co-pay per visit, waived if directly admitted (Hospitalization co-pays apply)
Mental Health Care	Mental health services <ul style="list-style-type: none"> Inpatient nervous and mental services 10 days each calendar year Outpatient nervous and mental services up to 15 visits per calendar year Except for severe mental illnesses, and serious emotional disturbances in children	\$200 co-pay per inpatient day \$15 co-pay per visit
Home Health Care	Medically necessary visits by home health personnel	\$10 per visit
Hospice Care	Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less	\$50 per day
Skilled Nursing Services	As medically necessary in lieu of hospitalization. Up to 100 days per calendar year Custodial care is not covered	\$50 per day
Speech/Physical/Occupational Therapy	Rehabilitative therapy services by a physical, occupational, respiratory or speech therapist in the following settings: <ul style="list-style-type: none"> In the rehabilitation unit of a hospital or skilled nursing facility for medically necessary days For services in the office 	\$50 per day \$15 co-pay per visit
Other	Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing and in-hospital blood processing)	No charge

Access + HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access + HMO specialist, and must be received while the patient is a current member. All care must be prescribed by and received from a Blue Shield Access + HMO physician or a physician to whom a Blue Shield HMO physician has referred you to for specific care. Payments for care that is not covered do not count toward your out-of-pocket maximum. Please read the Evidence of Coverage booklet for complete details of coverage.



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

Member Call Center
1-(877) 661-6230

Plan Highlights

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

Our members appreciate

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

Plan Providers

When you select CCHP for yourself and your family, you are gaining access to over 150 Primary Care Physicians and over 300 Specialist doctors. CCHP offers a choice of two "provider networks": One, our Health Center Network, offers primary care and access to specialty care through eight Health Centers and at the newest hospital in the East Bay, the Contra Costa Regional Medical Center in Martinez.

You would simply select the Health Center most conveniently located for you, and your doctor there will make sure you get all the preventive care, routine care, and referrals for specialty care that you need. The Regional Medical Center and local health centers are affiliated with the University of California Medical School at Davis, so you can be assured that you are getting the best medical care available.

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

How the Plan Works

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

When you join the Contra Costa Health Plan, we encourage you to call our Member Services Department. Our friendly Member Services Representatives will take as much time as you need to help with selecting your Primary Care Physician, and with any other questions you may have about how to access your plan services. You can change primary care doctors at any time, by calling Member Services and choosing another doctor from the physician network you have selected.

The 24-hour Advice Nurses are available to members every day of the year. Advice Nurses offer confidential and professional health advice, and important information about prenatal care services.

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

Your Copayments and Prescription Coverage

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

The maximum amount of co-payments you will pay is \$2,500 per person, or \$4,000 per family, in any calendar year.

Maximum Benefits

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

Important Information

To learn more about Contra Costa Health Plan's MRMIP, call our Marketing Department at 1-(800) 221-8040 (press 5).

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

Contra Costa Health Plan

Summary of Benefits

Type of Service	Description of Service	What You Pay Contra Costa Health Plan Provider
Calendar Year Deductible	There is no deductible	-0-
Co-payment	Your out-of-pocket expense for the cost of authorized and covered expenses	Inpatient medical \$200/day Inpatient psychiatric \$200/day Inpatient maternity \$200/day Outpatient ER \$25/visit Outpatient visits \$15/visit
Out-of-pocket Maximum	The annual maximum out-of-pocket expense you're responsible for (excluding unauthorized or non-covered services)	\$2,500 (per covered person) \$4,000 (per family)
Annual Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$75,000 in one calendar year for a member	
Lifetime Benefit Maximum	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches \$750,000 in a lifetime for a member	
Hospital Services	Semi-private room & board, and all medically necessary inpatient services and supplies including inpatient visits by physicians	\$200/day
Physician Care	Medical and surgical outpatient services performed or authorized by Contra Costa Health Plan provider	Office visits \$15/visit Well baby \$15/visit Physical exams \$15/visit
Diagnostic X-ray and Lab Tests	Inpatient and outpatient diagnostic X-ray and laboratory	-0-
Prescription Drugs	Drugs prescribed by a physician	20% of the cost of prescription obtained at Plan-authorized pharmacies
Durable Medical Equipment & Supplies	Purchase or rental as authorized by Contra Costa Health Plan and required for care of an illness or injury	-0-
Maternity Care	Treated as any other medical condition: Inpatient Outpatient	\$200/day \$15/visit
Ambulance	Ambulance service when required for an emergency or approved by a Contra Costa Health Plan physician	\$15 copay
Emergency Care Services	Services in an emergency room for emergency care only – non-emergency care not covered	\$25/visit
Mental Health Care	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Limitations do not apply to severe mental illnesses or serious emotional disturbances in children	\$200/day \$15/visit
Home Health Care/ Home Hospice Care	Medically necessary visits when authorized for diagnostic and treatment service and nursing care	-0-
Skilled Nursing Services	Provided only when Contra Costa Health Plan authorizes as medically necessary and more cost effective	-0-
Speech/Physical/ Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis	\$15/visit
Other	Blood and blood plasma, 24-hour Advice Nurse, member services, health education, and case management	-0-

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



KAISER PERMANENTE®

Northern California

(800) 464-4000

Plan Highlights

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

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

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

Plan Providers

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

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

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

Kaiser Permanente is available in the following Northern California counties:

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

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

How the Plan Works

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

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

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

Co-payments

The maximum amount you pay in co-payments is \$2,500 per individual and \$4,000 per family in a calendar year.

