NEW YORK EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Exclusive Provider Organization
Issuer Name	Oxford Health Insurance, Inc.
Product Name	EPO
Plan Name	Oxford EPO
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (State CHIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	Yes: New York will set habilitative services at modified parity with rehabilitative services. The intent is to set the habilitative benefit at parity with the rehabilitative benefit in the outpatient setting only. Further, in New York's Base Benchmark Plan, the rehabilitative services benefit is covered only if the services are provided on a post-hospitalization or post-surgical basis. By setting habilitative services at parity with rehabilitative services, New York will require the same types of services and the same number of covered days for both benefits, but New York does not consider the post-hospitalization and post-surgical requirements for rehabilitative services to be requirements for habilitative services.

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 for treatment of illness or injury	Covered	No						No
Specialist Visit	Yes	Physician (Specialist) Office and Home visits	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Certified Nurse Midwife or any duly licensed health professional under contract with us to provide covered services to our members	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Hospital & Ambulatory Surgical Center	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Hospital & Ambulatory Surgical Center	Covered	No						No
Hospice Services	Yes	Hospice Services & Home Hospice	Covered	Yes	210	Days per year			Benefit limited is combined IP & OP.	No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment	Yes	Infertility Services Basic & Comprehensive	Covered	No				Advanced Infertility is not covered. Excludes IVF, GIFT & ZIFT.	Infertility Treatments include Correctable Medical Conditions Leading to Infertility. Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy. Member must be between ages of 21 and 44	No
Long-Term/Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							

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Routine Eye Exam (Adult)			Not Covered						Available as optional buy up for groups to purchase. $50 reimbursement per exam. Limited to one per year.	
Urgent Care Centers or Facilities	Yes	Urgent Care Facility Services	Covered	No						No
Home Health Care Services	Yes	Home Healthcare	Covered	Yes	40	Visits per year				No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Ambulance Services	Covered	No						No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No						No
Inpatient Physician and Surgical Services	Yes	Inpatient Hospital Services	Covered	No						No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No						No
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility Services	Covered	Yes	200	Days per year				No
Prenatal and Postnatal Care	Yes	Obstetrical Services Pre and Post Natal	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Maternity and Newborn Care	Covered	No					Min stay requirements (48/96 hours), prenatal, postnatal care, parent education, breast/bottle feeding assistance, clinical assessments, home visit, etc.	No
Mental/Behavioral Health Outpatient Services	Yes	Outpatient Mental Health Services and Partial Hospitalization (includes Biologically Based services)	Covered	Yes	30	Visits per year			Benefit limits include Office Visit and Outpatient Visits combined. Biologically based service visits will count toward this limit.	No
Mental/Behavioral Health Inpatient Services	Yes	Inpatient Mental Health Services (includes Biologically based services)	Covered	Yes	30	Days per year			Members may choose to exchange 1 inpatient day for 2 visits of partial hospitalization. Visits for biologically based services will count towards this limit.	No
Substance Abuse Disorder Outpatient Services	Yes	Outpatient Alcohol & Substance Abuse Rehabilitation	Covered	Yes	60	Visits per year			Benefit limits include Office Visit and Outpatient Visits combined. Up to 20 of the visits may be used by the member's family.	No
Substance Abuse Disorder Inpatient Services	Yes	Inpatient Alcohol & Substance Abuse Rehabilitation	Covered	Yes	30	Days per year			Some limitations apply to Inpatient Alcohol & Substance Abuse Detoxification, see EHB Benchmark plan documents for additional details.	Yes
Generic Drugs	Yes	Generic	Covered	No					Mail Order up to a 90 day supply.	No
Preferred Brand Drugs	Yes	Preferred Brand	Covered	No					Mail Order up to a 90 day supply.	No

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Non-Preferred Brand Drugs	Yes	Non Preferred Brand	Covered	No					Mail Order up to a 90 day supply.	No
Specialty Drugs	Yes	Specialty Drugs	Covered	No					Mail Order up to a 90 day supply.	No
Outpatient Rehabilitation Services	Yes	Short Term Rehabilitative Therapy Services (Physical, speech and Occupational therapy) Outpatient	Covered	Yes	60	Visits per condition per lifetime combined			Short Term Rehabilitation Services: Physical, Speech Occupational. Speech & physical therapy are only covered following a hospital stay or surgery.	No
Habilitation Services	Yes	Short Term Habilitative Therapy Services (Physical, speech and Occupational therapy) Outpatient	Covered	Yes	60	Visits per condition per lifetime combined			New York intends to require habilitative services to be covered at parity with rehabilitative services.	No
Chiropractic Care	Yes	Chiropractic Services	Covered	No						No
Durable Medical Equipment	Yes	Durable Medical Equipment & Medical Supplies & Braces	Covered	Yes	1500	Dollars per year for non-essential DME & Medical supplies. Braces must be standard equipment only.		Orthotics, arch supports, corrective shoes, false teeth, maintenance and repairs due to member's misuse.	Coverage for standard equipment only. DME defined as Equipment which is 1). Designed and intended for repeated use, 2), primarily and customarily used to serve a medical purpose, 3). Generally not useful to person in the absence of disease or injury and 4) is appropriate for use in the home.	No
Hearing Aids	Yes	Hearing Aids	Covered	Yes	1500	Dollars per year. Limited to a single purchase (including repair/replacement) every three years.		Bone Anchored Hearing Aids unless certain criteria exists.		Yes
Diagnostic Test (X-Ray and Lab Work)	Yes	Laboratory Procedures & X-ray Examinations (including pre-admission testing)	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Laboratory Procedures & X-ray Examinations	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive services, screenings, immunizations, etc.	Covered	No					Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates.	No
Routine Foot Care			Not Covered							
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Pediatric Vision exams	Covered	No					(These are benefits supplemented with NY CHIP.)	No

