**Request for Proposals for Racial Equity Facilitation and Consultancy Support**

**ADM-DS 2021-02**

**Attachment 8**

**Health Care Accountability Ordinance (HCAO) &**

**Minimum Compensation Ordinance (MCO)**

**Declaration Forms**

**San Francisco Labor Laws for SFO Contractors**

## Effective July 1, 2019 – Excludes QSP

**Minimum Compensation Ordinance (MCO) – 12P**

***Wages and Paid Time Off (PTO)***

For a company that has 5 employees or greater, anywhere in the world. Includes subcontractors. Any employee who works on a City contract for services:

* For-profit rate is $17.66/hour as of 7/1/19
* Non-profit rate is $16.50/hour as of 7/1/19
* Public Entities rate effective 2/1/19 $16.00/hour; Effective 7/1/19 $16.50/hour
* 0.04615 hours of Paid Time Off (PTO) per hour worked (can be used as vacation or sick leave, and is vested and cashed out at termination)
* 0.0384 hours of Unpaid Time Off per hour worked – allowed without consequence
* Employee must sign a “Know Your Rights” form
* Posting Requirement

**Health Care Accountability Ordinance (HCAO) – 12Q**

For a company that has > 20 workers (for profit)/ > 50 workers (nonprofit), anywhere in the world – Includes subcontractors

Any employee who works **at least 20 hours a week** on a City contract for services:

* Either:
  1. Offer a compliant health plan with no premium charge to the employee. See Minimum Standards OR
  2. Pay $5.40\*\* per hour to SF General Hospital (not Healthy San Francisco and not a benefit to employees) OR
  3. Pay $5.40\*\* per hour to covered employee. N/A to SFO and San Bruno Jail locations. Employee must live outside of SF and work on a City contract outside of SF. See HCAO for more details.
* Employee must sign a “Know Your Rights” form
* Posting Requirement

Video [- https://youtu.be/Jgy5OpPzQqM](https://youtu.be/Jgy5OpPzQqM)

\*\* Rate changes every July 1

#### Beverly Popek, Compliance Officer

Office of Labor Standards and Enforcement (OLSE) City Hall Room, 430

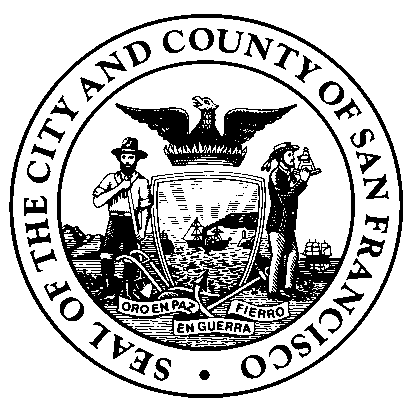
1 Dr. Carlton B. Goodlett Place San Francisco, CA 94102

(415) 554-6238 [beverly.popek@sfgov.org](mailto:beverly.popek@sfgov.org)

For more information, or to sign up for email updates on the MCO and HCAO, visit our website: sfgov.org/OLSE

*Please Post Where Employees Can Read It Easily*

#### CITY AND COUNTY OF SAN FRANCISCO



**NOTICE TO EMPLOYEES – JULY 1, 2019**

**Minimum Compensation Ordinance**

This employer is a contractor with the City and County of San Francisco. This contract agreement is subject to the Minimum Compensation Ordinance (MCO). If under this contract agreement you perform any work funded under an applicable contract, you must be provided no less than the Minimum Compensation outlined below.

##### THESE ARE YOUR RIGHTS . . .

1. **Minimum Hourly Compensation:**

For contracts entered into or amended on or after October 14, 2007

* + For-Profit Rate is **$17.66/hour effective 7/1/19**
  + Non-profit Rate is **$16.50/hour effective 7/1/19**
  + Public Entities Rate is **$16.50/hour effective 7/1/19**
  + Rates subject to change; your employer must pay the then-current rate posted on the OLSE web site: [www.sfgov.org/olse/mco](http://www.sfgov.org/olse/mco)

For contracts entered into prior to October 14, 2007

* + For work performed within the City Of S.F.: SF Minimum Wage ($15.59/hour effective 7/1/19)
  + For work performed outside of S.F.: $10.77/hour

##### Paid Days Off:

* + 12 paid days off per year for vacation, sick leave, or personal necessity
  + The paid days off for part-time employees are prorated based on hours worked

##### Unpaid Days Off:

* + 10 unpaid days off per year
  + Unpaid days off for part-time employees are prorated based on hours worked

##### IF YOU BELIEVE YOUR RIGHTS ARE BEING VIOLATED CONTACT THE OFFICE OF LABOR STANDARDS ENFORCEMENT AT (415) 554-7903.

Office of Labor Standards Enforcement (OLSE) City Hall, Room 430

**1 Dr. Carlton B. Goodlett Place San Francisco, CA 94102** [**www.sfgov.org/olse/mco**](http://www.sfgov.org/olse/mco)

**CITY AND COUNTY OF SAN FRANCISCO**

**GENERAL SERVICES AGENCY**

OFFICE OF LABOR STANDARDS ENFORCEMENT

**PATRICK MULLIGAN, DIRECTOR**

#### Minimum Compensation Ordinance (MCO) KNOW YOUR RIGHTS – JULY 1, 2019

This notice is intended to inform you of your rights under the Minimum Compensation Ordinance (MCO), Chapter 12P of the San Francisco Administrative Code. The MCO requires your employer to provide a prescribed minimum level of compensation be paid to employees of (1) contractors and their subcontractors providing services to the City and County; (2) public entities whose boundaries are coterminous with the City and County who have city contracts; and, (3) tenants and subtenants on Airport property and their subcontractors. The Office of Labor Standards Enforcement (OLSE) is charged with enforcing the MCO. You will be asked to sign this document after you have reviewed the following information. Do not sign this document unless you fully understand your rights under this law.

1. **Minimum Hourly Wage**

**THE MCO REQUIREMENTS**

* + For-Profit Rate is **$17.66/hour effective 7/1/19**
  + Non-profits pay no less than the S.F. Minimum Wage of **$16.50/hour effective 7/1/19**
  + Public Entities rate is **$16.60/hour effective 7/1/19**
  + For contracts entered into prior to October 14, 2007, the rate for work performed within the City of S.F. is the San Francisco minimum wage ($15.59/hour effective July 1, 2019). The rate for work performed outside of S.F. is $10.77/hour.
  + Rates are subject to change. Your employer is obligated to keep informed of the requirements and to notify employees in writing of any adjustment to the MCO wage.

1. **Paid Days Off**
   * 12 paid days off per year for vacation, sick leave or personal necessity
   * The paid days off for part-time employees are prorated based on hours worked
2. **Unpaid Days Off**
   * 10 unpaid days off per year
   * Unpaid days off for part-time employees are prorated based on hours worked
   * Temporary and casual employees are not eligible for unpaid time off

RETALIATION PROHIBITED

Your employer may not retaliate against you or any other employee for trying to learn more about the MCO or exercising your rights under the law. If you believe that you have been discriminated or retaliated against for inquiring about or exercising your rights under the MCO, contact the OLSE at (415) 554-7903 to file a MCO complaint.