Important Information

For more information about the Northern California Kaiser Permanente MRMIP Plan, please call our Member Service Call Center at (800) 464-4000.

Please note that the information presented on these pages is only a summary of the Kaiser Permanente MRMIP Plan for Northern California. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.

Kaiser Permanente Northern California

Summary of Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What You Pay</i>
Calendar Year Deductible	The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services	No deductible
Co-payment	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 co-pay per inpatient day
Physician Care	Primary and specialty care visits Allergy injections Routine physical examinations; hearing and vision tests Immunizations	\$20 co-pay per office visit \$3 co-pay per injection \$20 co-pay per office visit No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	\$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, Prosthetic Devices and Braces	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
Maternity Care	Prenatal and postnatal care Inpatient care, complications of pregnancy, C-section	\$15 co-pay per office visit \$200 co-pay per inpatient day
Ambulance	Ambulance services	\$75 per trip
Emergency Care Services	Emergency department visits	\$100 co-pay per incident (waived if admitted and hospitalization co-pays apply)
Mental Health Care	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Day and visit limits do not apply to severe mental illnesses and serious emotional disturbances in children	\$200 co-pay per inpatient day \$20 co-pay 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 co-pay per visit No charge

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

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



KAISER PERMANENTE®

Southern California

(800) 464-4000

Plan Highlights

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

Convenient Care

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

Broad-based Care

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

A Plan That's Easy to Use

- You do not need to file claim forms for services received at Kaiser Permanente facilities.
- When you present your Kaiser card at one of our Health Plan facilities, our computerized registration system will identify your benefits and co-payments 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 are available from Kaiser Permanente 24 hours a day, 7 days a week.

How the Plan Works

- **Always carry your Kaiser Permanente ID Card.** It has important information which will assist you in making appointments and utilizing services. You can make an appointment by calling one of our convenient appointment centers.
- **Laboratories, X-ray services, and pharmacies** – These are located at each medical center (many pharmacies are open 24 hours).
- **Urgent care** is available on a walk-in basis at each Medical Center. Medical advice by phone and emergency services are available 24 hours a day, seven days a week.

- **Referrals to specialists** – As a group practice, our physicians can easily refer you to a specialist within your service area, at another Kaiser Permanente service area.
- **Co-payments** – The maximum co-payments you pay in a calendar year are \$2,500 per individual and/or \$4,000 per family.

Important Information

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

Kaiser Permanente Southern California

Summary of Benefits

<i>Type of Service</i>	<i>Description of Service</i>	<i>What You Pay</i>
Calendar Year Deductible	The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services	No deductible
Co-payment	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 co-pay per inpatient day
Physician Care	Primary and specialty care visits Allergy injections Routine physical examinations, hearing and vision tests Immunizations	\$20 co-pay per office visit \$3 co-pay per injection \$20 co-pay per office visit No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	\$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, Prosthetic Devices and Braces	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
Maternity Care	Prenatal and postnatal care Inpatient care, complications of pregnancy, C-section	\$15 co-pay per office visit \$200 co-pay per inpatient day
Ambulance	Ambulance Services	\$75 per trip
Emergency Care Services	Emergency department visits	\$100 co-pay per incident (waived if admitted and hospitalization co-pays apply)
Mental Health Care	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Day and visit limits do not apply to severe mental illnesses and serious emotional disturbances in children	\$200 co-pay per inpatient day \$20 co-pay 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 co-pay per visit No charge

