HEALTH PLAN COMPARISON - DOCTOR SELECTION & REFERRAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
How often can members change their Primary Care Physician (PCP)?	*HMO: Anytime. Change must be requested by the 15th of the month to be effective the 1st of the following month* *MC, PPO & EPO: No PCP selection is required*	*If the request is made between the 1st-7th of the month, Anthem can retro back to the 1st of current month. If request is made after the 7th, the change will be effective on the 1st of the following month.* *For PPO plans: No PCP selection is required.*	*Participants may change anytime by contacting Member Services. Change will be effective on the 1st day of month following notice of approval. Member can also change the PCP online at: www.blueshieldca.com. They must register first.*	*A member may change as frequently as desired with a first of the month following effective date. However, if a member is in the middle of a treatment plan, say physical therapy with a Medical Group, they may not switch to a different Primary Care Physician (PCP) until the treatment plan has ended.*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 106*	*Anytime. Change must be requested by the 15th of the month to be effective the 1st of the following month.*	*N/A*	*Once a month within PMG/ IPA PMG/IPA may be changed once a month*
Can family members each choose a PCP from a different IPA/Medical Group?	*Yes*	*Yes*	*HMO: Yes* *PPO: N/A*	*Yes*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 106*	*Yes, but not recommended*	*N/A*	*Yes*
Self-referral available?	*No prior authorization or referral for OB/GYN (can be primary provider). The OB/GYN must be in the same medical group/ IPA as the PCP.*	*HMO: No prior authorization for OB/GYN.* *Other services: referral must be within the same medical group.* *PPO: Yes*	*HMO: No prior authorization or referral for OB/GYN (can be primary provider);* *Other services: if Access+ provider—yes* *All services: Specialist must be in same med. group/IPA as PCP* *PPO: Yes*	*Available only if the medical group participates in the program. No prior authorization or referral for OB/GYN (can be primary provider)*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 106*	*No prior authorization or referral for OB/GYN (can be primary provider). The OB/GYN must be in the same medical group/ IPA as the PCP.*	*Yes*	*HMO: Yes—OB/GYN visits only (OB/ GYN must be in same medical group as PCP)* *PPO: Yes—no PCP selection required* *EPO: Choose a primary care physician (PCP) contracted with the CommunityCare tailored network to coordinate their care.* *• Their PCP can refer to any specialist in the CommunityCare Network.* *• Care doesn't need to stay within the PCP's participating provider group (PPG).*
Express referral available?	*No—see self-referral information above*	*No*	*No—see self-referral information above*	*Available only if the medical group participates in the program*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 106*	*No*	*No*	*Yes—if a Rapid Access Provider*

HEALTH PLAN COMPARISON - DOCTOR SELECTION & REFERRAL

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
How often can members change their Primary Care Physician (PCP)?	*Anytime - change is effective immediately*	*Anytime - change is effective immediately*	*Unlimited*	*N/A - All plans are EPOs with no PCP requirement*	*Anytime - change is effective 1st of the following month*	*Members are not assigned to a PCP provider*	*Anytime – change is effective 1st of the following month.*	*HMO: As often as necessary (submit change request on or before the 15th in order to be effective the 1st of the following month)* *PPO: N/A*	*Once a month - changes are effective the first of the following month, provided the member is not in the course of treatment or hospitalized and no pending authorizations*
Can family members each choose a PCP from a different IPA/Medical Group?	*Yes:* *HMO: From Kaiser Permanente Physicians* *POS: From Private Healthcare Systems (PHCS)*	*No*	*Yes*	*N/A - All plans are EPOs with no PCP requirement*	*Yes*	*Members are not assigned to a PCP provider.*	*Yes*	*HMO: Yes* *PPO: N/A*	*Yes*
Self-referral available?	*No prior authorization or referral for OB/GYN (can be primary provider)* *Other Specialties: Yes—to certain specialties. Self-refer specialties list varies by geographical region*	*Yes - for OB/GYN visits*	*Yes*	*N/A - All plans are EPOs with no referral requirement*	*Yes - for OB/GYN visits if OB/GYN is in same IPA as PCP.*	*Self-referrals are not available.*	*Yes, self-referral is available for health coaching, behavioral health services, and OB/GYN services.*	*HMO: Yes - for OB/GYN visits (OB/GYN must be in the same medical group/IPA as your PCP)* *PPO: N/A*	*Yes – only for OB/GYN, annual eye exam, and behavioral health services*
Express referral available?	*Yes - referral direct from physician*	*Yes, direct from PCP Provider.*	*No referrals are required to see a specialist.*	*N/A - All plans are EPOs with no referral requirement*	*Yes - if available through medical group.*	*PCP provider will provide an express referral.*	*N/A*	*HMO: Yes - if an Express Referrals™ participating medical group. See Provider Directory or www.uhcwest.com for list of participating medical groups.* *PPO: Yes*	*N/A*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - HSAs, HRAs & OUT-OF-NETWORK

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Do any of your HSA-Compatible or HRA-Compatible High Deductible Health Plans (HDHP) have an embedded† deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible?	*Yes, all plans are based on embedded deductible*	*Yes*	*Yes*	*Yes* *All CalCPA Health HSA plans have an embedded deductible.*	*Yes*	*N/A*	*Yes*	*Yes*
On plans which include out-of-network benefits, what do you use to determine benefit [Limited Fee Schedule (LFS), Usual, Customary & Reasonable (UCR), percentage of Medicare, etc.]?	*Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out of-network health care providers is 100 percent of the rate that Medicare pays them.*	*Anthem's allowable amount (proprietary fee schedule).*	*Blue Shield's Allowable Amount (LFS)*	*LFS for all plans except the Protect 10 plan, which is UCR*	*HMO: N/A* *PPO: Negotiated Fee*	*N/A*	*Varies*	*MAA Maximum Allowable Amounts*

