HAWAII EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Hawaii Medical Service Association
Product Name	Preferred Provider Plan 2010
Plan Name	HMSA Preferred Provider Plan 2010
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

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Primary Care Visit to Treat an Injury or Illness. Covered, for an illness or injury, when you are inpatient or outpatient.	No						Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No
2	**Specialist Visit**	Covered	Primary Care Visit to Treat an Injury or Illness. Covered, for an illness or injury, when you are inpatient or outpatient.	No						Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Primary Care Visit to Treat an Injury or Illness. Covered, for an illness or injury, when you are inpatient or outpatient.	No						Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No

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4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility. Covered, including but not limited to Recovery and Treatment Rooms for Surgery and Ambulatory Surgery Center (ASC)	No							No
5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Cutting and Non-Cutting Surgery. Includes, but not limited to anesthesia, cutting surgery including preoperative and postoperative care; and non-cutting surgery.	No						Examples of non-cutting surgical procedures include diagnostic and endoscopic procedures; diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. Examples also include orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery; and acne treatment.	No
6	**Hospice Services**	Covered	Hospice. We follow Medicare guidelines to determine benefits, level of care and eligibility for hospice services.	No					You are not covered for hospice services provided by a hospice not under contract with us.	Also, we cover: Residential hospice room and board expenses directly related to the hospice care being provided, and Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Covered	Routine Dental Services covered under rider	No						Includes, but not limited to cleaning, exam, pulp vitality test, x-rays, restorative services, endodontic services, periodontic services, surgical services.	No

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9	**Infertility Treatment**	Covered	In Vitro Fertilization only. Coverage is limited to members who meet the following criteria: The in vitro fertilization is for you or your spouse. In vitro fertilization services are not covered when a surrogate is used; Either of the following two statements is true: You and your spouse have a history of infertility for at least five years; or The infertility is related to one or more of these medical conditions: endometriosis; exposure in utero to diethylstilbestrol (DES); blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility; You have been unable to attain a successful pregnancy through other covered infertility treatments; The in vitro procedures are performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.	Yes	1	Procedures per lifetime			Infertility Treatment. Except as described in Column C, you are not covered for services or supplies related to the treatment of infertility, including, but not limited to: Collection, storage and processing of semen; Cryopreservation of oocytes, semen and embryos; In vitro fertilization benefits when services of a surrogate are used; Cost of donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor semen; Ovum transplants; Gamete intrafallopian transfer (GIFT); Zygote intrafallopian transfer (ZIFT); Services related to conception by artificial means, including prescription drugs and supplies related to such services except as described Column C.	Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMSA member. If you receive benefits for in vitro fertilization benefits under an HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HMSA plan.	No
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									

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12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam (Adult). Covered under vision rider.	Yes	1	Visits per year					No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities. Covered, for an illness or injury.	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	150	Visits per year					No
15	**Emergency Room Services**	Covered	Emergency Services.	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance. Covered, for ground and intra-island or inter-island air ambulance services to the nearest; adequate hospital to treat your illness or injury.	No						Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii.	No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Hospital Room and Board; and Ancillary Services	No						Includes, but not limited to coverage for acute inpatient rehabilitation services.	No
18	**Inpatient Physician and Surgical Services**	Covered	Cutting and Non-cutting Surgery. Includes, but not limited to cutting surgery including preoperative and postoperative care; and non-cutting surgery.	No						Examples of non-cutting surgical procedures include diagnostic and endoscopic procedures; diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. Examples also include orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery; and acne treatment.	No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No							No
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility. Room and board is covered, but only for semi-private rooms.	Yes	120	Days per year				Services and supplies are covered, including routine surgical supplies, drugs, dressing, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.	No

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22	**Prenatal and Postnatal Care**	Covered	Maternity Care. Covered for physician services, including prenatal, false labor, delivery, and postnatal services.	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Maternity Care. Covered for maternity related services such as nursery care, labor room, hospital room and board, and ancillary services.	No							No
24	**Mental/ Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services. Covered in accordance with Federal Mental Health Parity for Hospital and Facility, and Physician services.	No						The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.	No
25	**Mental/ Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services. Covered in accordance with Federal Mental Health Parity for Hospital and Facility, and Physician services.	No							No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services. Coverage includes Hospital and Facility, and Physician services	No					You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.	The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services. Coverage includes Hospital and Facility, and Physician services	No					You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.		No

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28	**Generic Drugs**	Covered	Generic Drugs. Covered for A drug that is prescribed or dispensed under its commonly used generic name rather than a brand name.	No						Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs. Covered for Brand name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.	No						Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs. Covered for Brand name drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary.	No						Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
31	**Specialty Drugs**	Covered	Specialty Drugs. Covered for high cost drugs that are used to treat chronic, potentially life threatening diseases and are listed in the HMSA Select Prescription Drug Formulary	No							No
32	**Outpatient Rehabilitation Services**	Covered	Physical and Occupational Therapy; and Speech Therapy	No					Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.		No
33	**Habilitation Services**	Not Covered									
34	**Chiropractic Care**	Not Covered									
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment and Supplies.	No					Supplies and accessories necessary for the effective functioning of the equipment are covered subject to certain limitations and exclusions. Contact HMSA for details.	Durable medical equipment can be rented or purchased; however, certain items are covered only as rentals.	Yes
36	**Hearing Aids**	Covered	Hearing Aids.	Yes	1	Other other	1 Hearing aid per ear every 60 months		Fitting adjustment, repair and batteries are not covered.		No