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

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

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 1

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

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO ¹	KPNC ²
Subscriber Only	<15	\$205.00	\$587.50	\$176.52
	15-29	\$260.00	\$587.50	\$214.27
	30-34	\$363.75	\$736.71	\$265.90
	35-39	\$411.25	\$782.07	\$294.03
	40-44	\$515.00	\$847.40	\$347.30
	45-49	\$601.25	\$929.05	\$382.88
	50-54	\$755.00	\$1,016.15	\$457.02
	55-59	\$932.50	\$1,255.67	\$559.16
	60-64	\$1,043.75	\$1,614.95	\$602.46
	65-69	\$1,168.75	\$1,989.62	\$691.24
	70-74	\$1,231.25	\$2,394.97	\$730.33
>74	\$1,303.75	\$2,832.63	\$773.63	
Subscriber & 1 Dependent	<15	\$406.25	\$1,143.17	\$408.32
	15-29	\$716.25	\$1,143.17	\$399.69
	30-34	\$861.25	\$1,433.50	\$466.35
	35-39	\$966.25	\$1,527.85	\$505.33
	40-44	\$1,050.00	\$1,656.69	\$592.38
	45-49	\$1,203.75	\$1,810.92	\$664.18
	50-54	\$1,490.00	\$1,983.31	\$797.53
	55-59	\$1,795.00	\$2,449.65	\$970.23
	60-64	\$2,002.50	\$3,150.06	\$1,066.29
	65-69	\$2,242.50	\$3,880.88	\$1,218.29
	70-74	\$2,363.75	\$4,671.54	\$1,288.69
>74	\$2,503.75	\$5,525.21	\$1,370.30	
Subscriber & 2 or More Dependents	<15	\$595.00	\$1,776.45	\$678.40
	15-29	\$1,035.00	\$1,776.45	\$664.04
	30-34	\$1,230.00	\$2,170.21	\$740.42
	35-39	\$1,342.50	\$2,335.33	\$820.17
	40-44	\$1,462.50	\$2,464.16	\$947.66
	45-49	\$1,628.75	\$2,545.82	\$1,028.64
	50-54	\$1,907.50	\$2,582.11	\$1,155.76
	55-59	\$2,261.25	\$2,905.10	\$1,320.95
	60-64	\$2,466.25	\$3,540.19	\$1,376.86
	65-69	\$2,761.25	\$4,361.52	\$1,572.59
	70-74	\$2,910.00	\$5,250.11	\$1,667.66
>74	\$3,082.50	\$6,209.50	\$1,769.76	

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

² Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Amador—95640 and 95669;
El Dorado—95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, and 95762;
Kings—93230, 93232, 93242, 93631, and 93656;
Placer—95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, and 95765;
Sutter—95645, 95692, 95659, 95668, 95674, 95676, and 95837;
Tulare—93618, 93238, 93261, 93646, 93654, 93666, and 93673;
Yolo—95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, and 95798-99;
Yuba—95692, 95903, and 95961.

BC = Blue Cross
 BS HMO = Blue Shield HMO
 KPNC = Kaiser Permanente Northern California

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 2

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

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO ³	KPNC ⁴
Subscriber Only	<15	\$192.50	\$560.33	\$176.39
	15-29	\$250.00	\$560.33	\$214.31
	30-34	\$342.50	\$700.42	\$257.21
	35-39	\$388.75	\$743.97	\$293.40
	40-44	\$482.50	\$805.66	\$348.56
	45-49	\$561.25	\$881.87	\$390.07
	50-54	\$711.25	\$965.34	\$470.28
	55-59	\$888.75	\$1,192.16	\$575.74
	60-64	\$985.00	\$1,533.30	\$605.44
	65-69	\$1,102.50	\$1,889.02	\$690.35
	70-74	\$1,162.50	\$2,273.88	\$729.44
	>74	\$1,231.25	\$2,689.40	\$774.83
Subscriber & 1 Dependent	<15	\$397.50	\$1,088.73	\$407.96
	15-29	\$683.75	\$1,088.73	\$399.71
	30-34	\$821.25	\$1,360.91	\$454.99
	35-39	\$923.75	\$1,451.64	\$501.28
	40-44	\$1,005.00	\$1,571.40	\$591.39
	45-49	\$1,155.00	\$1,716.57	\$678.23
	50-54	\$1,426.25	\$1,881.69	\$820.74
	55-59	\$1,706.25	\$2,322.63	\$1,007.24
	60-64	\$1,912.50	\$2,988.57	\$1,071.40
	65-69	\$2,141.25	\$3,681.92	\$1,224.31
	70-74	\$2,256.25	\$4,432.05	\$1,292.91
	>74	\$2,390.00	\$5,241.95	\$1,369.03
Subscriber & 2 or More Dependents	<15	\$578.75	\$1,687.53	\$692.64
	15-29	\$1,000.00	\$1,687.53	\$678.67
	30-34	\$1,188.75	\$2,057.70	\$787.46
	35-39	\$1,296.25	\$2,217.38	\$806.22
	40-44	\$1,381.25	\$2,338.96	\$938.22
	45-49	\$1,547.50	\$2,420.61	\$997.11
	50-54	\$1,813.75	\$2,451.46	\$1,161.46
	55-59	\$2,155.00	\$2,759.93	\$1,383.02
	60-64	\$2,365.00	\$3,364.18	\$1,391.67
	65-69	\$2,648.75	\$4,144.67	\$1,590.90
	70-74	\$2,791.25	\$4,989.08	\$1,683.29
	>74	\$2,956.25	\$5,900.77	\$1,782.99

3 Blue Shield HMO available **only** to residents in these zip codes in these counties:

Fresno—All zip codes;
Kern—93203, 93205-6, 93215-6, 93220, 93222, 93224-6, 93238, 93240-1, 93243, 93249-52, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301-9, 93311-4, 93380-90, 93501-2, 93504-5, 93516, 93518, 93519, 93524, 93531, 93560-1, 93570, 93581, 93596.
Sacramento, San Joaquin, Solano, Sonoma and Stanislaus—All zip codes.

