

## WISCONSIN EHB BENCHMARK PLAN

---

### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Point of Service
<b>Issuer Name</b>	UnitedHealthcare Insurance Company
<b>Product Name</b>	Choice Plus
<b>Plan Name</b>	Choice Plus Definity HSA Plan A92NS
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"><li>• Pediatric Oral (FEDVIP)</li><li>• Pediatric Vision (FEDVIP)</li></ul>
<b>Habilitative Services Included Benchmark</b> (Yes/No)	No
<b>Habilitative Services Defined by State</b> (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 an Injury or Illness	No						Benefits include allergy injections.	No
2	Specialist Visit	Covered	Specialist Visit	No						Benefits include allergy injections.	No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Dentist, Podiatrist, clinical social worker, marriage and family therapist, nurse practitioner, professional counselor	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility - Surgery	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	OP Surgery Physician/Surg Svcs	No							No
6	Hospice Services	Covered	Hospice Care	No							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							This exclusion does not apply to services required to treat or correct underlying causes of infertility.		
10	Long-Term/ Custodial Nursing Home Care	Not Covered									
11	Private-Duty Nursing	Not Covered									
12	Routine Eye Exam (Adult)	Covered	Routine Vision Examinations	Yes	1	Other	1 exam every 2 years		Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.		No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Center Services	No							No

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
14	Home Health Care Services	Covered	Home Health Care	Yes	60	Visits per year				One visit equals up to four hours of skilled care services.	No
15	Emergency Room Services	Covered	Emergency Health Services - Outpatient	No							No
16	Emergency Transportation/ Ambulance	Covered	ER Ambulance Service - (air/ground)	No							No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	IP Hospital Services	No							No
18	Inpatient Physician and Surgical Services	Covered	Physician Fees for Surgical and Medical Services	No							No
19	Bariatric Surgery	Not Covered									
20	Cosmetic Surgery	Not Covered									
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	Yes	30	Days per year					No
22	Prenatal and Postnatal Care	Covered	Pre/Post Natal and Delivery - Physician	No							No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Inpatient Hospital Services	No							No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental Health Services	No							No
25	Mental/Behavioral Health Inpatient Services	Covered	Mental Health Services	No							No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance Use Disorder Services	No							No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Use Disorder Services	No							No
28	Generic Drugs	Covered	Generic	No							No
29	Preferred Brand Drugs	Covered	Preferred Brand	No							No
30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand	No							No
31	Specialty Drugs	Covered	Specialty	No							No

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
32	Outpatient Rehabilitation Services	Covered	PT, OT, Pulmonary Rehabilitation	Yes	20	Visits per year				20 visits for each type of therapy.	Yes
33	Habilitation Services	Not Covered									
34	Chiropractic Care	Covered	Manipulative Treatment	No							No
35	Durable Medical Equipment	Covered	Durable Medical Equipment	Yes	2500	Other	\$2500/year for non-essential DME		Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: Compression stockings, Ace bandages, Gauze and dressings, Urinary catheters, Tubings and masks unless necessary for the effective use of covered DME; Devices used specifically as safety items or to affect performance in sports-related activities; Blood pressure cuff/monitor, Enuresis alarm, Non-wearable external defibrillator, Trusses, Ultrasonic nebulizers; Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices covered under DME; Oral appliances for snoring; Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body; Repairs/Replacement due to misuse, malicious damage or gross neglect or to replace lost or stolen items	Includes cochlear implants. Examples of Durable Medical Equipment include: Equipment to assist mobility, such as a standard wheelchair; A standard Hospital-type bed; Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks); Delivery pumps for tube feedings (including tubing and connectors); Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage; Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage); Burn garments; Insulin pumps and all related necessary supplies as described under Diabetes Services; External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Certificate.	Yes

