NEW JERSEY EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	Horizon HMO
Product Name	HMO
Plan Name	Horizon HMO Access HSA Compatible
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

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	Primary care visit to treat an injury or illness	Covered	No						No
Specialist Visit	Yes	Specialist visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other practitioner office visits (nurse, physician assistant)	Covered	No				Care and/or treatment by a Christian Science practitioner or care by a family member.	Practitioner must be licensed and acting within the scope of the license, but also cover services of BCBA and BCaBA practitioners.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient facility fee	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient surgery; physician/surgical services	Covered	No				Local anesthesia billed separately when charges are included in surgery fee.	Pre-approval required.	No
Hospice Services	Yes	Hospice services	Covered	No				Private accommodations.	Inpatient hospice covered at the private room & board rate. Pre-approval required.	No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered						See "Other" for covered dental-related services.	
Infertility Treatment	Yes	Limited infertility treatment	Covered	No				Services or supplies to enhance fertility that involve harvesting, storage and/or manipulation of eggs and sperm, including in vitro fertilization, embryo transfer, embryo freezing, gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), donor sperm, surrogate motherhood, or sterilization reversal.	Pre-approval required. Except as specifically excluded, only artificial insemination and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs are covered.	No
Long-Term/Custodial Nursing Home Care			Not Covered					Custodial and domiciliary care		
Private-Duty Nursing		Covered as part of home health benefits only	Covered	Yes	60	Visits per year			Only covered under Home Health Care Services (see Home Health Care for other limits/conditions).	No
Routine Eye Exam (Adult)		Routine eye exam - adult (see exclusion/explanation)	Covered	No				Exams to determine the need for or changes of eyeglasses or lenses; eyeglasses or lenses of any type (other than initial replacements of the natural lens); eye surgery primarily intended to correct myopia, hyperopia or astigmatism.	Eye screenings provided as part of a routine physical exam are covered.	No

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Urgent Care Centers or Facilities	Yes	Urgent care centers or facilities	Covered	No						No
Home Health Care Services	Yes	Home health care services	Covered	Yes	60	Visits per year		Services furnished to family members, other than the patient. Services and supplies not included in the home health care plan.	Pre-approval required. Covers medically necessary and appropriate services in a written home health plan when certified as needed to avoid continuing hospitalization or confinement in a SNF. Services and supplies must be included in the written plan and furnished by a home health agency through recognized health care professionals. The covered person's practitioner must establish the written plan within 14 days after home health care starts and review it at least once every 60 days.	No
Emergency Room Services	Yes	Emergency room services	Covered	No					No referral or notice required prior, but coverage is provided only if written proof of the occurrence, nature and extent of the emergency service is submitted within 30 days. Coverage for emergency services includes only treatment needed to treat the emergency; pre-approval is required for coverage of elective procedures performed after admission as a result of an emergency. Emergency services of non-network providers covered only if it is determined the covered person's symptoms were severe and delay of treatment would have been detrimental to health, the symptoms occurred suddenly and the covered person sought immediate attention, and the service or supply is not normally provided on a non-emergency basis. Includes emergency room treatment at Level 1 and Level 2 trauma centers (as required by NJAC 11:24A-2.6).	No
Emergency Transportation/ Ambulance	Yes	Emergency transportation/ambulance	Covered	No				Chartered flights. Travel or communication expenses of patients, health care providers or family members. Services for ambulance transport from a hospital to another facility except when a member is transferred to another inpatient health care facility.	Covers medically necessary and appropriate charges for transporting a member to a local hospital or to the nearest hospital where needed care can be given, if a local hospital cannot provide such care (but see exclusion).	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient hospital services	Covered	No				Private accommodations	Pre-approval required. Covered at semi-private room and board rate. Includes nursing, intensive and special care facilities, imaging and laboratory services, drugs and biologicals, pre- and post-operative care, anesthesia, blood, surgical, medical and obstetrical services, etc.	No
Inpatient Physician and Surgical Services	Yes	Inpatient physician and surgical services	Covered	No				Local anesthesia charges if billed separately when charges are included in the fee for the surgery.	Pre-approval required for surgery.	No
Bariatric Surgery	Yes	Bariatric surgery	Covered	No					Pre-approval required.	No
Cosmetic Surgery			Not Covered					Cosmetic surgery, treatment for complications of cosmetic surgery, related services or supplies and drugs provided for cosmetic purposes.	Defined as any surgery or procedure that involves physical appearance that does not correct or materially improve a physiological function and is not medically necessary.	