Do not sign this document unless you fully understand your rights under this law. If you have any questions about your employer’s responsibilities or your rights under this Ordinance, contact the OLSE at (415) 554-7903 or visit [www.sfgov.org/olse/mco](http://www.sfgov.org/olse/mco) for more information about this law.

Print Name of Employee:

Signature of Employee: Date:

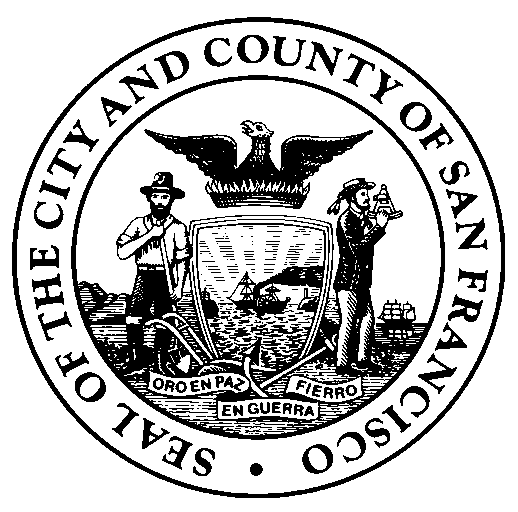
Para asistencia en Español, llame al (415) 554-7903

需要中文幫助﹐請電 (415) 554-7903

For a complete copy of the Minimum Compensation Ordinance, visit [www.sfgov.org/olse/mco](http://www.sfgov.org/olse/mco)**.**

SF OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY HALL ROOM 430 TEL (415) 554-6235 • FAX (415) 554-6291 1 DR. CARLTON B. GOODLETT PLACE • SAN FRANCISCO, CA 94102 [WWW.SFGOV.ORG/OLSE](http://WWW.SFGOV.ORG/OLSE)

#### CITY AND COUNTY OF SAN FRANCISCO



**NOTICE TO EMPLOYEES – JULY 1, 2019**

**Health Care Accountability Ordinance**

This employer is a contractor with the City and County of San Francisco. This contract agreement is subject to the Health Care Accountability Ordinance (HCAO). The HCAO requires your employer to provide health plan benefits to covered employees, make payments to the City for use by the Department of Public Health (DPH), or, under limited circumstances, make payments directly to employees. **If you work at least 20 hours per week on a City contract, you are a covered employee and your employer must choose one of the following options:**

###### PROVIDE YOU WITH A HEALTH PLAN THAT MEETS THE MINIMUM STANDARDS OUTLINED BY THE DIRECTOR OF PUBLIC HEALTH

* + Your employer cannot require you to contribute any amount towards the premiums for health plan coverage for yourself**.**
  + Coverage must begin no later than the first of the month that begins after 30 days from the start of employment on a covered contract.

**OR**

1. **PAY $5.40 PER HOUR WORKED TO THE CITY & COUNTY OF SAN FRANCISCO**
   * If you live within the City and County of San Francisco or work on a City contract within the City, the San Francisco Airport, or the San Bruno Jail, and your employer does not provide a health plan that meets the Minimum Standards, your employer must pay $5.40 hour for every hour you work (up to 40 hours a week) to the City and County of San Francisco.

**OR**

1. **PAY AN ADDITIONAL $5.40 PER HOUR WORKED TO THE EMPLOYEE**
   * If you live outside the City and County of San Francisco and work on a City contract located outside of the City, and not at the San Francisco Airport or at the San Bruno Jail and your employer does not provide a health plan that meets the Minimum Standards, your employer must pay you an additional $5.40/hour for every hour you work (up to 40 hours a week) to enable you to obtain health insurance coverage.

**IF YOU BELIEVE YOUR RIGHTS ARE BEING VIOLATED CONTACT THE OFFICE OF LABOR STANDARDS ENFORCEMENT AT (415) 554-7903.**

Office of Labor Standards Enforcement (OLSE) City Hall, Room 430

**1 Dr. Carlton B. Goodlett Place San Francisco, CA 94102** [**www.sfgov.org/olse/hcao**](http://www.sfgov.org/olse/hcao)

**CITY AND COUNTY OF SAN FRANCISCO**

**GENERAL SERVICES AGENCY**

OFFICE OF LABOR STANDARDS ENFORCEMENT

**PATRICK MULLIGAN, DIRECTOR**

#### Health Care Accountability Ordinance (HCAO) KNOW YOUR RIGHTS – JULY 1, 2019

This notice is intended to inform you of your rights under the Health Care Accountability Ordinance (HCAO), Chapter 12Q of the San Francisco Administrative Code. The HCAO requires your employer to provide health insurance to you. Your employer can do this by enrolling you in a health plan, by making payments to the City, or, under limited circumstances, by making payments directly to you. The Office of Labor Standards Enforcement (OLSE) is charged with enforcing this Ordinance. You will be asked to sign this document after you have reviewed the following information. Do not sign this document unless you fully understand your rights under this law.

**THE HCAO COMPONENTS**

1. If you live in San Francisco (regardless of where you work) or if you work in San Francisco, at the San Francisco Airport, or at the San Bruno Jail, your employer must:
   1. Offer you health coverage that meets the Minimum Standards starting on the first day of the month following 30 calendar days after your first day of work\*; **OR**
   2. For each month in which you averaged at least 20 hours of work per week, pay the City $5.40 per hour for each hour you work, up to 40 hours or $216 per week.
2. If you do not live in San Francisco and do not work in San Francisco, at the San Francisco Airport, or at the San Bruno Jail, your employer must:
   1. Offer you health coverage that meets the Minimum Standards starting on the first day of the month following 30 calendar days after your first day of work\*; **OR**
   2. For each month in which you averaged at least 20 hours of work per week, pay you $5.40 per hour for each hour you work, up to 40 hours or $216 per week, so that you can obtain health insurance coverage on your own.

***\*Note that your employer must offer at least one plan that does not require you to contribute any amount towards the cost of premiums for health plan coverage for yourself.***

**EXEMPTIONS FROM COVERAGE**

Certain categories of employees, including but not limited to students, trainees, and employees of employers subject to Prevailing Wage requirements, are exempt under the HCAO. For more information, go to [www.sfgov.org/olse/hcao](http://www.sfgov.org/olse/hcao) or call (415) 554-7903.

**VOLUNTARY WAIVER OF COVERAGE**

Employees may refuse health coverage offered by an employer if the employee signs the Voluntary Waiver Form. Employees may revoke this voluntary waiver at any time.

**RETALIATION PROHIBITED**

Your employer may not retaliate against you or any other employee for trying to learn more about the HCAO or exercising your rights under the law. If you believe that you have been discriminated or retaliated against for inquiring about or exercising your rights under the HCAO, contact the OLSE at (415) 554-7903 to file an HCAO complaint.

Do not sign this document unless you fully understand your rights under this law. If you have any questions about your employer’s responsibilities or your rights under this Ordinance, contact the OLSE at (415) 554-7903 or visit <http://sfgov.org/olse/hcao>for more information about this law.