† *When HSA plans were first introduced in 2004, IRS publications used the term "embedded deductible" to refer to the individual deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible. Current IRS publications do not use the term "embedded deductible."*

IRS Publication 969 (2010) "Health Savings Accounts and Other Tax-Favored Health Plans" provides the following HDHP eligibility clarification on page 4:

***"Family plans that do not meet the high deductible rules.** There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP."*

HEALTH PLAN COMPARISON - HSAs, HRAs & OUT-OF-NETWORK

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Do any of your HSA-Compatible or HRA-Compatible High Deductible Health Plans (HDHP) have an embedded† deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible?	*Yes*	*N/A*	*Yes*	*Yes*	*Yes*	*N/A*	*Yes*	*No*	*Yes*
On plans which include out-of-network benefits, what do you use to determine benefit [Limited Fee Schedule (LFS), Usual, Customary & Reasonable (UCR), percentage of Medicare, etc.]?	*HMO: N/A* *POS & PPO: UCR*	*Out of network claims are paid based on usual and customary charges.*	*Out of network benefits are calculated using a percentage of Medicare. If the service isn't listed, then UCR is utilized.*	*None of our plans cover out-of-network benefits except in case of emergency. Oscar bases rates for covered OON emergency services based on the greater of the median negotiated rate in a region and the Medicare rate.*	*Please contact your Word & Brown representative*	*Generally the out of network claims are paid as usual and customary.*	*SHP does not offer out-of-network benefits except for emergency or urgent care treatment. Benefits for emergency or urgent care services are calculated at billed charges. SHP does not use a specific fee schedule or UCR rate.*	*HMO: N/A* *PPO: Reimbursement for *Non-Network treatment is based on percentage (110%) of the published rates allowed by Medicare for the same or similar services*	*HMO: N/A*

† *When HSA plans were first introduced in 2004, IRS publications used the term "embedded deductible" to refer to the individual deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible. Current IRS publications do not use the term "embedded deductible."*

IRS Publication 969 (2010) "Health Savings Accounts and Other Tax-Favored Health Plans" provides the following HDHP eligibility clarification on page 4:

*"**Family plans that do not meet the high deductible rules.** There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP."*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - HOUSE CALLS, TELEMEDICINE
& OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Doctor House Calls available through Heal™ or another provider of this type of service?	HMO plans: No PPO plans: Yes	HMO plans: No PPO plans: Yes	As of 1/1/2020: TRIO HMO: Yes Access + HMO: No Local Access + HMO: No Full PPO/Tandem PPO: Yes	HMO plans: No PPO plans: No	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: No	HMO plans: Dependent on carrier PPO plans: Dependent on carrier	HMO plans: Urgent care only PPO plans: Yes
For more Information:	heal.com 844-644-4325 Download the Heal app. Available for Android™ and iPhone® mobile devices.	844.644.4325 (HEAL) or heal.com			Contact CaliforniaChoice customer service 800-558-8003			844-644-4325 (HEAL) or heal.com/healthnet
Nurse's Hotline available?	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans Yes	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans Yes	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: 1-888-243-8310	HMO plans: Yes, for additional telemedicine fee PPO plans: Yes, for additional telemedicine fee	HMO plans: Yes PPO plans: Yes
For more Information:	Informed Health Line 800-556-1555	Login at anthem.com/ca			Contact CaliforniaChoice customer service 800-558-8003			24 Hour Nurse Line 800-893-5597
Facetime/ Skype Access to Doctor?	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans: Yes Available through LiveHealth Online	HMO plans*: Yes PPO plans*: Yes ***Based on availability of physician**	HMO plans: Yes PPO plans: Yes	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	Some medical groups and physicians may offer these services via their own Patient Online Portal (POP)	HMO plans: Dependent on carrier PPO plans: Dependent on carrier	HMO plans: Yes PPO plans: Yes
For more Information:	Teladoc 855-835-2362 Teladoc.com/Aetna	www. livehealthonline.com			CaliforniaChoice customer service 800-558-8003			Teladoc 855-835-2362 Teladoc.com/hn
Email Access to Doctor?	HMO plans: N/A PPO plans: N/A (At the discretion of the provider.)	HMO plans: No PPO plans: No	HMO plans*: Yes PPO plans*: Yes ***Based on availability of physician**	HMO plans: No PPO plans: No	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	Some medical groups and physicians may offer these services via their own Patient Online Portal (POP	HMO plans: Yes, dependent on physician PPO plans: Yes, dependent on physician	HMO plans: At the discretion of the provider PPO plans: At the discretion of the provider
For more Information:					Contact CaliforniaChoice customer service 800-558-8003			
Any other alternative health care delivery service you offer?	HMO plans: No PPO plans: No	HMO plans: Yes PPO plans: Yes Members can visit with a doctor or therapist for urgent care and behavioral health support through LiveHealth Online via phone, webcam, computer	HMO plans: Teladoc PPO plans: Teladoc	HMO plans: Yes PPO plans: Yes Members can visit with a doctor or therapist for urgent care and behavioral health support through LiveHealth Online via phone, webcam, computer	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: N/A	HMO plans: N/A PPO plans: N/A	HMO plans: Yes; Teladoc telehealth services and CVS Minute Clinics PPO plans: Yes; Teladoc telehealth services and CVS Minute Clinics
For more Information:	N/A	www.livehealthonline.com or 844-784-8409 from 7 a.m. to 11 p.m.	N/A	www. livehealthonline.com	Contact CaliforniaChoice customer service 800-558-8003	N/A	N/A	Teladoc 855-835-2362 Teladoc.com/hn Minute Clinic minuteclinic.com

