The following document is the 2014-2016 Wisconsin EHB Benchmark Plan Summary.

WISCONSIN EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Point of Service
Issuer Name	UnitedHealthcare Insurance Company
Product Name	Choice Plus
Plan Name	Choice Plus Definity HSA Plan A92NS
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • 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 are Visit to Treat an Injury or Illness	Covered	No					Benefits include allergy injections.	No
Specialist Visit	Yes	Specialist Visit	Covered	No					Benefits include allergy injections.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Dentist, Podiatrist, clinical social worker, marriage and family therapist, nurse practitioner, professional counselor	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility - Surgery	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	OP Surgery Physician/Surgical Services	Covered	No						No
Hospice Services	Yes	Hospice Care	Covered	No						No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered					This exclusion does not apply to services required to treat or correct underlying causes of infertility.		
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)		Routine Vision Examinations	Covered	Yes	1	Exam every 2 years		Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.		No
Urgent Care Centers or Facilities	Yes	Urgent Care Center Services	Covered	No						No
Home Health Care Services	Yes	Home Health Care	Covered	Yes	60	Visits per year			One visit equals up to four hours of skilled care services.	No
Emergency Room Services	Yes	Emergency Health Services - Outpatient	Covered	No						No
Emergency Transportation/ Ambulance	Yes	ER Ambulance Service - (air/ground)	Covered	No						No

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Inpatient Hospital Services (e.g., Hospital Stay)	Yes	IP Hospital Services	Covered	No						No
Inpatient Physician and Surgical Services	Yes	Physician Fees for Surgical and Medical Services	Covered	No						No
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	30	Days per year				No
Prenatal and Postnatal Care	Yes	Pre/Post Natal and Delivery - Physician	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Inpatient Hospital Services	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Mental Health Services	Covered	No						No
Mental/Behavioral Health Inpatient Services	Yes	Mental Health Services	Covered	No						No
Substance Abuse Disorder Outpatient Services	Yes	Substance Use Disorder Services	Covered	No						No
Substance Abuse Disorder Inpatient Services	Yes	Substance Use Disorder Services	Covered	No						No
Generic Drugs	Yes	Generic	Covered	No						No
Preferred Brand Drugs	Yes	Preferred Brand	Covered	No						No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand	Covered	No						No
Specialty Drugs	Yes	Specialty	Covered	No						No
Outpatient Rehabilitation Services	Yes	PT, OT, Pulmonary Rehabilitation	Covered	Yes	20	Visits per year			20 visits for each type of therapy.	Yes
Habilitation Services	Yes	Habilitation Services	Covered	No						No
Chiropractic Care	Yes	Manipulative Treatment	Covered	No						No

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Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	Yes	1	Item per 3 years, up to 2500 dollars per 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
Hearing Aids	Yes	Hearing Aids - Covered Persons over age 18	Covered	Yes	2500	Dollars per year		Bone Anchored Hearing Aids unless certain criteria exists.	Limits do not apply to enrolled dependent children.	Yes
Diagnostic Test (X-Ray and Lab Work)	Yes	Lab, X-Ray and Diagnostics - Outpatient	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Services as defined by Health Care Reform	Covered	No						No
Routine Foot Care			Not Covered							
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

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Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit every 6 months			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	20	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	40	Visits per year				No
Well Baby Visits and Care			Not Covered							
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
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					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	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	Yes	30000	Dollars per transplant (OON only)				No
Accidental Dental	Yes	Accidental Dental	Covered	Yes	3000	Dollars per year				Yes
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing			Not Covered							
Chemotherapy			Not Covered							
Radiation			Not Covered							
Diabetes Education	Yes	Diabetes Education	Covered	No						No

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Prosthetic Devices	Yes	Prosthetic Devices	Covered	Yes	2500	Dollars per 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
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	Yes	1250	Dollars per year for diagnostic procedures and non-surgical treatment				No
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Mental Health Other	Yes	Mental Health Other	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Newborn Services Other	Yes	Newborn Services Other	Covered	No						No

OTHER BENEFITS

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?
Inpatient Rehab	Yes	Inpatient Rehab	Covered	Yes	60	Days per year				No
Outpatient Rehabilitation Services	Yes	ST	Covered	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
Outpatient Rehabilitation Services	Yes	cardiac rehabilitation	Covered	Yes	36	Visits per year				No
Outpatient Rehabilitation Services	Yes	post-cochlear implant aural therapy	Covered	Yes	30	Visits per year				No
Hearing Aids	Yes	Hearing Aids - Covered Persons over age 18	Covered	Yes	1	Purchase (including repair and replacement) every three years				No
Hearing Aids	Yes	Hearing Aids – Enrolled Dependent children under age 18	Covered	Yes	1	Hearing aid per ear, every three years				No
Hearing Aids	Yes	Bone Anchored Hearing Aids	Covered	Yes	1	Bone anchored hearing aid 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
Congenital Heart Disease Surgery	Yes	Congenital Heart Disease Surgery	Covered	Yes	30000	Dollars per surgery (OON only)				No
Dental Services - Accident Only	Yes	Dental Services - Accident Only	Covered	Yes	900	Dollars per tooth				No
Ostomy Supplies	Yes	Ostomy Supplies	Covered	Yes	2500	Dollars per year				No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	Yes	1	Purchase of a type of prosthetic device every three years				No

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Autism Spectrum Disorder Services - Intensive Level Services	Yes	Autism Spectrum Disorder Services - Intensive Level Services	Covered	Yes	50000	Dollars per enrolled dependent child per year			For groups with 51 or more employees, Benefit limits do not apply.	Yes
Autism Spectrum Disorder Services - Intensive Level Services	Yes	Autism Spectrum Disorder Services - Intensive Level Services	Covered	Yes	20	Hours of care per week for four years			For groups with 51 or more employees, Benefit limits do not apply.	No
Autism Spectrum Disorder Services - Non-Intensive Level Services	Yes	Autism Spectrum Disorder Services - Non-Intensive Level Services	Covered	Yes	25000	Dollars per enrolled dependent child per year			For groups with 51 or more employees, Benefit limits do not 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

CATEGORY	CLASS	SUBMISSION COUNT
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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	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

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	4
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	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

CATEGORY	CLASS	SUBMISSION COUNT
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
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