Name of Employee Date

Signature of Employee

**Para asistencia en Español, llame al 554-7903**

**需要中文幫助﹐請電 554-7903**

*NOTE: For a complete copy of the Health Care Accountability Ordinance or the Minimum Standards, visit*

[http://sfgov.org/olse/hcao.](http://sfgov.org/olse/hcao)

SF OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY HALL ROOM 430 TEL (415) 554-6235 • FAX (415) 554-6291 1 DR. CARLTON B. GOODLETT PLACE • SAN FRANCISCO, CA 94102 [WWW.SFGOV.ORG/OLSE](http://WWW.SFGOV.ORG/OLSE)



City and County of San Francisco London N. Breed

Mayor

San Francisco Department of Public Health

Barbara A. Garcia, MPA Director of Health

**San Francisco Health Care Accountability Ordinance Minimum Standards – Effective January 1, 2019**

The following minimum standards are effective January 1, 2019. A health plan must meet all 16 minimum standards as described below to be deemed compliant.

|  |  |
| --- | --- |
| **Benefit Requirement** | **Minimum Standard** |
| **Type of Plan** | Any type of plan that meets the Minimum Standards as described below.  All gold- and platinum-level plans are deemed compliant. |
| **1. Premium Contribution** | Employer pays 100% |
| **2. Annual OOP Maximum** | * In-Network: California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan’s effective date:   2019 = $7,550  2020 = To be determined in 2019   * Out-of-Network: Not specified   OOP Maximum must include all types of cost‐sharing (deductible, copays, coinsurance, etc.). |
| **3. Medical Deductible** | * In-Network: $2,000 * Out-of-Network: Not specified   The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard. |
| **4. Prescription Drug Deductible** | * In-Network: $200 * Out-of-Network: Not specified |
| **5. Prescription Drug Coverage** | Plan must provide drug coverage, including coverage of brand-name  drugs. |
| **6. Coinsurance Percentages** | * In‐Network: 80%/20% * Out‐of‐Network: 50%/50% |

|  |  |
| --- | --- |
| **Benefit Requirement** | **Minimum Standard** |
| **7. Copayment for Primary Care**  **Provider Visits** | * In‐Network: $45 per visit. * Out‐of‐Network: Not specified |
| **8. Ambulatory Patient Services**  **(Outpatient Care)** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: * Primary Care Provider: See Benefit Requirement #7 * Specialty visits: Not specified |
| **9. Preventive & Wellness**  **Services** | * In‐Network: Provided at no cost, per ACA rules. * Out‐of‐Network: Subject to the plan’s out‐of‐network fee requirements.   These services are standardized by federal ACA rules at no charge to the  member. The [California EHB Benchmark Plan](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) outlines the types of preventive services that are required. |
| **10. Pre/Post-Natal Care** | * In‐Network: Scheduled prenatal exams and first postpartum follow‐up   consult is covered without charge, per ACA rules.   * Out‐of‐Network: Subject to the plan’s out‐of‐network fee requirements.   These services are standardized by federal ACA rules at no charge to the  member. The [California EHB Benchmark Plan](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) outlines the types of pre- and post-natal services that are required. |
| **11. Hospitalization** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **12. Mental Health & Substance**  **Use Disorder Services, including Behavioral Health** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **13. Rehabilitative &**  **Habilitative Services** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **14. Laboratory Services** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **15. Emergency Room Services**  **& Ambulance** | Limited to treatment of medical emergencies. The in‐network deductible,  copayment, and coinsurance also apply to emergency services received  from an out‐of‐network provider. |
| **16. Other Services** | The full set of covered benefits is defined by the [California EHB](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf)  [Benchmark plan.](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) |

**CALIFORNIA EHB BENCHMARK PLAN**

SUMMARY INFORMATION

|  |  |
| --- | --- |
| **Plan Type** | Plan from largest small group product, Health Maintenance Organization |
| **Issuer Name** | Kaiser Foundation Health Plan, Inc. |
| **Product Name** | Small Group HMO |
| **Plan Name** | Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035 |
| **Supplemented Categories**  (Supplementary Plan Type) | * Pediatric Oral (State CHIP) * Pediatric Vision (FEDVIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | Yes |
| **Habilitative Services Defined by State**  (Yes/No) | Yes: “Habilitative services” means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy. |

California—1

BENEFITS AND LIMITS

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered):**  **Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes"**  **if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitativ e Limit is "Yes": Enter Limit Quantity** | **F**  **Limit Units Required if Quantitativ e Limit is "Yes": Select the correct limit units** | **G**  **Other Limit Units Description Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay Optional: Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions Optional: Enter any Exclusions for this benefit** | **J**  **Explanation: Optional Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions?**  **Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 1 | **Primary Care Visit to Treat an Injury or Illness** | Covered | Outpatient Care | No |  |  |  |  |  | Primary and specialty care consultations, exams treatment. | No |
| 2 | **Specialist Visit** | Covered | Outpatient Care | No |  |  |  |  |  | Primary and specialty care consultations, exams treatment. | No |
| 3 | **Other Practitioner Office Visit (Nurse, Physician Assistant)** | Covered | Outpatient Care | No |  |  |  |  |  | Primary and specialty care consultations, exams treatment. | No |
| 4 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | Outpatient Care | No |  |  |  |  |  |  | No |
| 5 | **Outpatient Surgery Physician/Surgical Services** | Covered | Outpatient Care | No |  |  |  |  |  | Outpatient Surgery covered if provided in outpatient or ambulatory surgery center or in a hospital operating room, or any setting if license staff member monitors your vital signs as patient resumes. | No |
| 6 | **Hospice Services** | Covered | Hospice Care | No |  |  |  |  |  |  | No |
| 7 | **Non-Emergency Care When Traveling Outside the U.S.** | Not Covered |  |  |  |  |  |  |  |  |  |
| 8 | **Routine Dental Services (Adult)** | Not Covered |  |  |  |  |  |  |  |  |  |
| 9 | **Infertility Treatment** | Not Covered |  |  |  |  |  |  |  |  |  |
| 10 | **Long-Term/Custodial Nursing Home Care** | Not Covered |  |  |  |  |  |  |  |  |  |
| 11 | **Private-Duty Nursing** | Not Covered |  |  |  |  |  |  |  |  |  |
| 12 | **Routine Eye Exam (Adult)** | Covered | Preventive care services | No |  |  |  |  |  | Eye exams for refraction and preventive vision screenings. | No |
| 13 | **Urgent Care Centers or Facilities** | Covered | Urgent Care | No |  |  |  |  |  |  | No |
| 14 | **Home Health Care Services** | Covered | Home Health Care | Yes | 100 | Visits per year |  |  | Care that an unlicensed family member or layperson could provide safely/ effectively or care in home if home is not safe and effective treatment setting. | Up to 2 hours per visit (nurse, msw, phys/occ/sp therapist) or 3 hours for home health aide. Three visits per day. | No |