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Skilled Nursing Facility	Yes	Skilled nursing facility	Covered	No				Private accommodations.	Pre-approval required. Coverage of network SNF services and supplies only for those constituting skilled nursing care.	No
Prenatal and Postnatal Care	Yes	Prenatal and postnatal care	Covered	No					See "Delivery and All Inpatient Services for Maternity Care." Mother may elect a home care program in lieu of the post-delivery hospital stay.	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and all inpatient services for maternity care	Covered	No			48	Private accommodations.	Mother and newborn may be covered up to 48/96 hours inpatient in a network hospital after a vaginal/caesarian delivery if the attending physician determines it is medically necessary or the mother requests it.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/behavioral health outpatient services	Covered	No				Custodial care, education and training.	See also "Other" for Autism and Developmental Disabilities.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/behavioral health inpatient services	Covered	No				Private accommodations, custodial care, education and training.	Pre-approval required.	No
Substance Abuse Disorder Outpatient Services	Yes	Substance abuse disorder outpatient services	Covered	No				Custodial care, education and training.		No
Substance Abuse Disorder Inpatient Services	Yes	Substance abuse disorder inpatient services	Covered	No				Private accommodations, custodial care, education and training.	Pre-approval required.	No
Generic Drugs	Yes	Generic drugs	Covered	No				Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. See "Other" for additional Prescription Drug information.	No
Preferred Brand Drugs	Yes	Preferred brand drugs	Covered	No				Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. Pre-approval required for certain prescription drugs. See "Other" for additional Prescription Drug information.	No
Non-Preferred Brand Drugs	Yes	Non-preferred brand drugs	Covered	No				Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. Pre-approval required for certain prescription drugs. See "Other" for additional Prescription Drug information.	No

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Specialty Drugs	Yes	Specialty drugs	Covered	No				Drugs prescribed for cosmetic purposes; nonprescription drugs.	All specialty drugs require pre-approval. Defined as drugs that have unique production, administration or distribution requirements, and require specialized patient education prior to use and ongoing patient assistance while under treatment. Must be dispensed through specialty pharmaceutical providers. See "Other" for Hemophilia services as well as Anti-cancer Prescription Drugs.	No
Outpatient Rehabilitation Services	Yes	Outpatient rehabilitation services	Covered	Yes	30	Visits per year			Pre-approval required. Separate from services provided through home health care benefits.	No
Habilitation Services	Yes	Habilitation services	Covered	No					Habilitation services are subject to the limits applicable to rehabilitation services, other therapies, services and supplies. Habilitations as provided through rehabilitation services are covered. See also: Hearing Aids; "Other" for Autism and Developmental Disabilities benefits, ST, PT/OT and ABA benefits; "Other" for Diabetes services.	No
Chiropractic Care	Yes	Therapeutic manipulation	Covered	Yes	30	Visits per year			Covered when therapeutic manipulation is provided in a network practitioner's office, for no more than two modalities per visit.	No
Durable Medical Equipment	Yes	Durable medical equipment	Covered	No					Pre-approval required, must be ordered by a network practitioner [and arranged through the carrier].	No
Hearing Aids	Yes	Hearing aids	Covered	Yes	1	Aid per hearing-impaired ear every 24-months			Covered for members 15 years old and younger. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic test (X-ray and lab work)	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET scans, MRIs)	Covered	No					Pre-approval required, including for: CT, PET, MRI, Computed Tomography Angiography (CTA), Magnetic Resonance Angiogram (MRA), and Nuclear Medicine (including Nuclear Cardiology).	No
Preventive Care/ Screening/Immunization	Yes	Preventive care/screening/immunization	Covered	No				Routine immunizations for the sole purpose of travel or as a requirement for a member's employment.	Includes USPSTF recommendations, but see "Other" for additional screening benefits.	No
Routine Foot Care			Not Covered						Routine foot care is excluded, except for the following: open cutting operations to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; removal of nail roots; treatment of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease. Also, see "Other" for Orthotics and Prosthetics benefits.	
Acupuncture			Not Covered						Covered when used as a substitute for other forms of anesthesia.	

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Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam for children	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of eyeglasses (lenses and frames) or contact lenses annually		Does not provide allowance for both glasses and contacts in a single year. No vision therapy; no other corrective treatments or devises, except as described (see "Explanation").	Includes coverage for exams by optometrist or ophthalmologist, including dilation. Includes allowances for lenses, frames, contacts, and discounts for laser surgery when using a contracted provider.	No
Dental Check-Up for Children	Yes	Dental Services (per CHIP)	Covered	No				Treatment for TMJ; limited to members age 19 and younger.	Coverage includes screenings and other preventive services, diagnostic services, major and minor restorative services, endodontic, surgical and adjunctive services, periodontic and prosthedontic services, as medically necessary. Begins at age 1 year. Dental services also include orthodontia—see "orthodontia."	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	30	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	30	Visits per year combined			Limit only applies when provided in a network practitioner's office—services provided under Home Health Care or to treat Autism or Developmental Disabilities do not apply towards this limit. Also note: the benefit limit for the standard small group plans is a combined 30 visit limit for PT and OT, but for the standard individual market, the benefit limit is 30 visits each for PT and OT.	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						No
Orthodontia - Child	Yes	Orthodontia (per CHIP)	Covered	No				Cosmetic orthodontia.	Coverage is limited to demonstration of at least one of the following: severe functional difficulties; developmental anomalies of facial bones and/or oral structure; facial trauma resulting in severe functional difficulties; or that psychological health requires orthodontic correction. Generally, coverage is limited to prevent or correct facial deformities, or functional difficulties in speech or mastication.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No						No
Basic Dental Care - Adult			Not Covered							