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37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Testing.	No						Includes, but not limited to Allergy Testing, Diagnostic Colonoscopy, routine hearing exam, and Genetic Screening and Testing.	Yes
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Radiology.	No						Includes, but not limited to Nuclear Medicine.	No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/ Immunizations. Covered in accordance with the Affordable Care Act (ACA) and guidelines set by the Advisory Committee on Immunization Practices (ACIP).	No						Screening Services and Preventive Counseling. Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: Preventive Counseling Services; Screening Laboratory Services; Screening Radiology Services. Covered for recommended preventive services for women developed by Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA). Covered, including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care; Immunizations. Covered, for standard immunizations and immunizations for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory committee on Immunization Practices (ACIP).	Yes
40	**Routine Foot Care**	Not Covered								Routine foot care for diabetics is covered.	
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									

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43	**Routine Eye Exam for Children**	Covered	Routine Eye Exam for Children. Covered in accordance with Bright Futures Recommendations for Preventive Pediatric Health Care.	No							No
44	**Eye Glasses for Children**	Covered	Eye glasses for Children. Covered under Vision Rider.	Yes	1	Other other	Lenses limited to one pair per calendar year. Frames limited to one frame every 24 months.				No
45	**Dental Check-Up for Children**	Covered	Dental Check-up for Children. Covered under Dental Rider	Yes	2	Visits per year				Clinical oral exams.	No

OTHER BENEFITS

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1	**Other**	Covered	Reconstructive Surgery.	No					Complications of a non-covered cosmetic reconstructive surgery are not covered.	Covered, but only for corrective surgery required to restore, reconstruct or correct: Any bodily function that was lost, impaired, or damaged as a result of an illness or injury; Developmental abnormalities when present from birth and that severely impair or impede normal, essential bodily functions; The breast on which a mastectomy was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered.	No
2	**Other**	Covered	Cochlear Implants	No							No
3	**Other**	Covered	Transplants	No						Covered for Corneal, Kidney, Heart, Heart and Lung, Liver, Lung, Pancreas, Simultaneous Kidney/Pancreas, Small Bowel and Multivisceral, and Stem-Cell Transplants (including Bone Marrow transplants).	No
4	**Preventive Care/ Screening/ Immunization**	Covered	Services required by Affordable Care Act (ACA)	No						All services required by the Affordable Care Act is covered by this plan including, but not limited to: Routing Mammography Screening, HPV/Cervical Cancer Screening, Newborn Screening (other than hearing); Pediatric Hearing Screening; Colorectal Cancer screening; Depression Screening (Adolescents and Adults); Diagnostic Bone Mass Measurement/Density Testing; Screening Colonoscopy; Diabetes Screening; Screening for Sexually Transmitted Infections - HIV; Screening for Sexually Transmitted Infections - Other; Anemia Screening for Pregnant Women; Bacteriuria Urinary Tract Screening for Pregnant Women; Bacteriuria Urinary Tract Screening for Pregnant Women; BRCA Screening and Counseling About Genetic Testing; Folic Acid Supplements for Women Who May Become Pregnant; Hepatitis B Screening for Newly Pregnant Women; Smoking and Tobacco Cessation Counseling; Diabetes Education and Counseling; Diabetes Monitoring; Breastfeeding/Lactation Counseling; Nutritional Counseling; Genetic Counseling.	No
5	**Preventive Care/ Screening/ Immunization**	Covered	Prostate Cancer Screening	Yes	1	Procedures per year	Men age 50 or older				No

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6	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Allergy Testing	No							No
7	**Other**	Covered	Allergy Injections	No							No
8	**Durable Medical Equipment**	Covered	Orthotics & External Prosthetics	No						Orthotics are covered when prescribe by your treating provider to provide therapeutic support or restore function such as braces, orthopedic footwear, and shoe inserts. External prosthetics are covered when prescribed by your treating provider to replace absent or non-functioning parts of the human body with an artificial substitute such as artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.	No
9	**Other**	Covered	Blood & Blood Products	No						Includes, but not limited to plasma.	No
10	**Other**	Covered	Voluntary Sterilization	No						Includes, but not limited to tubal ligation and male vasectomy.	No
11	**Other**	Covered	Chemotherapy & Radiation Therapy	No							No
12	**Other**	Covered	Pulmonary Rehab	No							No
13	**Other**	Covered	IV/Infusion Therapy & Injectibles	No							No
14	**Other**	Covered	Hyperbaric Oxygen Therapy	No							No
15	**Other**	Covered	Dialysis & Supplies	No							No
16	**Other**	Covered	Oxygen	No							No
17	**Other**	Covered	HIV/AIDS Treatment	No						Refer to drug rider.	No
18	**Other**	Covered	Diabetes Education & Counseling	No							No
19	**Other**	Covered	Diagnosis & Treatment of Lymphadema	No							No
20	**Other**	Covered	Termination of Pregnancy	No							No
21	**Other**	Covered	Coverage for Certain Clinical Trials -in accordance with Medicare guidelines	No							No
22	**Other**	Covered	Medical Foods	No						To treat inborn errors of metabolism in accord with Hawaii Law and HMSA guidelines.	No
23	**Other**	Covered	Vision Benefits covered under Vision Rider	No							No
24	**Other**	Covered	Dental Benefits covered under Dental Rider	No							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	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	22
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	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
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	2
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	8
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
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	3
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	2
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
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	2
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	33
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
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	1
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	3
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	11
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
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	10
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
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	10
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	5
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