

ARKANSAS EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from 3 rd largest small group product, Point of Service Plan
Issuer Name	HMO Partners, Inc.
Product Name	Open Access POS
Plan Name	HMO Partners, Inc. Open Access POS, 13262AR001
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none"> • Pediatric Oral (State CHIP) • Pediatric Vision (State CHIP) • Mental Health and Substance Use Disorder Services (Second Largest FEHBP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	<p>Yes</p> <p>Definition of Habilitative Services: Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.</p> <p>Coverage of Habilitative Services: Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.</p>

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	PCP office visit	No							No
2	Specialist Visit	Covered	Physician Specialist Office Visit	No						Coinsurance applies for services and procedures provided in the Specialist office other than consultation and evaluation.	No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	PCP or Physician Specialist Office Visit	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Services and Ambulatory Surgery Center Services	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Physician Surgical Services	No							No
6	Hospice Services	Covered	Hospice	No						In some instances.	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	Vision Exam	Yes	1	Visits per lifetime	Actual limit is every two years. Every two years was not a selection option.			Actual limit is every two years. Every two years was not a selection option.	No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Center	No						Coverage is the same for In Network and Out of Network.	No
14	Home Health Care Services	Covered	Home Health Services	Yes	50	Visits per year				per contract year.	No
15	Emergency Room Services	Covered	Emergency Care Services	No						Coverage is the same for In Network and Out of Network.	No
16	Emergency Transportation/ Ambulance	Covered	Ambulance Services	Yes	1	Visits per year	Ground transportation is limited to \$1,000 per trip. Air transportation is limited to one air trip per contract year			Ground transportation is limited to \$1,000 per trip. Air transportation is limited to one air trip per contract year.	No

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17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No							No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No							No
19	Bariatric Surgery	Not Covered									
20	Cosmetic Surgery	Not Covered								In some instances.	
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	Yes	60	Visits per year				Limited to 60 days per member per contract year.	No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No							No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and Inpatient Maternity Services	No						Certain services are not covered.	No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental Health Outpatient Services	No			Must have treatment plan preapproved				No
25	Mental/Behavioral Health Inpatient Services	Covered	Mental Health Inpatient Services	No			Must have treatment plan preapproved				No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Outpatient Services	No			Must have treatment plan preapproved				No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Inpatient Services	No			Must have treatment plan preapproved				No
28	Generic Drugs	Covered	Standard Formulary	Yes	34	Days per month				Please see NDC List.	No
29	Preferred Brand Drugs	Covered	Standard Formulary	Yes	34	Days per month				Please see NDC List.	No
30	Non-Preferred Brand Drugs	Covered	Standard Formulary	Yes	34	Days per month				Please see NDC List.	No
31	Specialty Drugs	Covered	Specialty Medications	Yes	1	Treatments per month	Limit depends on the specialty drug			Covered in some instances.	No
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	Yes	30	Procedures per year	Depends on the type of outpatient services			Limit to 30 aggregate visits per member per contract year. All therapies combined in the limit.	No
33	Habilitation Services	Not Covered									
34	Chiropractic Care	Covered	Chiropractic Services	Yes	30	Visits per year	Combined with other therapies			Limit to 30 aggregate visits per member per contract year.	No
35	Durable Medical Equipment	Covered	Durable Medical Equipment and Medical Supplies	No						Some restrictions apply.	No
36	Hearing Aids	Not Covered									
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Outpatient Diagnostic Services	No							No

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38	Imaging (CT/PET Scans, MRIs)	Covered	Advanced Diagnostic Imaging	No						Covered in some instances.	No
39	Preventive Care/Screening/Immunization	Covered	Preventive Care Services	Yes	1	Visits per year				Some restrictions apply.	No
40	Routine Foot Care	Not Covered								Routine foot care for diabetic diagnosis is covered.	
41	Acupuncture	Not Covered									
42	Weight Loss Programs	Not Covered									
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year				Supplemented using AR CHIP.	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)			Supplemented using AR CHIP. Contact Lenses covered only if medically necessary, prior authorization required.	No
45	Dental Check-Up for Children	Covered	Dental Care	Yes	2	Visits per year	Does not cover orthodontia; additional screenings available if medically necessary			Supplemented using AR CHIP.	No

OTHER BENEFITS

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	Other	Covered	Radiation Therapy	No							No
2	Other	Covered	Chemotherapy	No							No
3	Other	Covered	Infusion Therapy	No							No
4	Other	Covered	Renal Dialysis/Hemodialysis	No							No
5	Other	Covered	Message Therapy	No						Under chiropractor or physical therapy only.	No
6	Other	Covered	Allergy Treatment	No							No
7	Other	Covered	Injectable Drugs, Oral Drugs taken during an office visit	No						Take home drugs not covered.	No
8	Other	Covered	ABA	No						\$50,000 limit, only available for members under 18 years of age.	No
9	Other	Covered	Dental Surgery for Accidents	No						For non-diseased teeth.	No
10	Other	Covered	Cochlear Implants	No						Limited to \$35,000 per covered member, per lifetime.	No
11	Other	Covered	Transplants	No						In some instances.	No
12	Other	Covered	Diabetic Education Management	No						Limit to \$250 per program and one program per lifetime.	No
13	Other	Covered	Diabetic Supplies	No							No
14	Other	Covered	Physical, Occupational, Speech Therapy and Chiropractic Services	Yes	30	Visits per year				Limit to 30 aggregate visits per member per contract year.	No
15	Other	Covered	Other Practitioner Office Visit	No						Depends on how the APN bills.	No
16	Other	Covered	Outpatient Surgery	No						Depends on what type of surgery is performed.	No
17	Other	Covered	Hospice	No						Case management is involved.	No
18	Other	Covered	Vision Exam	No						Eyeglasses not covered.	No
19	Other	Covered	Skilled Nursing Facility	No						Case management is involved.	No
20	Other	Covered	Specialty Drugs	No						Each specialty drug has different limitations.	No
21	Other	Covered	Ground Ambulance	No			Ground transportation is limited to \$1,000 per trip.			Ground transportation is limited to \$1,000 per trip.	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	5
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENENTS/ANTI-CRAVING	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	2
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	17
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	16
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	10
ANTIBACTERIALS	MACROLIDES	4
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
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	8
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	7
ANTIFUNGALS	NO USP CLASS	22
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	3
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
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	5
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	4
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
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	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
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	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	3
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	31
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	13
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6

CATEGORY	CLASS	SUBMISSION COUNT
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	4
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	6
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	8
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	4
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	20
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1

CATEGORY	CLASS	SUBMISSION COUNT
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	14
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	8
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	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	4
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	9