California—2

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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered):**  **Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes"**  **if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitativ e Limit is "Yes": Enter Limit Quantity** | **F**  **Limit Units Required if Quantitativ e Limit is "Yes": Select the correct limit units** | **G**  **Other Limit Units Description Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay Optional: Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions Optional: Enter any Exclusions for this benefit** | **J**  **Explanation: Optional Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions?**  **Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 15 | **Emergency Room Services** | Covered | Emergency Services | No |  |  |  |  |  |  | No |
| 16 | **Emergency Transportation/ Ambulance** | Covered | Emergency transportation and ambulance when reasonable person would believe medical condition that required ambulance services or if treating physician determines you must be transported to another facility b/c condition not stabilized & svcs not available | No |  |  |  |  |  |  | No |
| 17 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Hospital Inpatient Services - services at plan hospital when services generally provided at acute care gen hosp in service area. | No |  |  |  |  |  |  | No |
| 18 | **Inpatient Physician and Surgical Services** | Covered | Hospital Inpatient Care - covers services of plan physicians and consultation and treatment by specialists | No |  |  |  |  |  |  | No |
| 19 | **Bariatric Surgery** | Covered | Bariatric surgery to treat obesity if complete pre- surgical education and medically necessary | No |  |  |  |  |  | Surgery must be medically necessary to treat obesity and patient must complete pre- surgical education. Covers travel if live more than 50 miles from facility to which patient referred. | No |
| 20 | **Cosmetic Surgery** | Not Covered |  |  |  |  |  |  |  |  |  |
| 21 | **Skilled Nursing Facility** | Covered | Skilled Nursing Facility Care | Yes | 100 | Other other | Days per benefit period |  |  |  | No |
| 22 | **Prenatal and Postnatal Care** | Covered | Scheduled prenatal exams and first postpartum follow- up consult is covered without charge | No |  |  |  |  |  |  | No |
| 23 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Hospital Inpatient Care | No |  |  |  |  |  |  | No |
| 24 | **Mental/Behavioral Health Outpatient Services** | Covered | Mental Health Services | No |  |  |  |  |  | For diagnosis or treatment of mental disorders  - as identified in DSM. | No |

California—3

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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered):**  **Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes"**  **if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitativ e Limit is "Yes": Enter Limit Quantity** | **F**  **Limit Units Required if Quantitativ e Limit is "Yes": Select the correct limit units** | **G**  **Other Limit Units Description Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay Optional: Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions Optional: Enter any Exclusions for this benefit** | **J**  **Explanation: Optional Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions?**  **Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 25 | **Mental/Behavioral Health Inpatient Services** | Covered | Inpatient Psychiatric Hospitalization and intensive psychiatric treatment programs | No |  |  |  |  |  |  | No |
| 26 | **Substance Abuse Disorder Outpatient Services** | Covered | Chemical Dependency Services - Outpatient chemical dependency. Includes day-treatment, intensive outpatient programs, individual and group counseling, and medical treatment for withdrawal symptoms. | No |  |  |  |  | Services in specialized facility not otherwise described in EOC | Includes transitional residential recovery services. | No |
| 27 | **Substance Abuse Disorder Inpatient Services** | Covered | Chemical Dependency Services - Inpatient detoxification | No |  |  |  |  |  |  | No |
| 28 | **Generic Drugs** | Covered | Outpatient Prescription Drugs, Supplies, and Supplements | No |  |  |  |  |  |  | No |
| 29 | **Preferred Brand Drugs** | Covered | Outpatient Prescription Drugs, Supplies, and Supplements | No |  |  |  |  |  | Kaiser does not use preferred/non-preferred categories. Kaiser categorizes drugs as generic, brand, or compound and formulary/ nonformulary. There is higher Cost Sharing than for Generic Drugs. | No |
| 30 | **Non-Preferred Brand Drugs** | Covered | Outpatient Prescription Drugs, Supplies, and Supplements | No |  |  |  |  |  | Kaiser does not use preferred/non-preferred categories. Kaiser categorizes drugs as generic, brand, or compound and formulary/ nonformulary. There is coverage for non- formulary if non-formulary is medically necessary. | No |
| 31 | **Specialty Drugs** | Covered | Outpatient Prescription Drugs, Supplies, and Supplements | No |  |  |  |  |  |  | No |
| 32 | **Outpatient Rehabilitation Services** | Covered | Physical, occupational, speech therapy | No |  |  |  |  |  |  | No |
| 33 | **Habilitation Services** | Covered | Habilitation Services | No |  |  |  |  | Certain limitations on types of care givers for behavioral health treatment as described in H&S Code section 1374.73. | CA Health and Safety Code sec. 1367.005 (Stats 2012, ch. 854) requires that individual or small group health care service plans provide habilitative services, to the extent required under state law and as required by federal rules and regulations in section 1302(b) of the ACA. | No |

California—4

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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered):**  **Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes"**  **if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitativ e Limit is "Yes": Enter Limit Quantity** | **F**  **Limit Units Required if Quantitativ e Limit is "Yes": Select the correct limit units** | **G**  **Other Limit Units Description Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay Optional: Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions Optional: Enter any Exclusions for this benefit** | **J**  **Explanation: Optional Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions?**  **Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 34 | **Chiropractic Care** | Not Covered |  |  |  |  |  |  |  |  |  |
| 35 | **Durable Medical Equipment** | Covered | Durable Medical Equipment for Home Use - plan formulary guidelines or medical necessity | No |  |  |  |  | Prior auth required |  | No |
| 36 | **Hearing Aids** | Not Covered |  |  |  |  |  |  |  |  |  |
| 37 | **Diagnostic Test**  **(X-Ray and Lab Work)** | Covered | Outpatient imaging, laboratory and special procedures | No |  |  |  |  |  |  | No |
| 38 | **Imaging (CT/PET Scans, MRIs)** | Covered | Outpatient imaging, laboratory and special procedures | No |  |  |  |  |  |  | No |
| 39 | **Preventive Care/ Screening/Immunization** | Covered | Outpatient imaging, laboratory and special procedures | No |  |  |  |  |  |  | No |
| 40 | **Routine Foot Care** | Not Covered | Exclusions |  |  |  |  |  |  | Medically necessary foot care is covered. |  |
| 41 | **Acupuncture** | Covered | Outpatient Care | No |  |  |  |  |  | Typically only for treatment of nausea or as part of comp. pain management program. | No |
| 42 | **Weight Loss Programs** | Covered | Weight Loss Programs | No |  |  |  |  |  |  | No |
| 43 | **Routine Eye Exam for Children** | Covered | Routine eye exam | Yes | 1 | Visits per year |  |  |  | California has chosen FEDVIP to supplement benchmark for pediatric vision care. | No |
| 44 | **Eye Glasses for Children** | Covered | Eyeglasses for adults and children | Yes | 1 | Other other | 1 pair of glasses (lenses and frames per year) |  |  | California has chosen FEDVIP to supplement benchmark for pediatric vision care. | No |
| 45 | **Dental Check-Up for Children** | Covered | Dental Check-Up for Children | Yes | 1 | Other other | 2 in a 12 month period |  |  | Supplemented using California CHIP. | No |

