WEST VIRGINIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Highmark Blue Cross Blue Shield West Virginia
Product Name	Super Blue Plus 2000
Plan Name	Super Blue Plus 2000 1000 Ded
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				All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
Specialist Visit	Yes	Specialist Visit, including second surgical opinion, therapy modalities	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (where the professional may be a Chiropractor, Nurse, Physician Assistant, podiatrist, psychologist or other professional whose services require payment under WV Code or Federal Mandate), and may include covered therapy modalities	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center but is not an office or clinic used for the private practice of a physician or other provider) and may include Therapy Services such as Radiation, Chemo, dialysis, PT, respiratory, Hyperbaric, pulmonary, speech and occupational modalities.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.	Non-emergency visits to a Hospital based clinic are paid as an outpatient service and not as an Office Visit. Outpatient facilities may be a part of Facility Other Providers, which include Alcoholism Treatment Center, Ambulatory Medical Facility, Ambulatory Surgical Facility, Birthing Center, Day/Night Psych facility, Dialysis Facility, Drug Abuse treatment facility, Freestanding Renal Dialysis Center, Home Health Agency, Hospice facility, psychiatric facility, psychiatric hospital, Rehabilitation facility, Skilled nursing facility as may be allowed by Federal or State law.	Yes
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician/Surgical Services performed within the scope of the provider's license.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No

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Hospice Services	Yes	Hospice Services based on an approved treatment plan when life expectancy is 6 months or less.	Covered	No				Hospice related prescription drugs are limited to a two week supply and must be for palliative or supportive care. Also excluded are physician visits, volunteer services, spiritual counseling, bereavement counseling, non-palliative chemo or radiation therapy. All Covered Services must be Medically Necessary unless otherwise specified.	Services are similar to home health and include Inpatient hospice care, Respite care, dietary guidance, DME, home health aide visits, prescription drugs.	No
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered					Exclusions include services related to Cloning, reversal of sterilization, In-vitro fertilization, gamete intra fallopian transfer and other ova transfer procedures.		
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing	Yes	Private-Duty Nursing.	Covered	Yes	5000	Dollars per year		Inpatient services are available when a provider's regular nursing staff cannot provide them. Non-medical and Custodial services are excluded.		No
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities per the Prudent Layperson standard.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Home Health Care Services	Yes	Homebound patients may receive intermittent skilled care, PT, OT or speech therapy, medical supplies, Oxygen, prescription drugs, medical social services, and home health aide visits for skilled nursing or therapy services, laboratory tests, home infusion therapy.	Covered	Yes	100	Visits per year		Excluded are dietician services, homemaker services, food or home delivered meals, Custodial Care, maintenance therapy, prenatal care, private duty nursing, personal comfort items. All Covered Services must be Medically Necessary unless otherwise specified.		No
Emergency Room Services	Yes	Emergency Room Services per the Prudent Layperson standard	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No

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Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No				Trips must be to the closest facility that can provide Covered Services appropriate for your condition. All Covered Services must be Medically Necessary unless otherwise specified.		No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Cosmetic Surgery	Yes	Cosmetic Surgery or reconstructive surgery to restore a body function or malformation caused by disease, trauma, birth defects, and growth defects, prior therapeutic processes such as mastectomy; or as a result of an act of family violence.	Covered	No				Surgery or other services primarily intended to improve appearance in the absence of disease; trauma or causes not defined as Reconstructive are excluded. All Covered Services must be Medically Necessary unless otherwise specified.		No
Skilled Nursing Facility	Yes	Providing inpatient services when authorized and based on a physician's Plan of Treatment and recertified every two weeks.	Covered	No				Custodial, ambulatory, rest or part-time care and pulmonary tuberculosis treatment is excluded; Benefits expire when the patient cannot present significant improvement. All Covered Services must be Medically Necessary unless otherwise specified.		No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care, including newborn care and circumcision.	Covered	No				Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care, when the newborn is added to coverage within 30 days of birth; Care for a covered newborn includes circumcision	Covered	No				Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No

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Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered, except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.	Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
Generic Drugs	Yes	Generic Drugs	Covered	No				Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days' supply corresponding to the amount of insulin dispensed.	No
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No				Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days' supply corresponding to the amount of insulin dispensed.	No

