PUERTO RICO EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Triple-S Salud, Inc.
Product Name	Óptimo Plus PPO
Plan Name	Óptimo Plus (Plan de Salud PG-OP 2008)
Supplemented Categories (Supplementary Plan Type)	Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	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					Non physician professionals or doctors in odontology including nurse and physician assistant except those required by local law such as: podiatrist, audiologist, optometrist, clinical psychologists and chiropractors.		No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Hospital Outpatient Surgery/Non-surgery facility	No					Services rendered in an outpatient facility that may be performed in physician's office		No

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5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Outpatient Surgery Physician/ Surgical Services	No					Cosmetic surgery, oral surgery that is dental in origin except those as a result of an accident, mammoplasty (except those required for patients after a breast cancer mastectomy), septoplasty, blepharoplasty, rinoseptoplasty, procedures to re-establish the ability to procreate, organ transplant procedures (OT covered as an optional benefit), induced abortion. experimental procedures, skin tags removal, ptosis repair, nail excisions, scalenotomy, Lasik and other surgical procedures to correct refractive defects, surgeries for sexual transformation, surgical assistance services, intravenous analgesia services or analgesia administered though inhalation at the physician or dentist's office, services for the treatment of the temporomandibular articulation syndrome, excision of granulomas or radicular cysts originated by infection in the tooth pulp; services to correct the vertical dimension or occlusion, removal of exostosis (mandibulary or maxillary.		No
6	**Hospice Services**	Not Covered									

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7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered									
8	**Routine Dental Services (Adult)**	Covered	Basic dental	Yes	2	Other	Dental checkup and cleanings 2 per policy year (every 6 months); bitewings and periapicals no more than one set every 3 years		Orthodontic, Periodontics, Endodontic and prosthetic dental services are not covered. Full mouth reconstructions.	(covered as an optional coverage) Fluoride treatment covered to members under age 19. Root canal only to anterior and posterior teeth	No
9	**Infertility Treatment**	Not Covered									
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam (Adult)	No					Refraction exam is covered one per year		No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Services in Emergency Room	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	40	Other	Combined limit. Limit applies to physical, occupational and speech therapy			Covered only if they begin 14 days after member's discharge from hospital of at least three (3) days and if they are provided for the same condition by he/she was admitted.	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No					Covered by reimbursement up to $80 per trip		No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No						Excludes services for personal comfort and or custodial services. Hospitalizations for services or procedures that may be performed in an outpatient services.	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No							No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	Yes	1	Procedures per lifetime	Per member				No
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	120	Other	Days per policy year, per member.			Covered only if they begin 14 days after member's discharge from hospital of at least three (3) days and if they are provided for the same condition by he/she was admitted.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No						Covered only for mainholder and dependent spouse.	No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No						Delivery of baby 48 hour minimum length for vaginal delivery and 96 for cesarean delivery. Covered only for main holder and dependent spouse.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	Yes	15	Other	Per year per member. Limit only applies to group therapies.				No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					Residential treatment outside service area is not covered. Limit applies: 90 days per year	Expenses for services resulting from the administration of an employer drug detection program.	No

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26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	15	Other	Limit applies for each type of covered service as allowed when federal law does not applies: group therapies, visits to psychiatrist or clinical psychologist, collateral visits and group therapy.			Expenses for services resulting from the administration of an employer drug detection program.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	30	Other	Days per member, per year. Partials are included: 2 partial hospital days equivalent to 1 regular day.		Residential treatment outside service area is not covered. Limit applies for residential treatment centers in service area: 90 days per year		No
28	**Generic Drugs**	Covered	Generic Drugs	No						Pharmacy benefit offered as an optional coverage. Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No						Pharmacy benefit offered as an optional coverage. Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No						Pharmacy benefit offered as an optional coverage. Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	No

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31	**Specialty Drugs**	Covered	Specialty Drugs	No						Tier covered under Pharmacy benefit that is offered as an optional coverage. There are some drugs under this class covered under the medical benefit for some conditions i.e.. injectable chemotherapy, immunoglobulin, renal, among others. Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	20	Other	Physical therapies or manipulations covered under a combined limit per year.		Services not covered include occupational, speech and language therapies, prosthetics and implants (covered in Major Medical coverage as an optional benefit). Orthopedics and orthotic devices, cardiac rehabilitation.	Services limited to physical therapies, except for those covered under home health care benefit.	No
33	**Habilitation Services**	Covered	Habilitation Services	Yes	20	Other	Physical therapies or manipulations covered under a combined limit per year.			Services limited to physical therapies, except for those covered under home health care benefit	No
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	20	Other	Physical therapies or manipulations covered under a combined limit per year.				No