HEALTH PLAN COMPARISON - HOUSE CALLS, TELEMEDICINE
& OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Doctor House Calls available through Heal™ or another provider of this type of service?	HMO plans: N/A PPO plans: N/A	HMO plans: Yes, HEAL is available for all HMO plans. This service is only available for urgent care PPO plans: No	HMO plans: Varies depending on plan option PPO plans: Varies depending on plan option	EPO plans: Yes Doctor On Call™ hioscar.com/doctor-on-call/la	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	No	HMO plans: No PPO plans: Yes	HMO plans: No PPO plans: N/A
For more Information:			Teladoc available		Phone appointments available dependent on physician - contact Sharp directly				
Nurse's Hotline available?	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	HMO plans: No PPO plans: No	EPO plans: No, but each member is given access to their concierge team, which includes a nurse	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	Yes	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans: N/A
For more Information:	24/7 Care Online via KP Member Services @ 800-464-4000	MediExcel has a Doctor's hotline in lieu of a nurses hotline: 619-365-4346			Contact Sharp directly and they will transfer you to a nurse 800-359-2002		Members may call the number on the back of the ID card: 855-836-3500.	Call the phone number on the back of the ID card to talk to an experienced registered nurse 24/7	877-793-3655
Facetime/ Skype Access to Doctor?	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	HMO plans: Varies depending on plan option PPO plans: Varies depending on plan option	EPO plans: No	Varies depending on physician selected	HMO plans: No PPO plans: No	Video Visits with advance practice clinicians are available through My Health Online. For more information visit https://www.sutterhealth.org/myhealthonline/video-visits.	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: N/A
For more Information:	https://mydoctor.kaiserpermanente.org/ncal/videovisit/#/		Teladoc available		Please contact your Primary Care physician			Virtual Visits: www.uhc.com/virtualvisits	
Email Access to Doctor?	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	HMO plans: No PPO plans: No	EPO plans: No, but text messaging available via Doctor On Call™ app	Varies, by physician selected	HMO plans: No PPO plans: No	Yes, if members select a provider who participates in My Health Online.	HMO plans: No PPO plans: No	HMO plans: N/A PPO plans: N/A
For more Information:	Kp.org				Please contact your Primary Care physician				
Any other alternative health care delivery service you offer?	HMO plans: Yes PPO plans: Yes	HMO plans: No PPO plans: No	HMO plans: No PPO plans: No	EPO plans: No	We offer MinuteClinic through CVS	HMO plans: No PPO plans: No	No	HMO plans: No PPO plans: No	HMO plans: N/A PPO plans: N/A
For more Information:	Phone appointments	N/A	N/A	N/A	N/A	N/A	N/A		N/A

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Acupuncture	*Covered in accordance with ACA requirement. Refer to Plan documents for benefit detail.*	*No visit limits for HMO or PPO.*	*HMO: Covered for off exchange and mirror plans* *PPO: Covered for off exchange and mirror plans*	*PPO Plans: Acupuncture care is covered, and limited to 12 visits combined for In/Out-of-Network per calendar year.* *HMO Plans: Acupuncture is covered when deemed medically necessary by your primary care provider.*	*See Plan Specific EOC or COI*	*Included with Medical*	*Covered*	*N/A - part of standard medical benefits. See plan summary for details.*
Chiropractic	*Refer to plan guide for benefit detail*	*HMO: Limited to 20 visits per calendar year.* *PPO: Limited to 20 visits per calendar year* *For more information, please see Plan Specific EOC.*	*HMO: Covered in off exchange only plans* *PPO: Covered in off exchange only plans*	*Chiropractic care is covered, and limited to 20 visits combined (participating and non-participating provider) per calendar year.*	*See Plan Specific EOC or COI*	*Not available*	*Covered*	• *Chiropractic benefits are available as a rider alongside all our HMO plans. Chiropractic is also embedded with several of our PPO and EnhancedCare PPO plans. For more information please see the plan's specific EOC.* • *X-rays and clinical laboratory tests are payable in full when provided by or referred by a contracted chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as medically necessary and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.* *What's not covered* *Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of your plan. Consult your plan's Evidence of Coverage for more information.*
Dental-Adult	*Available*	*Available*	*Available*	*N/A*	*Discount or Buy-up (available to all dependents)*	*Available*	*Available*	*Optional Health Net Dental & Vision plans available - call representative for details*
Dental-Pediatric **Included in rates?**	*Yes* *Yes*	*Yes - Pediatric dental is embedded within all medical plans.*	*Yes - automatically embedded with medical* *Yes*	*Yes* *Yes*	*Yes* *Yes*	*Yes* *Yes*	*Not Covered*	*Yes (Not covered in SIMNSA)*
Hearing Treatment	*Hearing exams are covered in accordance with ACA requirements as an essential health benefit.*	*Routine hearing tests covered; refer to EOC for details.*	*Routine hearing tests are covered in accordance with ACA requirements. Refer to preventive care guidelines.*	*Not covered - routine hearing tests, except as specifically provided under "Preventive Care" benefits of medical care that is covered (Beneficiaries age 7 and older).*	*See Plan Specific EOC or COI*	*Routine hearing test covered; refer to EOC for details.*	*Not Covered*	*HMO: Routine hearing screening in PCP's office—office visit copay* *PPO: Routine hearing exam - Office visit co-pay*
Hearing Aids Covered?	*Hearing Aids are not covered.*	*No*	*Blue Shield offers a hearing aid discount program through our Wellness offering through EPIC Hearing.*	*No*	*See Plan Specific EOC or COI*	*No*	*Not Covered*	*No*

