Managed Risk Medical Insurance Board (MRMIB)

California

Pre-Existing Condition Insurance Plan (PCIP)

Healthy Families Program (HFP)

Access for Infants and Mothers (AIM) Program

Major Risk Medical Insurance Program (MRMIP)

CALIFORNIA PCIP
Pre-Existing Condition Insurance Plan

Are you uninsured with a pre-existing medical condition?
There is a new health insurance plan for you.

About PCIP

- Temporary high risk pool for individuals who have been unable to obtain health insurance coverage due to pre-existing medical conditions.
- Available in every state as a result of the federal Affordable Care Act of 2010.
- MRMIB administers the California PCIP through the Federal Department of Health and Human Services.

About PCIP…

- California PCIP started enrollment on 10/25/10
- As of 8/21/2011: 3,883 enrolled
- Ending on 12/31/13
- On 1/1/14, subscribers will be transitioned to the National Health Insurance Exchange **and** per federal law, health insurance companies will no longer be able to deny health coverage due to pre-existing conditions.

Who Can Apply for PCIP?

- 18 years old and older
- On behalf of an individual under the age of 18:
  - Parents (natural or adoptive)
  - Legal Guardians
  - Step-parents
  - Foster Parents
  - Caretaker Relatives
- Emancipated minor

Eligibility Requirements

- Resident of California
- Pre-existing medical condition
- U.S. Citizen, U.S. National (SSN required), or lawfully residing
- No creditable health coverage in the last six months

Required Documentation

Submit with their application, one of the following to provide proof of a pre-existing condition:

- Denial letter or email from an insurance carrier; **or**
- Offer letter or email from an insurance carrier stating higher premium than MRMIP PPO rates dated within 12 months (365 days) of the application receipt date; **or**

Required Documentation

- Provider Letter or Form:
  - First and last name of the patient
  - Name, license number, and signature of a doctor, doctor of osteopathy, physician assistant, or nurse practitioner who is licensed to practice
  - Indicate the individual has, or has had, a medical condition, disability, or illness
  - Identify the medical condition, disability, or illness, and;
  - Is dated within the last 12 months (i.e. 365 days) of the date the application was received

Required Documentation Citizen:

- U.S. Citizens or U.S. Nationals: acceptable citizenship documentation
  - U.S. Passport (even if expired)
  - Birth Certificate (including hospital birth verification)
  - Naturalization/Citizenship Certificate
  - American Indian/Alaska Native Documentation

Required Documentation Immigrant:

- Lawfully residing in the U.S.: acceptable documentation that is not expired (i.e. INS Form or Green Card)
  - Documentation must be valid/unexpired at the time of enrollment and during enrollment
  - Acceptable documentation includes:
    - INS Form I-551 or stamp, or Green Card (Permanent Resident)
    - INS Form 688b (Conditional Entry)
    - Asylum Grant Letter (Asylum)

PCIP Application

- The PCIP/MRMIP Application and Handbook

PCIP/MRMIP Application

CALIFORNIA PCIP MRMIP

Inside this booklet:

2 Health Insurance for Californians
3 Are You Eligible for PCIP or MRMIP?
3 PCIP and MRMIP Benefits and Cost Comparison
4 PCIP and MRMIP Monthly Premiums Comparison Charts
10 PCIP and MRMIP Benefits Comparison Charts
16 Worksheet: Find Out Which Program Is Right for You
17 Application Checklist: *Important!*
18 PCIP and MRMIP Application Form
19 PCIP: Frequently Asked Questions
23 PCIP: Notice of Privacy Practices
25 MRMIP: Frequently Asked Questions
32 MRMIP: Notice of Privacy Practices
34 Important Notices and Declarations
35 Glossary of Definitions

Application and Handbook 2011

PCIP

California Pre-Existing Condition Insurance Plan

MRMIP

California Major Risk Medical Insurance Program

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Questions 1 – 3

- Applicant's information
- Health insurance program preference
- How Heard

Application Fill out this form to apply for PCIP **or** MRMIP.