4 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:

Fresno—93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, and 93888;
Madera—93601, 93602, 93604, 93614, 93623, 93626, 93637-39, 93643-45, 93653, 93669, and 93720;
Mariposa—93601, 93623, and 93653;
Napa—94503, 94508, 94515, 94558-59, 94562, 94567 (except the community of Knoxville), 94573-74, 94576, 94581, 94589-90, 94599, and 95476;
Sacramento, San Joaquin, and Solano—All zip codes;
Sonoma—94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 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.

BC = Blue Cross

BS HMO = Blue Shield HMO

KPNC = Kaiser Permanente Northern California

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 3

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

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO	CC ⁵	KPNC ⁶
Subscriber Only	<15	\$190.00	\$541.02	\$160.24	\$174.90
	15-29	\$250.00	\$541.02	\$203.83	\$214.65
	30-34	\$336.25	\$680.46	\$296.15	\$257.95
	35-39	\$383.75	\$727.64	\$296.15	\$291.94
	40-44	\$483.75	\$787.52	\$341.15	\$347.30
	45-49	\$557.50	\$858.28	\$341.15	\$381.05
	50-54	\$707.50	\$939.94	\$455.50	\$463.80
	55-59	\$883.75	\$1,164.94	\$455.50	\$571.92
	60-64	\$971.25	\$1,493.38	\$575.45	\$591.54
	65-69	\$1,087.50	\$1,839.84	\$772.25	\$674.23
	70-74	\$1,145.00	\$2,214.68	\$772.25	\$712.95
>74	\$1,212.50	\$2,619.38	\$772.25	\$754.50	
Subscriber & 1 Dependent	<15	\$400.00	\$1,056.07	\$395.50	\$404.53
	15-29	\$686.25	\$1,056.07	\$395.50	\$394.01
	30-34	\$816.25	\$1,328.25	\$524.84	\$467.42
	35-39	\$918.75	\$1,413.54	\$524.84	\$503.91
	40-44	\$1,007.50	\$1,533.30	\$648.55	\$594.04
	45-49	\$1,157.50	\$1,673.02	\$648.55	\$665.60
	50-54	\$1,430.00	\$1,836.33	\$888.48	\$812.65
	55-59	\$1,707.50	\$2,268.19	\$888.48	\$1,002.18
	60-64	\$1,918.75	\$2,915.99	\$1,147.15	\$1,044.96
	65-69	\$2,148.75	\$3,592.50	\$1,505.17	\$1,193.35
	70-74	\$2,265.00	\$4,324.41	\$1,505.17	\$1,261.27
>74	\$2,398.75	\$5,114.64	\$1,505.17	\$1,335.98	
Subscriber & 2 or More Dependents	<15	\$585.00	\$1,645.80	\$729.15	\$674.00
	15-29	\$1,007.50	\$1,645.80	\$729.15	\$656.48
	30-34	\$1,201.25	\$2,006.90	\$806.00	\$782.13
	35-39	\$1,313.75	\$2,164.76	\$806.00	\$809.70
	40-44	\$1,391.25	\$2,282.71	\$959.71	\$945.62
	45-49	\$1,560.00	\$2,358.92	\$959.71	\$1,026.07
	50-54	\$1,825.00	\$2,391.58	\$1,098.42	\$1,161.41
	55-59	\$2,162.50	\$2,694.61	\$1,098.42	\$1,328.37
	60-64	\$2,391.25	\$3,280.71	\$1,332.72	\$1,351.32
	65-69	\$2,678.75	\$4,041.84	\$1,784.46	\$1,498.50
	70-74	\$2,822.50	\$4,865.30	\$1,784.46	\$1,632.37
>74	\$2,990.00	\$5,754.37	\$1,784.46	\$1,730.40	

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

6 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, 94085-90, 94301-06, 94309-10, 94550, 95002, 95008-09, 95011, 95013-15, 95020, 95021, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, and 95196.

BC = Blue Cross

BS HMO = Blue Shield HMO

CC = Contra Costa Health Plan

KPNC = Kaiser Permanente Northern California

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 4

Counties: Orange, Santa Barbara, Ventura.

