**City and County of San Francisco** **Department of Public Health**

**Mitchell H. Katz, M.D.**
**Director of Health**

TO: Roma Guy, President and
Members of the San Francisco Health Commission

FROM: Mitchell H. Katz, M.D.
Director of Health

RE: Health Care Accountability Ordinance – Minimum Health Benefits Standards

DATE: May 29, 2001

This memorandum provides information on the Health Care Accountability Ordinance that was recently approved by the San Francisco Board of Supervisors. The ordinance is effective July 1, 2001. The ordinance requires the San Francisco Health Commission to establish minimum standards for health plan benefits offered by City and County contractors and lessees (including subcontractors and subtenants). Contracting parties are not subject to any component of the Health Care Accountability Ordinance until the Health Commission has adopted the minimum standards.

Attached for the Health Commission's consideration are the proposed minimum standards for health plan benefits along with a proposed resolution. In preparing the standards, the Department reviewed current health plan benefits and discussed its approach in open forums (e.g., San Francisco Board of Supervisors, Small Business Commission). In addition, in late May 2001, the Department met with the following interested parties to review the proposed standards:

- Bay Area Organizing Committee
- Committee on Jobs
- San Francisco Chamber of Commerce
- San Francisco Health Plan
- San Francisco Human Services Network
- Service Employees International Union Local 790

The proposed standards reflect input from the open forums and the meeting. As much as possible, the Department attempted to address the various and sometimes conflicting perspectives of the interested parties.

## HEALTH CARE ACCOUNTABILITY ORDINANCE

In a continued effort to expand health care coverage for uninsured San Francisco residents and San Francisco workers, Mayor Brown introduced the Health Care Accountability Ordinance (HCAO). The HCAO adds a new section to the San Francisco Administrative Code (Chapter 12Q) requiring contractors that provide services to the City and County or enter into certain

leases with the City and County (including certain subcontractors and subtenants) to do one of the following:

- offer health plan benefits to employees working on City and County contractors or leased property,
- make payments to the City and County for use by the Department of Public Health to help partially offset the cost of services for uninsured workers or
- participate in a health benefits program that will be developed by the Department of Public Health.

It is anticipated that small businesses will be most affected by this ordinance because medium and large employers generally provide health care coverage to employees working over 20 hours a week (the threshold as defined in the HCAO).

Attachment A provides the most recent City Attorney legislative digest (dated May 14, 2001) on HCAO. The digest defines the contracts subject to this ordinance, the employees entitled to health plan benefits under this ordinance, the health benefit options contractors and lessees have, exemptions to the ordinance, and administrative and enforcement provisions. Please note that since this writing of the legislative digest, the following amendments were adopted and are now specified in the ordinance:

- Additional specification that the employee work 20 hours or more per week,
- The maximum period for health benefits to become effective shall not exceed 30 days from the start of employment on a covered contract, subcontract, lease or sublease as specified under the minimum health plan benefit standards.
- Any adjustments made by the San Francisco Health Commission with respect to: (1) how much a contractor or lessee pays per hour for each hour worked -- $1.50 per hour -- and the (2) weekly maximum -- $60 per week -- must be approved by the San Francisco Board of Supervisors by resolution.
- Contracting parties are not required to meet any of the HCAO components until the Health Commission has approved the minimum standards for health plan benefits.

An estimated 16,050 uninsured workers would benefit from the proposed ordinance. This includes 1,900 for-profit contractors, 2,650 non-profit contractors, 5,750 Airport tenants and 5,750 tenants on other City property (e.g., Port, PUC, etc.). The City and County estimates that the proposed ordinance will costs approximately $4 million in fiscal year 2001-02 ($1.3 million for for-profit contractors and $2.7 million for non-profit contractors). This is based on the assumption that one-third of all contracts will be renewed or modified. The Mayor's Office intends to fund these additional costs through the General Fund. Comparable costs for fiscal year 2002-03 are also $4 million and $3.7 million for fiscal year 2003-04. There would be no increased costs to the City and County for those employees of leases or subleases because there is no pass-through mechanism under such leases or subleases.

With respect to HCAO, the Department of Public Health has two responsibilities:

- develop minimum standards for health plan benefits offered by City and County contractors and lessees to employees working on said contracts and/or leased property and
- develop a health benefits program/pool whereby contractors and lessees may participate to provide health benefits to their contract employees if they do not provide coverage through the commercial health insurance market.

At this time, the Department is presenting only the proposed minimum standards for health plan benefits. With respect to the health benefits program the Department has 12 months from the time the HCAO is approved to prepare, present and have the Health Commission approve a health insurance purchasing pool. The pool would enable employers who have difficulty purchasing health benefits on the open market to participate in a pool with other employers in order to collectively purchase health insurance benefits for their employees. The minimum standards for health plan benefits would also apply to the purchasing pool.

## PROPOSED MINIMUM HEALTH PLAN BENEFIT STANDARDS

All contractors and lessees offering health care coverage to their employees would have to meet minimum standards for employee health plan benefits. The standards are designed to ensure that employees have adequate access to an array of health services. The standards apply to contractors and lessees that currently provide health insurance and those who do not provide it, but will now have to provide coverage as a result of the Health Care Accountability Ordinance (HCAO). The standards must be reviewed every two years to ensure that they are current with State and federal law, and reflect existing health benefit practices. The components are:

- effective date of coverage,
- percentage of premium paid by employer and employee,
- benefits offered under coverage and
- employee co-payments when accessing services.

*Affordability*

The Health Care Accountability Ordinance (HCAO) is more likely affect to small employers versus large employers. Small businesses/employers are defined in State law as those with 2 to 50 employees. High premium costs are the major reason why small businesses are less likely to offer health benefits to their employees. With small profit margins, they generally cannot afford to offer coverage. A national survey found that two-thirds of small businesses would consider offering health benefits if the government provided financial assistance.[1] In addition, low-wage employees (irrespective of the size of the business) may be less inclined to accept health care coverage if out-of-pocket costs (both premium and co-payments) are too expensive. When this happens, the employee "take-up" rate for health insurance declines. As a result, the Department was cognizant of affordability in designing the standards.

At the same time, the Department understands that assumptions have been made with respect to increased employer costs under this ordinance. Specifically, it is assumed that:

- non-profit contractors will pass on (to the City and County via contract) 100% of the increased costs of providing health benefits to covered employees and
- for-profit contractors will pass on (to the City and County via contract) 50% of the increased costs of providing health benefits to covered employees.