1 Tell us about the person who needs coverage.

Last name: | First name: | Middle initial:

Date of birth (month/day/year): | Age: | Gender: ☐ Female ☐ Male

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner

Home address: | Are you a California resident? ☐ Yes ☐ No

City: | State: | ZIP code: | Telephone number:

Email address: | Cell number:

Mailing address *(if different from your home address)*:

City: | State: | ZIP code:

► Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No *If **Yes**, send documentation.* | If you **are** a U.S. Citizen or U.S. National, you **must** write your Social Security number here *(required for PCIP)*:

► If you are **not** a U.S. Citizen or U.S. National, are you lawfully present in the U.S.? ☐ Yes ☐ No *If **Yes**, send documentation.*

Household information *(optional)*

What language do you want us to use when speaking with you? | What is your family size?

What language should we use when writing to you? | What is your annual household income?

Tell us about your ethnicity *(optional)*

☐ White ☐ Black, African American

Hispanic: ☐ Cuban ☐ Mexican, Mexican American ☐ Puerto Rican ☐ Other Hispanic _____

Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Japanese ☐ Amerasian ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Filipino ☐ Other Asian _____

Pacific Islander: ☐ Hawaiian ☐ Guamanian ☐ Samoan ☐ Other Pacific Islander _____

☐ Aleut/Alaska Native ☐ American Indian, Native American ☐ Eskimo

Other, not listed above _____

2 Tell us which health insurance program you want to be enrolled in.

If you qualify for **both** PCIP and MRMIP, which one do you want to be enrolled in? Check only one box: ☐ PCIP ☐ MRMIP

*If you **do not select a program**, we will enroll you in PCIP.*

3 Tell us how you learned about PCIP or MRMIP.

How did you learn about PCIP or MRMIP? *(Check all that apply.)*

☐ Insurance Agent/Broker ☐ TV/radio ☐ Community clinic ☐ Insurance carrier ☐ Employer
☐ Certified Application Assistant ☐ Website/internet ☐ Hospital ☐ Health plan referral ☐ Church
☐ Health Fair/Community Event ☐ Newspaper/print ad ☐ Pharmacy ☐ Friend/relative
☐ Disease management organization ☐ Doctor's office ☐ Government office ☐ Other _____

A1

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Questions 4 & 5

- Previous health coverage information for the MRMIP
- Dependent information for MRMIP

4 Information for MRMIP coverage

If you qualify for MRMIP, which health plan do you want? *(see pages 10–15)* ☐ Anthem Blue Cross ☐ Contra Costa ☐ Kaiser Permanente

Were you covered by a similar MRMIP high-risk insurance program in another state within the last 12 months? ☐ Yes ☐ No

If you do not qualify for MRMIP right now but expect to qualify soon, are you applying for deferred enrollment? ☐ Yes ☐ No
(see page 26) *If **Yes**, please provide the following information:*

Name of current insurance company: | Date your coverage started:

Reason for future termination: | Date your coverage will end:

► If you are applying for deferred enrollment, send a copy of a letter from your health insurance plan indicating when your coverage will end.

Have you met the requirements to avoid all (or part) of the MRMIP exclusion/waiting period? *(see page 25)* ☐ Yes ☐ No
*If **Yes**, please fill in these blanks:*

Name of prior insurance company:

Date that your coverage started: | Date that your coverage will end:

► If you have met the requirements to avoid all (or part) of the exclusion/waiting period, send a copy of your health insurance policy (including Medicare and Medi-Cal) indicating when your coverage ended.

5 If you are applying for MRMIP and want coverage for dependents, list the dependents here.
*PCIP does **not** provide coverage for dependents. Each person interested in PCIP must complete a separate application. He or she must qualify to be enrolled.*

Name of dependent Last, First, Middle Initial, SSN (optional)	Gender Female or Male	Age	Date of birth Month/Day/Year	Married? Yes or No	Relationship to applicant Check one:
1.	☐ F ☐ M		/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Other _____
2.	☐ F ☐ M		/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Other _____
3.	☐ F ☐ M		/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Other _____

► If a dependent child is over 23 years old, send a doctor's letter with the application for each child over 23 stating that the person cannot work because of a physical or mental disability that started before age 23. The dependent child cannot be married.
Is the dependent child (who is over 23 years old) covered by Medicare? ☐ Yes ☐ No