California—5

OTHER BENEFITS

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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitative Limit is "Yes"):**  **Enter Limit Quantity** | **F**  **Limit Units (Required if Quantitative Limit is "Yes"):**  **Select the correct limit units** | **G**  **Other Limit Units Description (Required if "Other" Limit Unit):**  **If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions (Optional): Enter any Exclusions for this benefit** | **J**  **Explanation: (Optional)**  **Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions? (Required if benefit is Covered):**  **Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 1 | **Other** | Covered | Allergy injections | No |  |  |  |  |  |  | No |
| 2 | **Other** | Covered | Voluntary Termination of Pregnancy | No |  |  |  |  |  |  | No |
| 3 | **Other** | Covered | Dental and Orthodontic Services | No |  |  |  |  |  | Preparations for radiation therapy and Dental anesthesia for children under age 7, developmentally disabled, or health is compromised, status or underlying condition and procedure doesn't ordinarily require anesthesia. | No |
| 4 | **Other** | Covered | Asthma Supplies and Equipment | No |  |  |  |  |  |  | No |
| 5 | **Other** | Covered | Dialysis Care | No |  |  |  |  |  |  | No |
| 6 | **Other** | Covered | Hearing Screenings & Exams - preventive care services | No |  |  |  |  |  |  | No |
| 7 | **Other** | Covered | Ostomy and Urological Supplies | No |  |  |  |  |  |  | No |
| 8 | **Other** | Covered | AIDS Vaccine | No |  |  |  |  |  |  | No |
| 9 | **Other** | Covered | HIV Testing | No |  |  |  |  |  |  | No |
| 10 | **Other** | Covered | Alzheimer's Disease Treatment | No |  |  |  |  |  |  | No |
| 11 | **Other** | Covered | Breast Cancer Screening, Diagnosis, Treatment, Prosthetic Devices or Reconstructive Surgery | No |  |  |  |  |  |  | No |
| 12 | **Other** | Covered | Cancer Screenings | No |  |  |  |  |  |  | No |
| 13 | **Other** | Covered | Cervical Cancer Screenings | No |  |  |  |  |  |  | No |
| 14 | **Other** | Covered | Cancer Clinical Trials | No |  |  |  |  |  |  | No |
| 15 | **Other** | Covered | Contraceptive Methods | No |  |  |  |  |  |  | No |
| 16 | **Other** | Covered | Diabetes Equipment, Supplies, Prescription Drugs, Education | No |  |  |  |  |  |  | No |
| 17 | **Other** | Covered | Laryngectomy-Prosthetic Devices | No |  |  |  |  |  |  | No |
| 18 | **Other** | Covered | Maternity Coverage | No |  |  |  |  |  |  | No |
| 19 | **Other** | Covered | Maternity-Prenatal Alpha Feto Protein Programs | No |  |  |  |  |  |  | Yes |
| 20 | **Other** | Covered | Genetic Disorders of the Fetus | No |  |  |  |  |  |  | No |
| 21 | **Other** | Covered | Osteoporosis | No |  |  |  |  |  |  | No |
| 22 | **Other** | Covered | Phenylketonuria | No |  |  |  |  |  |  | No |
| 23 | **Other** | Covered | Prostate Cancer Screening and Diagnosis | No |  |  |  |  |  |  | No |
| 24 | **Other** | Covered | Reconstructive Surgery | No |  |  |  |  |  |  | No |
| 25 | **Other** | Covered | Surgical Procedures for the Jawbone | No |  |  |  |  |  |  | No |
| 26 | **Other** | Covered | Basic Dental Care – Child | No |  |  |  |  |  | Limitations, including dollar limits, may apply. | No |
| 27 | **Other** | Covered | Major Dental Care – Child | No |  |  |  |  |  | Limitations, including dollar limits, may apply. | No |

California—6

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| **Row Number** | **A**  **Benefit** | **B**  **Covered (Required): Is benefit Covered or Not Covered** | **C**  **Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name** | **D**  **Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies** | **E**  **Limit Quantity (Required if Quantitative Limit is "Yes"):**  **Enter Limit Quantity** | **F**  **Limit Units (Required if Quantitative Limit is "Yes"):**  **Select the correct limit units** | **G**  **Other Limit Units Description (Required if "Other" Limit Unit):**  **If a Limit Unit of "Other" was selected in Limit Units, enter a description** | **H**  **Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number** | **I**  **Exclusions (Optional): Enter any Exclusions for this benefit** | **J**  **Explanation: (Optional)**  **Enter an Explanation for anything not listed** | **K**  **Does this benefit have additional limitations or restrictions? (Required if benefit is Covered):**  **Select "Yes" if there are additional limitations or restrictions that need to be described** |
| 28 | **Other** | Covered | Orthodontia - Child | No |  |  |  |  |  | Limitations, including dollar limits, may apply. Covered only if child meets eligibility requirements for medically necessary orthodontia coverage under California Children’s Services (CCS). | No |

California—7

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

|  |  |  |
| --- | --- | --- |
| **CATEGORY** | **CLASS** | **SUBMISSION COUNT** |
| ANALGESICS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 10 |
| ANALGESICS | OPIOID ANALGESICS, LONG-ACTING | 3 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 8 |
| ANESTHETICS | LOCAL ANESTHETICS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | ALCOHOL DETERRENTS/ANTI-CRAVING | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | OPIOID ANTAGONISTS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | SMOKING CESSATION AGENTS | 0 |
| ANTI-INFLAMMATORY AGENTS | GLUCOCORTICOIDS | 1 |
| ANTI-INFLAMMATORY AGENTS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 10 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 7 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 13 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 14 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 4 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 11 |
| ANTIBACTERIALS | MACROLIDES | 3 |
| ANTIBACTERIALS | QUINOLONES | 5 |
| ANTIBACTERIALS | SULFONAMIDES | 4 |
| ANTIBACTERIALS | TETRACYCLINES | 4 |
| ANTICONVULSANTS | ANTICONVULSANTS, OTHER | 1 |
| ANTICONVULSANTS | CALCIUM CHANNEL MODIFYING AGENTS | 2 |
| ANTICONVULSANTS | GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS | 4 |
| ANTICONVULSANTS | GLUTAMATE REDUCING AGENTS | 3 |
| ANTICONVULSANTS | SODIUM CHANNEL AGENTS | 5 |
| ANTIDEMENTIA AGENTS | ANTIDEMENTIA AGENTS, OTHER | 0 |
| ANTIDEMENTIA AGENTS | CHOLINESTERASE INHIBITORS | 2 |
| ANTIDEMENTIA AGENTS | N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST | 1 |
| ANTIDEPRESSANTS | ANTIDEPRESSANTS, OTHER | 5 |
| ANTIDEPRESSANTS | MONOAMINE OXIDASE INHIBITORS | 2 |
| ANTIDEPRESSANTS | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 6 |
| ANTIDEPRESSANTS | TRICYCLICS | 8 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 9 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 3 |
| ANTIFUNGALS | NO USP CLASS | 10 |
| ANTIGOUT AGENTS | NO USP CLASS | 4 |
| ANTIMIGRAINE AGENTS | ERGOT ALKALOIDS | 2 |