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO	KPSC ⁷
Subscriber Only	<15	\$216.25	\$406.09	\$171.60
	15-29	\$256.25	\$406.09	\$187.51
	30-34	\$355.00	\$508.07	\$246.67
	35-39	\$415.00	\$544.37	\$282.67
	40-44	\$507.50	\$589.73	\$325.45
	45-49	\$605.00	\$644.17	\$378.06
	50-54	\$748.75	\$707.68	\$461.17
	55-59	\$931.25	\$869.17	\$539.90
	60-64	\$1,033.75	\$1,121.39	\$581.38
	65-69	\$1,157.50	\$1,381.56	\$662.62
	70-74	\$1,220.00	\$1,663.03	\$699.60
	>74	\$1,292.50	\$1,966.92	\$741.86
Subscriber & 1 Dependent	<15	\$441.25	\$794.77	\$300.29
	15-29	\$717.50	\$794.77	\$354.39
	30-34	\$867.50	\$994.37	\$452.68
	35-39	\$961.25	\$1,061.51	\$516.09
	40-44	\$1,055.00	\$1,150.43	\$593.04
	45-49	\$1,220.00	\$1,252.04	\$684.62
	50-54	\$1,490.00	\$1,373.62	\$832.20
	55-59	\$1,800.00	\$1,696.61	\$971.87
	60-64	\$2,012.50	\$2,184.72	\$1,034.77
	65-69	\$2,253.75	\$2,691.58	\$1,183.40
	70-74	\$2,375.00	\$3,239.94	\$1,250.43
	>74	\$2,515.00	\$3,832.00	\$1,325.52
Subscriber & 2 or More Dependents	<15	\$643.75	\$1,230.27	\$435.88
	15-29	\$1,085.00	\$1,230.27	\$552.20
	30-34	\$1,291.25	\$1,504.26	\$667.65
	35-39	\$1,378.75	\$1,622.21	\$749.51
	40-44	\$1,472.50	\$1,705.68	\$860.60
	45-49	\$1,650.00	\$1,765.56	\$958.46
	50-54	\$1,932.50	\$1,789.15	\$1,102.64
	55-59	\$2,315.00	\$2,014.15	\$1,238.46
	60-64	\$2,528.75	\$2,455.09	\$1,271.24
	65-69	\$2,832.50	\$3,024.67	\$1,451.58
	70-74	\$2,983.75	\$3,640.90	\$1,534.72
	>74	\$3,161.25	\$4,306.23	\$1,630.75

⁷ Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
Orange—All zip codes;
Ventura—90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93010-12, 93015-16, 93020-21, 93040, 93062-66, 93093, 93094, and 93099.

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 5

County: Los Angeles.

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO ⁸	KPSC ⁹
Subscriber Only	<15	\$223.75	\$331.68	\$170.86
	15-29	\$275.00	\$331.68	\$187.14
	30-34	\$380.00	\$415.53	\$237.72
	35-39	\$452.50	\$442.75	\$276.00
	40-44	\$545.00	\$479.04	\$331.72
	45-49	\$640.00	\$526.22	\$382.24
	50-54	\$796.25	\$577.03	\$458.39
	55-59	\$991.25	\$709.49	\$533.85
	60-64	\$1,111.25	\$910.91	\$579.70
	65-69	\$1,245.00	\$1,122.24	\$656.06
	70-74	\$1,312.50	\$1,350.87	\$692.76
	>74	\$1,388.75	\$1,597.73	\$734.86
Subscriber & 1 Dependent	<15	\$450.00	\$645.98	\$295.55
	15-29	\$756.25	\$645.98	\$353.47
	30-34	\$927.50	\$809.29	\$436.99
	35-39	\$1,043.75	\$865.54	\$500.66
	40-44	\$1,146.25	\$936.31	\$593.80
	45-49	\$1,323.75	\$1,019.78	\$683.51
	50-54	\$1,617.50	\$1,121.39	\$825.17
	55-59	\$1,952.50	\$1,382.69	\$957.24
	60-64	\$2,167.50	\$1,778.26	\$1,039.72
	65-69	\$2,426.25	\$2,190.82	\$1,172.68
	70-74	\$2,556.25	\$2,637.16	\$1,236.43
	>74	\$2,707.50	\$3,119.07	\$1,313.55
Subscriber & 2 or More Dependents	<15	\$668.75	\$1,005.26	\$425.39
	15-29	\$1,140.00	\$1,005.26	\$571.78
	30-34	\$1,366.25	\$1,224.82	\$691.12
	35-39	\$1,500.00	\$1,319.18	\$770.97
	40-44	\$1,607.50	\$1,393.58	\$872.26
	45-49	\$1,800.00	\$1,437.13	\$955.67
	50-54	\$2,106.25	\$1,457.09	\$1,102.39
	55-59	\$2,506.25	\$1,643.98	\$1,237.95
	60-64	\$2,770.00	\$2,001.45	\$1,297.64
	65-69	\$3,102.50	\$2,465.79	\$1,465.25
	70-74	\$3,270.00	\$2,968.15	\$1,550.73
	>74	\$3,463.75	\$3,510.55	\$1,646.52

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

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

California Major Risk Medical Insurance Program

Monthly Subscriber Contributions

Area 6

Counties: Riverside, San Bernardino, San Diego.

