

NORTH CAROLINA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross and Blue Shield of NC
Product Name	Blue Options
Plan Name	Blue Options
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none"> • Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?	
Primary Care Visit to Treat an Injury or Illness	Yes	Primary Care Visit to Treat an Injury or Illness	Covered	No				Prescription drugs that can be self-administered.	Includes services such as: Allergy testing; Office surgery; Drugs that must be administered by a provider.	No	
Specialist Visit	Yes	Specialist Visit	Covered	No				Prescription drugs that can be self-administered.	Includes services such as: Allergy testing; Office surgery; Drugs that must be administered by a provider.	No	
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No					Includes: Drugs that must be administered by a provider and nutritional counseling for ESRD	No	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	No					Outpatient surgeries and procedures including: Reconstructive surgery; Reconstructive procedures; Internal prosthesis; Voluntary male sterilization; Termination of pregnancy	No	
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician/Surgical Services	Covered	No					Outpatient surgeries and procedures including: Reconstructive surgery; Reconstructive procedures; Internal prosthesis; Voluntary male sterilization; Termination of pregnancy	No	
Hospice Services	Yes	Hospice Services	Covered	No				Homemaker services such as: Cooking; Housekeeping; Food or meal preparation.	Requires life expectancy of 6 months or less.	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	Yes	Infertility Treatment	Covered	Yes	5000	Dollars per member per lifetime		Services for or related to invitro fertilizaion, GIFT, ZIFT and reversal of voluntary sterilization. No coverage for dependent children. Infertility resulting from menopause. Ovum or embryo placement. Intracytoplasmic sperm injection (ICSI). Donor eggs and sperm. Surrogate mothers.	Services to diagnose cause of infertility, services for or related to artificial insemination, care needed to correct an underlying cause of infertility.	No	
Long-Term/Custodial Nursing Home Care			Not Covered								
Private-Duty Nursing	Yes	Private Duty Nursing	Covered	No					Private duty nursing must provide more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency.	No	
Routine Eye Exam (Adult)		Routine screening and refraction	Covered	Yes	1	Visit per year				No	

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Urgent Care Centers or Facilities	Yes	Urgent care centers	Covered	No						No
Home Health Care Services	Yes	Home health care services	Covered	No				Homemaker services, such as cooking and housekeeping. Dietician services or meals.		No
Emergency Room Services	Yes	Emergency room services	Covered	No						No
Emergency Transportation/Ambulance	Yes	Emergency Transportation/Ambulance	Covered	No				Transportation for convenience or comfort or any non-medically necessary conditions.	Ground transportation to the hospital and between facilities and air ambulance when necessary.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	No				Admissions primarily for the purpose of receiving rehab therapy.	Inpatient surgeries and procedures including: Reconstructive surgery; Reconstructive procedures; Internal prosthesis; Voluntary male sterilization; Termination of pregnancy; Intensive care units	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No					Therapy limits do not apply when inpatient. Inpatient surgeries and procedures including: Reconstructive surgery; Reconstructive procedures; Internal prosthesis; Voluntary male sterilization; Termination of pregnancy; Intensive care units; Rehab services	No
Bariatric Surgery	Yes	Bariatric services	Covered	No						No
Cosmetic Surgery			Not Covered						Reconstructive surgery is covered.	
Skilled Nursing Facility	Yes	Skilled nursing facility	Covered	Yes	60	Days per year				No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Services related to surrogacy. No coverage for dependents except for mandated complications of pregnancy.	Includes: Pregnancy testing when performed in physician office and complications of pregnancy	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No				Dependent maternity except for state mandated complications of pregnancy and federally mandated services. Services related to surrogacy.	Includes: Complications of pregnancy; Anesthesia; Newborn nursery and care; Neonatal intensive care unit; Circumcision	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				Marital counseling.	Includes: Evaluation and diagnosis; Medically necessary biofeedback; Neuro psychological testing; Partial day hospitalization; Intensive therapy services	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				Inpatient residential treatment centers. Supervised living.		No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No					Includes: Evaluation and diagnosis; Partial day hospitalization; Intensive therapy services	No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				Inpatient residential treatment centers. Supervised living.	Inpatient services Including: Inpatient residential treatment centers; and Detoxification	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						No

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Specialty Drugs	Yes	Specialty drugs	Covered	No						No
Outpatient Rehabilitation Services	Yes	Outpatient therapy	Covered	No				Cognitive therapy.	Quantitative limit units apply, see EHB benchmark plan documents. These outpatient rehab services have limitations. See the Other Benefits table below.	Yes
Habilitation Services			Not Covered						Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking, talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	30	Visits per year			Quantitative limit units apply, see EHB benchmark plan documents. Combined with physical and occupational therapies. Includes spinal manipulation.	No
Durable Medical Equipment	Yes	Durable medical equipment	Covered	No				Wigs. Items of personal comfort. Home exercise. Pools, whirlpools, spas, hydrotherapy equipment. Surgical supports, corsets, clothing unless for the purpose of recovery from surgery or injury. Common first aid supplies. Health club membership.	Includes: Orthotics; Prosthetics; Medical devices; Medical equipment and supplies	Yes
Hearing Aids	Yes	Hearing aids	Covered	Yes	1	Hearing aid per hearing impaired ear, and replacement hearing aids. Once every 36 months. \$2500 per hearing impaired ear every 36 months.			State mandated benefit for members under age 22.	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

