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

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Primary Care Visit to treat injuries or illnesses	Covered	No						No
Specialist Visit	Yes	Visits to a specialist	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Office visit with Nurse or PA	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient surgery physician/surgical services	Covered	No						No
Hospice Services	Yes	Hospice Services	Covered	Yes	6	Months per year			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.	No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment	Yes	Infertility Treatment	Covered	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.	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

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Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)		Routine eye exam including refraction	Covered	Yes	1	Visit per year				No
Urgent Care Centers or Facilities	Yes	Treatment for sudden and unexpected illness or injury	Covered	No						No
Home Health Care Services	Yes	Medically necessary home health services.	Covered	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
Emergency Room Services	Yes	Emergency Room services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Medically necessary Emergency transportation	Covered	No						No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	No				Medically necessary inpatient hospital services generally performed and customarily provided by acute care general hospitals with Pre-Certification		No
Inpatient Physician and Surgical Services	Yes	Inpatient physician and surgical services	Covered	No						No
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	90	Days per year Combined with rehabilitative facilities		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.		No
Prenatal and Postnatal Care	Yes	Prenatal and Post natal care covered	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All inpatient Services for maternity Care	Covered	No			48	Home delivery (except in emergency)		No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Out Patient services covered	Covered	No						No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Inpatient services covered	Covered	No						No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient services covered	Covered	No						No

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Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services covered	Covered	No						No
Generic Drugs	Yes	Generic Drugs	Covered	No					30 day supply or 90 day mail order	No
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No					30 day supply or 90 day mail order	No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No					30 day supply or 90 day mail order	No
Specialty Drugs	Yes	Specialty Drugs	Covered	No					30 day supply or 90 day mail order	No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	Yes	40	Visits per year Combined PT/OT/ST visits		Medically necessary short term outpatient rehabilitative therapy (including those services rendered at a day program facility and in an office).	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
Habilitation Services	Yes	Unless provided under "Autism Services"	Covered	No						No
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	20	Visits per year		Medically necessary short-term services include but are not limited to office visits and manipulation are covered , after appropriate cost sharing to maximum benefit	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
Durable Medical Equipment)	Yes	Durable medical equipment	Covered	No					Explanations apply, see EHB benchmark plan documents.	No
Hearing Aids	Yes	Hearing Aids	Covered	No				Not covered if over age 12	Only for age 12 and under; 1 every 24 months	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No				Diagnostic x-rays and lab work provided after the applicable cost share amount and depending on where the procedures are rendered.		No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No				Covered when medically necessary and ordered by a physician.		No

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Preventive Care/ Screening/ Immunization	Yes	Preventive Care/ Screening/Immunization	Covered	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
Routine Foot Care		Routine Foot Care	Not Covered					Unless medically necessary for neuro-circulatory conditions		
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No
Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit 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
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No						No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No						No
Well Baby Visits and Care			Not Covered							
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No

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X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No						No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No						No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No						No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No						No
Accidental Dental			Not Covered							
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling	Yes	Nutritional Counseling	Covered	Yes	2	Visits per Year				No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No					Breast reconstruction after mastectomy.	No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No

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Early Intervention Services	Yes	Early Intervention Services	Covered	No						No
Rehabilitative Occupational Therapy	Yes	Rehabilitative Occupational Therapy	Covered	No						No
Accidental Ingestion of a Controlled Drug	Yes	Accidental Ingestion of a Controlled Drug	Covered	No						No
Bone Marrow Testing	Yes	Bone Marrow Testing	Covered	No						No
Bones/Joints	Yes	Bones/Joints	Covered	No						No
Developmental Needs of Children & Youth with Cancer	Yes	Developmental Needs of Children & Youth with Cancer	Covered	No						No
Network Retail Pharmacy (60-90 Day Supply) Covered	Yes	Network Retail Pharmacy (60-90 Day Supply) Covered	Covered	No						No
Post-Mastectomy Care	Yes	Post-Mastectomy Care	Covered	No						No
Wound Care for Individuals with Epidermolysis Bullosa	Yes	Wound Care for Individuals with Epidermolysis Bullosa	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
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Lyme Disease	Yes	Lyme Disease	Covered	No						No
Allergy Office Visits	Yes	Allergy Office Visits	Covered	Yes	315	Dollars every two years for testing, office visits for allergy shots are unlimited (specialist copay)				No
Autism Services	Yes	Autism Services	Covered	No						Yes
Off-Label Use of FDA-approved prescription drugs	Yes	Off-Label Use of FDA-approved prescription drugs	Covered	No					Off-Label Use of FDA-approved prescription drugs for the treatment of certain types of cancer or disabling or life-threatening chronic diseases	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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
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

CATEGORY	CLASS	SUBMISSION COUNT
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	17
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
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

CATEGORY	CLASS	SUBMISSION COUNT
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	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