This will help mitigate increased personnel costs for some employers. In addition, the Department believes that all small businesses subject to HCAO should be informed that under state and federal law, they can deduct 100% of the employer contribution of health insurance premiums. The fact that premiums are tax deductible can make offering a health plan more

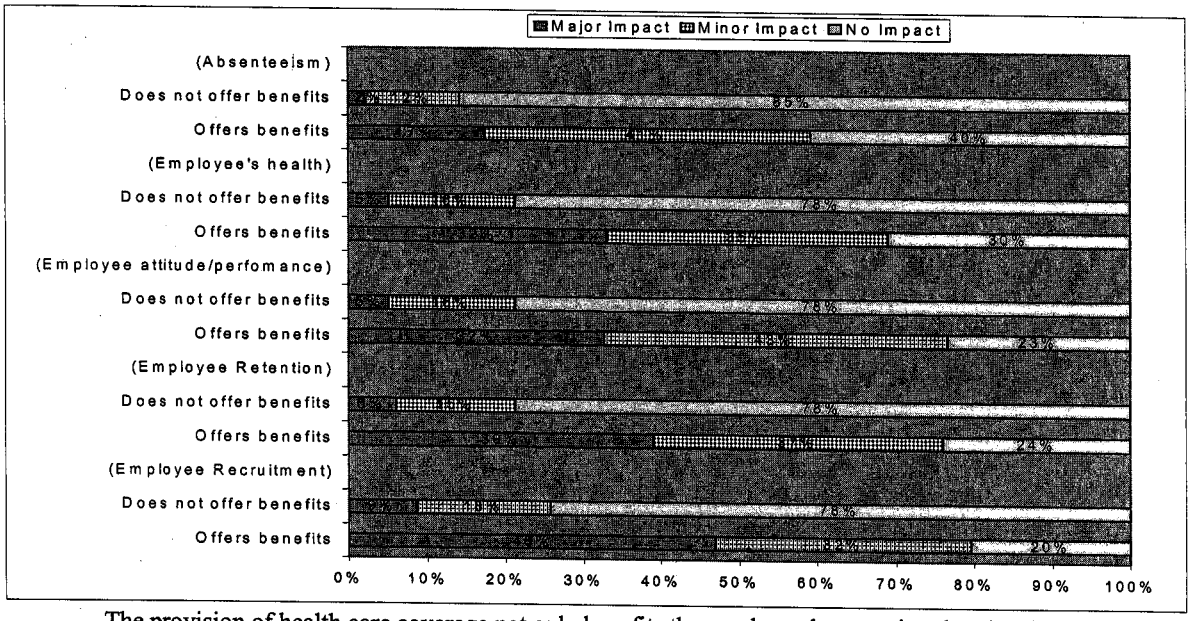
[1] Paul Fronstin and Ruth Helman, *EBRI Issue Brief No. 226 and Special Report SR 35 (2000 Small Employer Health Benefits Survey)*, Employee Benefit Research Institute, October 2000.

desirable for some small employers. Several surveys have found that many small business owners are unaware of this tax advantage.

*Benefits of Health Care Coverage to Employers and Employees*

Providing health care coverage can have a positive impact on an employer's workforce – both in turns of recruitment, productivity and retention. The national 2000 Small Employer Health Benefits Survey found the following:

**Impact of Offering or Not Offering Health Benefits to Employees (Percentage of Respondents)**




The provision of health care coverage not only benefits the employee by ensuring that they have access to needed primary, preventive and inpatient services, but also employers.

*Principles*

The Department adopted the following principles in developing the minimum health plan benefit standards:

- Minimize disruption for employers and lessors who currently provide a comprehensive scope of medical benefits.
- Out-of-pocket costs (both premiums and co-payments) should not be so high that they decrease employee "take-up" rate (that is, the percentage of employees who are offered health insurance and who decide to accept the coverage).
- The minimum benefit standards are designed to ensure that contractors and lessees provide a comprehensive scope of medical benefits. Catastrophic benefit coverage is not comprehensive.

Competing interests must be balanced in designing the minimum standards. On one hand, for those employers and lessees who currently provide a comprehensive benefits package to their employees, the standards should recognize this and reflect, as much as possible, what the prevailing market provides and what these businesses provide. On the other hand, for those employers and lessees who currently do not provide health care coverage, as much as possible these businesses should not have an incentive to purchase health care coverage with out-of-pocket employee costs at the top scale of the cost-sharing provisions of the minimum standards. The principle also recognizes that a different set of standards cannot be applied for employers and lessees that currently provide coverage and another set of standards applied to those who currently do not provide coverage.

*General Comments*

As these minimum health plan benefit standards are reviewed, the following should be noted:

- The minimum benefits standards are based on a health maintenance organization benefits plan.
- In developing the minimum benefits standards, the Department examined health benefit packages currently offered to small businesses – that is, what an employer can currently purchase in the health care market. For example, the Department looked at packages offered by PacAdvantage (formerly HIPC), Kaiser, Blue Cross, Blue Shield, Aetna, etc.). The Department also surveyed some of its larger contractors to determine whether they provided coverage and if so, the components of the health insurance benefits package.
- Employers and lessees must offer at least one health benefits package. If an employer or lessee offers more than one health insurance package to its employees, then at least one of the products must meet the minimum standard.

*Effective Date of Coverage*

Effective date of coverage refers to the time at which an employee receives health insurance coverage from their employer after starting employment. The effective date of coverage varies across employers – from 30, 60 to 90 days. Employers have discretion over setting the effective date of coverage, but the date must take into account time needed to process health insurance paperwork. It is standard for the effective date to always start at the beginning of the month. This has been established by the health insurance industry.

The 2000 Annual Employer Health Benefits Survey[2] found the following with respect to the effective date of coverage (or sometimes referred to as the waiting period):

[2] The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *2000 Annual Survey – employer Health Benefits* (2000).

| *Firm Size* | *Average Wait for Health Coverage (Months)* |
|---|---|
| Small (3 – 199 workers) | 2.1 |
| Midsize (200 – 999 workers) | 1.5 |
| Large (1,000 – 4,999 workers) | 1.4 |
| Jumbo (5,000+ workers) | 1.2 |
| All Firms, Regions and Industries | 1.5 |

In should be noted that this information is not specific to California, but is based on a national survey of employers of all sizes. In the western region of the United States, the average wait for health care coverage was 1.6 months.

The HCAO currently states that "the minimum standards shall provide for a maximum period for each Covered Employee's health benefits to become effective, not to exceed 30 days from the start of employment." However, the Department is concerned that some employers will be unable to meet this standard because employees who begin work in the middle or later part of the month must wait until the beginning on the next month following full calendar month. For example, if an employees starts on June 15, 2001, and there is a 30 day period on the effective date of coverage, then the employees coverage actually begins August 1, 2001 – 45 days later – since coverage does not begin in the middle of the month. Therefore, the Department believes that either the ordinance should be amended to take this into account, or regulations that will promulgated by the City and County's Director of Purchasing should address this discrepancy. Absent specifying a number of days, the provision concerning the time period for effective date of coverage could be revised to read "no later than the first day following the first complete month worked by the employee."

***EFFECTIVE DATE OF COVERAGE RECOMMENDATION:***
The effective date of coverage shall be no later than the first day following the first complete calendar month worked by the employee.

*Premium Payment*

Premiums reflect the amount that it costs to provide coverage to an employee. It is usually shown as a monthly figure. Premium costs are generally shared between employer and employee. The employer determines the cost-sharing ratios for the health care premiums. This provision of the minimum standards will establish the maximum amount that an employee must pay of the health care premium.

For low-income workers, it is particularly important to keep premiums affordable. If premium is too high, employees will not accept ("take up") the coverage offered to them. As noted previously, small businesses, who might disproportionately be subject to the Health Care Accountability Ordinance, have a more difficult time affording health care coverage. Small employers may require their employees to pay a larger percentage of the monthly health care premium (than larger employers) in order to be able to offer coverage.