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Preventive Care/ Screening/ Immunization	Yes	Preventive Care/ Screening/ Immunization	Covered	No					Includes: Preventative health care services mandated by ACA; PSA; Routine hearing test; Oral contraceptives; Contraceptive-IUD; Contraceptives – injection; Contraceptive-patch; Contraceptive-diaphragm; Contraceptive-implant; Comprehensive lactation support and counseling by trained provider for pregnant women and those in the postpartum period; Purchase of lactation equipment; Screening and counseling for interpersonal and domestic violence; Pediatric preventive services mandated by the ACA. Purchase of lactation equipment was covered as of 8/1 implementation of ACA women's preventive mandate.	No	
Routine Foot Care	Yes	Routine foot care only for persons diagnosed with diabetes.	Covered	No				Routine foot care that is palliative or cosmetic.		No	
Acupuncture			Not Covered								
Weight Loss Programs			Not Covered								
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No	
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No	
Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit per 6 months			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	
Rehabilitative Speech Therapy	Yes	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	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	Yes	Basic Dental Care – Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	
Major Dental Care - Child	Yes	Major Dental Care – Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	

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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				Investigational transplant services. Purchase price of any organ or tissue. Donor services if the recipient is not a member. Services for or related to the transplantation of animal or artificial organs or tissues.	Includes: Hematopoietic stem-cell; Cardiac; Heart-Lung; Lung and Lobar Lung; Pancreas; Renal; -Small Bowel; Small Bowel with Liver; Multi Visceral; Islet Cell; Liver; Donor Search; Transportation and Lodging; Recipient must be a member.	No	
Accidental Dental	Yes	Accidental Dental	Covered	No						No	
Dialysis	Yes	Dialysis	Covered	No					Dialysis includes renal dialysis and hemodialysis.	No	
Allergy Testing	Yes	Allergy Testing	Covered	No						No	
Chemotherapy	Yes	Chemotherapy	Covered	No						No	
Radiation	Yes	Radiation	Covered	No						No	
Diabetes Education	Yes	Diabetes Education	Covered	No						No	
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No	
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No	
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No				Treatment for periodontal disease. Dental implants or root canals. Crowns and bridges Orthodontic braces Occlusal (bite) adjustments. Extractions.	Includes: Diagnostic, therapeutic or surgical procedures. Surgical correction of malocclusion. Splinting. Intraoral prosthetic appliances	No	
Nutritional Counseling			Not Covered								
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No	
Clinical Trials	Yes	Clinical Trials	Covered	No						No	
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No	
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No	
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No	
Mental Health Other	Yes ⁽⁵⁾	Mental Health Other	Covered	No						No	
Congenital Anomaly, including Cleft Lip/Palate	Yes	Congenital Anomaly, including Cleft Lip/Palate	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	Cardiac rehab	Covered	Yes	30	Visits per year			More available beyond the initial allotment if deemed medically necessary.	No
Outpatient Rehabilitation Services	Yes	Pulmonary rehab	Covered	Yes	1	Course of treatment per year		Group classes		No
Outpatient Rehabilitation Services	Yes	Physical therapy	Covered	Yes	30	Visits per year			Visit limit combined with occupational therapy and chiropractic therapy.	No
Outpatient Rehabilitation Services	Yes	Occupational therapy	Covered	Yes	30	Visits per year			Visit limit combined with physical therapy and chiropractic therapy.	No
Outpatient Rehabilitation Services	Yes	Speech therapy	Covered	Yes	30	Visits per year		Speech therapy for stuttering is not covered.		No
Durable Medical Equipment	Yes	Orthotic device for positional plagiocephaly	Covered	Yes	600	Dollar lifetime maximum				No
Cochlear implants	Yes	Cochlear implants	Covered	No						No
Dental	Yes	Dental	Covered	No					Services provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This benefit is only available to DEPENDENT CHILDREN below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth CONGENITAL deformity, including cleft lip and cleft palate. Removal of: tumors; cysts which are not related to teeth or associated dental procedures; exostoses for reasons other than for preparation for dentures.	No
Organ Donor Search	Yes	Organ Donor Search	Covered	Yes	10000	Dollars per transplant			Services related to the search for a living donor for a member recipient.	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	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	10
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
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	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	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	20
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
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	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	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	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	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	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	33
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	9

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
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)	GLUCOCORTICOID/MINERALOCORTICOID	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	4
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	7
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	16
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOID	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	11
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
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	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	4
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
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	7