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Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No				Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days' supply corresponding to the amount of insulin dispensed.	No
Specialty Drugs	Yes	Specialty Drugs, generally understood to be drugs not covered under the pharmacy benefit but furnished on an outpatient basis such as infusion therapy and some injectable drugs.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services to treat Stroke, Spinal cord injury, Congenital deformity, Amputation, Major multiple traumas, Fracture of femur, brain injury, Polyarthritis, including rheumatoid arthritis, Neurological disorders, Cardiac disorders and Burns when there is a reasonable likelihood services will restore optimal physical, medical, psychological, social, emotional, vocational and economic status.	Covered	No				Excluded services are those associated with Mental conditions, chemical dependency, vocational rehabilitation, long term maintenance, custodial services. All Covered Services must be Medically Necessary unless otherwise specified.		Yes
Habilitation Services			Not Covered						This service is not defined by applicable State Code or in the Certificate of Coverage.	
Chiropractic Care	Yes	Chiropractic Care manipulations are considered same as Physical therapy	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No

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Durable Medical Equipment	Yes	Durable Medical Equipment purchase or rental at our option when prescribed by a provider practicing within the scope of their license, including orthotics, prosthetics.	Covered	No				Excluding dental appliances, elastic bandages, garter belts or similar supplies, orthopedic shoes, items not serving a medical purpose, items not able to withstand repeated use. All Covered Services must be Medically Necessary unless otherwise specified.		No
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work) when ordered by a physician or qualified provider operating within the scope of their license, includes pre-admission testing	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs) ordered by a physician or other qualified provider operating within the scope of their license	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/ Immunization to the extent mandated by State and Federal Code.	Covered	No						No
Routine Foot Care			Not Covered							
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 every 6 months			Supplemented using WV CHIP. Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No						No

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Rehabilitative Occupational and Rehabilitative Physical Therapy			Not Covered							
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
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 if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development.	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	Yes	150	Dollars per day for meal, transportation and lodging up to $10,000 for recipient and one additional adult (or 2 adults if patient is a minor)		All Covered Services must be Medically Necessary unless otherwise specified. Bone marrow procedures to treat T-Cell leukemia virus and AIDS are excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Transplant includes bone marrow procedures and human organ transplants including heart, heart/lung, lung, liver, and pancreas. Includes expenses of recipient, pre/post-operative care and immunosuppressant drugs. Coverage is provided for 4 listed types of bone marrow transplants for 5 listed covered diseases (page 28 of benefit booklet).	No
Accidental Dental			Not Covered							
Dialysis			Not Covered							
Allergy Testing	Yes	Allergy Testing	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.	Allergy tests and treatment; includes desensitization treatment	No
Chemotherapy			Not Covered							

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Radiation			Not Covered							
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices			Not Covered							
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	Yes	1	Item every 3 years (orthotics, splints and appliances)		Treatment to alter vertical dimension is excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Exam, DX, imaging, injections, PT and physiotherapy, Surgery when needed due to physical trauma or organic disease are COVERED.	No
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Mental Health Other	Yes(S)	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?
Abortion, elective and therapeutic	Yes	Abortion, elective and therapeutic	Covered	No				Partial Birth abortion.		No
Mental/Behavioral Health Outpatient Services	Yes	Applied Behavioral Analysis (ABA) for Autism	Covered	Yes	30000	Dollars per year for ABA therapy during first 3 years DX'd; $2000/month thereafter to age 18.		All Covered Services must be Medically Necessary unless otherwise specified.		No
Oral Surgery for boney tooth impaction	Yes	Oral Surgery for boney tooth impaction	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Sterilization surgery not subject to Medical Necessity	Yes	Sterilization surgery not subject to Medical Necessity	Covered	No				Reversal of sterilization is excluded.		No
Assistant at Surgery, A Physician's help to a surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.	Yes	Assistant at Surgery, A Physician's help to a surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.	Covered	No				All Covered Services must be Medically Necessary unless otherwise specified.		No
Outpatient Rehabilitation Services	Yes	Speech therapy	Covered	No				Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified.		No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Speech therapy	Covered	No				Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified.		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
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	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
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	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