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35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	Yes	5000	Other	Maximum benefit per policy year, per member.			Covers with a preauthorization from plan rental or purchase of Oxygen and necessary equipment for its administration/wheelchair/hospital bed. Mechanical respirators and ventilators are covered without limits as required by local law to member's patients under age of 21.	No
36	**Hearing Aids**	Not Covered	Hearing Aids								
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	Yes	1	Other	per year for PET & PET/CT. per anatomical region per year for MRI & CT				No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screening/ Immunization	No						Preventive care that meets recommendations described in ACA	No
40	**Routine Foot Care**	Covered	Routine Foot Care	No							No
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs								
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year				Supplemented using FEDVIP	No
44	**Eye Glasses for Children**	Covered	Eyeglasses for children	Yes	1	Other	1 pair of glasses (lenses and frames per year)			Supplemented using FEDVIP	No

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45	**Dental Check-Up for Children**	Covered	Basic dental	Yes	2	Other	Dental checkup and cleanings 2 per policy year (every 6 months); bitewings and periapicals no more than one set every 3 years			Covered under the dental benefit which is offered as an optional benefit	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	Allergy tests	Yes	50	Other	Tests per year			Vaccines not covered	No
2	**Other**	Covered	Dialysis and hemodialysis	Yes	90	Other	Days			Services related to any type of dialysis or hemodialysis, as well as services for any complication that may arise and their corresponding hospital or medical-surgical services, will be covered for the first 90 days from: a) the date in which the member became eligible for the policy during the first time or, b) the date in which he/she received the first dialysis and hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical conditions.	No
3	**Other**	Covered	Injectable chemotherapy	No							No
4	**Other**	Covered	Radiation therapy	No							No
5	**Other**	Covered	Intra-articular injections	Yes	12	Other	Injections per year, up to 2 daily injections				No
6	**Other**	Covered	Cryo-surgery of the uterus	Yes	1	Procedures per year					No
7	**Other**	Covered	Sterilization	No							No
8	**Other**	Covered	Invasive cardiovascular, non-invasive cardiovascular procedures and tests	No						Electromiograms covered up to 2 procedures year year	No
9	**Other**	Covered	Nuclear medicine tests	No							No
10	**Other**	Covered	Nerve conduction velocity tests	Yes	2	Other	Procedures per policy year				No
11	**Other**	Covered	Gastrointestinal endoscopies	No							No
12	**Other**	Covered	Polysomnography	Yes	1	Other	Type of test per lifetime				No
13	**Other**	Covered	Tympanometry	Yes	1	Other	Per policy year				No
14	**Other**	Covered	Nutritionist services	Yes	4	Other	Per policy year			Limited to morbid, renal and diabetes conditions. Covered by reimbursement up to $20 per visit	No

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15	**Other**	Covered	Transplant Services	No						Medical benefit covers skin, bone and corneal transplants. Other transplant procedures such as heart, lung, heart-lung, kidney, liver, liver-pancreas, small intestine and bone marrow, including pre-transplant, post transplant and immunosuppressive therapy covered under optional organ transplant coverage subject to a six month waiting period. Waiting period is reduced or eliminated if member has previous coverage and not exceeded allowed period without coverage as allowed by law.	No
16	**Other**	Covered	Orthognatic surgery	No						Expenses related for materials are excluded.	No
17	**Other**	Covered	Lithotripsy	No							No
18	**Other**	Covered	Air ambulance	No						Out of area air ambulance coverage is not covered.	No
19	**Other**	Covered	Out of area coverage (US)	No						Services are covered for emergency cases or cases that required equipment, treatment and facilities not available in Puerto Rico. Services are subject to preauthorization from plan except for an emergency. Elective treatments, not considered as an emergency, are not covered by this policy	No
20	**Other**	Covered	Biophysical profile	Yes	1	Other	Procedures per pregnancy				No
21	**Other**	Covered	MRA	No							No
22	**Other**	Covered	Contraceptive methods	No							No
23	**Other**	Covered	Neurological tests and procedures	No							No
24	**Other**	Covered	All Puerto Rico mandated benefits	No							No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	7
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	1
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	19
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	13
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	11
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	7
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	5
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
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	7
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	3
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	8
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	5
ANTIFUNGALS	NO USP CLASS	24
ANTIGOUT AGENTS	NO USP CLASS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	0
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	2
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
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	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	0
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	9
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	17
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7

CATEGORY	CLASS	SUBMISSION COUNT
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	6
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	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	7
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	12
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	3
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	6
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	3
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	1
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	2
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	5
DERMATOLOGICAL AGENTS	NO USP CLASS	24
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	6
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	4
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	7
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/ MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23

CATEGORY	CLASS	SUBMISSION COUNT
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	4
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	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	6
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/ MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	8
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	7
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	14
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	6
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	7

CATEGORY	CLASS	SUBMISSION COUNT
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	3
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	7