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
36	Hearing Aids	Covered	Hearing Aids - Covered Persons over age 18	Yes	2500	Other	\$2500/year		Bone Anchored Hearing Aids unless certain criteria exists.	Limits do not apply to enrolled dependent children.	Yes
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Lab, X-Ray and Diagnostics - Outpatient	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	No							No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Services as defined by Health Care Reform	No							No
40	Routine Foot Care	Not Covered	Non-Diabetic Foot Care								
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	1 pair of glasses (lenses and frames per year				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply.	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	Inpatient Rehab	Yes	60	Days per year					No
2	Outpatient Rehabilitation Services	Covered	ST	Yes	20	Visits per year			Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.		No
3	Outpatient Rehabilitation Services	Covered	cardiac rehabilitation	Yes	36	Visits per year					No
4	Outpatient Rehabilitation Services	Covered	post-cochlear implant aural therapy	Yes	30	Visits per year					No
5	Durable Medical Equipment	Covered	Durable Medical Equipment	Yes	1	Other	Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.				No
6	Hearing Aids	Covered	Hearing Aids - Covered Persons over age 18	Yes	1	Other	Limited to a single purchase (including repair and replacement) every three years.				No
7	Hearing Aids	Covered	Hearing Aids – Enrolled Dependent children under age 18	Yes	1	Other	Hearing aid per ear, every three years.				No

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
8	Hearing Aids	Covered	Bone Anchored Hearing Aids	Yes	1	Other	1/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
9	Other	Covered	Congenital Heart Disease Surgery	Yes	30000	Other	\$30,000/surgery (OON only)				No
10	Other	Covered	Dental Services - Accident Only	Yes	3000	Other	\$3,000/year				Yes
11	Other	Covered	Dental Services - Accident Only	Yes	900	Other	\$900/tooth				No
12	Other	Covered	Ostomy Supplies	Yes	2500	Other	\$2,500/year				No
13	Other	Covered	Prosthetic Devices	Yes	2500	Other	\$2,500/year		Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces; Cranial banding; Repairs/Replacement due to misuse, malicious damage or gross neglect or to replace lost or stolen items.		Yes
14	Other	Covered	Prosthetic Devices	Yes	1	Other	Limited to a single purchase of a type of prosthetic device every three years.				No
15	Other	Covered	Transplants	Yes	30000	Other	\$30,000/transplant (OON only)				No
16	Other	Covered	Autism Spectrum Disorder Services - Intensive Level Services	Yes	50000	Other	\$50,000 per Enrolled Dependent child per year			For groups with 51 or more employees, Benefit limits do not apply.	Yes

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
17	Other	Covered	Autism Spectrum Disorder Services - Intensive Level Services	Yes	20	Other	A minimum of 20 hours care per week for four years.			For groups with 51 or more employees, Benefit limits do not apply.	No
18	Other	Covered	Autism Spectrum Disorder Services - Non-Intensive Level Services	Yes	25000	Other	\$25,000 per Enrolled Dependent child per year			For groups with 51 or more employees, Benefit limits do not apply.	No
19	Other	Covered	Temporomandibular Joint Disorders	Yes	1250	Other	\$1,250 per year for diagnostic procedures and non-surgical treatment				No
20	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
21	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
22	Other	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply.	No



**PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS**

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	18
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	9
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	2
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	18
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	8
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	7
ANTIBACTERIALS	SULFONAMIDES	3
ANTIBACTERIALS	TETRACYCLINES	3
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	3
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	4
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	3
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	8
ANTIEMETICS	ANTIEMETICS, OTHER	8
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	4
ANTIFUNGALS	NO USP CLASS	17
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	1
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	1
ANTIMYCOBACTERIALS	ANTITUBERCULARS	3
ANTINEOPLASTICS	ALKYLATING AGENTS	2
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	1
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	1
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	0
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	6
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	1
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	7
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2
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	3
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	4
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	2
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	5
ANTIVIRALS	ANTI-INFLUENZA AGENTS	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	8
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	18
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	3
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	12
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	8
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	1
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	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3
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	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	26
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	3
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	4
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	5
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	2
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	2
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	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	3
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	13
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	5
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
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	1
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	5
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	10

<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	11
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	6
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	1
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	7
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	0
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	3
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	2
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	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4