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

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 for treatment of illness or injury	No							No
2	**Specialist Visit**	Covered	Physician (Specialist) Office and Home visits	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Certified Nurse Midwife or any duly licensed health professional under contract with us to provide covered services to our members	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Hospital & Ambulatory Surgical Center	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Hospital & Ambulatory Surgical Center	No							No
6	**Hospice Services**	Covered	Hospice Services & Home Hospice	Yes	210	Days per year				Benefit limited is combined IP & OP.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered									
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Covered	Infertility Services Basic & Comprehensive	No			Member must be between ages of 21 and 44		Advanced Infertility is not covered	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.	No
10	**Long-Term/Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Not Covered	Vision Care							Available as optional buy up for groups to purchase. $50 reimbursement per exam. Limited to one per year.	

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13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Facility Services	No							No
14	**Home Health Care Services**	Covered	Home Healthcare	Yes	40	Visits per year					No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance Services	No							No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No							No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Hospital Services	No							No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No							No
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility Services	Yes	200	Days per year					No
22	**Prenatal and Postnatal Care**	Covered	Obstetrical Services Pre and Post Natal	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Maternity and Newborn Care	No						Min stay requirements (48/96 hours), prenatal, postnatal care, parent education, breast/bottle feeding assistance, clinical assessments, home visit, etc.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Outpatient Mental Health Services and Partial Hospitalization (includes Biologically Based services)	Yes	30	Visits per year				Benefit limits include Office Visit and Outpatient Visits combined. Biologically based service visits will count toward this limit.	No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Inpatient Mental Health Services (includes Biologically based services)	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
26	**Substance Abuse Disorder Outpatient Services**	Covered	Outpatient Alcohol & Substance Abuse Rehabilitation	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 members family.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Inpatient Alcohol & Substance Abuse Rehabilitation	Yes	30	Days per year					Yes
28	**Generic Drugs**	Covered	Generic	No						Mail Order up to a 90 day supply.	No
29	**Preferred Brand Drugs**	Covered	Preferred Brand	No						Mail Order up to a 90 day supply.	No

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30	**Non-Preferred Brand Drugs**	Covered	Non Preferred Brand	No						Mail Order up to a 90 day supply.	No
31	**Specialty Drugs**	Covered	Specialty Drugs	No						Mail Order up to a 90 day supply.	No
32	**Outpatient Rehabilitation Services**	Covered	Short Term Rehabilitative Therapy Services (Physical, speech and Occupational therapy) Outpatient	Yes	60	Other	60 visits per condition per lifetime			Short Term Rehabilitation Services: Physical, Speech Occupational.	No
33	**Habilitation Services**	Not Covered	Short Term Habilitative Therapy Services (Physical, speech and Occupational therapy) Outpatient							New York intends to require habilitative services to be covered at parity with rehabilitative services.	
34	**Chiropractic Care**	Covered	Chiropractic Services	No							No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment & Medical Supplies & Braces	Yes	1500	Other	$1500 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
36	**Hearing Aids**	Covered	Hearing Aids	Yes	1500	Other	$1,500/year. Limited to a single purchase (including repair/replacement) every three years.		Bone Anchored Hearing Aids unless certain criteria exists.		Yes
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Laboratory Procedures & X-ray Examinations (including pre-admission testing)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Laboratory Procedures & X-ray Examinations	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive services, screenings, immunizations, etc.	No						Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates.	No
40	**Routine Foot Care**	Not Covered									
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									

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43	**Routine Eye Exam for Children**	Covered	Pediatric Vision exams	No						(These are benefits supplemented with NY CHIP.)	No
44	**Eye Glasses for Children**	Covered	Pediatric Vision appliances	Yes	1	Other	Glasses and frames covered once in any 12 month period			Contact lenses covered if medically necessary. (These are benefits supplemented with NY CHIP.)	No
45	**Dental Check-Up for Children**	Covered	Dental Check-Up for Children	Yes	2	Visits per year				(Supplemented by NY CHIP program.)	No

OTHER BENEFITS

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1	**Substance Abuse Disorder Inpatient Services**	Covered	Inpatient Alcohol & Substance Abuse Detoxification	Yes	7	Days per year				Inpatient Detoxification.	No
2	**Hearing Aids**	Covered	Bone Anchored Hearing Aids	Yes	1	Other	1 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
3	**Other**	Covered	Prosthetic Devices - External	Yes	1	Other	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.	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).	No
4	**Other**	Covered	Elective Termination of Pregnancy	Yes	1	Treatments per year			Therapeutic termination of pregnancy unlimited.		No
5	**Other**	Covered	Bereavement Counseling	Yes	5	Other	5 sessions for members family either before or after death of the member				No
6	**Other**	Covered	Transplants	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

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7	**Other**	Covered	Oral Surgery	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
8	**Other**	Covered	Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection	No							No
9	**Other**	Covered	Comprehensive care facility for eating disorders	No							No
10	**Other**	Covered	Diabetic equipment, supplies, education and self-management	No							No
11	**Other**	Covered	Enteral formulas	No							No
12	**Other**	Covered	Family Planning - Contraceptive drugs and devices, vasectomies, tubal ligations	No							No
13	**Other**	Covered	Allergy testing and treatment	No							No
14	**Other**	Covered	Autism spectrum disorder screening, diagnosis and treatment	Yes	45000	Other	$45,000 per year for ABA, with adjustments.			Benefit is not in coverage documents b/c newly enacted mandate (2011).	No
15	**Other**	Covered	Prostate cancer screening	Yes	1	Other	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
16	**Other**	Covered	Exercise Facility Reimbursement	Yes	200	Other	$200/$100 every 6 months for member/spouse.			Partial reimbursement for facility fees every 6 months if at least 50 visits.	No
17	**Other**	Covered	Inpatient Rehabilitation Services	Yes	1	Other	1 consecutive 60 day period per condition per lifetime in a rehabilitation facility.			Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).	No

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18	**Other**	Covered	Reconstructive and corrective surgery	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
19	**Other**	Covered	Internal Prosthetic Devices	No						Covered if improves or restores function of internal body part; includes implanted breast prostheses; includes repair and replacement.	No
20	**Other**	Covered	Chemotherapy	No							No
21	**Other**	Covered	Second Opinion (surgical)	No						Second surgical opinion on the need for surgery.	No
22	**Other**	Covered	End of Life Care	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
23	**Other**	Covered	Second Opinion (Specialist - cancer)	No						Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.	No
24	**Other**	Covered	Out of Network Dialysis	No						Coverage for out of network provider on an in-network basis if member is traveling outside the service area.	No
25	**Other**	Covered	Correctable Medical Conditions Leading to Infertility	No							No
26	**Other**	Covered	Mastectomy Care	No						Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.	No
27	**Other**	Covered	Experimental or Investigational Services	No						Covered when approved by an external appeal agent.	No
28	**Other**	Covered	Off Label Cancer Drugs	No							No
29	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
30	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No

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31	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply. 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

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
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
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
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
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