

## PROPOSED NEW JERSEY EHB BENCHMARK PLAN

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### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Health Maintenance Organization
<b>Issuer Name</b>	Horizon HMO
<b>Product Name</b>	HMO
<b>Plan Name</b>	Horizon HMO Access HSA Compatible
<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</b>	Yes

## 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							No
2	Specialist Visit	Covered	Specialist Visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No					Care and/or treatment by a Christian Science Practitioner		No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Fee	No						Pre-approval required.	No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery Physician/Surgical Services	No					Local anesthesia charges billed separately if such charges are included in the fee for the surgery.	Pre-approval required	No
6	Hospice Services	Covered	Hospice Services	No					Private accommodations.	Subject to pre-approval. Inpatient hospice covered at the semi-private room and board accommodation.	No
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered	Non-Emergency Care When Traveling Outside the US								
8	Routine Dental Services (Adult)	Not Covered	Routine Dental Services (Adult)						Dental care or treatment, including appliances and dental implants. Extraction of teeth.		
9	Infertility Treatment	Covered	Infertility Treatment	No					Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), donor sperm and surrogate motherhood.	Pre-Approval required - Procedures and prescriptions are covered to enhance fertility except where specifically excluded. We cover charges for: artificial insemination,; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs.	No
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care						Services related to custodial or domiciliary care.		

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11	Private-Duty Nursing	Covered	Private Duty Nursing	Yes	60	Other other	Covered as part of the Home Health benefits with 60 visits per person per calendar year.				No
12	Routine Eye Exam (Adult)	Not Covered	Routine Eye Exam (Adult)						Services or supplies in connection with: a) exams to determine the need for (or changes of) eyeglasses or lenses of any type; b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).	Only the eye screening provided as part of the routine physical exam is covered.	
13	Urgent Care Centers or Facilities	Covered	Urgent Care Centers or Facilities	No							No

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14	Home Health Care Services	Covered	Home Health Care Services	Yes	60	Other other	Visit limit is per calendar year			Pre-Approval required. Home health care may be covered when services can take the place of inpatient care under a written home health plan. Covers medically necessary and appropriate services. The covered person's practitioner must certify that home health care is needed in place of inpatient care in a recognized facility. Home health care is covered only in situations where continuing hospitalization or confinement in a skilled nursing facility or rehabilitation center would otherwise have been required if home health care were not provided. The Services and supplies must be 1) ordered by the covered person's practitioner; 2) included in the home health care plan; and 3) furnished by, or coordinated by, a home health agency according to the written home health care plan. Services and supplies must be furnished by a recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis. The home health care plan must be set up in writing by the covered person's practitioner within 14 days after home health care starts. It must be reviewed by the covered person's practitioner at least once every 60 days.	Yes

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15	<b>Emergency Room Services</b>	Covered	Emergency Room Services	No						Coverage for emergency services includes only such treatment as is needed to treat the emergency. Any elective procedures performed after a member has been admitted to a facility as a result of an emergency shall require pre-approval. Emergency medical and hospital services performed within or outside the service area by non-network providers is only covered if: a) review determines that a member's symptoms were severe and delay of treatment would have been detrimental to a members' health; the symptoms occurred suddenly; and member sought immediate medical attention. b) the service rendered is provided as a covered service or supply under the EOC and is not a service or supply which is normally provided on a Non-Emergency basis; and c) we are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. A member shall be responsible for payment for services received unless we determine that a member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until proper written proof is received.	No
16	<b>Emergency Transportation/ Ambulance</b>	Covered	Emergency Transportation/ Ambulance	No					Chartered air flights. Travel or communication expenses of patients, practitioners, nurses or family members. Services for ambulance for transportation from a hospital or other health care facility unless the covered person is being transferred to another inpatient health care facility.	Covers Medically Necessary and appropriate charged for transporting a covered person to: a) a local hospital if needed care and treatment can be provided by a local hospital; b) the nearest hospital where needed care and treatment can be given, if a local hospital cannot provide such care and treatment. But it must be connected with an inpatient confinement; or c) transporting a covered person to another inpatient health care facility. It can be by professional ambulance service, train or plane.	No

