CONNECTICUT EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Largest Health Maintenance Organization Plan
Issuer Name	Connecticare, Inc.
Product Name	HMO
Plan Name	Connecticare HMO
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

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	Primary Care Visit to treat injuries or illnesses	No							No
2	**Specialist Visit**	Covered	Visits to a specialist	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Office visit with Nurse or PA	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient surgery physician/surgical services	No							No
6	**Hospice Services**	Covered	Hospice care is **covered** if the Member has a life expectancy of six months or less and if the care is Pre-Authorized or Pre-Certified by us. The Member's physician must contact us to arrange Hospice care.	Yes	6	Months per year	Life expectancy of less than 6 months to live				No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered									
8	**Routine Dental Services (Adult)**	Not Covered									

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9	**Infertility Treatment**	Covered	Medically necessary diagnostic and testing procedures and therapy needed to treat diagnosed infertility are covered for a member up to his/her 40th birthday	No			Ovulation induction 4 cycles, intrauterine insemination 3 cycles within 30 day period, IVF, GIFT, ZIFT, 2 cycles combined for all procedures. Genetic testing as part of IVF, Gift or ZIFF or low tubal ovum transfer.		Cryopreservation of eggs, embryos, or sperm. Expenses of donors, reversal of sterilization, surrogacy, genetic analysis except as previously stated and sexual dysfunction medications.		No
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Covered	Routine eye exam including refraction	Yes	1	Visits per year					No
13	**Urgent Care Centers or Facilities**	Covered	Treatment for sudden and unexpected illness or injury	No							No
14	**Home Health Care Services**	Covered	Medically necessary home health services.	Yes	100	Days per year			Care provided by home health aides that is not patient care of a medical or therapeutic nature or care or provided by non-licensed professionals		No
15	**Emergency Room Services**	Covered	Emergency Room services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Medically necessary Emergency transportation	No							No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Medically necessary inpatient hospital services generally performed and customarily provided by acute care general hospitals with Pre-Certification	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									
21	**Skilled Nursing Facility**	Covered	Medically necessary skilled nursing care in a Skilled Nursing Facility, and acute Rehabilitation Facility or on a specialized inpatient rehabilitation floor in an acute care hospital.	Yes	90	Days per year	Combined with rehabilitative facilities				No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Post natal care covered	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All inpatient Services for maternity Care	No				48	Home delivery (except in emergency)		No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Out Patient services covered	No							No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Inpatient services covered	No							No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient services covered	No							No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services covered	No							No
28	**Generic Drugs**	Covered	Generic Drugs	No			30 day supply or 90 day mail order				No

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29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No			30 day supply or 90 day mail order				No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No			30 day supply or 90 day mail order				No
31	**Specialty Drugs**	Covered	Specialty Drugs	No			30 day supply or 90 day mail order				No
32	**Outpatient Rehabilitation Services**	Covered	Medically necessary short term outpatient rehabilitative therapy (including those services rendered at a day program facility and in an office).	Yes	40	Visits per year	Combined PT/OT/ST visits			Services are limited to short-term physical, occupational and speech therapy necessary to restore a function lost through or to eliminate an abnormal function that has developed due to injury or illness. Speech therapy for developmental speech delays, stuttering, lisps, and other non-injury or non-illness related speech impediments are not covered, except as provided in the “Autism Services” or “Birth To Three Program (Early Intervention Services)” provisions of “Other Outpatient Services” subsection. © Post-operative physical therapy for temporomandibular joint (TMJ) dysfunction surgery is covered when the TMJ surgery is covered under this Plan. This physical therapy must be obtained during the 90-day period beginning on the date of the covered TMJ surgery and it must be Pre-Authorized by us as part of the surgical procedure.	No
33	**Habilitation Services**	Not Covered	Unless provided under "Autism Services"								
34	**Chiropractic Care**	Covered	Medically necessary short-term services include but are not limited to office visits and manipulation are covered , after appropriate cost sharing to maximum benefit	Yes	20	Visits per year				Limited to short term services, include but not limited to office visits and manipulation if they are expected to return function to pre-illness or pre-injury levels. There is no coverage for physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.	**No**
35	**Durable Medical Equipment)**	Covered	Durable medical equipment	No						Some DME may need pre-authorization. DME, including prosthetics, consists of non-disposable equipment which is primarily used to serve a medical purpose that is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home, including breast prosthetics following a mastectomy DME benefits also include DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes and craniofacial disorders,	No