Have any of your dependents met the requirements to avoid all (or part) of the exclusion/waiting period? *(see page 25)* ☐ Yes ☐ No
*If **Yes**, list their names below:*

Name of dependent	Name of prior health insurance company	Date coverage started	Date coverage ended
1.		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /

► If the dependent has met the requirements to avoid all (or part) of the exclusion/waiting period, send a copy of the health insurance policy (including Medicare and Medi-Cal) indicating when his or her coverage ended.
If you have more dependents, photocopy pages A2 and A3 and fill them out. Send the additional pages with your application.
Subscriber dependents age 18 and under are not subject to the pre-existing condition exclusion period or the post-enrollment waiting period.

A2

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Questions 6 - 7

- Recent health insurance information
- MRMIP Dispute Resolution information

6 Tell us about your recent health insurance experience.

► Have you received a denial letter from a health insurance company within the past 12 months? ☐ Yes ☐ No
*If **Yes**, provide a copy of the **denial letter**.*

► **For PCIP:** Have you received an offer of individual health insurance coverage within the past 12 months at higher rates than the MRMIP PPO product? *If **Yes**, provide a copy of the **offer letter**.* ☐ Yes ☐ No

► **For MRMIP:** Have you received an offer of individual (not group) health insurance coverage within the past 12 months at higher rates than the MRMIP health plan choice? *If **Yes**, provide a copy of the **offer letter**.* ☐ Yes ☐ No

Within the past 6 months, have you had any of the following types of health coverage? ☐ Yes ☐ No
*If **Yes**, please indicate by checking the boxes below.*

- ☐ Another state's PCIP program _____
  - ☐ No other health insurance coverage after disenrolled from another state's PCIP program
- ☐ Individual or job-based health coverage, including COBRA or Cal-COBRA
- ☐ Medicare Part A and/or Part B
- ☐ Medi-Cal (Medicaid)
- ☐ Children's Health Insurance Program (CHIP) or Healthy Families Program (HFP)
- ☐ A state high-risk pool (or MRMIP)
- ☐ TRICARE (military health insurance)
- ☐ Health benefit plan provided to Peace Corps workers
- ☐ Health coverage provided by a public health plan established by a state, the U.S. government (such as coverage provided to veterans enrolled in VA health care), or a foreign country
- ☐ FEHBP (health insurance for federal employees or retirees), including Temporary Continuation of Coverage (TCC)
- ☐ Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition

If you had health insurance within the past 6 months, please provide the reason your health insurance coverage ended.

- ☐ You or someone in your family lost or left his or her job
- ☐ Your insurance company stopped covering dependents
- ☐ You or someone in your family stopped working full time and were no longer eligible for benefits
- ☐ You moved out of the insurance company's service area (or moved out of state)
- ☐ Your insurance premiums were too high
- ☐ Your COBRA coverage ended
- ☐ You voluntarily ended your insurance coverage
- ☐ You are no longer eligible for publicly sponsored coverage
- ☐ Other. Explain the reason your coverage ended: _____

Has your employer or an insurance company discouraged you from getting health insurance coverage that you qualified for? ☐ Yes ☐ No
*If **Yes**, provide more information below.*

Name of employer or health insurance company:

Address:

City:	State:	ZIP code:

7 MRMIP Dispute Resolution

Each plan has its own rules for resolving disputes about delivery, services, and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have a dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan and request an Evidence of Coverage or Certificate of Insurance booklet.

This plan DOES NOT require binding arbitration: Contra Costa Health Plan.

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

A3

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Questions 8 - 10

- Important notices & declarations
- Permission to Share Information
- Insurance Agents/Brokers or Certified Application Assistants (CAAs)**– must be completed to be eligible for payment**

8 Important notices and declarations, and understandings and responsibilities

I declare that I have read this application, the answers provided, and the documents enclosed. I certify that the information provided with this application is true, complete, and correct to the best of my knowledge. I have read and understand the Notices, and I am making the Declarations on page 34. I have also read and I understand the MRMIP Dispute Resolution on page A3.