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Acupuncture	For effective dates 1/1/19 - 12/1/19, Combined coverage for chiropractic and acupuncture care is included with the following plans: *Platinum 90 HMO 0/10 + Child Dental Alt *Gold 80 HMO 500/30 + Child Dental Alt *Silver 70 HMO 1000/55 + Child Dental Alt *Silver 70 HMO 1800/55 + Child Dental Alt Services are administered by American Specialty Health Plans of California, Inc® (ASH Plans).	Not covered	Not covered	Oscar covers acupuncture as medically necessary if Members meeting the criteria outlined in our Acupuncture Clinical Guideline	Covered benefit - please see member handbook for details. Additional Acupuncture riders available for purchase.	Covered after a $10 copayment.	Acupuncture is a standard benefit and is embedded into all HMO Plans. Enhanced acupuncture benefits are also available through purchase of an optional rider.	Acupuncture is a standard benefit and is embedded into all HMO and PPO plans. HMO: $10 copayment PPO: See plan summary for benefit details	$15 per visit
Chiropractic	For effective dates 1/1/19 - 12/1/19, Combined coverage for chiropractic and acupuncture care is included with the following plans: *Platinum 90 HMO 0/10 + Child Dental Alt *Gold 80 HMO 500/30 + Child Dental Alt *Silver 70 HMO 1000/55 + Child Dental Alt *Silver 70 HMO 1800/55 + Child Dental Alt Services are administered by American Specialty Health Plans of California, Inc® (ASH Plans).	Not covered	Covered under outpatient physical medicine which has a limit of 30 visits per plan year.	Coverage Exclusion	Chiro riders available for purchase.	Not covered	Yes, chiropractic coverage is available as an optional benefit. It is not available with high-deductible plans.	Chiropractic is a standard benefit and is embedded into most HMO and all PPO plans HMO: $15 per visit with a 20 visit max (except Multi-Choice State Package HMO plans, this benefit is excluded and no rider option available) PPO: Manipulative Treatments (Chiro) are included in all PPO plans; benefits are limited to 24 visits per year, see plan summary for benefit details.	$15 per visit (up to 20 visits per year).
Dental-Adult	Available	Available	Not covered	Dental care for Members age nineteen (19) and older is a coverage exclusion.	Not covered	If the voluntary dental option is available only.	Yes, adult dental coverage is an optional benefit available to purchase.	Available	Available as a rider only
Dental-Pediatric **Included in rates?**	Yes Yes	Included in all small group plans Yes	For the wellness visits covered under ACA, they are included in the rates.	Covered. Yes, included in medical plan premium rate	Yes - embedded into base medical plan Yes	Covered under the medical option. Yes	Pediatric dental benefits are embedded for members age 19 and under.	Yes - embedded into base medical pan Yes	Yes Yes
Hearing Treatment	HMO & PPO: Coverage includes medical examinations of the ear and audiometric examination to measure hearing acuity.	Routine hearing exam	No	No	Hearing Exams in PCP office as part of a physical exam.	Any services that are medically necessary would be covered.	SHP covers preventive hearing exams and medically necessary services.	Contact your Word & Brown representative	Routine hearing exam Office visit co-pay
Hearing Aids Covered?	No	No	No	No	Not covered	No	No	Yes - contact your Word & Brown representative for more details.	No

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Infertility	*All plans: Coverage only for the diagnosis and treatment of the underlying medical condition. Member cost sharing is based on the type of service performed and place where it is rendered. (See certificate Book for details). No coverage for artificial insemination, IVF, ZIFT, ICSI & other related services. GIFT is covered selected plans only with a lifetime maximum of $2,000 per member. IVF and injectable medications are excluded. Refer to plan documents for details.*	*Covered services include diagnostic testing to determine the cause of infertility and treat underlying medical conditions.* *Optional Rider plans available.*	*HMO/PPO: Not covered. Rider available*	*Covered: California regulations require limited infertility coverage to be offered, at an additional premium cost. If you would like information on this coverage please contact Banyan Administrators within 30 days of the employer effective date.*	*See Plan Specific EOC or COI*	*Not covered. Rider available.*	*Benefits are included for procedures which are consistent with established medical practices in the treatment of infertility by a Physician. These procedures include, but are not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer. Benefits will not be available for in-vitro fertilization procedures.*	*Optional rider available for infertility benefits. Please see the Evidence of Coverage (EOC) or Certificate of Insurance (COI) for complete details on coverage and exclusions.*
Life	*No*	*Available*	*Available*	*N/A*	*Available*	*No*	*Covered*	*Available*
Speech Therapy	*Covered as outlined in Plan Documents.*	*Covered as outlined in the Schedule of Benefits or Evidence of Coverage.*	*Covered as outlined in the Schedule of Benefits and Evidence of Coverage.*	*Yes - outpatient speech therapy following injury or organic disease.*	*See Plan Specific EOC or COI*	*Covered as outlined in the Schedule of Benefits or Evidence of Coverage*	*Covered*	*HMO: Office visit copay - provided as long as significant improvement is expected.* *PPO: Applicable copay/ coinsurance applies*

NOTE: Unless otherwise noted, information shown on this page reflects in-network benefits.

