VERMONT EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	The Vermont Health Plan, LLC
Product Name	CDHP-HMO
Plan Name	BlueCare, The Vermont Health Plan, LLC, CDHP
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Primary Care Visit to Treat 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					Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Hospice Services	Yes	Hospice Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents. Must meet hospice requirements for benefit eligibility.	Yes
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No				Excluded UNLESS member qualifies for coverage due to sabbatical or attending college in a foreign country.		No
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered						Refer to Infertility Drug limitation in Generic, Preferred and Non-Preferred Prescription Drug categories.	
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing	Yes	Private-Duty Nursing	Covered	Yes	2000	Dollars per plan year			Requires prior approval and recertification of treatment plan every 60 days.	No
Routine Eye Exam (Adult)		Routine Eye Exam (Adult)	Covered	Yes	1	Routine eye exam per calendar year		Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.		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	No					Quantitative limit units apply, see EHB benchmark plan documents.	No

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Emergency Room Services	Yes	Emergency Room Services	Covered	No				Excludes benefits for an emergency room services that does not meet definition of Emergency Service.	Emergency room services include emergency room physician services and emergency mental health and substance use physician and facility services. Insured's condition must meet the criteria for an emergency medical condition.	Yes
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No				Insured's condition must meet the criteria for an emergency medical condition. Insured must get approval within 48 hours after emergency air or water transport.		No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Yes	1	Day per episode			Coverage for either day of admission OR day of discharge but not both.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	Yes	1	Provider visit only may be covered in a given day				Yes
Bariatric Surgery	Yes	Bariatric Surgery	Covered	Yes	10000	Dollars per lifetime				No
Cosmetic Surgery	Yes	Cosmetic Surgery	Covered	No				Cosmetic Surgery is an excluded benefit except for prior approval for reconstruction as detailed in certificate of coverage.		No
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	No					Covered by participating facility only for Acute Care. Includes room, board, general nursing care, medication and drugs given by SNF during a covered stay and medical services included in the rates of a SNF.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No					See Maternity Office Visits and Inpatient Hospital Services for additional benefit information.	Yes
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No					Covered as an Inpatient Hospital Stay.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents. Includes mental/behavioral health office visits, individual and group psychotherapy, family and couples therapy, intensive programs, partial hospital day treatment, psychological testing when integral to treatment, psychotherapy programs to improve compliance with prescribed medical treatment regimens for diabetes, hypertension, ischemic heart disease and emphysema.	Yes
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes hospitalization, residential treatment programs.	No

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Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No					Includes substance use disorder office visits and detoxification in outpatient rehab facility (including services for the patient's family when necessary).	Yes
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes detoxification in an inpatient rehabilitation facility.	No
Generic Drugs	Yes	Generic Drugs	Covered	Yes	90	Day supply for retail and home delivery (mail order) per fill				Yes
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	Yes	90	Day supply for retail and home delivery (mail order) per fill			The limit quantity applies per script on retail and home delivery.	Yes
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	Yes	90	Day supply for retail and home delivery (mail order) per fill			The limit quantity applies per script on retail and home delivery.	Yes
Specialty Drugs	Yes	Specialty Drugs	Covered	Yes	30	Day supply		ONLY Participating Specialty pharmacies may be utilized for Specialty drugs.		Yes
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	Yes	30	Outpatient sessions combined per plan year			Typically include physical, occupational, and speech therapy, but may also include radiation therapy, chemotherapy, dialysis, infusion therapy. Cardiac Rehabilitation is covered up to 36 visits per cardiac event. Three supervised exercise sessions per week up to total of 36 sessions for cardiac and pulmonary rehab programs.	Yes
Habilitation Services	Yes	Habilitation Services	Covered	No					Autism Coverage per Vermont State Mandate for ages zero to six years.	No
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	12	Visits per year; prior approval is required after the 12th visit			Prior approval required after 12 visits; includes treatment for neuromusculoskeletal conditions by a network provider working within the scope of their license.	No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents. Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, and devices. Threshold applies.	Yes
Hearing Aids			Not Covered							

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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					Includes routine physical examinations, immunizations, well-child care, screening mammogram, screening colonoscopy, preventive GYN.	No
Routine Foot Care	Yes	Routine Foot Care	Covered	No				Covered for Diabetics ONLY; excluded for all other members.		No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine Eye Exam for Children	Covered	Yes	1	Routine eye exam per member per calendar year		Does not cover the evaluation and fitting of contact lenses or other supplemental tests.		No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	No					Refer to "Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery" on Other tab for more information.	No
Dental Check-Up for Children	Yes	Dental Check-Up for Children	Covered	Yes	2	Visits per year				No
Rehabilitative Speech Therapy			Not Covered							
Rehabilitative Occupational and Rehabilitative Physical Therapy			Not Covered							
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
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			Not Covered							
Orthodontia - Child			Not Covered							
Major Dental Care - Child			Not Covered							
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							