In developing this standard, the Department reviewed the California Employer Health Benefits Survey.[3] The survey includes small, medium and large employers in California over five industry groupings. The survey asked questions about HMO, PPO and POS plans. Conventional (fee-for-service) plans are excluded since they are a small share of the California market. Because the information is aggregated, the Department is unable to provide specific information on small employers.

The survey revealed the following regarding premium payments:

- For calendar year 2000, monthly premiums for employer provided health insurance averaged $192 for single coverage. Premiums for health maintenance organizations were lower than for other forms of insurance at $166 per month for single coverage. Coverage in Preferred Provider Organizations (PPOs), which provide greater choice of providers and fewer restrictions on access to care costs on average $241 for single coverage.
- In 2000, California workers on average paid 10% of the premium for individual coverage. This was virtually unchanged from 1999 – where the percentage was 11%. It is important to note that this aggregated figure includes small, medium and large businesses. Many small businesses may need employees to pay a larger portion of the premium in order to offer coverage.
- Premium increases averaged 6.0% in 2000, up from 4.8% in 1999.

While less specific to California, the 2000 Annual Employer Health Benefits Survey indicated the following information on the percentage of premium paid by the employer.

**Percentage of Premium Paid by Firm for Single Coverage, by Firm Size, 2000**

| *Firm Size* | *HMO* | *PPO* | *POS* |
|---|---|---|---|
| Small (3 – 199 workers) | 83% | 87% | 86% |
| Midsize (200 – 999 workers) | 91% | 88% | 84% |
| Large (1,000 – 4,999 workers) | 80% | 82% | 85% |
| Jumbo (5,000+ workers) | 86% | 84% | 84% |
| All Firm Sizes | 85% | 85% | 85% |

For firms located in the western region of the United States the information was as follows:

**Percentage of Premium Paid by Firm for Single Coverage in West Region, 2000**

| *Region* | *HMO* | *PPO* | *POS* |
|---|---|---|---|
| West Region (All Firm Sizes) | 84% | 85% | 85% |

Finally with respect to the employer paying the entire premium cost, the survey found the following:

[3] The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *California Employer Health Benefits Survey* (March 2001).

**Percentage of Employees in Plans Where Employer Pays Entire Cost of Single Coverage, Small Firms, 1988 – 2000**

| *Type of Plan* | *1988* | *1996* | *1999* | *2000* |
|---|---|---|---|---|
| Conventional | 62% | 48% | 61% | 63% |
| HMO | 54% | 30% | 55% | 47% |
| PPO | 92% | 32% | 52% | 49% |
| POS | N/A | 37% | 60% | 50% |
| All Plans | 63% | 36% | 56% | 50% |

In addition to reviewing these surveys, the Department surveyed some its larger contractors and found that these contractors required employee contributions anywhere from 0% to 25% with the majority being between 0% - 20%. Finally, the Department looked at the PacAdvantage (formerly HIPC) program. PacAdvantage is the State's health insurance purchasing pool for small employers. It requires a minimum employer contribution of 50% of the premium cost. This means that employee contributions could be anywhere from 0% - 50% of the premium.

Because PPO/POS insurance is more expensive, it is reasonable for employers to pass on a portion of the cost to employees. However, if employers offered only a PPO/POS plan, some employees would not have an affordable option. Therefore, although we recommend that employers be allowed to pass on up to 25% of the premium cost of a PPO/POS health plan, the Department believes this option should be available only if there is also a plan (HMO or POS/PPS) with 0% employee contribution toward the premium. Because the portion of the premium paid by employees should be designed to encourage employee take-up rates the following recommendation is made:

***DISTRIBUTION OF PREMIUM PAYMENT RECOMMENDATION***

| ***Premium Paid By*** | ***HMO Coverage Percentage Paid*** | ***PPO or POS Percentage Paid*** |
|---|---|---|
| Employee | 0% | 0% - 25% |
| Employer | 100% | 75% - 100% |

However, employers must offer at least one policy in which the entire monthly premium is at 100% employer expense (i.e., the employee pays 0% of the monthly premium).

*Health Benefits*

The health benefits are essentially the services that the employee will be entitled to receive. Because the Department wants to ensure that the health benefit coverage offered to employees is not limited to catastrophic care, it is recommending comprehensive health coverage (i.e., medical coverage). All employers would have to ensure that their health plan offers, at a minimum, these benefits. The benefits are specified on the next page.

***HEALTH BENEFIT RECOMMENDATION***

- Outpatient Services
- Outpatient Procedures
- Diagnostic, X-Ray and Laboratory Services
- Perinatal/Maternity
- Preventive Care
- Family Planning
- Prescription Drug Coverage
- Hospital Services (inpatient and outpatient)
- Emergency Health
- Ambulance Services
- Mental Health (inpatient and outpatient)
- Alcohol and Substance Abuse Care (inpatient and outpatient)
- Rehabilitative Therapies (inpatient and outpatient)
- Home Health Services
- Durable Medical Equipment
- Hospice
- Skilled Nursing

*Co-Payment Component*

The co-payment represents the out-of-pocket costs borne by the employee when accessing services. The co-payment is made to the provider. Co-payments are often structured to create incentives for appropriately utilizing services. But, this must be balanced with making co-payments affordable. In developing the co-payments the Department examined the benefit packages and co-payments offered to small businesses participating in:

- Aetna
- Blue Cross
- Blue Shield
- Health Net
- Kaiser Permanente
- PacAdvantage (HIPC)
- PacifiCare

Attachments B and C are copies of the Kaiser and PacAdvantage benefit packages and co-payment schedule.

In 2000, the California Employer Health Benefits Survey found the following with respect to co-payments:

- 46% of HMO enrollees have a specified $10 co-payment for visits (28% are at $5 per visit and 18% are at $15 per visit) and
- average HMO drug co-payment was $7 for generic drugs and $12 for brand name drugs.

## CO-PAYMENT RECOMMENDATIONS

| Benefit | Components | Co-Payment |
|---|---|---|
| Outpatient Services | In a physician's office or other designated facility | Max. $10/visit |
| Outpatient Procedures | In a physician's office, surgery center, or other designated facility | Max. $100/Procedure |
| Diagnostic, X-Ray – Laboratory Services | Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests, laboratory tests for the management of diabetes | No Charge |
| Perinatal and Maternity<br>Office visits<br><br>Inpatient | Prenatal care and postnatal care<br><br>Inpatient, newborn nursery care while the mother is hospitalized and for the first 30 days of life | Max. $10/visit<br><br>Max. $100/admission |
| Preventive Services | Well visits, annual, general medical check-ups, immunizations, periodic health exams | Max. $10/visit |
| Family Planning Services | Counseling, surgical procedures for sterilization, contraceptives, elective abortion | Max. $10/visit |
| Prescription Drug Coverage | Inpatient drugs and drugs administered in a doctor's office, as well as, FDA approved contraceptive drugs and devices | Generic: Max. $15/30 days<br><br>Brand: Max. $25/30 days |
| Hospital Services<br>Inpatient<br><br><br><br><br><br>Outpatient | Medically necessary facility charges room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology during inpatient stay<br><br>Medically necessary facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology | Max. $100/Admission<br><br><br><br><br><br>Max. $75/visit |