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Infertility	*The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.* *If infertility is offered, all plans must have infertility and a plan without infertility cannot be offered.* *PPO plan designs include infertility and cannot be purchased without infertility. PPO plan can be offered with a HMO that does not have infertility.*	*Covered benefit, please see EOC for details on coverage.*	*Yes, for groups with 50 or more employees, fertility is covered up to a maximum of $10k per plan year.*	*Oscar covers basic infertility services when medically necessary. If Member enrolls in an INF plan.*	*If a 20+ group, optional riders available for ART (Assisted Reproductive Technologies) —call your Word & Brown representative for details.*	*Not covered*	*SHP offers small group "Plus" plan designs that include embedded infertility benefits.*	*HMO: 2019 Optional benefit is available. Infertility Rider rate is calculated at a 4.8% premium increase.* *PPO: Services to treat or correct underlying causes of infertility are covered. Benefits are limited to $2,000 per covered person during the entire period of time he or she is enrolled for coverage under the policy. Pre-service notification is required. See Certificate of Coverage for details.* ***Infertility is excluded from Multi-Choice State Select package plans*	*Optional rider to Employers with 20 eligible Employees 50% Co-pay*
Life	*Not Available*	*No*	*N/A*	*Coverage Exclusion*	*Not Available*	*Not Available*	*N/A*	*Available*	*N/A*
Speech Therapy	*HMO & PPO: Covered if deemed medically necessary by Health Plan physician.*	*Covered benefit, please see EOC for details on coverage.*	*Covered under outpatient physical medicine which has a limit of 30 visits per plan year.*	*Covered Benefit. Please see SBC for benefit limits.*	*Covered benefit, please see summary of benefits and member handbook for details on coverage.*	*Covered after a $10 copayment.*	*SHP covers medically necessary speech therapy services.*	*Speech Therapy is a standard benefit and is embedded into all HMO and PPO plans* *HMO: No visit limitation; copay varies by plan.* *PPO: No visit limitation. Copayment/ Coinsurance varies by plan.*	*HMO: Covered - see plan's co-payment summary.*

NOTE: Unless otherwise noted, information shown on this page reflects in-network benefits.

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - PRESCRIPTIONS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net*
If generic available, and doctor has not indicated "dispense as written," will member receive a generic equivalent rather than a brand name drug?	*Yes—if the member requests a name brand, they will pay the applicable copayment, plus the difference between the generic and brand name price.*	*If the member doesn't present a script with dispense as written (DAW) included but still prefers the brand, they can get the brand drug in that case, too, and the member pays the generic copay plus the cost difference between the generic and the brand cost. If the member doesn't have a script with dispense as written noted in it, and does NOT prefer the brand, they'll receive the generic, if available.*	*Yes—or member must pay generic copay plus difference between cost of generic and brand name drug*	*Yes*	*See PRESCRIPTIONS starting on page 106*	*Yes - Generic unless specified*	*No*	*Yes—member will receive generic unless brand is requested. If brand is requested by member, the member will pay the brand copay plus the difference in cost between the brand and generic*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay amount?	*No—if the member requests a name brand, they will pay the applicable copayment, plus the difference between the generic and brand name price.*	*Yes, but only if this is a brand drug with no generic equivalent. If there is a generic equivalent, and a DAW prescription is presented, the scenario described directly above applies.*	*No, the member is responsible for the difference in cost between the brand and generic, in addition to the generic drug copayment*	*No, generic substitution is mandatory. The doctor must obtain authorization through a clinical review. Otherwise, the member will be responsible for the difference in price between the generic and brand.*	*See PRESCRIPTIONS starting on page 106*	*No - member is responsible for the difference in cost between the brand and generic, in addition to the generic drug copayment*	*Yes*	*Varies by plan. Members should refer to EOC/ Certificate for specific information*
Does carrier use Rx formulary?	*Yes*	*Non-formulary drugs are not covered.*	*Yes—for all plans*	*Yes*	*See PRESCRIPTIONS starting on page 106*	*Yes*	*Yes*	*Yes - Health Net refers to their Formulary. Members should refer to EOC for copayment.*
Are non-formulary drugs available?	*No*	*Non-formulary drugs are not covered.* *Please note: Usually non-formulary drugs can still be obtained/covered via the prior auth process if the drug is deemed to be clinically appropriate.*	*<u>All HMO Plans</u>: Yes* *<u>All PPO Plans</u>: Yes* *<u>All HSA Plans</u>: Yes*	*Yes*	*See PRESCRIPTIONS starting on page 106*	*Non-formulary not covered unless exception request is processed and approved*	*Yes*	*Member should refer to EOC for copayment information.*
Mail Order	*<u>HMO & PPO plans</u>: 2X retail copay - 31 day up to 90 day supply available*	*Please see plan specific EOC.*	*All plans*	*Yes—using Prescription Drug Program*	*See MAIL ORDER starting on page 108*	*Yes*	*Yes*	*Member should refer to EOC for copayment information.*

**HEALTH NET: Prescriptions filled at a non-participating pharmacy will have a separate $100 deductible per member and 50% coinsurance. PPO, EOA, & HMO Value plans: Brand Name deductible Options Plans (all): $200 brand deductible per member per calendar year.*

Salud con Health Net plan design varies depending on whether the Los Angeles, Orange and Ventura County provider network or the Mexico provider network is utilized by the employee and dependents. Therefore, the benefit information cannot be outlined on this page. Please call your Word & Brown sales representative for details. Salud Mexico's plan design cannot be clearly outlined on this page. Please call your Word & Brown sales representative for details.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

