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, 2021

The following minimum standards are effective January 1, 2021. A health plan must meet all 16 minimum standards as described below to be deemed compliant.

Benefit Requirement	New Minimum Standard
Type of Plan	Any type of plan that meets all the Minimum Standards as described below. All gold- and platinum-level plans are deemed compliant if the employer funding requirements and coverage for required services described below are satisfied.
1. Premium Contribution	Employer pays 100 percent
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 • Out-of-Network: Not specified 2021 = $8,200 2022 = To be determined in spring of 2021 OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).
3. Medical Deductible	• In-Network: $3,000 • Out-of-Network: Not specified The employer must cover 100 percent of actual expenditures that count towards the medical deductible, regardless of plan type and level. Employers may use any health savings or reimbursement product that supports compliance with this minimum standard.
4. Prescription Drug Deductible	• In-Network: $300 • Out-of-Network: Not specified
5. Prescription Drug Coverage	Plan must provide drug coverage, including coverage of brand-name drugs.

Benefit Requirement	New Minimum Standard
6. Coinsurance Percentages	• In-Network: 80 percent/20 percent • Out-of-Network: 50 percent/50 percent
7. Copayment for Primary Care Provider Visits	• In-Network: $50 per visit • Out-of-Network: Not specified
8. 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 outlines the types of preventive services that are required.
9. 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 outlines the types of pre- and post-natal services that are required.
10. 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
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 Benchmark plan.

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.

BENEFITS AND LIMITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Outpatient Care	Covered	No					Primary and specialty care consultations, exams treatment.	No
Specialist Visit	Yes	Outpatient Care	Covered	No					Primary and specialty care consultations, exams treatment.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Outpatient Care	Covered	No					Primary and specialty care consultations, exams treatment.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Care	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Care	Covered	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
Hospice Services	Yes	Hospice Care	Covered	No						No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered							
Long-Term/Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)		Preventive care services	Covered	No					Eye exams for refraction and preventive vision screenings.	No
Urgent Care Centers or Facilities	Yes	Urgent Care	Covered	No						No
Home Health Care Services	Yes	Home Health Care	Covered	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
Emergency Room Services	Yes	Emergency Services	Covered	No						No

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Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No					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 and services not available.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	No					Hospital Inpatient Services - services at plan hospital when services generally provided at acute care gen hospital in service area.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No					Hospital Inpatient Care - covers services of plan physicians and consultation and treatment by specialists	No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	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
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility Care	Covered	Yes	100	Days per benefit period				No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No					Scheduled prenatal exams and first postpartum follow-up consult is covered without charge	No
Delivery and All Inpatient Services for Maternity Care	Yes	Hospital Inpatient Care	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Mental Health Services	Covered	No					For diagnosis or treatment of mental disorders - as identified in DSM.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No					Inpatient Psychiatric Hospitalization and intensive psychiatric treatment programs	No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				Services in specialized facility not otherwise described in EOC	Chemical Dependency Services - Outpatient chemical dependency. Includes day-treatment, intensive outpatient programs, individual and group counseling, and medical treatment for withdrawal symptoms. Includes transitional residential recovery services.	No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No					Chemical Dependency Services - Inpatient detoxification	No
Generic Drugs	Yes	Generic Drugs	Covered	No					Outpatient Prescription Drugs, Supplies, and Supplements	No
Preferred Brand Drugs	Yes	Outpatient Prescription Drugs, Supplies, and Supplements	Covered	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

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Non-Preferred Brand Drugs	Yes	Outpatient Prescription Drugs, Supplies, and Supplements	Covered	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
Specialty Drugs	Yes	Outpatient Prescription Drugs, Supplies, and Supplements	Covered	No						No
Outpatient Rehabilitation Services	Yes	Physical, occupational, speech therapy	Covered	No						No
Habilitation Services	Yes	Habilitation Services	Covered	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
Chiropractic Care			Not Covered							
Durable Medical Equipment	Yes	Durable Medical Equipment for Home Use - plan formulary guidelines or medical necessity	Covered	No				Prior authorization required		No
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Outpatient imaging, laboratory and special procedures	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Outpatient imaging, laboratory and special procedures	Covered	No						No
Preventive Care/ Screening/Immunization	Yes	Outpatient imaging, laboratory and special procedures	Covered	No						No
Routine Foot Care			Not Covered						Medically necessary foot care is covered.	
Acupuncture	Yes	Outpatient Care	Covered	No					Typically only for treatment of nausea or as part of comp. pain management program.	No
Weight Loss Programs		Weight Loss Programs	Covered	No						No
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year			California has chosen FEDVIP to supplement benchmark for pediatric vision care.	No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year			California has chosen FEDVIP to supplement benchmark for pediatric vision care.	No
Dental Check-Up for Children	Yes	Dental Check-Up for Children	Covered	Yes	1	Visit per 6 months			Supplemented using California CHIP.	No