Signature of applicant/parent or legal guardian ▸▸ _____ Date: _____

If you are a parent or legal guardian of the person applying for coverage, you must sign above and provide the following information:

Full name: | Telephone number:

Mailing address:

City: | State: | ZIP code:

Check your relationship to the person applying for coverage: ☐ Parent ☐ Stepparent ☐ Caretaker Relative ☐ Legal Guardian ☐ Other _____

For **MRMIP only**, the dependent(s) listed on this application must sign here:

Signature of applicant's spouse/registered domestic partner: _____ Date: _____

Signature of applicant's dependent age 18 or over: _____ Date: _____

Signature of applicant's dependent age 18 or over: _____ Date: _____

9 Permission to share PCIP or MRMIP information

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

Person's name: | EE/CAA number: *(if applicable)*:

CA Agent/Broker license number *(if applicable)*:

Applicant's signature ▸▸ _____ **Date:** _____

10 For Insurance Agents/Brokers or Certified Application Assistants (CAAs) only:

If you assisted an applicant in completing this application, please complete this section. You must complete all boxes. You will not be paid if you do not complete this section prior to sending the application. Missing information cannot be submitted at a later date for payment. (Please see note to agents on pages 22 and 31 of the handbook.) If your client wants PCIP or MRMIP to provide you with the status of his or her application and final eligibility decision, make sure the client signs Section 9 above.

Agent name: | CAA name:

Street address: | City:

State: | ZIP code: | Phone: | Email address:

CA Agent/Broker license number: | Tax I.D./Social Security number:

CAA number: | EE number:

I understand that payment will not be made unless and until this applicant is enrolled in the program. I certify that I provided free assistance to the applicant.

Agent/Broker or EE/CAA signature: _____ **Date:** _____

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Application Process

- Complete applications: processed within **10 calendar days**

- Complete **by** the 10th of the month and determined eligible, the subscriber will have an effective coverage date of the 1st of the following month

- Complete **after** the 10th of the month and determined eligible, the subscriber will have an effective coverage date of the 1st of the second month

Questions

?s

Payment for Application Assistance

- Application assistance payment to each approved Enrollment Entity for each applicant successfully enrolled in the PCIP

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Application Assistance Registration Two-Step Process:

1. Enrollment Entity (EE) must submit a complete Invitation to Participate (ITP) and receive written approval to participate. PCIP will send a Welcome Letter.

2. EE staff must become a PCIP Certified Application Assistant (CAA) via on-line training

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Application Assistance Registration

Step 1 Invitation to Participate (ITP)

- ITP will be available at www.pcip.ca.gov late August, 2011; and
- Now, you can contact the EE/CAA Liaison & Help Desk, Monday thru Friday, 8:30 am to 5:00 pm at 800-279-5012, or at:

ee-caaliaison@maximus.com

Point of Information:

- If your organization is currently registered as an EE for HFP, you do not need to re-apply; use your existing EE number

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Invitation to Participate (ITP) Application Sample

HEALTHY FAMILIES AND
PRE-EXISTING INSURANCE
CONDITION PLAN
INVITATION TO PARTICIPATE

HEALTHY FAMILIES

CALIFORNIA PCIP Pre-Existing Condition Insurance Plan

Mail your completed ITP, applicable State License or tax status verification, completed W-9, signed EE and CAA agreement(s) to:

Healthy Families & Pre-Existing Condition Insurance Plan
EE/CAA Registration
625 Coolidge Drive Suite 100, Folsom, California 95630
Attention: EE/CAA Liaison Department
Email: ee-caaliaison@maximus.com
Fax: (916) 673-4530 **Phone:** (800) 279-5012

1. Indicate the type of Enrollment Entity your organization is registering as:
   NEW Enrollment Entity (EE) Healthy Families
   _____ NEW Enrollment Entity (EE) Pre-Existing Condition Insurance Plan
   RENEWING Enrollment Entity (EE) if your payment contract has expired

2. If you checked "RENEWING Enrollment Entity," please write your previous EE number here: _____

3. Organization Name _____

Identify the person who is authorized to enter into this agreement. This must be the same person who signs the EE Agreement/W-9 Tax Form.

4. Authorized Person_____ Title_____

5. Telephone Number (_____)_____

6. E-mail address _____

Identify the person who is the authorized contact for billing inquiries.