HEALTH PLAN COMPARISON - PRESCRIPTIONS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
If generic available, and doctor has not indicated "dispense as written," will member receive a generic equivalent rather than a brand name drug?	*HMO: Yes* *POS: Yes*	*N/A*	*Yes*	*Yes*	*Yes—or member must pay non-formulary copay*	*N/A*	*Yes*	*Managed or Closed Formulary Plans: Yes* *Open Formulary Plans: Yes*	*Yes—or you must pay the brand copay plus the difference in cost between the brand name and generic equivalent*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay amount?	*HMO: Yes* *POS: Yes—if brand name is on Health Plan Formulary*	*Yes*	*Regardless of whether the doctor or the patient requests the brand when there is a generic equivalent, the patient will receive the generic. If the doctor or patient wants the brand when a generic equivalent is available, they can do so but the customer will pay the brand name copay (if the plan chosen has an Rx copay) PLUS the different between the brand and generic cost.*	*If provider checks DAW prescription, Member gets Rx at the tiered copay the brand and generic cost.*	*Yes*	*N/A*	*Yes, the member will receive the brand drug with the cost share of the generic copay plus the cost difference between the brand and generic.*	*No*	*Yes*
Does carrier use Rx formulary?	*HMO: Yes* *POS: Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*N/A*	*Yes*	*Yes*	*Yes, a preferred drug list*
Are non-formulary drugs available?	*HMO: Yes—if deemed medically necessary by Plan Physician* *POS: Yes—$40 non-formulary copay applies. Select prescription medications are excluded from out-of-network coverage*	*Yes—non-formulary copay applies*	*Any drug not listed on the formulary is excluded and not covered.*	*We only cover non-formulary drugs if they are determined to be medically necessary for a particular member. Members can have their provider apply for a Non-Formulary Exception to Caremark to prove medical necessity.*	*Yes—non-formulary copay applies*	*N/A*	*Yes, if medically necessary and the member has tried and failed preferred alternatives.*	*HMO: Yes non-formulary covered under non-formulary RX benefit* *PPO: No. Closed formulary.* *PPO GenericRx plans: NO*	*Yes—non-preferred medication*
Mail Order	*Prescriptions plans that have up to a 30-day supply: 1 copay for up to a 30-day supply or 2 copays for a 31-to 100-day supply Prescriptions plans that have up to a 100-day supply: 1 copay for up to 100 supply (mail order or pharmacy) (plus Brand name deductible where applicable)*	*Mail Order Service is not available*	*90 day supply*	*90 day supply*	*Yes—medication needs to be on maintenance list.*	*N/A*	*Mail order is available up to a 100-day supply of their maintenance prescription drugs for the cost of two retails copays.*	*HMO: Yes—2X retail copay* *PPO: Yes—2.5X retail copay*	*90 day supply*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Use Employer or Employee ZIP Code?	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Employee ZIP Code*	*Call your Word & Brown representative*	*Employer ZIP Code*	*Employee*	*Employer ZIP Code*
How are out-of-state employees rated?	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Call your Word & Brown representative*	*Employer ZIP Code*	*New Hire rates will be based on the member's age at the member's enrollment date*	*Employer's physical address in CA*
DE-9C statement required?	*2-5 & virgin groups: Yes* *Groups 6+: DE-9C, Prior Carrier Bill, and Proof of Eligibility Form – not required* **Tax documents may be requested at the discretion of the underwriter.*	*Not required for ancillary lines.*	*Yes—and it must be unaltered. If any alterations special requirements apply. Call your Word & Brown representative for details.*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Payroll records OK if no DE-9C?	*Call your Word & Brown representative*	*Anthem may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.*	*Call your Word & Brown representative*	*Yes*	*Call your Word & Brown representative*	*Yes - minimum 6 weeks*	*Yes*	*Yes—4 weeks of payroll is sufficient for groups of 6+ enrolling. Less than that requires payroll showing they've been in business for 50% of the prior calendar quarter. Prior bills are required for employer paid dental rates, COBRA enrollment, and certain LOA situations.*
Is a prior booklet required?	*No* *May be requested at the discretion of the underwriter.*	*No*	*No*	*No*	*Yes—only if any employees take PPO Dental*	*No*	*No*	*No*
Is prior billing required?	*No* *May be requested at the discretion of the underwriter.*	*Call your Word & Brown representative*	*Yes for prior carrier deductible credit*	*Call your Word & Brown representative*	*Call your Word & Brown representative*	*Call your Word & Brown representative*	*No*	*Call your Word & Brown representative*

† *Payroll records must include the number of hours worked for each employee. If no DE-9C, group must also submit copy of their business license and tax ID number. Group must be in business a minimum of 50% of prior quarter in order to be guaranteed issue.*