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Eye Glasses for Children	Yes	Pediatric Vision appliances	Covered	Yes	1	Pair of glasses and frames covered once in any 12 month period			Contact lenses covered if medically necessary. (These are benefits supplemented with NY CHIP.)	No
Dental Check-Up for Children	Yes	Dental Check-Up for Children	Covered	Yes	2	Visits per year			(Supplemented by NY CHIP program.)	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	60	Outpatient visits per condition per lifetime combined			Speech therapy is only covered following a Hospital stay or surgery.	No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	60	Outpatient visits per condition per lifetime combined			Physical therapy is only covered following a Hospital stay or surgery.	No
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if the child does not meet the criteria described above.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							

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Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No				Transplants outside of designated network. Experimental & Investigational Transplants.	Covered at designated networks only, transplants for surgeries determined to be non-experimental and non-investigational.	No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis	Yes	Dialysis	Covered	No					Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	No
Allergy Testing	Yes	Allergy Testing	Covered	No					Allergy Testing includes allergy testing and treatment.	No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	Yes	1	External prosthetic device per limb per lifetime (limit does not apply to internal devices)		Coverage for external repairs or replacement in adults. Coverage for wigs made from human hair unless member is allergic to synthetic wig materials.	Prosthetic devices includes both external and internal prosthetic devices. 1 external prosthetic device per limb per lifetime (limit does not apply to internal devices). Additional coverage for external device replacement for children for devices that have been outgrown. Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g., chemotherapy). Covered if improves or restores function of internal body part; includes implanted breast prostheses; includes repair and replacement.	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No					Covered when medical in nature	No
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No					Covered in accordance with USPSTF A & B recommendations	No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No					Limited to correct a congenital birth defect of dependent child or incidental to surgery or follows surgery necessitated by trauma, infection or disease.	No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No					Diabetes Care Management includes diabetic equipment, supplies, education and self-management.	No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Post-Mastectomy Care	Yes	Post-Mastectomy Care	Covered	No					Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.	No

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Autism Spectrum Disorders	Yes	Autism Spectrum Disorders	Covered	Yes	680	Hours per year, 45000 dollars per year for ABA, with adjustments			Autism Spectrum Disorders benefits include autism spectrum disorder screening, diagnosis and treatment. Coverage applicable to ABA treatment for autism spectrum disorders. Benefit is not in coverage documents b/c newly enacted mandate (2011).	No
Breast Reconstructive Surgery	Yes	Breast Reconstructive Surgery	Covered	No					Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection.	No
Eating Disorder Treatment	Yes(S)	Eating Disorder Treatment	Covered	No					Eating Disorder Treatment includes comprehensive care facility for eating disorders.	No
Experimental or Investigational Services	Yes	Experimental or Investigational Services	Covered	No					Covered when approved by an external appeal agent.	No
Family Planning Services	Yes	Family Planning Services	Covered	No					Family Planning Services includes contraceptive drugs and devices, vasectomies, and tubal ligations.	No

OTHER BENEFITS

Benefit Information			General Information							
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Hearing Aids	Yes	Bone Anchored Hearing Aids	Covered	Yes	1	Hearing aid per lifetime			Bone anchored hearing aids are excluded except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.	No
Elective Termination of Pregnancy	Yes	Elective Termination of Pregnancy	Covered	Yes	1	Treatment per year		Therapeutic termination of pregnancy unlimited.		No
Bereavement Counseling	Yes	Bereavement Counseling	Covered	Yes	5	Sessions for members family either before or after death of the member				No
Oral Surgery	Yes	Oral Surgery	Covered	No				Cysts related to teeth, oral surgery result of injury for teeth that are not sound/natural tooth.	Oral Surgery due to injury is limited to sound and natural teeth only, oral surgery due to congenital anomaly, removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips.	No
Enteral formulas	Yes	Enteral formulas	Covered	No						No
Allergy testing and treatment	Yes	Allergy testing and treatment	Covered	No						No
Prostate cancer screening	Yes	Prostate cancer screening	Covered	Yes	1	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history			Includes exam and antigen test, per mandate.	No
Exercise Facility Reimbursement	Yes	Exercise Facility Reimbursement	Covered	Yes	200	Dollars every 6 months for member; 100 dollars every 6 months for spouse			Partial reimbursement for facility fees every 6 months if at least 50 visits.	No
Inpatient Rehabilitation Services	Yes	Inpatient Rehabilitation Services	Covered	Yes	1	Consecutive 60 day period per condition per lifetime in a rehabilitation facility			Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).	No
Second Opinion (surgical)	Yes	Second Opinion (surgical)	Covered	No					Second surgical opinion on the need for surgery.	No

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End of Life Care	Yes	End of Life Care	Covered	No					If member is diagnosed with cancer and has less than 60 days to live; covers care in specified facilities for terminally ill patients.	No
Second Opinion (Specialist - cancer)	Yes	Second Opinion (Specialist - cancer)	Covered	No					Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.	No
Off Label Cancer Drugs	Yes	Off Label Cancer Drugs	Covered	No						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	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	15
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	11
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	3
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	5
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	5
ANTIFUNGALS	NO USP CLASS	20
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	1
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	6
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
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	11
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	19
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
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	8
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	5
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	7
DERMATOLOGICAL AGENTS	NO USP CLASS	34
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	6
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
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	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	7
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	17
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	7
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	10

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	1
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
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	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	5