| Benefit | Components | Co-Payment |
|---|---|---|
| Emergency Services | 24-hour care for sudden, serious and unexpected illness including psychiatric screening, examination and treatment, injury or condition requiring immediate diagnosis and out of the Plan | Max. $50/visit (waived if admitted) |
| Ambulance Services (Medically Necessary) | Ambulance transportation when medically necessary | Max. $50/trip (waived if medically necessary) |
| Mental Health Services<br>Inpatient (minimum of 10 days)<br><br>Outpatient (minimum of 20 visits/yr) | Inpatient and outpatient care for the treatment of mental health illness or crisis intervention. | Max. $100/Admission<br><br>Max. $20/visit |
| Alcohol/Substance Abuse Care<br>Inpatient (detox)<br><br>Outpatient (minimum of 20 visits/yr) | Inpatient detoxification<br><br>Crisis intervention and alcohol or drug abuse treatment as medically necessary | Max. $100/day<br><br>Max. $20/visit |
| Rehabilitative Services<br>Office/Outpatient<br><br><br><br>Inpatient | Physical, occupational, speech therapy up to 60 calendar days – additional treatment if authorized by plan<br><br>Physical, occupational, speech therapy | Max. $20/visit<br><br><br><br>Max. $100/day |
| Home Health Services (minimum 100 days/yr) | Medically necessary skilled care (not custodial). Home visits, physical, occupational and speech therapy | Max. $15/visit |
| Durable Medial Equipment | Equipment suitable for use in the home, such as blood glucose monitors, apnea monitors, asthma-related equipment and supplies | 50% of allowable charges |
| Hospice Care | Medically necessary hospice services | Max. $15/visit |

| Benefit | Components | Co-Payment |
|---|---|---|
| Skilled Nursing Services (maximum 100 days/yr) | Medically necessary skilled nursing services | Max. $100/admission or $50/day |
| Yearly Out-of-Pocket | Total yearly costs paid by person accessing services | Max. $2,000/year |

The Department recognizes that some contractors and lessees may already provide comprehensive health insurance to their employees, but that the co-payments may be higher than those recommended. These contractors and lessees have entered into contractual agreements with their health insurance providers that cannot be amended until the contract expires. As a result, they would be unable to meet the minimum standards because they cannot get their health insurer to change their existing co-payment policy. Given this, the Department believes that it is prudent to also adopt another provision with respect to the co-payment component. The recommendation is designed to minimize disruption for these contractors and lessees and their employees. This recommendation should not affect the effective date of coverage or percentage of premium paid by the employee since these are at the employer's discretion.

***RECOMMENDATION***

If a contractor, subcontractor, lessee or subtenant provides comprehensive health care coverage to their employees, but the employee co-payments are higher than those adopted by the Health Commission, the contractor will have one year to come into compliance by securing a health plan which meets all components of the minimum standards including effective date of coverage, percentage of premium paid by employee, benefits covered and benefit co-payments.

*Revenue from HCAO*

With respect to the $1.50 per hour payment to the City and County, it is intended to partially offset the City's costs of providing health care to uninsured persons. For the 2001-02 fiscal year, we have estimated that $550,000 of new revenue will be allocated to the Department as a result of the $1.50 per hour payment. The additional revenue will be used to hire staff into currently budgeted, but vacant positions. We have chosen this flexible method of budgeting because at the current time, we do not know how many workers' employers will opt to pay the $1.50 rather provide health insurance benefits.

*Concluding Comments*

The Department believes that these minimum health plan benefit standards meet the principles outlined above. The Department developed these by researching prevailing practice in the health care coverage industry.

The Department believes that expanding health care coverage to a previously uninsured population will improve the health status of the uninsured individuals, and also contribute to improving health outcomes and health status for our entire community.

FILE NO. Attachment A

# LEGISLATIVE DIGEST

[Health Care Accountability Ordinance.]

**Ordinance amending the San Francisco Administrative Code by adding Chapter 12Q, encompassing sections 12Q.1 through 12Q.11, to require 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, with respect to covered employees, to offer health plan benefits to employees, to make payments to the City for use by the Department of Public Health, to make payments directly to employees under limited circumstances, or to participate in a health benefits program developed by the Director of Health.**

## Existing Law

Currently, the City does not encourage its contractors, subcontractors, tenants and subtenants to offer health insurance benefits to employees who work on City contracts or on City property. The City provides health care to the indigent through San Francisco General Hospital and other City health clinics. Employers contracting with the City or leasing land from the City do not presently have a direct means of assisting in defraying such expenses.

## Amendments to Current Law

This legislation will add a new Chapter 12Q to the City's Administrative Code, entitled the San Francisco Health Care Accountability Ordinance. Pursuant to Chapter 12Q, various entities will be required to choose between offering health plan benefits to specified employees or making payments to either the City or the covered employee, as set forth below.

## COVERED CONTRACTS:

The following contracts will be subject to Chapter 12Q:

- City Contracts and Subcontracts for public works or improvements to be purchased, or for services to be performed, at City expense;
- Leases and Subleases on City-owned or City-controlled property within the City limits or under the jurisdiction of the San Francisco Airport Commission;
- Contracts and Subcontracts with covered Tenants and Subtenants to perform services on a City leasehold.

Contracts and Leases that are not initially subject to the Health Care Accountability Ordinance may become subject to the Ordinance if they are amended.

COVERED EMPLOYEES:

The following "Covered Employees" will be entitled to health plan benefits (or their alternatives):

- Employees of Contractors and Subcontractors who work on a City Contract or Subcontract, within the United States, 20 hours or more per week;
- Employees of Tenants or Subtenants who work 20 hours or more per week on property that is covered by a City Lease or Sublease; and
- Employees of the Contractors and Subcontractors of City Tenants and Subtenants who work on property covered by a City Lease 20 hours or more per week.
- Beginning on July 1, 2002, the number of hours an employee must work per week in order to be considered a "Covered Employee" will be 15 or more.

There are several exceptions to the group of Covered Employees, as follows:

- Student employees under the age of 18, provided that they do not replace, displace or lower the wage or benefits of any existing employees;
- Trainees in certain bona fide training programs;
- Employees subject to prevailing wage requirements; and
- Disabled employees covered by or eligible for an U.S. Department of Labor sub-minimum wage certificate.

HEALTH CARE ACCOUNTABILITY COMPONENTS:

Employers will have several options with respect to providing health benefits, depending upon where the Covered Employee lives and provides services, as follows:

- With respect to each Covered Employee who either resides in San Francisco (regardless of where the Covered Employee provides services) or provides services covered by Chapter 12Q in San Francisco, at the San Francisco Airport or at the San Bruno Jail, the employer must do one of the following, at the employer's option:
    - Offer to the Covered Employee health plan benefits that meet minimum standards approved by the Health Commission; or
    - For each week in which the Covered Employee works the applicable minimum number of hours on a City contract or City property (20 hours per week until 7/1/02, and 15 hours per week after 7/1/02), *pay to the City* $1.50 per hour for each hour the Covered Employee works on the covered Contract or Subcontract or on property covered by a Lease, but not to exceed $60 in any week. The City shall appropriate money received

pursuant to this option for the use of the Department of Public Health. The Health Commission may increase this hourly rate and weekly maximum; or

- Participate in a health benefit program developed by the Health Director and approved by the Health Commission.