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17	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	Covered	Inpatient Hospital Services	No					Private accommodations	Pre-Approval required. Covered at the semi-private room and board accommodation.	No
18	<b>Inpatient Physician and Surgical Services</b>	Covered	Inpatient Physician and Surgical Services	No					Local anesthesia charges billed separately if such charges are included in the fee for the surgery.	Pre-Approval required.	No
19	<b>Bariatric Surgery</b>	Covered	Bariatric Surgery	No					Local anesthesia charges billed separately if such charges are included in the fee for the surgery. Private accommodations.	Pre-Approval required	No
20	<b>Cosmetic Surgery</b>	Not Covered	Cosmetic Surgery						Cosmetic surgery, services or supplies related to cosmetic surgery, complication of cosmetic surgery and drugs provided for cosmetic purposes.		
21	<b>Skilled Nursing Facility</b>	Covered	Skilled Nursing Facility	No					Private accommodations	Pre-Approval required. Network skilled nursing facility services and supplies are limited to those that constitute skilled nursing care.	No
22	<b>Prenatal and Postnatal Care</b>	Covered	Prenatal and Postnatal Care	No						As an alternative to the minimum level of inpatient care as described in the benefit Delivery and All Inpatient Services for Maternity Care, the mother may elect to participate in a home care program.	No
23	<b>Delivery and All Inpatient Services for Maternity Care</b>	Covered	Delivery and All Inpatient Services for Maternity Care	No					Private accommodations	Coverage for the mother and newly born child for: a) up to 48 hours of inpatient care in a network hospital following a vaginal delivery; and b) a minimum of 96 hours of inpatient care in a network hospital following a cesarean section. Coverage is provided subject to a) the attending practitioner must determine that inpatient care is medically necessary; or b) the mother must request the inpatient care.	No
24	<b>Mental/Behavioral Health Outpatient Services</b>	Covered	Mental/Behavioral Health Outpatient Services	No					Custodial care, education and training.		No
25	<b>Mental/Behavioral Health Inpatient Services</b>	Covered	Mental/Behavioral Health Inpatient Services	No					Private accommodations. Custodial care, education and training.	Pre-Approval required	No

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26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					Custodial care, education and training.		No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					Private accommodations. Custodial care, education and training.	Pre-Approval required.	No
28	Generic Drugs	Covered	Generic Drugs	No					Drugs prescribed for cosmetic purposes. Non-prescription drugs. A prescription or refill will not include a prescription or refill that is more than: a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or b) the amount usually prescribed by the Network practitioner. In certain instances additional amounts above limits based on approved FDA labeling are not covered.		No
29	Preferred Brand Drugs	Covered	Preferred Brand Drugs	No					Drugs prescribed for cosmetic purposes. Non-prescription drugs. A prescription or refill will not include a prescription or refill that is more than: a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or b) the amount usually prescribed by the Network practitioner. In certain instances additional amounts above limits based on approved FDA labeling are not covered.	Subject to Pre-Approval for certain prescription drugs	No
30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Drugs	No					Drugs prescribed for cosmetic purposes. Non-prescription drugs. A prescription or refill will not include a prescription or refill that is more than: a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or b) the amount usually prescribed by the Network practitioner. In certain instances additional amounts above limits based on approved FDA labeling are not covered.	Subject to Pre-Approval for certain prescription drugs	No

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31	Specialty Drugs	Covered	Specialty Drugs	No					Drugs prescribed for cosmetic purposes. Non-prescription drugs. A prescription or refill will not include a prescription or refill that is more than: a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or b) the amount usually prescribed by the Network practitioner. In certain instances additional amounts above limits based on approved FDA labeling are not covered.	All specialty drugs are subject to pre-approval. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These prescription drugs must be dispensed through Specialty pharmaceutical providers.	No
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	No						Subject to Pre-Approval	No
33	Habilitation Services	Covered	Habilitation Services	No			Habilitation services as provided through rehabilitation services are covered				Yes
34	Chiropractic Care	Covered	Chiropractic Care	No						Therapeutic manipulations and therapy services as listed separately are subject to visit limit maximums.	No
35	Durable Medical Equipment	Covered	Durable Medical Equipment	No						Requires Pre-Approval and must be ordered by a Network practitioner and arranged through us.	No
36	Hearing Aids	Covered	Hearing Aids	Yes	2	Other other	One hearing aid for each hearing impaired ear every 24 months is covered for a member age 15 or younger, subject to a maximum amount payable for each hearing aid of \$1,000. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.				No
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Text (X-Ray and Lab Work)	No							No

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38	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs)	No						All require Pre-Approval - Computed Tomography (CT); Computed Tomography Angiography (CTA); Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA) Positron Emission Tomography (PET); Nuclear Medicine (including Nuclear Cardiology)	No

