Major Risk Medical Insurance Program
2008 F.A.Q.'s

1. **What does the annual household deductible mean for my MRMIP health plan?**
   The deductible is the annual dollar amount that each household is responsible to pay each year before the health plan pays for health care services.

2. **How much is the annual household deductible?**
   The annual household deductible amount is $450 for February 1, 2008 through December 31, 2008.

3. **When will the annual household deductible be effective?**
   The annual household deductible will be effective February 1, 2008 through December 31, 2008 for the 2008 benefit year.

4. **What health care services do not apply toward my household annual deductible?**
   Preventive care services and other services as described by your MRMIP health plan. See your health plan Evidence of Coverage booklet for services subject to the deductible. (See chart below)

5. **Do preventive care services apply toward my annual household deductible?**
   No. Preventive care services are paid in full by your MRMIP health plan. However, you will have to pay the applicable copayments and/or coinsurance. See your health plan Evidence of Coverage booklet for more details.

   Copayments – A specific dollar amount that you must pay when you receive a covered service as described in the benefits description section of the Evidence of Coverage booklet.

   Coinsurance – A percentage of the cost of services due and payable to the provider of care, as described in the benefits section of the Evidence of Coverage booklet.

6. What services are considered Preventive Care?

The following Preventive Care Services are excluded from the Annual Deductible regardless of which plan you choose.

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

Some plans offer other benefits outside the deductible. The chart below describes how each plan will apply the deductible to benefits beyond than those listed above.

Plan Name	Additional Benefits Excluded from the Deductible
Blue Cross of California PPO	No additional benefits other than those listed are excluded from the deductible
Blue Shield of California HMO+ Access	• Outpatient Prescription Drugs
Contra Costa Health Plan	All benefits are excluded from the deductible EXCEPT for Inpatient Hospital Services
Kaiser Permanente Northern CA	No additional benefits other than those listed are excluded from the deductible
Kaiser Permanente Southern CA	No additional benefits other than those listed are excluded from the deductible

7. **If my household already met the annual deductible at the beginning of the year but changes health plans later on, does my household need to meet the annual deductible again?**
   No. Each household is responsible for only one deductible annually regardless if the household changed plans.

8. **Once I have paid the household deductible for the year, do I have to pay for any other services covered under the plan?**
   You will still have to pay copayments or coinsurance up to the out-of-pocket maximum.

9. **Will I have to provide payment towards my annual household deductible at the time of service?**
   You may be asked to provide payment towards your annual household deductible at the time of service. However, most providers will bill you if you ask. This will vary on a case by case basis depending on the provider. Many providers will work out a payment plan with you if you ask.

10. **How much will I have to pay in copayments or coinsurance?**
    Health Maintenance Organizations (HMOs) in MRMIP require a fixed dollar copayment for some services and up to 25% of the cost for other services. The Preferred Provider Organization (PPO) in MRMIP also may require a fixed dollar copayment for certain services and up to 25% of the cost for other services. See your health plan's Evidence of Coverage booklet for more details.

11. **What is the annual out-of-pocket maximum and how does it work?**
    The out-of-pocket maximum per calendar year is $2,500 for individuals and $4,000 for an entire household. All deductible, copayments and/or coinsurance for a subscriber and enrolled dependents combined are applied to the annual out-of-pocket maximum. Once the individual or household has reached its out-of-pocket maximum for the year, the plan pays all of the cost of services. You will not have to pay any additional copyments and/or coinsurance.

12. **If I go to a non-participating provider, does the amount I pay count toward the out-of-pocket maximum?**
    No, costs for non-participating providers are not counted toward the out-of-pocket maximum.

13. Is there a change to the annual benefit maximum or lifetime benefit maximum and how do they work?

No. The annual benefit maximum is still $75,000 and the lifetime benefit maximum is $750,000. This means that once payment for your health care services reaches $75,000 in one year (or $750,000 in your lifetime), the plan no longer pays for your health care services. You will be responsible for paying all your medical costs.