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Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No						No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No						No
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Covered only if child meets eligibility requirements for medically necessary orthodontia coverage under California Children's Services (CCS).	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No						No
Accidental Dental			Not Covered							
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No						No

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Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No					Diabetes Equipment, Supplies, Prescription Drugs, Education.	No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No					Phenylketonuria	No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Coverage for Effects of Diethylstilbestrol	Yes	Coverage for Effects of Diethylstilbestrol	Covered	No						No
Organ Transplants	Yes	Organ Transplants	Covered	No						No
Mastectomy-Related Coverage	Yes	Mastectomy-Related Coverage	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Allergy injections	Yes	Allergy injections	Covered	No						No
Voluntary Termination of Pregnancy	Yes	Voluntary Termination of Pregnancy	Covered	No						No
Dental and Orthodontic Services	Yes	Dental and Orthodontic Services	Covered	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
Asthma Supplies and Equipment	Yes	Asthma Supplies and Equipment	Covered	No						No
Dialysis Care	Yes	Dialysis Care	Covered	No						No
Hearing Screenings & Exams - preventive care services	Yes	Hearing Screenings & Exams - preventive care services	Covered	No						No
Ostomy and Urological Supplies	Yes	Ostomy and Urological Supplies	Covered	No						No
AIDS Vaccine	Yes	AIDS Vaccine	Covered	No						No
HIV Testing	Yes	HIV Testing	Covered	No						No
Alzheimer's Disease Treatment	Yes	Alzheimer's Disease Treatment	Covered	No						No
Breast Cancer Screening, Diagnosis, Treatment, Prosthetic Devices or Reconstructive Surgery	Yes	Breast Cancer Screening, Diagnosis, Treatment, Prosthetic Devices or Reconstructive Surgery	Covered	No						No
Cancer Screenings	Yes	Cancer Screenings	Covered	No						No
Cervical Cancer Screenings	Yes	Cervical Cancer Screenings	Covered	No						No
Contraceptive Methods	Yes	Contraceptive Methods	Covered	No						No
Laryngectomy-Prosthetic Devices	Yes	Laryngectomy-Prosthetic Devices	Covered	No						No
Maternity Coverage	Yes	Maternity Coverage	Covered	No						No
Maternity-Prenatal Alpha Fetoprotein Programs	Yes	Maternity-Prenatal Alpha Fetoprotein Programs	Covered	No						Yes

Benefit Information			General Information								
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Genetic Disorders of the Fetus	Yes	Genetic Disorders of the Fetus	Covered	No						No
Osteoporosis	Yes	Osteoporosis	Covered	No						No
Prostate Cancer Screening and Diagnosis	Yes	Prostate Cancer Screening and Diagnosis	Covered	No						No
Surgical Procedures for the Jawbone	Yes	Surgical Procedures for the Jawbone	Covered	No						No

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

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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	ANXIOLYTICS, OTHER	3
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

CATEGORY	CLASS	SUBMISSION COUNT
DERMATOLOGICAL AGENTS	NO USP CLASS	20
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	4
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

CATEGORY	CLASS	SUBMISSION COUNT
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	7
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
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

City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Grant Colfax, MD
Director of Health

Office of Policy and Planning

2021-2022 HCAO Minimum Standards: Common Clarifications

Minimum Standard	Clarification
Type of Plan	• All gold- and platinum-level plans are deemed compliant if the plan satisfies the following Minimum Standards: ➢ employer funding requirements (standards 1 and 3); and ➢ coverage for required services described below (standards 8-16). • Plans may reviewed by designated DPH staff to determine whether the plan complies with all requirements for covered services.
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 Out-of-Pocket 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: 2021 = $8,200 2022 = To be determined in spring of 2021 Out-of-Network: Not specified OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.).	• The annual out-of-pocket (OOP) maximum is synced 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.

Minimum Standard	Clarification
3. Medical Deductible In-Network: $3,000 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 a HRA or 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.
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.

For more information

tinyurl.com/sfhcao

sfgov.org/olse/hcao

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