7. Authorized Billing Name_____ Title _____

8. Billing Telephone Number (_____)_____

All reimbursement checks and statements will be mailed to the billing address. (Billing addresses are verified with a W-9 Tax Form)

9. Business Billing Address_____

   City _____ State _____ Zip _____

Identify the person who will be the contact for applicants seeking application assistance.

Important - This contact information will be published on HFP and PCIP websites.
If you don't want your contact information published on HFP and/or PCIP websites, check the appropriate box(es).
HFP ☐ **PCIP** ☐

10. Outreach Contact Name _____ Title _____

11. E-Mail Address _____

12. Telephone Number (_____)_____ Fax Number (_____)_____

13. Service Location Address_____

    City _____ State _____ Zip _____

    County _____

If you prefer general letters to be mailed to an address other than the service location address on line 13, include a mailing address.

14. Business Mailing Address_____

8/2/2011

1 of 1

Application Assistance Registration
Step 2 Become a Certified Application Assistant (CAA)

- To become a PCIP CAA:
  - ✓ Complete the PCIP 101 training course at www.pcip.ca.gov, available late August 2011; and
  - ✓ Pass the PCIP 101 training course exam.

Costs for Covered Services

Subscriber's Cost Sharing

- **Deductible:** fixed amount a Subscriber must pay first for certain covered services and supplies before PCIP starts paying for them. When a covered service or supply is subject to a deductible, only the Plan Allowance for the service or supply counts toward the deductible.
- **Annual Medical Deductible:** $1,500/in-network and $3,000/out-of-network
- **Annual Brand Name Prescription Drug Deductible:** $500/in-network and $500/out-of-network

PCIP Medical Benefits

The Summary Plan Description (SPD) booklet summarizes the benefits, policies and coverage under PCIP find it at www.pcip.ca.gov

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
Annual Deductible	$1,500	$3,000	There are separate deductibles for in-network and out-of-network services.
Coinsurance	15%	50%	Coinsurance for services provided in-network is based on the Plan Allowance. Coinsurance for services provided out-of-network is 50% of the Plan Allowance plus any additional provider charges.
Annual Out-Of-Pocket Maximum	$2,500	N/A	Includes in-network medical and brand name prescription drug deductibles, and any in-network co-payments and coinsurance. When a Subscriber reaches the annual maximum, the PCIP pays 100% of covered services in-network for the remainder of the calendar year. There is no out-of-pocket maximum for services received out-of-network.

Medical Benefits (continued)

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
Preventive Care	0%	50%*	Covered services include: routine physical examination and related laboratory services, routine gynecological examination, routine mammogram, routine Pap smear, Human Papillomavirus (HPV) screening, ovarian and cervical cancer screening, cytology examinations, family planning counseling services, health education services, prostate screening, hearing and vision examinations for children, newborn blood tests, sexually transmitted infections tests, Human Immunodeficiency Virus (HIV) testing, well baby and well child care, certain immunizations for adults and children, and disease management programs. Innetwork preventive care services are not subject to a deductible, copayment, or coinsurance. If you receive preventive care services from an out-of-network provider, you will have to pay any out-ofnetwork deductible that you have not met and then 50% of the Plan Allowance plus any additional provider charges.
Doctor Office Visit	$25	50%*	$25 copayment for in-network office visits. In-network office visits are not subject to the annual deductible.
Doctor Inpatient Visit	15%*	50%*	Doctor visits while you are in the hospital.
Inpatient Hospital Services	15%*	50%*	Prior authorization is required. You must contact PCIP within 48 hours of an emergency admission.
Inpatient Acute Rehabilitation	15%*	50%*	Prior authorization is required.

Medical Benefits (continued)

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
Outpatient Hospital Services	15%*	50%*	Prior authorization is required for certain surgical procedures.
Emergency Room Services	15%*	15%*	Limited to treatment of a medical emergency. The in-network deductible and coinsurance apply to emergency services received from an out-of-network provider.
Ambulance	15%*	15%*	Limited to a transport during a medical emergency. The in-network deductible, coinsurance, and out-of-pocket maximum apply to emergency services received from an out-of-network provider.
Surgery & Anesthesia	15%*	50%*	Prior authorization is required for certain surgical procedures.
Organ Transplants	15%*	50%*	Some transplants must be performed in a Center of Expertise to receive the in-network benefit. Prior authorization is required.
Blood & Blood Products	15%*	50%*	
Cancer Clinical Trials	15%*	50%*	Prior authorization is required.
Outpatient Diagnostic X-ray & Laboratory Services	15%*	50%*	Prior authorization is required for certain radiological procedures.