See below for service areas and available zip codes.

Rating Group	Age	BC	BS HMO ¹⁰	KPSC ¹¹
Subscriber Only	<15	\$200.00	\$426.56	\$170.00
	15-29	\$235.00	\$426.56	\$178.93
	30-34	\$335.00	\$535.29	\$243.07
	35-39	\$398.75	\$569.77	\$287.22
	40-44	\$472.50	\$618.76	\$324.60
	45-49	\$553.75	\$673.20	\$380.31
	50-54	\$701.25	\$740.34	\$459.98
	55-59	\$867.50	\$914.53	\$540.83
	60-64	\$1,010.00	\$1,175.83	\$595.43
	65-69	\$1,132.50	\$1,448.62	\$683.19
	70-74	\$1,192.50	\$1,743.76	\$720.51
>74	\$1,262.50	\$2,062.41	\$763.69	
Subscriber & 1 Dependent	<15	\$400.00	\$832.88	\$329.81
	15-29	\$656.25	\$832.88	\$347.31
	30-34	\$813.75	\$1,045.18	\$459.91
	35-39	\$907.50	\$1,114.14	\$533.68
	40-44	\$972.50	\$1,204.86	\$593.76
	45-49	\$1,105.00	\$1,315.55	\$689.06
	50-54	\$1,380.00	\$1,442.57	\$828.37
	55-59	\$1,708.75	\$1,783.71	\$968.30
	60-64	\$1,881.25	\$2,289.97	\$1,058.83
	65-69	\$2,106.25	\$2,821.24	\$1,215.55
	70-74	\$2,220.00	\$3,396.02	\$1,283.15
>74	\$2,351.25	\$4,016.60	\$1,364.39	
Subscriber & 2 or More Dependents	<15	\$587.50	\$1,295.59	\$498.14
	15-29	\$977.50	\$1,295.59	\$619.19
	30-34	\$1,186.25	\$1,578.66	\$702.94
	35-39	\$1,277.50	\$1,702.05	\$785.70
	40-44	\$1,351.25	\$1,794.59	\$868.87
	45-49	\$1,532.50	\$1,854.47	\$983.51
	50-54	\$1,813.75	\$1,881.69	\$1,146.82
	55-59	\$2,141.25	\$2,115.77	\$1,293.22
	60-64	\$2,330.00	\$2,580.29	\$1,338.16
	65-69	\$2,610.00	\$3,178.92	\$1,539.48
	70-74	\$2,750.00	\$3,826.58	\$1,625.62
>74	\$2,912.50	\$4,525.84	\$1,728.33	

¹⁰ Blue Shield HMO available **only** in the following zip codes:

Riverside—all zip codes;

San Bernardino—91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-9, 91761-4, 91784-6, 91798, 92252, 92256, 92267-8, 92277-8, 92284-6, 92301, 92304-5, 92307-18, 92321-7, 92329, 92332-42, 92345-7, 92350, 92352, 92354, 92356-9, 92364-6, 92368-9, 92371-8, 92382, 92385-6, 92391-4, 92397-9, 92401-8, 92410-16, 92418, 92420, 92423-4, 92427, 93523, 93558, 93562, and 93592.

San Diego—91901-3, 91905-6, 91908-17, 91921, 91931-5, 91941-48, 91950-51, 91962-3, 91976-80, 91987, 91990, 92003-4, 92007-9, 92013-4, 92018-30, 92033, 92036-40, 92046, 92049, 92051-2, 92054-61, 92064-72, 92074-5, 92078-9, 92081-6, 92088, 92090-3, 92096, 92101-24, 92126-40, 92142-3, 92145, 92147, 92149-50, 92152-5, 92158-79, 92182, 92184, 92186-7, and 92190-9.

¹¹ Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:

San Bernardino—91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91766, 91784-86, 91798, 92305, 92307-8, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-8, 92410-15, 92418, 92420, 92423-24, 92427, and 92880.

San Diego—91901-3, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-9, 92011, 92013, 92014, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, and 92190-99.