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39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/ Screening/ Immunizations	No					Routine immunizations for the sole purpose of travel or as a required by a member's employment.	Includes coverage for services such as - Newborn Hearing Screening coverage is provided up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, coverage is provided between the age of 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss. Well child care from birth including immunizations (when policy covers children); routine gynecologic exams and related services; routine ear and hearing exams; and routine allergy injections and immunizations. Colorectal Cancer screening coverage to a member age 50 or over and to younger members who are considered to be high risk for colorectal cancer. Coverage for the colorectal cancer screening is subject to the American Cancer Society guidelines and medical necessity as determined by the member's practitioner in consultation with the member regarding methods to use, we will cover: a) annual gFOBT (guauac-based fecal occult blood test) with high test sensitivity for cancer; b) annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer; c) stool DNA (sDNA) test with high sensitivity for cancer; d) flexible sigmoidoscopy; e) colonoscopy; f) contrast barium enema; g) computed tomography (CT) colonography; h) any combination of the services listed a-g (for the colorectal cancer screening benefit) ; or i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines. Routine eye screening, as provided as part of a routine physical, is covered.	No

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40	Routine Foot Care	Not Covered	Routine Foot Care						Services or supplies related to routine foot care, except; a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; b) the removal of nail roots; and c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.		
41	Acupuncture	Not Covered	Acupuncture							Only covered when used as a substitute for other forms of anesthesia	
42	Weight Loss Programs	Not Covered	Weight Loss Programs								
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year					No
44	Eye Glasses for Children	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Limitations, including dollar limits, may apply	No
46	Other										

## OTHER BENEFITS

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1	Other	Covered	Therapeutic manipulation	Yes	30	Other other	Therapeutic manipulation provided in a network practitioner's office is covered with a maximum of 30 visits per calendar year.				No
2	Other	Covered	speech and cognitive therapy	Yes	30	Other other	Speech and Cognitive therapy when provider in a Network practitioner's office have a combined limit of 30 visits per calendar year				No
3	Other	Covered	Physical and Occupational Therapy	Yes	30	Other other	Physical and occupational therapy provided in provided in a network practitioner's office have a combined limit of 30 visits per calendar year.				No
4	Other	Covered	Speech Therapy	Yes	30	Other other	Speech Therapy in a Network practitioner's office provided under the diagnosis and treatment of autism and other developmental disabilities provision has a maximum of 30 visits per calendar year				No
5	Other	Covered	Physical and Occupational Therapy provided under the diagnosis and treatment of autism and other developmental disabilities provision	Yes	30	Other other	Physical and occupational therapy provided in provided in a network practitioner's office for the diagnosis and treatment of autism and other developmental disabilities provision have a combined limit of 30 visits per calendar year.				No
6	Other	Covered	Food and Food Products for Inherited Metabolic Diseases	No						We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formulas) and low protein modified food products as determined medically necessary by a Member's network practitioner.	No

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7	Other	Covered	Specialized non-standard infant formula	No						Are covered to the same extent and subject to the same terms and conditions as prescription drugs. Specialized non-standard infant formulas are covered provided : a) the child's network practitioner has diagnosed the child as having multiple food protein intolerance and has determined the formula to be medically necessary; and b) the child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. Subject to the continued medical necessity and appropriateness review.	No
8	Other	Covered	Blood, Blood products and Blood transfusions	No					Blood which has been donated or replaced on behalf of a member.	Blood, blood products, blood transfusions and the cost of testing and processing blood.	No
9	Other	Covered	Dental Care and Treatment	No					Orthodontic treatment.	The following are the only services covered: 1) the diagnosis and treatment of oral tumors and cysts; and 2) the surgical removal of bony impacted teeth. Treatment of an injury to natural teeth or the jaw, but only if: 1) the injury was not cause directly or indirectly by biting or chewing; and 2) all treatment is finished within six months of the date of injury. Treatment includes replacing natural teeth lost due to such injury. For a member who is severely disabled or who is a child under age six, we cover: general anesthesia and hospitalization for dental services; and b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by the EOC which requires hospitalization or general anesthesia.	No
10	Other	Covered	Temporomandibular Joint Disorder (TMJ)	No					Services or supplies for orthodontia, crowns or bridgework.	Covered when medically necessary and appropriate surgical and non-surgical treatment of TMJ.	No