- With respect to each Covered Employee who does not reside in San Francisco, and who does not provide services covered by Chapter 12Q in San Francisco, at the San Francisco Airport or at the San Bruno Jail, the employer must do one of the following, at the employer's option:

    - Offer to the Covered Employee health plan benefits that meet minimum standards prepared by the Health Director and approved by the Health Commission; or
    - For each week in which the Covered Employee works the applicable minimum number of hours on a City contract or City property, *pay to the Employee* an additional $1.50 per hour for each hour the Covered Employee is employed on the covered Contract or Subcontract or on property covered by a Lease, but not to exceed $60 in any week, to enable the employee to obtain health insurance coverage. The Health Commission may increase this hourly rate and weekly maximum.

If an employer has 20 or fewer employees (or, in the case of a Nonprofit Corporation, 50 or fewer employees), the employer shall not be obligated to provide the Health Care Accountability Components set forth above to its Covered Employees. In determining the number of employees, all employees of all of the employer's parents and subsidiaries shall be included.

CONTRACTS AND LEASES THAT ARE EXEMPT:

Various Contracts and Leases are exempt from Chapter 12Q, including:

- Contracts of less than 1 year;
- Contracts predominately for the purchase or lease of goods, or for guarantees, warranties, shipping, delivery, installation or maintenance of such goods;
- Contracts of less than $25,000 (in the case of a for-profit entity or person) or less than $50,000 (in the case of a Nonprofit Corporation). However, if the Contracting Party has multiple agreements with the City in a given fiscal year cumulatively worth $75,000 or more, the provisions of this Chapter shall apply to each such agreement;
- Contracts between a Tenant or Subtenant and a Contractor to perform services on property covered by a Lease if the employees of the Contractor (and any Subcontractors) cumulatively work on the Lease property less than 130 days within a 12-month period;
- Contracts executed before the Effective Date (unless amended) or pursuant to bid packages or requests for proposals advertised before the Effective Date (unless amended);

- Contracts involving the expenditure by the City of special funds or other non-General Fund revenues to the extent that application of this Chapter would require the City to use General Fund monies to supplement the special funds or other non-General Fund revenues to maintain the current level of services;
- Contracts that require the expenditure of grant funds awarded to the City by another entity, with respect to such grant funds only;
- Contracts pursuant to which the City awards a grant to a Nonprofit Corporation;
- Contracts and Leases with a public entity, unless the public entity is the San Francisco Redevelopment Agency, the San Francisco LAFCO, the San Francisco Transportation Authority, the San Francisco Parking Authority or the San Francisco Health Authority;
- Leases of less than 29 consecutive days in any calendar year;
- Leases that do not give exclusive use of the property to the tenant;
- Franchises, easements, revocable at-will use or encroachment permits for the use of or encroachment on City Property, street excavation, street construction or street use permits, and agreements for the use of a City right-of-way;
- Agreements governing the use of City Property primarily for recreational activities (but not for the operation of a business that provides recreational or entertainment activities).

ADMINISTRATIVE AND ENFORCEMENT PROVISIONS:

This legislation includes various administrative and enforcement provisions and waivers, including:

- The Director of Purchasing will be responsible for administering and enforcing Chapter 12Q, and may promulgate regulations after public hearing.
- The Director of Purchasing may waive the requirements of Chapter 12Q in certain circumstances, such as sole source contracts, emergency situations, or where its application would constitute an adverse impact on services or an unreasonable adverse financial impact on the City.
- Under specified circumstances, the General Manager of the Public Utilities Commission may waive the requirements of Chapter 12Q with respect to certain contracts for the provision, conveyance or transmission of wholesale or bulk water, electricity or natural gas, and ancillary requirements such as spinning reserve, voltage control, or loading scheduling.
- The Director of Purchasing may audit contractors and investigate complaints of noncompliance. If the Director of Purchasing determines a contractor has violated Chapter 12Q, the Director may take certain actions, including:
    - Charging the Contracting Party for any amounts that should have been paid to the City, with interest;
    - Assessing liquidated damages of $50 a day for each Covered Employee each day that a Contracting Party failed to pay to the City the required amounts;
    - Setting off the amount that a Contracting Party owes to the City against amounts due to a Contractor;

- Terminating the Contract or Lease;
- Barring a Contracting Party from entering into future Contracts or Leases with the City for three (3) years.

Attachment B

# Traditional Plan for Small Business — Northern California Area

**New groups only. Effective 1/1/01.**

| FEATURES | Plan B Member Pays | Plan C Member Pays | Plan D Member Pays | Plan E Member Pays |
|---|---|---|---|---|
| **Calendar Year Deductible:** Individual/family | $0 | $0 | $0 | $0 |
| **Out-of Pocket Maximum** | $1,500 individual $3,000 family | $1,500 individual $3,000 family | $1,500 individual $3,000 family | $1,500 individual $3,000 family |
| **In the Medical Office:** | | | | |
| Physician office visits | $5 | $10 | $15 | $20 |
| Physical exams | $5 | $10 | $15 | $20 |
| Maternity/prenatal care* | No charge | No charge | No charge | No charge |
| Scheduled well-child visits** | No charge | No charge | No charge | No charge |
| Immunizations | No charge | No charge | No charge | No charge |
| Lab, imaging, other tests (mammography and pap smears included) | No charge | No charge | No charge | No charge |
| **Emergency Services:** In or out of our Service Area (In a Plan or an Out-of-Plan Facility; waived if admitted) | $35 | $35 | $35 | $35 |
| **Prescriptions:** Must fall within our broad Health Plan formulary guidelines (up to a 100-day supply) | $5 per prescription | $7 per prescription | $10 per prescription | $15 per prescription |
| **Hospital Care:** | | | | |
| Physicians' services, room and board, tests, and supplies | No charge | No charge | No charge | No charge |
| Skilled nursing, home health, hospice | No charge | No charge | No charge | No charge |
| **Mental Health***:** | | | | |
| In the Medical Office (20 visits maximum per calendar year) | $5 | $10 | $15 | $20 |
| In the Hospital (30 days maximum per calendar year) | No charge | No charge | No charge | No charge |
| **Alcoholism and Drug Dependency Care:** | | | | |
| In the Medical Office (counseling for dependency; medical management of withdrawal symptoms) | $5 individual $2 group therapy | $10 individual $5 group therapy | $15 individual $5 group therapy | $20 individual $5 group therapy |
| In the Hospital (medical management of withdrawal symptoms) | No charge | No charge | No charge | No charge |
| Transitional Residential Recovery Services (in a non-medical setting) | $100 per admission | $100 per admission | $100 per admission | $100 per admission |
| **Durable Medical Equipment, Orthotics, and Prosthetics** | No charge | No charge | No charge | No charge |
| **Optical (lenses and frames)** | $60 per frame or $60 per set of contact lens allowance | Not covered | Not covered | Not covered |

* Scheduled prenatal visits and the first postpartum visit.
** After age 24 months, regular copayments apply.
*** Visit or day limits do not apply to certain mental health care described in the *Evidence of Coverage*.
Dependents are covered to age 19; students are eligible as dependents to age 24.
**This chart is a summary only.** Additional information is provided in the Group's Evidence of Coverage.
Age-banded plans are non-federally qualified benefit plans.