Riverside—91752, 92220, 92223, 92320, 92324, 92373, 92399, 92501-9, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, and 92877-83

BC = Blue Cross

BS HMO = Blue Shield HMO

KPSC = Kaiser Permanente Southern California

Checklist for Enrollment Application

Please use the following checklist to ensure better processing of your application:

- Review** the handbook to learn about the eligibility requirements for the California Major Risk Medical Insurance Program (MRMIP) and to choose your health plan before completing the Enrollment Application.
- Complete** the Enrollment Application on pages 25-28 of this handbook. All questions must be answered in full. If you do not provide all necessary information (including the required documentation, signatures, and payments), your application will be incomplete, which will cause delays in processing your application.
- Sign and date** the completed Enrollment Application on page 28.
- Attach** the following items (your entire application may be returned to you if you do not provide the following):
 - Your **supporting documentation** that indicates your eligibility for MRMIP.
(Page 2 of this handbook describes how eligibility can be demonstrated.)
 - A **check** for one month's subscriber contribution for your chosen health plan.
Make check payable to **California Major Risk Medical Insurance Program**.
(Monthly subscriber contribution rates are listed on pages 18-23 of this handbook).
Payments that **do not equal the exact amount that is due** may delay the processing of your application.
 - Proof of Qualifying Prior Coverage**, if applicable to you, to waive all or part of your Exclusion/Waiting Period must be received prior to or with your first month's subscriber contribution for credit to be given.
(Please see page 4 of this handbook for more information.)
- Insurance Agents or Brokers:** You must complete **all** boxes at the bottom of page 25 of the Enrollment Application to request reimbursement.
- Mail** the completed Enrollment Application with your check and all necessary attachments to:

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

California Major Risk Medical Insurance Program Enrollment Application

Instructions:

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

- Read the handbook to learn about eligibility and to 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 in full. **If you do not provide all necessary information (including the required supporting documentation, signatures, and payments), your application will be incomplete, which will cause delays in processing your application or may result in a denial.**
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

Attach check to page 26 where indicated.
 Please submit one month's subscriber contribution for your chosen health plan.
 Regardless of which plan you choose, **make your check payable to California Major Risk Medical Insurance Program.**

Submit check, application and all necessary documentation to:

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

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

Agent Name		CA Agent/Broker License No.	Tax I.D. No./Soc. Sec. No.	
Street Address		I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program. <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
City	State			Zip
Phone No.	FAX No: (if available)			
		Signature		

1. Check One: New Enrollment Add Dependents **Use blue or black ink only.**

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

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

3. Applicant Information: Applicant must complete this section. (If parent or legal guardian is completing this application for the applicant, please mark this box.)

Last Name	First Name	M.I.	Social Security Number (optional)	Age	Birthdate	10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female
				Mo Day Yr		
Check One	1 <input type="checkbox"/> Single 3 <input type="checkbox"/> Widowed 2 <input type="checkbox"/> Married 4 <input type="checkbox"/> Divorced	Home Phone ()		County		
Street Address (must be completed; P.O. Box not acceptable)			Suite or Unit #	City	State	Zip
Billing Name, if different						
Billing Address, if different				City	State	Zip
Employer, if employed				Occupation	Business Phone ()	
Employer Street Address				City	State	Zip

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

10 <input type="checkbox"/> Aleut	Hispanic	Asian	Pacific Islander
11 <input type="checkbox"/> American Indian, Native American	21 <input type="checkbox"/> Cuban	41 <input type="checkbox"/> Asian Indian	61 <input type="checkbox"/> Filipino
12 <input type="checkbox"/> Black/African American	22 <input type="checkbox"/> Mexican, Mexican-American, Chicano	42 <input type="checkbox"/> Cambodian	62 <input type="checkbox"/> Guamanian
13 <input type="checkbox"/> Eskimo	23 <input type="checkbox"/> Puerto Rican	43 <input type="checkbox"/> Chinese	63 <input type="checkbox"/> Samoan
14 <input type="checkbox"/> White	92 <input type="checkbox"/> Other; please specify: <div style="border:1px solid black; width:150px; height:20px; margin-top:5px;"></div>	44 <input type="checkbox"/> Japanese	Other not listed; please specify: 99 <input type="checkbox"/> <div style="border:1px solid black; width:150px; height:20px; margin-top:5px;"></div>
		45 <input type="checkbox"/> Korean	
		46 <input type="checkbox"/> Laotian	
		47 <input type="checkbox"/> Vietnamese	
		94 <input type="checkbox"/> Other; please specify: <div style="border:1px solid black; width:150px; height:20px; margin-top:5px;"></div>	

STAPLE CHECK HERE
payable to California Major Risk Medical Insurance Program

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

30 <input type="checkbox"/> Husband 40 <input type="checkbox"/> Wife	Last Name	First Name	M.I.	Social Security Number (optional)	Age	Birthdate
						Mo Day Year
30 <input type="checkbox"/> Domestic Partner						
50 <input type="checkbox"/> Son 70 <input type="checkbox"/> Daughter			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			
51 <input type="checkbox"/> Son 71 <input type="checkbox"/> Daughter			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			
52 <input type="checkbox"/> Son 72 <input type="checkbox"/> Daughter			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			
53 <input type="checkbox"/> Son 73 <input type="checkbox"/> Daughter			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			
54 <input type="checkbox"/> Son 74 <input type="checkbox"/> Daughter			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			

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

Is this dependent child covered by Medicare? Yes No

12/05

6. Program Eligibility: To be eligible for the program you must answer “yes” to one of the first four questions. Provide a copy of any letter or formal written communication from a health plan documenting all “yes” answers.