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Use Employer or Employee ZIP Code?	*Employer ZIP Code*	*Employer ZIP Code*	*Employer*	*Employer*	*Employer ZIP Code*	*Employer ZIP Code*	*Rates are based the ZIP code for the employer's headquarters or location within SHP's licensed service area.*	*Employer ZIP Code*	*Employer ZIP Code*
How are out-of-state employees rated?	*N/A*	*Out of State employees not eligible, unless employee reports to worksite in San Diego County or Imperial County.*	*It is a blended rate*	*N/A*	*N/A*	*Not covered, employee is required to work out of San Diego or Imperial County to be covered.*	*Rates are based the ZIP code for the employer's headquarters or location within SHP's licensed service area.*	*Employer ZIP Code*	*N/A*
DE-9C statement required?	*Yes—must also submit payroll records for employees hired after DE-9C filing*	*Yes*	*Yes, we do require a quarterly contribution/ wage report for each employer from their respective state(s).*	*Yes*	*Yes*	*Yes*	*Reconciled DE-9C is required for one to five eligible employees and any group size for sole proprietor and partners. Completed New Employee Verification Form is required for employees not listed on the DE-9C* *SHP Underwriting reserves the right to request a DE-9C.*	*Employers with 1-9 eligible employees: Yes, a copy of the most recent quarterly DE-9 and DE-9C with all employees listed (including all pages).* *Employers with 10+ Eligible employees: No, a completed and signed UHC Participation Certification form can be submitted in lieu of DE-9C.*	*Yes*
Payroll records OK if no DE-9C?	*No*	*Yes*	*If none filed, yes and may require additional documents.*	*Yes*	*Yes—require minimum of six weeks*	*No*	*Yes, along with a completed New Employee Verification Form, except for sole proprietors or partnerships. Sole proprietors and partnerships must provide reconciled DE-9C only and are not allowed to use the employee verification form.*	*See note above*	*Yes—if DE-9C not filed yet, minimum 2 payroll records required (and DE-9C when available)*
Is a prior booklet required?	*No*	*No*	*No*	*No*	*No*	*No*	*No*	*No*	*No*
Is prior billing required?	*Call your Word & Brown representative*	*No*	*Yes*	*No*	*No—but underwriter may require upon request.*	*No*	*No, but the employer may provide prior carrier premium invoice in lieu of reconciled DE-9C. Completed new Employee Verification Form is required for employees not listed on the current premium invoice.*	*For Dental only*	*No - may be provided in lieu of DE9C*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Must submit check with initial application?	*ACH debit form is preferred method of premium payment.*	*Yes*	*Yes or initial payment form with copy of voided check*	*No*	*Yes*	*Yes*	*No*	*Yes - minimum 75% of the 1st month's premium.*
Make check payable to	*Aetna Health of California, Inc.*	*Anthem Blue Cross*	*Blue Shield of California*	*Check not required with submission*	*CaliforniaChoice®*	*Chinese Community Health Plan*	*E.D.I.S.*	*Health Net*
New in Business Minimum length of time in business?	*Six weeks prior to the effective date and meet all other requirements of a Small Employer*	*Start up company form is required*	*Start up attestation and form W4 or one pay cycle required*	*No minimum required*	*Call your Word & Brown representative*	*Six weeks prior to the effective date and meet all other requirements of a Small Employer.*	*No*	*Groups enrolling 2-5: Half the prior calendar quarter* *Groups 6-100: 4 weeks prior to effective date.*
Payroll records† required? If yes, how long?	*6+ enrolled, no payroll or prior carrier bill is required.* **subject to UW discretion*	*Start-up companies must provide the first 30 days of payroll records for all employees within 45 days of the effective date.*	*Yes—Call your Word & Brown representative*	*No—except when spouse is enrolled as an employee Or when DE9C is not yet available.*	*A minimum of 1 run or from start date to current, whichever is greater.*	*Yes* *DE-9C or 4 weeks of payroll are required.*	*6 weeks*	*DE-9C required unless not in business long enough to have one. Then 4 weeks of payroll is sufficient for groups of 6+ enrolling. Less than that requires payroll showing they've been in business for 50% of the prior calendar quarter. Prior bills are required for employer paid dental rates, COBRA enrollment, and certain LOA situations.*
Copy of business license?	*Refer to other documents required*	*Yes*	*Call your Word & Brown representative*	*No*	*Call your Word & Brown representative*	*Yes*	*No*	*Acceptable ownership documentation varies by business structure—call Word & Brown rep*
Other documents required?	*Call your Word & Brown representative*	*Depending on the type of organization, other documents may be required. Please refer to the 2019 Underwriting Guidelines.*	*Call your Word & Brown representative*	*Subscription Agreement with CalCPA membership number, or if not, currently a photocopy of Society membership application and proof of payment of dues.*	*Call your Word & Brown representative*	*Please refer to the New Group Submission Checklist.*	*Call your Word & Brown representative*	*Acceptable ownership documentation varies by business structure—call your Word & Brown representative*

† *Payroll records must include the number of hours worked for each employee. If no DE-9C, group must also submit copy of their business license and tax ID number. Group must be in business a minimum of 50% of prior quarter in order to be guaranteed issue.*