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# Added Choice for Small Business — Northern California

**New groups only. Effective 1/1/01.**

**If your employee selects the Traditional HMO option, the benefits are as follows:**

**If your employee selects the Point-of-Service option, the benefits are as follows:**

| FEATURES | Member Pays | Kaiser Permanente Provider (HMO In-Network) Member Pays | Participating Provider* (Out-of-Network/ Community Care Network) Member Pays | Any Other Provider** (Out- of -Network) Member Pays |
|---|---|---|---|---|
| **Calendar Year Deductible:** | | | | |
| Individual | $0 | $0 | $500[1] | |
| Family | $0 | $0 | $1,000[1] | |
| **Out-of Pocket Maximum** | $1,500 individual<br>$3,000 family | $1,500 individual<br>$3,000 family | $2,500 individual<br>$7,500 family | $5,000 individual<br>$15,000 family |
| **In the Medical Office†:** | | | | |
| Physician office visits | $10 | $15 | 20% | 40% |
| Physical, vision, and hearing exams | $10 | $15 | Covered In-Network only | Covered In-Network only |
| Maternity/prenatal care[2] | No charge | No charge | 20% | 40% |
| Women's preventive screening exam | No charge | No charge | 20%[3] | 40%[3] |
| Scheduled well-child visits[4] | No charge | No charge | Covered In-Network only | Covered In-Network only |
| Immunizations | No charge | No charge | Covered In-Network only | Covered In-Network only |
| Infertility services | 50% | 50% | 20%[5] | 40%[5] |
| Occupational, physical, respiratory, and speech therapy | $10 | $15 | 20%[6] | 40%[6] |
| Lab, imaging, and other tests | No charge | No charge | 20% | 40% |
| **Emergency Services[7]:** Emergency care is available from Kaiser Permanente 24 hours a day, 7 days a week. Certain emergency care received from non-Kaiser Permanente providers is also covered under Traditional HMO and In-Network coverage. | $35 | $35 | Out-of-Network charges incurred for emergency services will be covered In-Network. | |
| **Prescriptions:** (up to a 100-day supply) | Kaiser Permanente Plan pharmacy (including affiliated pharmacies)[8] | Kaiser Permanente Plan pharmacy (including affiliated pharmacies)[8] | Participating pharmacy[9] | Any other pharmacy[10] |
| Formulary | $7 | $10 | $15 | $25 |
| Non- formulary | Member rate | $25 | $25 | $25 |
| **Hospital Care†:** | | | | |
| Physicians' services, room and board, tests, medications, supplies, therapies | No charge | No charge | 20% | 40% |
| Skilled nursing care | No charge (100-day limit per benefit period) | No charge (100-day limit per benefit period) | 20% (Combined 60-day limit per benefit period) | 40% |
| Hospice care | No charge | No charge | 20% (Combined 180-day limit per benefit period) | 40% |
| Home health care | No charge | No charge | 20%[11] | 20%[11] |
| **Mental Health***:** | | | | |
| In the Medical Office (20 visits per calendar year maximum) | $10 | $15 | Covered In-Network only | Covered In-Network only |
| In the Hospital (30 days per calendar year maximum) | No charge | No charge | Covered In-Network only | Covered In-Network only |
| **Alcoholism and Drug Dependency Care:** | | | | |
| In the Medical Office (counseling for dependency; medical management of withdrawal symptoms) | $10 individual<br>$5 group therapy | $15 individual<br>$5 group therapy | Covered In-Network only<br>Covered In-Network only | Covered In-Network only<br>Covered In-Network only |
| In the Hospital (medical management of withdrawal symptoms) | No charge | No charge | Covered In-Network only | Covered In-Network only |
| Transitional residential recovery services (in a nonmedical setting) | $100 per admission | $100 per admission | Covered In-Network only | Covered In-Network only |
| **Durable Medical Equipment, Orthotics, and Prosthetics** | No charge | No charge | 20%[12] | 40%[12] |

* Based on contracted rates.

** Based on Usual, Customary and Reasonable charges. Member is responsible for any charges that exceed Usual, Customary and Reasonable charges.

*** Visit or day limits do not apply to certain mental health care described in the *Evidence of Coverage*.

**This chart provides only a brief summary of the coverage available under the Policy. For a complete understanding of the terms of coverage, please read this chart in conjunction with the Added Choice *Disclosure Form* and the Kaiser Permanente Insurance Company *Certificate of Insurance*.**

Dependents are covered to age 19; students are eligible as dependents to age 24.

**See important footnotes on the following pages.**

**Footnotes**

[1] Deductible amounts are combined for Out-of-Network services provided by Participating Providers and Any Other Providers. Deductibles do not count toward satisfying the out-of-pocket maximum. Lifetime maximum is $2,000,000 combined for Out-of-Network services provided by Participating Providers and Any Other Providers.

[2] Scheduled prenatal visits and first postpartum visit.

[3] Exempt from deductibles.

[4] Covered by HMO In-Network only.

[5] Benefits payable for treatment of infertility are limited to $1,000 per calendar year combined for Out-of-Network services provided by Participating Providers or Any Other Providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

[6] All outpatient therapies are limited to 60 visits per calendar year combined for both Participating Providers and Any Other Providers.

[7] Non-emergency medical services received in an emergency care setting that are not covered as an In-Network benefit, may be covered as an Out-of-Network benefit. Emergency department surcharge fees are not covered Out-of-Network.

[8] Prescription drugs for the treatment of infertility are covered at 50% of the member rate at Kaiser Permanente Plan Pharmacies only.

[9] Participating Pharmacy copayments are not subject to, nor do they contribute towards satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from Out-of-Network Coverage. Participating Pharmacies are Albertsons, Kmart, Longs, Raleys, Rite Aid, Safeway, Sav-on, Vons, and Walgreens (except certain Rite Aid locations in Stanislaus which are designated as Affiliated Pharmacies).

[10] Prescriptions filled at non-participating pharmacies are subject to the noted per prescription deductible. Deductibles paid for prescriptions filled at non-participating pharmacies are not subject to, nor do they contribute towards satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from Out-of-Network Coverage.

[11] Home health care is limited to a maximum of 100 visits per calendar year combined for Out-of-Network services provided by Participating Providers and Any Other Providers. Deductible amount is limited to a maximum of $50 per Calendar Year.

[12] Durable Medical Equipment/Orthotics, Prosthetics and Special Footwear benefits are limited to a maximum of $2,000 per calendar year combined for Out-of-Network services provided by Participating Providers and Any Other Providers.

**†Precertification of Out-of-Network Services**

Precertification is required for all hospital confinements including preadmission testing, inpatient care at a skilled nursing facility or other licensed, free-standing facilities, such as hospice care, home health care, or care at a rehabilitation facility, or select outpatient procedures. Failure to obtain precertification will result in an additional deductible of $500 per occurrence for covered charges incurred in connection with these services. This additional deductible will not count toward the satisfaction of any calendar year deductibles or out-of-pocket maximums.