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Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No					Costs associated with the transplant, including inpatient services, and practitioner services. Inpatient hospital services and practitioner services, including associated dose-intensive chemotherapy, but only if performed by institutions approved by the NCI, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Inpatient hospital costs of donors associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. Transplants include cornea, kidney, lung, liver, heart, pancreas, intestine, allogenic bone marrow, autologous bone marrow, peripheral blood stem cells, and transplant donor costs, see EHB benchmark plan documents for additional details.	No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis	Yes	Dialysis	Covered	No					Includes both hemodialysis and peritoneal dialysis and treatment in a dialysis center by an appropriately licensed network provider.	No
Allergy Testing			Not Covered							
Chemotherapy	Yes	Chemotherapy	Covered	No					Must be rendered by an appropriately licensed Network provider.	No
Radiation	Yes	Radiation	Covered	No					Must be rendered by an appropriately licensed Network provider.	No
Diabetes Education			Not Covered							
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No					Prosthetic Devices include orthotics and prosthetics. Covered if the member's practitioner determines it is medically necessary, and obtained from a licensed orthotist, prosthetist or certified pedorthist in-network.	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No					Treatment involving the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion. Pre-approval required. See also "Hemophilia" benefits; infusion therapy is not limited to hemophilia treatment.	No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No				Services or supplies for orthodontia, crowns or bridgework.	Surgical and nonsurgical treatment of TMJ is covered when medically necessary and appropriate.	No

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Nutritional Counseling	Yes	Nutritional Counseling	Covered	No					For management of disease with specific criteria that can be verified (including diabetes); see also Diabetes services	No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No					The Inherited Metabolic Disorder benefit includes Food/Food Products for Inherited Metabolic Diseases. Coverage for charges incurred for medical foods (enteral formulas) and low protein modified food products as determined medically necessary by the member's practitioner for the therapeutic treatment of inherited metabolic diseases.	No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No					Coverage must be provided for off-label prescriptions when certain protocols are met.	No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No				Anesthesia for dental services other than an described under "Explanation"	Covered: when a member is severely disabled or a child under age six, general anesthesia and hospitalization for dental services, and dental services rendered by a dentist regardless of where provided when for a medical condition requiring hospitalization or general anesthesia.	No
Mental Health Other	Yes	Mental Health Other	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Second Opinion	Yes	Second Opinion	Covered	No						No
Autism Spectrum Disorders	Yes	Autism Spectrum Disorders	Covered	No						Yes
Domestic Violence Treatment	Yes	Domestic Violence Treatment	Covered	No						No
Infant Formulas	Yes	Infant Formulas	Covered	No					Infant Formulas include Specialized non-standard infant formula for infants and toddlers. Covered as if a prescription drug for children diagnosed with multiple food protein intolerance for whom the formula is medically necessary and for whom trials of other non-cow milk-based formulas have not been successful.	No
Sickle Cell Anemia	Yes	Sickle Cell Anemia	Covered	No						No
Third Opinion	Yes	Third Opinion	Covered	No						No
Treatment of Hemophilia	Yes	Treatment of Hemophilia	Covered	No					Home treatment services for bleeding episodes are covered, including blood, blood products (factors), infusion equipment, and training. Clinical laboratory services at state-designated regional care centers are covered under certain circumstances whether or not the facility is in-network.	No
Wilm's Tumor	Yes	Wilm's Tumor	Covered	No						No

