IOWA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Wellmark Inc.
Product Name	Alliance Select
Plan Name	Copyament Plus
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

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 Office Visit	No							No
2	**Specialist Visit**	Covered	Specialist Office Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Surgery and Ancillary Supplies/Services	No						Includes voluntary male sterilization, and abortion.	No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery and Physician/Surgical Services	No						Includes voluntary male sterilization, and abortion.	No
6	**Hospice Services**	Covered	Hospice Services	No							Yes
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)**	Not Covered	Routine Dental Services (Adult)								
9	**Infertility Treatment**	Covered	Infertility Treatment	No					Artificial insemination and in vitro fertilization; including forms of in vitro fertilization, or any treatment related to those procedures. Infertility treatment if the result of voluntary sterilization, collection or purchase of semen or oocytes, or reversal of tubal ligation or vasectomy.	Infertility treatment limited to diagnosis; benefits will end beginning on the day any non-covered procedures are received.	No

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10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Custodial Nursing Home Care							This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel therefore it is not a covered benefit.	
11	**Private-Duty Nursing**	Covered	Private Duty Nursing In the Home	No							No
12	**Routine Eye Exam (Adult)**	Not Covered	Routine Eye Exam (Adult)							Vision examination is only covered when related to an illness or injury.	
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No							No
14	**Home Health Care Services**	Covered	Home Health Services	No					Custodial home care.	In order for the care to be approved, it must be approved by a physician.	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No							Yes
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No						Includes voluntary male sterilization and abortion.	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No						Includes voluntary male sterilization and abortion.	No
19	**Bariatric Surgery**	Covered	Morbid Obesity Treatment	No					Weight reduction programs or supplies including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs.		No
20	**Cosmetic Surgery**	Not Covered	Cosmetic Services							Cosmetic services, supplies, or drugs, if provided primarily to improve physical appearance; including treatment for complications resulting from a non-covered cosmetic procedure.	
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	90	Days per year				90 days per benefit year in a hospital or nursing facility.	No

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22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No					Maternity services and newborn care if the mother is a surrogate mother.	Prenatal and postnatal care includes complications of pregnancy.	Yes
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care - Vaginal Delivery	No				48	Maternity services and newborn care if the mother is a surrogate mother.	Minimum maternity stay requirements of 48 hours for vaginal delivery unless attending provider and mother choose otherwise. Includes delivery and complications of pregnancy.	Yes
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	Yes	52	Visits per year	This limit is combined with Substance Abuse Disorder Outpatient Services.		Communication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services.	Treatment for certain psychiatric, psychological, or emotional conditions as an outpatient; includes schizophrenia, bipolar disorder, and autistic disorders.	No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	Yes	30	Days per year	This limit is combined with Substance Abuse Disorder Inpatient Services.		Communication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services.	Treatment for certain psychiatric, psychological, or emotional conditions as an outpatient; includes schizophrenia, bipolar disorder, and autistic disorders.	No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	52	Visits per year	This limit is combined with Mental/ Behavioral Health Outpatient Services.		Residential facility services.	Treatment for a condition with physical or psychological symptoms, produced by habitual use of certain drugs.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	30	Days per year	This limit is combined with Mental/ Behavioral Health Inpatient Services.		Residential facility services.	Treatment for a condition with physical or psychological symptoms, produced by habitual use of certain drugs.	No
28	**Generic Drugs**	Covered	Generic Drugs	No							No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No							No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No							No
31	**Specialty Drugs**	Covered	Specialty Drugs	No							No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	No						This includes cardiac rehabilitation.	Yes