**Out-of-Network Exclusions and Limitations**

Unless specifically covered under the Group Policy, expenses incurred in connection with the following services are excluded: Charges, services or care that are: provided or reimbursed by KFHP; not Medically Necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort. Emergency department facility fees or charges for non-emergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policyholder or Member is required by law to maintain alternative insurance or coverage. Charges for military service related conditions or where care is provided at government expense. Services or care provided in a Member's home, by a family member or by a resident of the household. Dental care, appliances or orthodontia, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs KPIC determines to be experimental or investigational. Education, counseling, therapy or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with: obesity; craniomandibular or tempromandibular joint disorders, unless for medically necessary surgical treatment of the disorder; musculoskeletal therapy; weight management; health education; biofeedback; hypnotherapy; routine adult physical exams; immunizations; medical social services; hearing exams, aids or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Treatment of: mental illness; substance abuse. Services or supplies necessary to treat an injury to which a contributing cause was a Member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication; or under the influence of a narcotic, unless administered by a Physician. Services of a private duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses or fittings; drugs and medicine for smoking cessation; well-child care and immunizations.

**Important Information**

Written information on topics related to coverage offered to employer groups in the small group market is available and can be obtained by contacting your broker or a Kaiser Permanente Small Business Representative at **1-800-730-4661.**

*Topics include:*
1.Factors that affect rate setting and rate adjustments.
2.Provisions related to renewing coverage.
3.Plan designs and premiums available to small groups.
4.Geographic areas covered by the Health Plan.

*Note: Kaiser Permanente plans do not include a pre-existing condition clause.*

**In-Network HMO benefits** are provided by Kaiser Foundation Health Plan, Inc., one of the nation's largest and most experienced prepaid group practice health plans.

**Out-of-Network benefits** under the Point-of-Service option are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of Kaiser Foundation Health Plan, Inc.

**KPIC** contracts with **CCN**, the administrator of the Participating Provider Network. Together they are dedicated to delivering quality health care at an affordable cost for small businesses.



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Attachment C

Health Insurance Plan of California's

# *PacAdvantage*

# Q&A

PacAdvantage

Choice • Simplicity • Affordability

www.pacadvantage.org

January, 2000

# *Put the plan that delivers choice, simplicity & affordability to work*

*What is the Plan of Choice?*

Through Pacific Health Advantage (PacAdvantage), also known as the Health Insurance Plan of California, small businesses can get affordable coverage by buying health care together as one big group. This gives small employers real purchasing power.

PacAdvantage also gives each employee more plan choices than many large corporations. PacAdvantage is made up of 15 health plans and offers HMO and POS plan options. This makes it easy for you and each of your employees to choose the health plan that best meets individual needs.

Small businesses with 2-50 employees may enroll in PacAdvantage. There are no restrictions based on the type of business you operate, the health of your group, or the age of your employees.

*What about dependents of employees?*

Dependents of employees are eligible if they are the spouse, qualified domestic partner, or any unmarried child (adopted or a stepchild or a recognized natural child) under age 23.

PacAdvantage provides a comprehensive choice of benefits (see back cover). The benefits offered by each health plan are designed to be the same. This frees you to make health plan choices based on quality, cost, doctor/hospital network, level of co-payment and type of plan.

*What makes PacAdvantage so simple?*

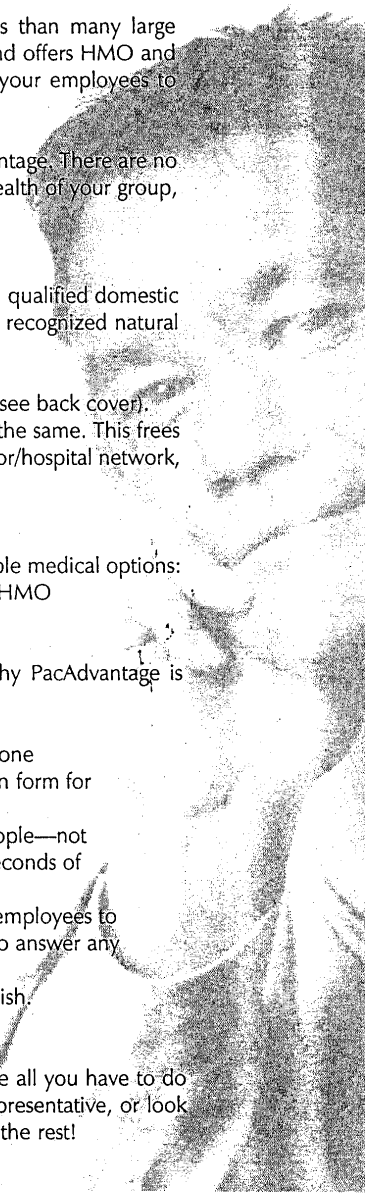
Employees may select from one of four co-payment/deductible medical options:

- $5 co-pay HMO
- $10 co-pay HMO
- $15 co-pay HMO
- $10 co-pay POS

No one wants to deal with reams of paperwork. That's why PacAdvantage is making insurance easy. Take a look at these advantages:

- PacAdvantage streamlines administration. You will have one administrative contact, one bill, and the same application form for all plans.
- PacAdvantage has one toll-free hotline. You'll talk to people—not answering machines. And we will speak to you within seconds of receiving your call.
- PacAdvantage will place welcome calls to each of your employees to introduce them to the plan and benefits available, and to answer any questions they may have.
- PacAdvantage provides service in both Spanish and English. Translation service is also available in other languages.

Simply put, to receive health benefits through PacAdvantage all you have to do is call your independent agent or a PacAdvantage Sales Representative, or look us up on the web at **www.pacadvantage.org**. We'll handle the rest!



PacAdvantage offers dental and vision coverage, too! The PacAdvantage dental benefit package is offered by seven dental plans and includes orthodontia. Vision coverage is offered through VSP and AVP. Chiropractic and acupuncture benefits are available through American Specialty Health Plans.

Rates are guaranteed for one year upon enrollment. Call your independent agent for a price illustration or call us toll free at 1-877-735-5742.
With PacAdvantage, the choice is yours.

**Each Employee can choose from the following plans:**

## Health plans

Aetna US Healthcare

CCHP

Champion Health

Health Net® California's Health Plan

Community

National HMO

Kaiser Permanente

Universal Care

Sharp

PacifiCare® of California

San Francisco Health Plan — Here for you

Blue Shield of California

UHC Healthcare

## Dental plans

Pacific Life & Annuity Companies

Humana

Dental Benefit Providers of California, Inc.