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										hearing aids for a Member age 12 and under and wigs for a Member suffering hair loss as a result of chemotherapy or radiation therapy when the wig as prescribed by an oncologist. Certain DME is covered after the Durable Medical Equipment (Including Prosthetics) Cost-Share, up to the benefit maximum, if any, as shown on the Benefit Summary. Not all DME is covered. To find out if an item is covered, call our Member Services Department at the appropriate telephone number listed in the “Important Telephone Numbers And Addresses” subsection of the “Important Information” section of this Membership Agreement. Tip: Before calling, ask your doctor for the applicable code for the equipment he or she is prescribing. This will help us to determine if the equipment is covered. We have the right to change the list of covered DME from time to time, at our discretion. The following limitations and conditions apply to the DME Benefit: Some DME requires Pre-Authorization before it will be covered. The DME that requires Pre-Authorization is listed in the “Services Requiring Pre-Authorization Or Pre-Certification” subsection of the “Managed Care Rules And Guidelines” section of this Membership Agreement. To be covered, DME must be: (a) prescribed by a physician; and (b) Pre-Authorized by us (as required); and (c) provided by a DME supplier that is a Participating Provider in order for the DME to be covered at the highest level of benefits under this Plan. However, if the Participating Provider does not carry the covered DME, it may be purchased at a store that is a Non-Participating Provider as long as both (a) and (b), above, are met. Having a prescription for DME from a physician is not a guarantee the DME is covered. DME will also be covered without Pre-Authorization if it is dispensed in: (a) a physician’s office as part of physician services; (b) an emergency room as part of Emergency Services; or (c) an Urgent Care Center as part of Urgent Care. In these cases, DME will be covered as part of the DME, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable. DME may be authorized for rental or purchase based on the expected length of medical need and the cost/benefit of a purchase or rental. We will decide whether DME is to be rented or purchased. If a rental item is converted to a purchase, the Coinsurance the Member pays for the	

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										purchase will be based on only the balance remaining to be paid in order to purchase the equipment. To be covered, DME must not duplicate the function of any previously obtained equipment. DME for the treatment of craniofacial disorders is covered. DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes is covered. Hearing aids for a Member age 12 and under are covered up to a yearly maximum of $1,000 every 24 months. Wigs prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy are covered without Pre-Authorization up to a yearly maximum of $350. There is no coverage for: Hearing aids, except as noted. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies. Non-durable equipment such as orthopedic or prosthetic shoes, foot orthotics, and prophylactic anti-embolism stockings (jobst stockings) without a history deep vein thrombosis and varicose veins. Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except as noted. If this Plan has a DME benefit maximum (as shown on your Benefit Summary), that maximum is separate from the benefit maximum for hearing aids for a Member age 12 and under. This means that if that Member receives coverage for other DME, he or she is still eligible for $1,000 of hearing aid coverage every 24 months. And if the Member receives coverage for a hearing aid, he or she is still eligible for the maximum amount of DME coverage specified on your Benefit Summary for other covered DME. If this Plan has a DME benefit maximum (as shown on the Benefit Summary), that maximum does not apply to DME for a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy as well as DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes and the treatment of craniofacial disorders. However, if the Member obtains a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy	

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										as described, the wig does count towards meeting that benefit maximum, just as DME for the treatment of diabetes or appliances for the treatment of craniofacial disorders as described, count towards meeting that benefit maximum. For example, if this Plan has a $1,500 benefit maximum for DME and the Member receives $500 worth of covered equipment for the treatment of diabetes, $250 worth of appliances for the treatment of craniofacial disorders, and $250 for a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy these amounts are accumulated toward the $1,500 benefit maximum and the Member will only be able to obtain benefits for another $500 for any non diabetes, non craniofacial disorders or non wig related DME in that year. If the $1,500 benefit maximum is ultimately reached in that year, the Member will still be covered for additional DME for the treatment of diabetes, craniofacial disorders, and a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy.	
36	**Hearing Aids**	Covered	Only for age 12 and under	No					Not covered if over age 12		No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic x-rays and lab work provided after the applicable cost share amount and depending on where the procedures are rendered.	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Covered when medically necessary and ordered by a physician.	No							No

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39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screening/Immunization	No						Office visits for adult preventive care services (routine exams and preventive care) are **covered** in accordance with national guidelines. The following is a suggested schedule for adult preventive care services: Ages 22 to 49: Every 1-3 Years, as appropriate Age 50 and Over: Annually, as appropriate The frequency of adult preventive care services is determined by the Member's physician. Office visits for infant/pediatric preventive care services (routine exams and preventive care) are covered in accordance with national guidelines. The following is a suggested schedule for infant/pediatric preventive care services: Under Age 2: At months 1, 2, 4, 6, 9, 12, 15, 18 and 24Ages 3 to 6: Every Year Ages 8 and 10: Every Year Ages 11 to 21: Every Year Blood lead screening and risk assessments ordered by the Member's Primary Care Provider are covered as follows, as required by State law. Lead Screenings: At least annually for a child from nine to 35 months of age; and For a child three to six years of age who has not been previously screened or is at risk. Risk Assessments: to six years of age; and at any time in accordance with state guidelines for a child age 36 months or younger.	No
40	**Routine Foot Care**	Not Covered	Unless medically necessary for neuro-circulatory conditions								
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					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				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Covered at 100% if the services were provided In Network and at 90% if they were Out of Network subject to the annual $10,000 maximum.	No

OTHER BENEFITS

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1	**Other**	Covered	Lyme Disease	No							No
2	**Other**	Covered	Allergy Office Visits	No			$315 every two years for testing, office visits for allergy shots are unlimited (specialist copay)				No
3	**Other**	Covered	Autism Services	No							Yes
4	**Other**	Covered	Off-Label Use of FDA-approved prescription drugs for the treatment of certain types of cancer or disabling or life-threatening chronic diseases	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	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
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	2
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	5
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	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	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	26
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	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	3
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
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	6
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
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	4
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
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	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
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	10
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	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	17
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	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	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	24
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	4
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	15
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
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	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
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	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	11