DELAWARE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from 2nd largest small group product, Exclusive Provider Organization
Issuer Name	Blue Cross Blue Shield of Delaware
Product Name	Simply Blue EPO
Plan Name	Simply Blue EPO 100 500
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)	Yes: Delaware will require that coverage for habilitative services be on parity with those for rehabilitative services as outlined in the state's Essential Health Benefit benchmark.

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 an Injury or Illness	Covered	No						No
Specialist Visit	Yes	Specialist Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician/Surgical Services	Covered	No				Change of sex surgery, except to correct congenital defect surgery to reverse voluntary sterilization	Dental surgery is only covered for extracting bony impacted teeth or correcting accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of mouth.	No
Hospice Services	Yes	Hospice Services	Covered	Yes	240	Days per episode				No
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No						No
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered							
Long-Term/Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered						Outpatient PDN is not covered. Inpatient PDN is covered for up to 240 hours in a 12 month period.	
Routine Eye Exam (Adult)		Routine Eye Exam (Adult)	Covered	Yes	1	Visit every 24 months				No
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No						No
Home Health Care Services	Yes	Home Health Care Services	Covered	Yes	100	Visits per year				No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/Ambulance	Covered	No						No

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Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (Hospital Stay)	Covered	No						No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				Change of sex surgery, except to correct congenital defect surgery to reverse voluntary sterilization		No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No						No
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	120	Days per admission			Benefits renew after 180 days without care.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	Yes	20	Visits per year			Limits do not include serious mental illness which is covered as any other illness.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	Yes	31	Days per year		Covered for up to 31 inpatient days and 62 partial hospital days per calendar year. One inpatient day reduces partial hospital days by two days. Two days of partial hospital care reduce inpatient days by one day. Covered for up to 31 inpatient days and 62 partial hospital days per calendar year. One inpatient day reduces partial hospital days by two days. Two days of partial hospital care reduce inpatient days by one day.	Limits do not include serious mental illness which is covered as any other illness.	No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No						No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No						No
Generic Drugs	Yes	Generic Drugs	Covered	No						No
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No						No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No					Dental Delaware prescription drug coverage essentially has an open formulary as the law requires coverage of all FDA-approved drugs, even for off-label use, so long as the drug is recognized for treatment of the prescribed indication in substantially accepted peer reviewed medical literature.	No
Specialty Drugs	Yes	Specialty Drugs	Covered	No						No

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Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	No					See rehabilitation services and limits in "other benefits" section.	Yes
Habilitation Services			Not Covered							
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	30	Visits per year			Three modalities per visit. One visit per day.	No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No						No
Hearing Aids	Yes	Hearing Aids	Covered	No				Hearing aids for members age 24 or over.	$1,000 per individual hearing aid, per ear, every three (3) years for children less than 24 years of age	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No						No
Preventive Care/ Screening/Immunization	Yes	Preventive Care/ Screening/ Immunization	Covered	No					Based on preventive schedule.	No
Routine Foot Care			Not Covered							
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered						Weight loss programs are available to members 18 and over as a value added feature.	
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			Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using Delaware CHIP.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	30	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	30	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

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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. Covered only with prior authorization.	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	No				See pages 16/17 of benefit booklet for various sub limitations. Transplants performed at non-participating hospitals are not covered.		No
Accidental Dental			Not Covered							
Dialysis			Not Covered							
Allergy Testing			Not Covered							
Chemotherapy			Not Covered							
Radiation			Not Covered							
Diabetes Education			Not Covered							
Prosthetic Devices			Not Covered							
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders			Not Covered							
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
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Mental Health Other	Yes[1]	Mental Health Other	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs 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?
Outpatient Rehabilitation Services	Yes	Physical Therapy and Occupational Therapy Combined	Covered	Yes	30	Visits per year				Yes
Outpatient Rehabilitation Services	Yes	Speech Therapy	Covered	Yes	30	Visits per year				Yes
Outpatient Rehabilitation Services	Yes	Cognitive Therapy	Covered	Yes	30	Consecutive days beginning on the first day of treatment				Yes
Outpatient Rehabilitation Services	Yes	Cardiac Therapy	Covered	Yes	3	Sessions per week and 3 months of treatment				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	1
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	27
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	2
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	5
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	3
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	10
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	15
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	2
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