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Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	Yes	35000	Dollars per transplant				No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis			Not Covered							
Allergy Testing			Not Covered							
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation			Not Covered							
Diabetes Education			Not Covered							
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling	Yes	Nutritional Counseling	Covered	Yes	3	Visits per plan year		Visits for treatment of diabetes do not count toward this visit limit.		No
Reconstructive Surgery			Not Covered							
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	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
Bones/Joints	Yes	Bones/Joints	Covered	No						No
Nutrition/Formulas	Yes	Nutrition/Formulas	Covered	Yes	2500	Dollars per year			For medical foods prescribed for the medically necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.	No
Outpatient Contraceptive Services Including Sterilizations	Yes	Outpatient Contraceptive Services Including Sterilizations	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
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Outpatient Surgery Physician/ Surgical Services	Yes	Neuropsychological Testing	Covered	Yes	8	Hours per year				No
Hospice Services	Yes	Home Health Aide	Covered	Yes	100	Hours per month			For personal care services only.	No
Dental Services (not Routine)	Yes	Dental Services (not Routine)	Covered	No					Includes treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started with six months of the accident; also includes surgery to correct gross deformity from major disease or surgery with service occurring within six months of the onset of disease or within six months of surgery.	No
Inpatient Physician and Surgical Services	Yes	Sterilization Reversal	Covered	Yes	1	Procedures per lifetime			Covers only one attempt at reversal of sterilization.	No
Durable Medical Equipment	Yes	Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery.	Covered	Yes	1	Set of accompanying eyeglasses or contact lenses for the original prescription and one set for each new prescription.				Yes
Durable Medical Equipment	Yes	Dental prosthetics	Covered	No				Repair or replacement of dental appliances or dental prosthetics.	With prior approval and only of required to treat an accidental injury (except injury as a result of chewing or biting); or to correct gross deformity resulting from major disease or Surgery; to treat obstructive sleep apnea; or to treat craniofacial disorders, including temporomandibular joint syndrome.	No
Generic Drugs	Yes	Infertility medications	Covered	Yes	4	Months of fertility medication per plan year when attempting to conceive through natural means				No

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Preferred Brand Drugs	Yes	Infertility medications	Covered	Yes	4	Months of fertility medication per plan year when attempting to conceive through natural means				No
Non-Preferred Brand Drugs	Yes	Infertility medications	Covered	Yes	4	Months of fertility medication per plan year when attempting to conceive through natural means				No
Prenatal and Postnatal Care	Yes	Maternity Office Visits	Covered	No					Includes coverage by a Physician or other Professional during a woman's pregnancy for pre-natal visits and other care and post-natal visits.	No
Transplant Services - deceased donor	Yes	Transplant Services - deceased donor	Covered	Yes	35000	Dollars per solid organ transplant			For search, removal, storage, and transportation of the organ from a deceased donor.	No
Hospice Services	Yes	Hospice Services Homemaker Services	Covered	Yes	100	Hours per month				No
Hospice Services	Yes	Hospice Continuous Care Services in Home	Covered	Yes	5	Days per admission, or 120 hours of continuous care			For in home care.	No
Hospice Services	Yes	Hospice Respite Care	Covered	Yes	72	Hours per month				No
Hospice Services	Yes	Hospice Social Services Visits	Covered	Yes	6	Visits per lifetime				No
Hospice Services	Yes	Hospice Bereavement visits	Covered	Yes	2	Visits per lifetime			Two bereavement visits following death.	No
Generic Drugs	Yes	Antibiotics and Narcotic Day Supply Limitation	Covered	Yes	30	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No

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Preferred Brand Drugs	Yes	Antibiotics and Narcotic Day Supply Limitation	Covered	Yes	30	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
Non-Preferred Brand Drugs	Yes	Antibiotics and Narcotic Day Supply Limitation	Covered	Yes	30	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
Specialty Drugs	Yes	Antibiotics and Narcotic Day Supply Limitation	Covered	Yes	30	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
Transplant Services - Live donor	Yes	Transplant Services - Live donor	Covered	Yes	65000	Dollars per covered transplant procedure completed			For the live donor's surgical expenses and storage and transportation of the organ. Costs for a donor must be incurred within 120 days from the date of the donor's surgery.	No
Transplant Recipient - Benefit Coverage Time Period	Yes	Transplant Recipient - Benefit Coverage Time Period	Covered	Yes	370	Days per transplant; 395 days per bone marrow transplant			From 30 days before the transplant to 365 days after the transplant for bone marrow transplants OR From five days before the transplant to 365 days after the transplant.	No
Durable Medical Equipment	Yes	Pre-fabricated knee braces	Covered	No				Custom-fabricated or custom-molded knee braces.		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	26
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	3
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	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
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	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
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	17
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	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	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4