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Must submit check with initial application?	*No—but they do need a copy of check*	*Yes*	*Yes, but if electing autopay, no check is needed*	*No*	*ACH form can be submitted in lieu of check*	*Yes - Effective 03/28/2016 we are now requesting for the binder check when the group is submitted.*	*Yes*	*Yes*	*Yes, if paying via Echeck no check is required*
Make check payable to	*Kaiser Permanente*	*MediExcel Health Plan*	*National General Insurance*	*Oscar Health Plan of California*	*HMO: Sharp Health Plan* *PPO: Please contact your Word & Brown rep*	*SIMNSA Health Plan 2088 Otay Lakes Road, #102 Chula Vista, CA 91915*	*Sutter Health Plus*	*UnitedHealthcare*	*WHA*
New in Business Minimum length of time in business?	*50% of previous calendar quarter. If proves less, Kaiser Permanente will recertify the group upon the first renewal*	*4 weeks*	*No Minimum*	*4 weeks*	*45 days*	*New business is required to be established for at least 3 months and provide the most recent DE9C.*	*Employer must have a minimum of 1-100 full-time equivalent eligible employees on at least 50% of its working days during the preceding calendar quarter or calendar year. Startup groups are allowed with 4 weeks of payroll and must meet all other eligibility requirements.*	*2 weeks of payroll.*	*30 days*
Payroll records required? If yes, how long?	*Varies depending on when the business was established but 1 month may be acceptable*	*DE-9C or 4 weeks of payroll are required.*	*Yes, 60 days*	*DE 9C or 4 weeks of payroll are required.*	*Yes—6 weeks*	*No - DE-9C report*	*Yes, a minimum 4 weeks of payroll are required.*	*Depends on business entity—call your Word & Brown representative*	*30 days*
Copy of business license?	*Yes*	*Only if enrolling business owners are not on the DE9C*	*Only if other documentation cannot be provided.*	*Groups must submit any one of the following: Current/active business license; Fictitious Business Name statement; Statement of Information; Articles of Incorporation*	*Yes*	*No*	*Refer to SHP's Small Group Submission Broker Checklist.*	*Depends on business entity—call your Word & Brown representative*	*No*
Other documents required?	*New group application, employee applications, declination of coverage, and proprietor/ partner/ corporate officer form*	*New group application, employee applications.* *Waivers are only required when only enrollees are business owners.*	*Depending on information provided it may be possible.*	*Depends on the type of business.*	*Yes—refer to SHP website for details. Groups with less than 4 enrolled requires submission of stamped and filed SOI showing officers OR current, complete business taxes.*	*DE-9C*	*Refer to SHP's Small Group Submission Broker Checklist.*	*Depends on business entity—call your Word & Brown representative*	*New group application, employee applications, declination of coverage, and proprietor/ partner/ corporate officer form*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - WRAP† REQUIREMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net
Can be written with Kaiser?	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*
Can be written with another carrier's PPO or indemnity plan?	*Group Size 1-100: Yes - standard participation of 60% must be met in order for a group to qualify for coverage. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier.*	*Yes If group is 4 or less employees, 65% participation required. If group is 5-100 employees, 25% participation required Participation in other carrier is not considered a valid waiver*	*Group Size 1-100: No If the group qualifies for the relaxed participation program, we do allow one other carrier HMO and/or PPO alongside. For off exchange portfolio only*	*Group Size 2+: Yes (with Kaiser Permanente only)*	*Group Size 1-100: No*	*Group Size 1-100: Yes*	*No*	*Group Size 1-5: Yes - may write alongside another carrier as long as HN has 66% participation. Group Size 6-100: Yes - may write alongside another carrier as long as HN has 50% participation.*
Can be written with another carrier's HMO, POS or EPO?	*Group Size 1-100: Groups offering other carrier's HMO must have at least 25% participation and a minimum of five employees enrolling in an Aetna plan. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier. (Standard participation applies alongside another carrier's POS, EPO or PPO plans.) Alongside Staff Model: Groups offering other carrier's HMO must have at least 25% participation and a minimum of five employees enrolling in an Aetna plan. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier. (Standard participation applies alongside another carrier's POS, EPO or PPO plans.)*	*Yes If group is 4 or less employees, 65% participation required. If group is 5-100 employees, 25% participation required Participation in other carrier is not considered a valid waiver*	*Group Size 1-100: Mirror Package: No, Blue Shield must be the only carrier offered. Blue Shield Off Exchange package: Yes, 65% of total employee count must enroll and a minimum of 5 or 50% (whichever is greater) must enroll on a Blue Shield plan. Note: Blue Shield does not wrap with EPO plans.*	*Group Size 2+: Yes (with Kaiser Permanente only)*	*Group Size 1-100: No*	*Group Size 1-100: Yes*	*Yes*	*Group Size 1-5: Yes - may write alongside another carrier as long as HN has 66% participation Group Size 6-100: Yes - maybe write alongside another carrier as long as HN has 50% participation*

†Indicates flexibility in being offered with products of another carrier.

HEALTH PLAN COMPARISON - WRAP† REQUIREMENTS

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Can be written with Kaiser?	*N/A*	*Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Yes - minimum of 5 enrolled employees. PPO plan is not available.*	*Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*	***Groups offering UnitedHealthcare and a staff model:*** *Choice Simplified Package: There must be at least 60% participation between the two carriers with 5 California employees enrolling with UnitedHealthcare, excluding COBRA participants.* A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/ waivers from any employees not reflected on the billing statement.* *Multi-Choice State Package: There must be at least 60% participation with UnitedHealthcare, excluding COBRA participants. A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/ waivers from any employees not reflected in the billing statement.*	*Yes*
Can be written with another carrier's PPO or indemnity plan?	*Group Size 1-100: Yes - for HMO and POS plans only. 70% of group's eligible employee population should be covered by a group health care plan. If a group chooses a PPO, they cannot have another carrier written alongside.*	*Group Size 1-100: Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Sharp will allow wrap with other carrier. Requires 5 enrolled subscribers on SHP.* *SHARP WILL NOT PERMIT WRAP WITH CALIFORNIACHOICE®*	*Group Size 5-100: Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*		*Group Size 1-100: Yes*
Can be written with another carrier's HMO, POS or EPO?	*Group Size 1-100: Yes - for HMO and POS plans only. 70% of group's eligible employee population should be covered by a group health care plan. If a group chooses a PPO, they cannot have another carrier written alongside.*	*Group Size 1-100: Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Yes— Sharp requires 5 enrolled subscribers.* *SHARP WILL NOT PERMIT WRAP WITH CALIFORNIACHOICE®*	*Group Size 5-100: Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*		*Group Size 1-100: Yes*

†Indicates flexibility in being offered with products of another carrier.

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*