California—8

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| **CATEGORY** | **CLASS** | **SUBMISSION COUNT** |
| ANTIMIGRAINE AGENTS | PROPHYLACTIC | 3 |
| ANTIMIGRAINE AGENTS | SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS | 2 |
| ANTIMYASTHENIC AGENTS | PARASYMPATHOMIMETICS | 2 |
| ANTIMYCOBACTERIALS | ANTIMYCOBACTERIALS, OTHER | 2 |
| ANTIMYCOBACTERIALS | ANTITUBERCULARS | 6 |
| ANTINEOPLASTICS | ALKYLATING AGENTS | 7 |
| ANTINEOPLASTICS | ANTIANGIOGENIC AGENTS | 2 |
| ANTINEOPLASTICS | ANTIESTROGENS/MODIFIERS | 2 |
| ANTINEOPLASTICS | ANTIMETABOLITES | 2 |
| ANTINEOPLASTICS | ANTINEOPLASTICS, OTHER | 5 |
| ANTINEOPLASTICS | AROMATASE INHIBITORS, 3RD GENERATION | 3 |
| ANTINEOPLASTICS | ENZYME INHIBITORS | 3 |
| ANTINEOPLASTICS | MOLECULAR TARGET INHIBITORS | 12 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 1 |
| ANTINEOPLASTICS | RETINOIDS | 2 |
| ANTIPARASITICS | ANTHELMINTICS | 3 |
| ANTIPARASITICS | ANTIPROTOZOALS | 10 |
| ANTIPARASITICS | PEDICULICIDES/SCABICIDES | 1 |
| ANTIPARKINSON AGENTS | ANTICHOLINERGICS | 3 |
| ANTIPARKINSON AGENTS | ANTIPARKINSON AGENTS, OTHER | 2 |
| ANTIPARKINSON AGENTS | DOPAMINE AGONISTS | 4 |
| ANTIPARKINSON AGENTS | DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS | 2 |
| ANTIPARKINSON AGENTS | MONOAMINE OXIDASE B (MAO-B) INHIBITORS | 2 |
| ANTIPSYCHOTICS | 1ST GENERATION/TYPICAL | 10 |
| ANTIPSYCHOTICS | 2ND GENERATION/ATYPICAL | 5 |
| ANTIPSYCHOTICS | TREATMENT-RESISTANT | 1 |
| ANTISPASTICITY AGENTS | NO USP CLASS | 4 |
| ANTIVIRALS | ANTI-CYTOMEGALOVIRUS (CMV) AGENTS | 3 |
| ANTIVIRALS | ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS | 5 |
| ANTIVIRALS | ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS | 11 |
| ANTIVIRALS | ANTI-HIV AGENTS, OTHER | 3 |
| ANTIVIRALS | ANTI-HIV AGENTS, PROTEASE INHIBITORS | 9 |
| ANTIVIRALS | ANTI-INFLUENZA AGENTS | 4 |
| ANTIVIRALS | ANTIHEPATITIS AGENTS | 11 |
| ANTIVIRALS | ANTIHERPETIC AGENTS | 4 |
| ANXIOLYTICS | ANXIOLYTICS, OTHER | 3 |

California—9

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| **CATEGORY** | **CLASS** | **SUBMISSION COUNT** |
| ANXIOLYTICS | SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS) | 3 |
| BIPOLAR AGENTS | BIPOLAR AGENTS, OTHER | 5 |
| BIPOLAR AGENTS | MOOD STABILIZERS | 5 |
| BLOOD GLUCOSE REGULATORS | ANTIDIABETIC AGENTS | 5 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 1 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 6 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | ANTICOAGULANTS | 3 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | BLOOD FORMATION MODIFIERS | 5 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | COAGULANTS | 1 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | PLATELET MODIFYING AGENTS | 6 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC AGONISTS | 4 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC BLOCKING AGENTS | 4 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN II RECEPTOR ANTAGONISTS | 1 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS | 2 |
| CARDIOVASCULAR AGENTS | ANTIARRHYTHMICS | 9 |
| CARDIOVASCULAR AGENTS | BETA-ADRENERGIC BLOCKING AGENTS | 6 |
| CARDIOVASCULAR AGENTS | CALCIUM CHANNEL BLOCKING AGENTS | 6 |
| CARDIOVASCULAR AGENTS | CARDIOVASCULAR AGENTS, OTHER | 2 |
| CARDIOVASCULAR AGENTS | DIURETICS, CARBONIC ANHYDRASE INHIBITORS | 2 |
| CARDIOVASCULAR AGENTS | DIURETICS, LOOP | 3 |
| CARDIOVASCULAR AGENTS | DIURETICS, POTASSIUM-SPARING | 1 |
| CARDIOVASCULAR AGENTS | DIURETICS, THIAZIDE | 4 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES | 2 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS | 4 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, OTHER | 3 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL | 2 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON- AMPHETAMINES | 1 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 1 |
| CENTRAL NERVOUS SYSTEM AGENTS | FIBROMYALGIA AGENTS | 0 |
| CENTRAL NERVOUS SYSTEM AGENTS | MULTIPLE SCLEROSIS AGENTS | 5 |
| DENTAL AND ORAL AGENTS | NO USP CLASS | 6 |
| DERMATOLOGICAL AGENTS | NO USP CLASS | 20 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 8 |
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 4 |

California—10

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| **CATEGORY** | **CLASS** | **SUBMISSION COUNT** |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 3 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 3 |
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 0 |
| GASTROINTESTINAL AGENTS | LAXATIVES | 1 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 2 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 1 |
| GENITOURINARY AGENTS | BENIGN PROSTATIC HYPERTROPHY AGENTS | 5 |
| GENITOURINARY AGENTS | GENITOURINARY AGENTS, OTHER | 3 |
| GENITOURINARY AGENTS | PHOSPHATE BINDERS | 2 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL) | GLUCOCORTICOIDS/MINERALOCORTICOIDS | 16 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY) | NO USP CLASS | 3 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS) | NO USP CLASS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANABOLIC STEROIDS | 0 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANDROGENS | 4 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ESTROGENS | 2 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | PROGESTINS | 5 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) | NO USP CLASS | 2 |
| HORMONAL AGENTS, SUPPRESSANT (ADRENAL) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PITUITARY) | NO USP CLASS | 5 |
| HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) | ANTIANDROGENS | 3 |
| HORMONAL AGENTS, SUPPRESSANT (THYROID) | ANTITHYROID AGENTS | 2 |
| IMMUNOLOGICAL AGENTS | IMMUNE SUPPRESSANTS | 15 |
| IMMUNOLOGICAL AGENTS | IMMUNIZING AGENTS, PASSIVE | 2 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 7 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 2 |
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |

California—11

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| **CATEGORY** | **CLASS** | **SUBMISSION COUNT** |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 7 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 2 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 3 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 2 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 6 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 9 |
| OTIC AGENTS | NO USP CLASS | 2 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 5 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 4 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 1 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 5 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 4 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 3 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 2 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 1 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 1 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 4 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 7 |

California—12



City and County of San Francisco London N. Breed

Mayor

### San Francisco Department of Public Health

Barbara A. Garcia, MPA Director of Health

Office of Policy and Planning

**2019-2020 HCAO Minimum Standards Common Clarifications**

|  |  |
| --- | --- |
| **Minimum Standard** | **Clarification** |
| **1. Premium Contribution**  Employer pays 100% of the premium contribution. | * Refers only to individual **medical** coverage, not vision/dental. * No money may come out of an employee’s paycheck to pay the premium contribution. * Employer is only required to offer at least 1 HCAO compliant health plan for which the employer must pay 100% of the premium contribution for the covered employee. * Employer has the discretion to offer any additional health plans for which there can be an option for employees to contribute to their premiums. |
| **2. Annual OOP Maximum**  In-Network: California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan’s effective date:  2019 = $7,550  2020 = To be determined in 2019 Out-of-Network: Not specified  OOP Maximum must include all types of cost‐  sharing (deductible, copays, coinsurance, etc.). | * The Annual OOP Maximum is tethered to the OOP maximum   benchmark designated by the California Patient-Centered Benefit Design for a silver coinsurance or copay plan. The update for the 2020 Annual OOP Maximum is expected in spring 2019 following the determination by the Covered California Board of Directors. |
| **3. Medical Deductible**  In-Network: $2,000  Out-of-Network: Not specified  The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard. | * If an HRA/HSA is utilized to cover the employee’s medical   deductible, there is no need to pre-fund the full medical deductible amount.   * Employer may use a third-party administrator or other appropriate option to manage reimbursement of employees’ medical expenditures that count towards the medical deductible as long as employees’ protected health information remain private and confidential in accordance with state and federal laws. * Employers are encouraged to discuss the optimal reimbursement mechanism with their benefits administrator. |

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| **Minimum Standard** | **Clarification** |
| **16. Other Services**  The full set of covered benefits is defined by the California EHB Benchmark plan. | * Although all gold- and platinum-tier health plans are   considered automatically compliant under the HCAO Minimum Standards, **they must still offer coverage for the full set of covered benefits as defined by the California EHB Benchmark plan.**   * Health plans offered by out of state contractors doing business with or in the City and County of San Francisco must provide coverage for the services covered by the California EHB Benchmark plan. |

## More Information

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City and County of San Francisco London N. Breed

Mayor

### San Francisco Department of Public Health

Grant Colfax, MD Director of Health

**San Francisco Health Care Accountability Ordinance Minimum Standards – Effective January 1, 2020**

The following minimum standards are effective January 1, 2020. A health plan must meet all 16 minimum standards as described below to be deemed compliant.

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| **Benefit Requirement** | **Minimum Standard** |
| **Type of Plan** | Any type of plan that meets the Minimum Standards as described below.  All gold- and platinum-level plans are deemed compliant. |
| **1. Premium Contribution** | Employer pays 100% |
| **2. Annual OOP Maximum** | * In-Network: California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan’s effective date:   2020 = $7,850   * Out-of-Network: Not specified   OOP Maximum must include all types of cost‐sharing (deductible, copays, coinsurance, etc.). |
| **3. Medical Deductible** | * In-Network: $2,000 * Out-of-Network: Not specified   The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard. |
| **4. Prescription Drug Deductible** | * In-Network: $200 * Out-of-Network: Not specified |
| **5. Prescription Drug Coverage** | Plan must provide drug coverage, including coverage of brand-name  drugs. |
| **6. Coinsurance Percentages** | * In‐Network: 80%/20% * Out‐of‐Network: 50%/50% |

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| **Benefit Requirement** | **Minimum Standard** |
| **7. Copayment for Primary Care**  **Provider Visits** | * In‐Network: $45 per visit. * Out‐of‐Network: Not specified |
| **8. Ambulatory Patient Services**  **(Outpatient Care)** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: * Primary Care Provider: See Benefit Requirement #7 * Specialty visits: Not specified |
| **9. Preventive & Wellness**  **Services** | * In‐Network: Provided at no cost, per ACA rules. * Out‐of‐Network: Subject to the plan’s out‐of‐network fee requirements.   These services are standardized by federal ACA rules at no charge to the  member. The [California EHB Benchmark Plan](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) outlines the types of preventive services that are required. |
| **10. Pre/Post-Natal Care** | * In‐Network: Scheduled prenatal exams and first postpartum follow‐up   consult is covered without charge, per ACA rules.   * Out‐of‐Network: Subject to the plan’s out‐of‐network fee requirements.   These services are standardized by federal ACA rules at no charge to the  member. The [California EHB Benchmark Plan](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) outlines the types of pre- and post-natal services that are required. |
| **11. Hospitalization** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **12. Mental Health & Substance**  **Use Disorder Services, including Behavioral Health** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **13. Rehabilitative &**  **Habilitative Services** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **14. Laboratory Services** | * When coinsurance is applied See Benefit Requirement #6 * When copayments are applied for these services: Not specified |
| **15. Emergency Room Services**  **& Ambulance** | Limited to treatment of medical emergencies. The in‐network deductible,  copayment, and coinsurance also apply to emergency services received  from an out‐of‐network provider. |
| **16. Other Services** | The full set of covered benefits is defined by the [California EHB](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf)  [Benchmark plan.](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf) |



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Mayor

### San Francisco Department of Public Health

Grant Colfax, MD Director of Health

Office of Policy and Planning

**2019-2020 HCAO Minimum Standards Common Clarifications**

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| **Minimum Standard** | **Clarification** |
| **1. Premium Contribution**  Employer pays 100% of the premium contribution. | * Refers only to individual medical coverage and not   vision/dental.   * No money may come out of an employee’s paycheck to pay the premium contribution. * Employer is only required to offer at least 1 HCAO compliant health plan for which the employer must pay 100% of the premium contribution for the covered employee. * Employer has the discretion to offer any additional health plans for which there can be an option for employees to contribute to their premiums. |
| **2. Annual OOP Maximum**  In-Network: California Patient-Centered Benefit Design Out-of-Pocket limit for a silver coinsurance or copay plan during the plan’s effective date:  2020 = $7,850  Out-of-Network: Not specified  OOP Maximum must include all types of cost‐ sharing (deductible, copays, coinsurance, etc.). | * The Annual OOP Maximum is tethered to the OOP maximum   benchmark designated by the California Patient-Centered Benefit Design for a silver coinsurance or copay plan. The annual maximum is adjusted and determined by the Covered California Board of Directors. |
| **3. Medical Deductible**  In-Network: $2,000  Out-of-Network: Not specified  The employer must cover 100% of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings/reimbursement product that supports compliance with this minimum standard. | * If an HRA/HSA is utilized to cover the employee’s medical   deductible, there is no need to pre-fund the full medical deductible amount.   * Employer may use a third-party administrator or other appropriate option to manage reimbursement of employees’ medical expenditures that count towards the medical deductible as long as employees’ protected health information remain private and confidential in accordance with state and federal laws. * Employers are encouraged to discuss the optimal reimbursement mechanism with their benefits administrator. |