Medical Benefits (continued)

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
Family Planning Services	15%*	50%*	Some birth control products are covered under the prescription drug benefit.
Pregnancy and Maternity Care	15%*	50%*	Includes prenatal care, delivery services and postpartum care.
Infusion Therapy	15%*	50%*	
Physical Therapy	15%*	50%*	
Occupational Therapy	15%*	50%*	Prior authorization is required.
Speech Therapy	15%*	50%*	Prior authorization is required.
Skilled Nursing Facility	15%*	50%*	Services are available only when determined to be a medically appropriate alternative plan of treatment that is cost effective. Prior authorization is required.
Home Health Care	15%*	50%*	Prior authorization is required.
Hospice Care	15%*	50%*	Prior authorization is required.

Medical Benefits (end)

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
Durable Medical Equipment	15%*	50%*	Prior authorization is required for certain durable medical equipment.
Orthotics and Prosthetics	15%*	50%*	
Inpatient Mental Health Care Services	15%*	50%*	Inpatient treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child has no day limits. All other inpatient mental health care is limited to 10 days each calendar year. Prior authorization is required.
Outpatient Mental Health Care Services	15%*	50%*	Outpatient treatment of severe mental illness is unlimited. All other outpatient mental health care is limited to 15 visits each calendar year.
Inpatient Alcohol and Substance Abuse Treatment	15%*	50%*	Services are covered to remove toxic substances from the system. Prior authorization is required.
Outpatient Alcohol and Substance Abuse Treatment	15%*	50%*	Limited to 20 visits each calendar year. Additional visits may be available with prior authorization.

Prescription Drug Benefits

Prescription Drug	In-Network Pharmacy	Mail Order	Out-of-Network Pharmacy**	Limitations and Explanations
Annual Brand Name Drug Deductible	$500		$500	There are separate deductibles for in-network and out-of-network pharmacies.
Generic Drug Co-pay	$5	$5	50%*	If you choose a brand-name drug for which a generic drug exists, you will pay the generic co-pay plus the difference between the cost of the brand-name drug and the cost of the generic drug, unless your doctor indicates medical necessity by writing "do not substitute" or "dispense as written" on the prescription order or by requesting and receiving prior authorization from PCIP.
Preferred Brand Name Drug Co-pay	$15*	$15*	50%*	
Non-Preferred Brand Name Drug Co-pay	$30*	$30*	50%*	
Specialty Drugs	N/A	$30*	N/A	Specialty drugs require prior authorization.
Maximum Supply	30 days	90 days	30 days	

* Annual brand name prescription drug deductible applies

** Subscriber pays the full cost of all drugs at an out-of-network pharmacy, PCIP reimburses the subscriber 50% of the charges for generic or brand name prescription drug after the subscriber submits a claim.

PCIP Resources

- Outreach materials: go to the outreach tab at www.pcip.ca.gov
- Enrollment Entity & Certified Application Assistants Liaison: 1-800-279-5012, M - F, 8:30 am to 5:00 pm; ee-caaliaison@maximus.com
- PCIP Customer Service Representatives: 1-877-428-5060, M-F 8am-8pm, Sat 8am-5pm
- Detailed Benefits: go to the services tab at www.pcip.ca.gov for the Summary Plan Description booklet

CA PCIP Website

www.pcip.ca.gov

- The CA PCIP website is a great tool that provides useful information, including:
  - Cost of the program
  - Health Care providers
  - Services Covered
  - Download PCIP forms
  - Claim status & PCIP Benefits
  - Important resources for insurance agents, brokers, health-related organizations and community-based organizations

THANK YOU!

We appreciate your interest in the California PCIP.

Our goal is to help uninsured Californian's get the coverage they need. With your help we can insure the uninsured!