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11	Other	Covered	Cancer Clinical Trials	No						Cover practitioner's fees, laboratory expenses and expenses associated with hospitalization, the administering of treatment and evaluation of the member during the course of treatment of a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a member receives medical care associated with an Approved Cancer Clinical Trial. Such services are only covered if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.	No
12	Other	Covered	Pain Management Services	No						Pre-Approval Required	No
13	Other	Covered	Chelation Therapy	No						Administration of drugs or chemicals to remove toxic concentrations of metals from the body by a network provider.	No
14	Other	Covered	Chemotherapy	No						Treatment by a network provider of malignant disease by chemical or biological antineoplastic agents	No
15	Other	Covered	Dialysis Treatment	No						Treatment by a network provider of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body, includes hemodialysis and peritoneal dialysis.	No
16	Other	Covered	Radiation Therapy	No						Treatment by a network provider of disease by c-ray, radium, cobalt or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic service requiring the use of radioactive materials are not radiation therapy.;	No
17	Other	Covered	Respiration Therapy	No						Treatment by a network provider which introduces dry or moist gases into the lungs	No
18	Other	Covered	Infusion Therapy	No						Pre-Approval Required. Treatment by a network provider with the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.	No

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19	Other	Covered	Intravenous injections and solutions	No						Pre-Approval Required	No
20	Other	Covered	Reconstructive Breast Surgery	No						Pre-Approval required. Inpatient Hospital services for Surgery to restore and achieve symmetry between the two breast and the cost of prostheses following a mastectomy on one breast or both breasts. Also covered is the treatment of the physical complications of mastectomy, including lymphedemas.	No
21	Other	Covered	Cornea, Kidney, Lung, Liver, Heart, Pancreas and Intestine transplants	No						Pre-Approval Required. Inpatient hospital services for the following transplants: cornea; kidney; lung; liver; heart; pancreas and intestines.	No
22	Other	Covered	Autologous Bone Marrow Transplant	No						Pre-Approval Required. Inpatient Hospital services for Autologous bone marrow transplant and associated dose-intensive chemotherapy, but only if performed by institutions approved by the National Cancer institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.	No
23	Other	Covered	Peripheral blood stem cell transplants	No						Pre-Approval required. Inpatient Hospital services for Peripheral blood stem cell transplants but only if performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists	No
24	Other	Covered	Donor Costs associated with Transplants	No					Travel, accommodations , meals or comfort items.	Pre-Approval required. Inpatient Hospital Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor.	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
25	Home Health Care Services	Covered	Home Health Care Services	No			Pre-Approval required. Home health care may be covered when services can take the place of inpatient care under a written home health plan. Covers medically necessary and appropriate services. The covered person's practitioner must certify that home health care is needed in place of inpatient care in a recognized facility. Home health care is covered only in situations where continuing hospitalization or confinement in a skilled nursing facility or rehabilitation center would otherwise have been required if home health care were not provided. The Services and supplies must be 1) ordered by the covered person's practitioner; 2) included in the home health care plan; and 3) furnished by, or coordinated by, a home health agency according to the written home health care plan. Services and supplies must be furnished by a recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis. The home health care plan must be set up in writing by the covered person's practitioner within 14 days after home health care starts. It must be reviewed by the covered person's practitioner at least once every 60 days				No
26	Habilitation Services	Covered	Habilitation Services	No			Habilitation services as provided through rehabilitation services are covered				No
27	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
28	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
29	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	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	10
ANESTHETICS	LOCAL ANESTHETICS	2
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	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	18
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	12
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	4
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	BARBITURIC ACID DERIVATIVE	1
ANTICONVULSANTS	BENZODIAZEPINE DERIVATIVE	3
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	8
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	ANTIFUNGALS	19
ANTIGOUT AGENTS	ANTIGOUT AGENTS	4
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	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS	6
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	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	4
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
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	ANTISPASTICITY AGENTS	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	8
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4

Category	Class	Submission Count
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	7
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	9
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	6
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
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	2
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	5
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	DENTAL AND ORAL AGENTS	6
DERMATOLOGICAL AGENTS	DERMATOLOGICAL AGENTS	24
ENZYME REPLACEMENT/MODIFIERS	ENZYME REPLACEMENT/MODIFIERS	10
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	2
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7

Category	Class	Submission Count
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	24
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	14
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	9
IMMUNOLOGICAL AGENTS	VACCINES	0
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	8
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	METABOLIC BONE DISEASE AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	8
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES	1
OTIC AGENTS	OTIC AGENTS	4
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	7
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	8
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3

<b>Category</b>	<b>Class</b>	<b>Submission Count</b>
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	4
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	SKELETAL MUSCLE RELAXANTS	8
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	1