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| **Minimum Standard** | **Clarification** |
| **16. Other Services**  The full set of covered benefits is defined by the California EHB Benchmark plan. | * Although all gold- and platinum-tier health plans are   considered automatically compliant under the HCAO Minimum Standards, **they must still offer coverage for the full set of covered benefits as defined by the California EHB Benchmark plan.**   * Health plans offered by out of state contractors doing business with or in the City and County of San Francisco must provide coverage for the services covered by the California EHB Benchmark plan. |

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**CITY AND COUNTY OF SAN FRANCISCO GENERAL SERVICES AGENCY**

OFFICE OF LABOR STANDARDS ENFORCEMENT

**PATRICK MULLIGAN, DIRECTOR**

RFQ TC68430 Disposal of Biosolids Services SE: 0000002752

**Health Care Accountability Ordinance (HCAO) Declaration**

**What the Ordinance Requires.** The Health Care Accountability Ordinance (HCAO), which became effective July 1, 2001, requires Contractors that provide services to the City or enter into certain leases with the City, and certain Subcontractors, Subtenants and parties providing services to Tenants and Subtenants on City property, to provide health plan benefits to Covered Employees, or make payments to the City for use by the Department of Public Health (DPH), or, under limited circumstances, make payments directly to Employees.

The HCAO applies only to Contractors with at least $25,000 ($50,000 for non-profit organizations) in cumulative annual business with a City department(s) and have more than 20 Employees (50 Employees for non-profit organizations) including Employees of any parent or subsidiaries.

The City may require Contractors to submit reports on the number of Employees affected by the HCAO.

**Effect on City Contracting.** For contracts and amendments signed on or after July 1, 2001, the HCAO requires the following:

* Each contract must include terms ensuring that the Contractor will agree to abide by the HCAO and either to provide its employees with health plan benefits meeting the Minimum Standards set forth by the Director of Health or to make the payments required by the HCAO;
* All City Contractors must agree to comply with the requirements of the HCAO unless the Contracting Department has obtained an approved exemption or waiver under the HCAO from the Office of Labor Standards (OLSE).
* Contractors must require any Subcontractors subject to the HCAO to comply with the HCAO:

**The Purpose of This Declaration.** By submitting this declaration, you are providing assurances to the City that, beginning with the first City contract or amendment you receive after July 1, 2001 and until further notice, you will either provide the health plan benefits meeting the Minimum Standards to your covered employees or make the payments required by the HCAO, and will ensure that your Subcontractors also abide by these requirements. **If you cannot provide this assurance, do *not* return this form.**

**To obtain more information regarding the HCAO,** Visit our website, which includes links to the complete text of the HCAO, at [www.sfgov.org/olse/hcao;](http://www.sfgov.org/olse/hcao) send an e-mail to [HCAO@sfgov.org;](mailto:HCAO@sfgov.org) or call (415) 554-7903.

**Where to Send this Form.** Submit this form via San Francisco’s centralized [vendor portal](https://sfcitypartner.sfgov.org/) [sfcitypartnersupport@sfgov.org](mailto:sfcitypartnersupport@sfgov.org)

or call the Supplier Support Desk at 415-944-2442, Ext 1

#### Declaration

In order to be a certified vendor with the City and County of San Francisco, the company named below will either provide, if applicable, health benefits specified in the HCAO to our covered employees or make the payments required by the HCAO, and will ensure that our subcontractors that are subject to the HCAO also comply with these requirements, until further notice. The company named below will provide such notice as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Signature Date

Print Name Bidder/Supplier # - if known

( )

Company Name Phone Federal Employer ID #

SF OFFICE OF LABOR STANDARDS ENFORCEMENT, CITY HALL ROOM 430 MCO/HCAO TEL (415) 554-7903 • FAX (415) 554-6291 1 DR. CARLTON B. GOODLETT PLACE • SAN FRANCISCO, CA 94102 [WWW.SFGOV.ORG/OLSE](http://WWW.SFGOV.ORG/OLSE)

**CITY AND COUNTY OF SAN FRANCISCO GENERAL SERVICES AGENCY**

OFFICE OF LABOR STANDARDS ENFORCEMENT

**PATRICK MULLIGAN, DIRECTOR**

RFQ TC68430 Disposal of Biosolids Services SE: 0000002752

**Minimum Compensation Ordinance (MCO) Declaration**

**What the Ordinance does.** The Minimum Compensation Ordinance (MCO) became effective October 8, 2000, and was later amended by the Board of Supervisors, with an effective date for the amendments of October 14, 2007. The MCO requires City contractors and subcontractors to pay Covered Employees a minimum hourly wage and to provide 12 compensated and 10 uncompensated days off per year. The minimum wage rate may change from year to year and Contractor is obligated to keep informed of the then-current requirements.

The MCO applies only if you have at least $25,000 in cumulative annual business with a City department or departments and have more than 5 employees, including employees of any parent, subsidiaries and subcontractors.

The City may require contractors to submit reports on the number of employees affected by the MCO.

**Effect on City contracting.** For contracts and amendments signed on or after October 8, 2000 the MCO will have the following effect:

* In each contract, the contractor will agree to abide by the MCO and to provide its employees the minimum benefits the MCO requires, and to require its subcontractors subject to MCO to do the same.
* If a contractor does not agree to provide the MCO’s minimum benefits, the City will award a contract to that contractor **only if** the contractor has received an approved exemption or waiver under MCO from the Office of Labor Standards Enforcement (OLSE) through the contracting Department. The contract will not contain the agreement to abide by the MCO if there is an exemption or waiver on file.

**What this form does.** If you can assure the City now that, beginning with the first City contract or amendment you receive after October 8, 2000 and until further notice, you will provide the minimum benefit levels specified in the MCO to your covered employees, and will ensure that your subcontractors also subject to the MCO do the same, this will help the City’s contracting process.

If you cannot make this assurance now, please do not return this form.

**For more information,** (1) see our Website, including the complete text of the ordinance: [www.sfgov.org/olse,](http://www.sfgov.org/olse) (2) e-mail us at: [MCO@sfgov.org,](mailto:MCO@sfgov.org) (3) Phone us at (415) 554-7903.

**Where to Send this Form.** Submit this form via San Francisco’s centralized [vendor portal](https://sfcitypartner.sfgov.org/) [sfcitypartnersupport@sfgov.org](mailto:sfcitypartnersupport@sfgov.org)

or call the Supplier Support Desk at 415-944-2442, Ext 1

#### Declaration

In order to be a certified vendor with the City and County of San Francisco, this company will provide, if applicable, the minimum benefit levels specified in the MCO to our Covered Employees, and will ensure that our subcontractors also subject to the MCO do the same, until further notice. This company will give such notice as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Signature Date

Print Name Bidder/Supplier # - if known

( )

Company Name Phone Federal Employer ID #

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