OTHER BENEFITS

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Speech and Cognitive therapy	Yes	Speech and Cognitive therapy	Covered	Yes	30	Visits per year combined			Limit only applies when provided in a network practitioner's office—services provided under Home Health Care or to treat Autism or Developmental Disabilities do not apply towards this limit. Also note: the benefit limit for the standard small group plans is combined for speech and cognitive therapy for a total of 30 visits, but for the standard individual plan market, the limit is 30 visits each for speech and cognitive therapy.	Yes
Autism/Developmental Disabilities - Speech therapy (Habilitative/rehabilitative)	Yes	Autism/Developmental Disabilities -Speech therapy (Habilitative/rehabilitative)	Covered	Yes	30	Visits per year			Limit does not apply against other ST benefits under the policy. Only available for treatment of diagnosis of autism or developmental disability. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce these therapy benefits.	No
Autism/Developmental Disabilities - Physical and Occupational therapy (Habilitative/rehabilitative)	Yes	Autism/Developmental Disabilities - Physical and Occupational therapy (Habilitative/rehabilitative)	Covered	Yes	30	Visits per year combined			Limit does not apply against other PT/OT benefits under the policy. Only available for treatment of diagnosis of autism or developmental disability. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce these therapy benefits.	No
Autism/Developmental Disabilities - Applied Behavior Analysis or Related Structured Behavior Services (Habilitative/rehabilitative)	Yes	Autism/Developmental Disabilities - Applied Behavior Analysis or Related Structured Behavior Services (Habilitative/rehabilitative)	Covered	No					For members <21 years old. Available to treat primary diagnosis of autism. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce any benefit. Treatment plan by physician required, reviewed semi-annually.	No
Blood, blood products and blood transfusions	Yes	Blood, blood products and blood transfusions	Covered	No				Blood donated or replaced on behalf of a member.	Includes the cost of testing and processing of blood. See also "Treatment of Hemophilia"	No
Dental Care and Treatment -- Illness and injury	Yes	Dental Care and Treatment -- Illness and injury	Covered	No				General dental services, both prophylactic and corrective.	Covered: diagnosis and treatment of oral tumors and cysts; surgical removal of bony impacted teeth; treatment of an injury to natural teeth or the jaw, including replacing natural teeth, if the injury was not caused (directly or indirectly) by biting or chewing, and all treatment is complete w/in 6 months from date of injury. Includes related dental ex-rays.	No

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Cancer Clinical Trials	Yes	Cancer Clinical Trials	Covered	No				Costs of investigational drugs or devices, costs of non-health services, costs related to managing the research, any costs that would not be covered for treatments that are not Experimental or Investigational.	Fees and expenses are covered for treatment of a condition associated with a complication of the underlying disease (cancer) through an Approved Cancer Clinical Trial if such fees and expenses would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.	No
Pain Management Services	Yes	Pain Management Services	Covered	No					Pre-approval required.	No
Chelation therapy	Yes	Chelation therapy	Covered	No					Must be rendered by an appropriately licensed Network provider.	No
Respiration therapy	Yes	Respiration therapy	Covered	No					Treatment by a network provider that introduces dry or moist gases into the lungs.	No
Newborn hearing screening	Yes	Newborn hearing screening	Covered	No					Electrophysiologic screening covered during first 28 days after birth. Periodic monitoring for delayed onset hearing loss covered from age 29 days through 36 months after birth.	No
Mammograms	Yes	Mammograms	Covered	No					Includes a base line mammogram from ages 35-39; covers annual mammograms from age 40 on, or at younger ages if a women is at risk.	No
Lead screening, follow-up treatment of high levels of lead in blood	Yes	Lead screening, follow-up treatment of high levels of lead in blood	Covered	No					Required during childhood.	No
Mastectomy inpatient stay	Yes	Mastectomy inpatient stay	Covered	No			48			No
Reconstructive breast surgery	Yes	Reconstructive breast surgery	Covered	No					Pre-approval required. Surgery to restore and achieve symmetry, and/or cost of prostheses following a mastectomy on one or both breasts; treatment of physical complications, including lymphedemas.	No
Diabetes Treatment -- services and supplies	Yes	Diabetes Treatment -- services and supplies	Covered	No					Coverage for self-management education and nutrition counseling as medically necessary; coverage for insulin syringes and insulin needles; glucose test strips; lancets; pumps and infusers, drugs, etc.	No
Prescription drugs -- contraceptives	Yes	Prescription drugs -- contraceptives	Covered	No					Prescribed female contraceptives. Religious employers may request exclusion of the benefit.	No
Prescription drugs -- open formulary and mail order restrictions	Yes	Prescription drugs -- open formulary and mail order restrictions	Covered	No					It is impermissible to require use of mail order only; it is impermissible to impose closed formularies.	No
Anti-cancer Prescription Drugs	Yes	Anti-cancer Prescription Drugs	Covered	No					Orally administered anti-cancer prescription drugs must be covered on a basis at least as favorable as intravenously administered or injected anti-cancer medications.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	16
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	12
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	6
ANTIBACTERIALS	MACROLIDES	4
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	7
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	19
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
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	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
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	12
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	7
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5
DENTAL AND ORAL AGENTS	NO USP CLASS	6
DERMATOLOGICAL AGENTS	NO USP CLASS	31
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
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	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	16
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	11
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	9
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	4
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	5