City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

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

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

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

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

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

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15	**Emergency Room Services**	Covered	Emergency Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency transportation and ambulance when reasonable person would believe medical condition that required ambulance services or if treating physician determines you must be transported to another facility b/c condition not stabilized & svcs not available	No							No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Hospital Inpatient Services - services at plan hospital when services generally provided at acute care gen hosp in service area.	No							No
18	**Inpatient Physician and Surgical Services**	Covered	Hospital Inpatient Care - covers services of plan physicians and consultation and treatment by specialists	No							No
19	**Bariatric Surgery**	Covered	Bariatric surgery to treat obesity if complete pre-surgical education and medically necessary	No						Surgery must be medically necessary to treat obesity and patient must complete pre-surgical education. Covers travel if live more than 50 miles from facility to which patient referred.	No
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility Care	Yes	100	Other other	Days per benefit period				No
22	**Prenatal and Postnatal Care**	Covered	Scheduled prenatal exams and first postpartum follow-up consult is covered without charge	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Hospital Inpatient Care	No							No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental Health Services	No						For diagnosis or treatment of mental disorders - as identified in DSM.	No

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25	**Mental/Behavioral Health Inpatient Services**	Covered	Inpatient Psychiatric Hospitalization and intensive psychiatric treatment programs	No							No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Chemical Dependency Services - Outpatient chemical dependency. Includes day-treatment, intensive outpatient programs, individual and group counseling, and medical treatment for withdrawal symptoms.	No					Services in specialized facility not otherwise described in EOC	Includes transitional residential recovery services.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Chemical Dependency Services - Inpatient detoxification	No							No
28	**Generic Drugs**	Covered	Outpatient Prescription Drugs, Supplies, and Supplements	No							No
29	**Preferred Brand Drugs**	Covered	Outpatient Prescription Drugs, Supplies, and Supplements	No						Kaiser does not use preferred/non-preferred categories. Kaiser categorizes drugs as generic, brand, or compound and formulary/ nonformulary. There is higher Cost Sharing than for Generic Drugs.	No
30	**Non-Preferred Brand Drugs**	Covered	Outpatient Prescription Drugs, Supplies, and Supplements	No						Kaiser does not use preferred/non-preferred categories. Kaiser categorizes drugs as generic, brand, or compound and formulary/ nonformulary. There is coverage for non-formulary if non-formulary is medically necessary.	No
31	**Specialty Drugs**	Covered	Outpatient Prescription Drugs, Supplies, and Supplements	No							No
32	**Outpatient Rehabilitation Services**	Covered	Physical, occupational, speech therapy	No							No
33	**Habilitation Services**	Covered	Habilitation Services	No					Certain limitations on types of care givers for behavioral health treatment as described in H&S Code section 1374.73.	CA Health and Safety Code sec. 1367.005 (Stats 2012, ch. 854) requires that individual or small group health care service plans provide habilitative services, to the extent required under state law and as required by federal rules and regulations in section 1302(b) of the ACA.	No

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34	**Chiropractic Care**	Not Covered									
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment for Home Use - plan formulary guidelines or medical necessity	No					Prior auth required		No
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Outpatient imaging, laboratory and special procedures	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Outpatient imaging, laboratory and special procedures	No							No
39	**Preventive Care/ Screening/Immunization**	Covered	Outpatient imaging, laboratory and special procedures	No							No
40	**Routine Foot Care**	Not Covered	Exclusions							Medically necessary foot care is covered.	
41	**Acupuncture**	Covered	Outpatient Care	No						Typically only for treatment of nausea or as part of comp. pain management program.	No
42	**Weight Loss Programs**	Covered	Weight Loss Programs	No							No
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year				California has chosen FEDVIP to supplement benchmark for pediatric vision care.	No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year)			California has chosen FEDVIP to supplement benchmark for pediatric vision care.	No
45	**Dental Check-Up for Children**	Covered	Dental Check-Up for Children	Yes	1	Other other	2 in a 12 month period			Supplemented using California CHIP.	No

OTHER BENEFITS

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1	**Other**	Covered	Allergy injections	No							No
2	**Other**	Covered	Voluntary Termination of Pregnancy	No							No
3	**Other**	Covered	Dental and Orthodontic Services	No						Preparations for radiation therapy and Dental anesthesia for children under age 7, developmentally disabled, or health is compromised, status or underlying condition and procedure doesn't ordinarily require anesthesia.	No
4	**Other**	Covered	Asthma Supplies and Equipment	No							No
5	**Other**	Covered	Dialysis Care	No							No
6	**Other**	Covered	Hearing Screenings & Exams - preventive care services	No							No
7	**Other**	Covered	Ostomy and Urological Supplies	No							No
8	**Other**	Covered	AIDS Vaccine	No							No
9	**Other**	Covered	HIV Testing	No							No
10	**Other**	Covered	Alzheimer's Disease Treatment	No							No
11	**Other**	Covered	Breast Cancer Screening, Diagnosis, Treatment, Prosthetic Devices or Reconstructive Surgery	No							No
12	**Other**	Covered	Cancer Screenings	No							No
13	**Other**	Covered	Cervical Cancer Screenings	No							No
14	**Other**	Covered	Cancer Clinical Trials	No							No
15	**Other**	Covered	Contraceptive Methods	No							No
16	**Other**	Covered	Diabetes Equipment, Supplies, Prescription Drugs, Education	No							No
17	**Other**	Covered	Laryngectomy-Prosthetic Devices	No							No
18	**Other**	Covered	Maternity Coverage	No							No
19	**Other**	Covered	Maternity-Prenatal Alpha Feto Protein Programs	No							Yes
20	**Other**	Covered	Genetic Disorders of the Fetus	No							No
21	**Other**	Covered	Osteoporosis	No							No
22	**Other**	Covered	Phenylketonuria	No							No
23	**Other**	Covered	Prostate Cancer Screening and Diagnosis	No							No
24	**Other**	Covered	Reconstructive Surgery	No							No
25	**Other**	Covered	Surgical Procedures for the Jawbone	No							No
26	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
27	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No

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28	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply. Covered only if child meets eligibility requirements for medically necessary orthodontia coverage under California Children's Services (CCS).	No

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
ANXIOLYTICS	ANXIOLYTICS, OTHER	3

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

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

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