SafeGuard

DentiCare of California

PacifiCare® Dental

Universal Care Dental

## Vision plans

VSP

AVP Vision Plans

## Chiropractic/Acupuncture

American Specialty Health Plans

*for you and your employees*

# *PacAdvantage Benefit Summary*

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.**

| *Benefit* | *HMO Standard* | *HMO Plus* | *HMO Preferred* | *POS-In Network* | *POS-Out of Network* |
|---|---|---|---|---|---|
| Deductibles | $0 | $0 | $0 | $0 | $500 |
| Lifetime Maximum Benefits | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| Yearly Out-of-Pocket Maximum (individual/family) | $2,000/$4,000 | $2,000/$4,000 | $2,000/$4,000 | $2,000/$4,000 | $5,000/$10,000 |
| **Professional Services** | | | | | |
| Physician Office Visits | $15 | $10 | $5 | $10 | 30% |
| Preventive Care | $15 | $10 | $5 | $10 | not covered |
| Prenatal Care | $5 | $5 | $5 | $5 | 30% |
| Well-Baby Care ( 0-2 yrs.) | $5 | $5 | $5 | $5 | 30% |
| **Outpatient Services** | | | | | |
| Infertility Services | 50% | 50% | 50% | 50% | not covered |
| Laboratory & Radiology | $0 | $0 | $0 | $0 | 30% |
| Outpatient Surgery | $100 | $75 | $50 | $75 | 30% |
| **Hospitalization Services** | | | | | |
| Inpatient Hospital Benefits | $250 per Admission | $100 per Admission | $100 per Admission | $100 per Admission | 30% |
| Skilled Nursing Care | $100 per Admission | $0 | $0 | $100 per Admission | 30% |
| **Emergency Health Coverage** | | | | | |
| Emergency Care Services | $50, if not admitted | $50, if not admitted | $50, if not admitted | $50, if not admitted | $50, if not admitted |
| Ambulance Services | $0 | $0 | $0 | $0 | $0 |
| **Prescription Drug Coverage** | | | | | |
| Generic 30-34 Days | $10 | $10 | $5 | $10 | not covered |
| Brand 30-34 Days | $20 | $15 | $15 | $15 | not covered |
| **Mail Order** | | | | | |
| Generic 90 Days | $20 | $20 | $10 | $20 | not covered |
| Brand 90 Days | $40 | $30 | $30 | $30 | not covered |
| **Durable Medical Equipment** | | | | | |
| Durable Medical Equipment | $0 | $0 | $0 | $0 | not covered |
| Corrective Appliances and Prosthetics | $0 | $0 | $0 | $0 | not covered |
| **Mental Health Services** | | | | | |
| Inpatient (Max. 10 days/yr.) | $100 per Admission | $0 | $0 | $100 per Admission | not covered |
| Outpatient (Max. 20 visits/yr.) | $20/20 visits or approved alternative | $20/20 visits or approved alternative | $20/20 visits or approved alternative | $20/20 visits or approved alternative | not covered |
| **Chemical Dependency Services** | | | | | |
| Inpatient (Detox. Only) | $100 per Admission | $0 | $0 | $100 per Admission | 30% |
| Outpatient (subject to benefit year limit) | $20/20 visits or approved alternative | $20/20 visits or approved alternative | $20/20 visits or approved alternative | $20/20 visits or approved alternative | not covered |
| **Home Health Services** | | | | | |
| Home Care | $15 | $10 | $5 | $10 | 30% |
| Hospice Care | $15 | $10 | $5 | $10 | 30% |

All services covered by your selected health plan are fully described in the Evidence of Coverage or Certificate of Insurance document that will be mailed to you once you are accepted into the program. Please note that the information presented on these pages is only a summary of the benefits provided by each of the health plans participating in PacAdvantage. For exact terms and conditions of the health care benefits, provisions, exclusions, and limitations of each plan, please refer to the Evidence of Coverage booklet or Certificate of Insurance.

**Recyclable**

*6759-03-12699*

RESOLUTION OF THE HEALTH COMMISSION APPROVING AND ADOPTING MINIMUM STANDARDS FOR HEALTH PLAN BENEFITS REQUIRED IN THE HEALTHCARE ACCOUNTABILITY ACT.

Whereas, the Board of Supervisors passed the Healthcare Accountability Act on May 29, 2001, requiring that contractors of the City and lessees of City property provide healthcare insurance to their employees; and

Whereas, the Ordinance requires that the Health Commission adopt minimum standards for health plan benefits offered by City and County contractors and/or lessees; and

Whereas, the components of the minimum standard for health plan benefits includes: 1) effective date of coverage, 2) percentage of premium paid by employer and employee, 3) benefits offered under coverage and 4) employee co-payments for receiving services; and

Whereas, in developing minimum health plan benefits, the Department of Health staff researched insurance plans in the California marketplace; and

Whereas, the Department adopted the following principles in developing the minimum health plan benefit standards:

- Minimize disruption for employers and lessors who currently provide a comprehensive scope of medical benefits,
- Out-of-pocket costs (both premiums and co-payments for employees) should not be so high that they decrease employees' acceptance of health plan coverage,
- The minimum benefit standards should be designed to ensure that contractors and lessees provide a comprehensive scope of medical benefits. (Catastrophic benefit coverage is not comprehensive; and

Whereas, the Department will review the standards annually and recommend changes to the minimum standards in accordance with changes in the health plan marketplace; therefore be it

Resolved: That the Health Commissions sets the minimum standard for healthcare benefits, consistent with the health plan standards in the Bay Area, as follows:

- The effective date of coverage shall be no later than the first day following the first complete calendar month worked by the employee;

- Employers shall offer at least one health plan option in which the premium is entirely paid for by the employer;

- The health benefits shall include the following services:
  Outpatient Procedures
  Diagnostic, X-Ray and Laboratory Services
  Perinatal/Maternity
  Preventive Care
  Family Planning
  Prescription Drug Coverage
  Hospital Services (inpatient and outpatient)
  Emergency Health
  Ambulance Services
  Mental Health (inpatient and outpatient)
  Alcohol and Substance Abuse Care (inpatient and outpatient)
  Rehabilitative Therapies (inpatient and outpatient)
  Home Health Services
  Durable Medical Equipment
  Hospice Care
  Skilled Nursing Services;

- CoPayment requirements shall be:

| Benefit | CoPayment |
|---|---|
| Outpatient Services | Max. $10/visit |
| Outpatient Procedures | Max. $100/Procedure |
| Diagnostic, X-Ray – Laboratory Services | No Charge |
| Perinatal and Maternity | |
| Office visits | Max. $10/visit |
| Inpatient | Max. $100/admission |
| Preventive Services | Max. $10/visit |
| Family Planning Services | Max. $10/visit |

| | |
|---|---|
| Prescription Drug Coverage | Generic: Max. $15/30 days<br>Brand: Max. $25/30 days |
| Hospital Services | |
| Inpatient | Max. $100/Admission |
| Outpatient | Max. $75/visit |
| Emergency Services | Max. $50/visit (waived if admitted) |
| Ambulance Services<br>(Medically Necessary) | Max. $50/trip (waived if medically necessary) |
| Mental Health Services | |
| Inpatient (minimum of 10 days) | Max. $100/Admission |
| Outpatient (minimum of 20 visits/yr) | Max. $20/visit |
| Alcohol/Substance Abuse Care | |
| Inpatient (detox) | Max. $100/day |
| Outpatient (min. of 20 visits/yr) | Max. $20/visit |
| Rehabilitative Services | |
| Office/Outpatient | Max. $20/visit |
| Inpatient | Max. $100/day |
| Home Health Services<br>(minimum 100 days/yr) | Max. $15/visit |
| Durable Medial Equipment | 50% of allowable charges |
| Hospice Care | Max. $15/visit |
| Skilled Nursing Services<br>(at least 100 days/yr) | Max. $100/admission or $50/day |
| Yearly Out of Pocket<br>(Total yearly costs paid by person accessing services) | Co Payment Max. $2,000/year |