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

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

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

8. Authorization and Conditions of Enrollment

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

Privacy Notification

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

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

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

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

I understand that if I am enrolled in certain plans, I agree to have certain claims (which may include medical malpractice disputes) decided by neutral binding arbitration. I give up my right to a jury or court trial. (Page 6 has information about each plan and the arbitration requirements. For additional information, you may call the plan you choose.)

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 this contract may have waiting periods for pre-existing conditions.

I, the applicant, certify that the information provided on this application is true and correct.

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Signature of Applicant/Parent or Legal Guardian Required	Date	Signature of Applicant's Spouse/Domestic Partner Required (If listed on this application)	Date
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date	Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date

After filling out the application, signing and securing all necessary documentation, submit with a check for one month's subscriber contribution for your chosen health plan. **Make your check payable to California Major Risk Medical Insurance Program** and mail to:

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

FAQ's

Answers to Frequently Asked Questions about Guaranteed Coverage

- 1. How was the MRMIP restructured?**
 - A.** The MRMIP was restructured beginning September 1, 2003 pursuant to Assembly Bill 1401, which was enacted by the California Legislature and signed by the Governor in 2002.

The restructuring requires MRMIP subscribers and their dependents to transition out of MRMIP after 36 consecutive months of enrollment into guaranteed coverage that health plans are required to offer in the individual insurance market. In order to access guaranteed coverage, the MRMIP subscriber must apply for enrollment into an individual insurance policy no later than 63 days after disenrollment from MRMIP and cannot be eligible for both Part A and Part B of Medicare, unless eligible solely because of end-stage renal disease.
- 2. Why have these changes been made to the MRMIP program?**
 - A.** MRMIP was restructured to reduce the applicant waiting list for MRMIP and to serve more individuals with the limited funding.
- 3. Will my benefits change under the guaranteed coverage plan?**
 - A.** The guaranteed coverage benefits are similar to what the four plans participating in MRMIP currently offer, with the exception of Contra Costa Health Plan which is unavailable for guaranteed coverage.

Under the guaranteed coverage plan the annual benefit limit is increased from \$75,000 to \$200,000 with subscribers beginning a new lifetime benefit maximum of \$750,000.
- 4. Will the new plan have prescription benefits?**
 - A.** Yes.
- 5. How much will my premiums increase?**
 - A.** Premiums will increase 10% above what subscribers pay for the comparable MRMIP product. The State and health plans are jointly subsidizing the remaining cost of the guaranteed coverage.
- 6. How long will I be able to stay on the guaranteed coverage?**
 - A.** Individuals who transition from MRMIP into the guaranteed coverage can remain with their new individual insurance until they become eligible for Medicare, or obtain other health insurance.
- 7. When will I be disenrolled from MRMIP and offered enrollment to the guaranteed coverage?**
 - A.** Your transition will occur after being enrolled for 36 consecutive months in MRMIP. 90 days prior to the completion of your 36th month, you will receive a notice regarding the transition.
- 8. Will I be able to select insurance carriers other than the carriers offered in MRMIP program for the guaranteed coverage?**
 - A.** Yes, you may select any carrier in the individual insurance market that is offering the guaranteed coverage in your area of residence.
- 9. How do I qualify for the guaranteed coverage?**
 - A.** After completing 36 consecutive months of enrollment in the MRMIP program you will become eligible for the guaranteed coverage. 90 days prior to transition from the MRMIP program to the guaranteed coverage, you will receive notification from MRMIP.
- 10. How long will I have to apply for the guaranteed coverage once I have been disenrolled from the MRMIP program?**
 - A.** You must apply for guaranteed coverage within 63 days of your termination date from the MRMIP.

The law does not dictate pre-enrollment into the guaranteed policies. The timeframes for enrollment in the guaranteed policies may vary by health plan. However, the subscriber can start researching which plan would be best for them as soon as they receive their 90 day notice.
- 11. If I am disenrolled from my guaranteed coverage, can I re-enroll in MRMIP?**
 - A.** There will be a 12-month waiting period for individuals who lose their guaranteed coverage before they can re-apply for MRMIP.
- 12. Can a subscriber transfer from one guaranteed coverage to another?**
 - A.** Under very limited circumstances a subscriber may be allowed to transfer. For example, if a subscriber moves to another area not covered by their health plan or if a health plan no longer covers the subscriber's area of residence.
- 13. Do Contra Costa Health Plan members have to transition to guaranteed coverage even though Contra Costa Health Plan is exempt from offering guaranteed coverage?**
 - A.** Yes, all members regardless of their health plan must transition to guaranteed coverage. Contra Costa Health Plan members will need to choose a new carrier for their guaranteed coverage.

Flex Your Power



California's Energy Challenge

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

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

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

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

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