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33	**Habilitation Services**	Covered	Habilitation Services	No					Therapies rendered primarily for job training and therapy services related to general conditioning of the patient. Any habilitation not related to developmental delay is not covered.	Habilitative services driven by congenital disorders/ developmental delays are covered.	No
34	**Chiropractic Care**	Covered	Chiropractic Care Office Services	No							No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					Orthotics, wigs or hair pieces, pools, whirlpools, spas, common first-aid supplies, and health club memberships.	Equipment that is primarily and customarily manufactured to serve a medical purpose including diabetic supplies and prosthetic limbs.	No
36	**Hearing Aids**	Not Covered	Hearing Aids								
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No					Genetic testing for purely informational purposes.	Tests, screenings, imagings, and evaluation procedures as medically necessary. Includes allergy testing and genetic testing in the following situations: The member is an appropriate candidate for a test under medically recognized standards, and the outcome of the test is expected to result in a covered course of treatment.	Yes
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/Immunization	No					Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.	Preventive care such as immunizations and medical evaluations related to nicotine dependence.	Yes
40	**Routine Foot Care**	Not Covered	Routine Foot Care								

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41	**Acupuncture**	Not Covered	Acupuncture								
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs								
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

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1	**Hospice Services**	Covered	Respite Care	Yes	5	Other	Hospice respite care must be used in increments of not more than 5 days at a time.			Short-term, temporary relief to those who are caring for family members	No
2	**Hospice Services**	Covered	Respite Care	Yes	15	Other	15 days per lifetime for inpatient and 15 days per lifetime for outpatient.			Short-term, temporary relief to those who are caring for family members	No
3	**Emergency Transportation/ Ambulance**	Covered	Professional Air Ambulance Transportation	No					Interfacility transport as a result of convenience to any party involved and deceased individuals who were pronounced dead at the scene.	Air ambulance transport service to the nearest hospital/nursing facility or from a current facility to another facility/hospital.	No
4	**Emergency Transportation/ Ambulance**	Covered	Professional Ground Ambulance Transportation	No					Transportation for convenience.	Professional ground ambulance transportation to a hospital or nursing facility if medically necessary.	No
5	**Prenatal and Postnatal Care**	Covered	Pregnancy testing when performed in physician's office	No							No
6	**Delivery and All Inpatient Services for Maternity Care**	Covered	Anesthesia for inpatient maternity care	No							No
7	**Delivery and All Inpatient Services for Maternity Care**	Covered	Newborn Nursery and Care	No							No
8	**Delivery and All Inpatient Services for Maternity Care**	Covered	Neonatal Intensive Care Unit	No							No
9	**Outpatient Rehabilitation Services**	Covered	Occupational Therapy	No					Occupational therapy supplies and occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.	Services to treat the upper extremities, which mean the arms from the shoulders to the finders.	No

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10	**Outpatient Rehabilitation Services**	Covered	Speech Therapy	No					Speech therapy services not provided by a licensed or certified Speech Pathologist. Speech therapy to treat certain developmental, learning, or communication disorders such as: stuttering and stammering.	Rehabilitative Speech Therapy services when related to a specific illness, injury, or impairment.	No
11	**Outpatient Rehabilitation Services**	Covered	Physical Therapy	No					Physical therapy as provided as an inpatient in the absence of a separate medical condition that requires hospitalization.		No
12	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Hearing Exams	No						Only in the case of an illness or injury.	No
13	**Preventive Care/ Screening/Immunization**	Covered	Preventive Physical Examination	Yes	1	Visits per year				Preventive gynecological exam is covered as part of preventive physical examination.	No
14	**Preventive Care/ Screening/Immunization**	Covered	Mammogram	Yes	1	Visits per year				Mammography benefits are covered once per year.	No
15	**Preventive Care/ Screening/Immunization**	Covered	Well-Child Care	No						AAP recommended schedule of well-child visits covered through age 6. Well-child care includes newborn care, physical examinations, development assessments, immunizations, and laboratory services.	No
16	**Preventive Care/ Screening/Immunization**	Covered	Contraceptives	No						Injected, implanted and devices are covered under health policy. Contraceptive drugs (oral) and contraceptive drug delivery devices like insertable rings and patches are covered under drug.	No
17	**Other**	Covered	Radiation Therapy	No						Use of radiation to treat or control a serious illness.	No
18	**Other**	Covered	Chemotherapy	No						Use of a chemical agent to treat or control a serious illness.	No
19	**Other**	Covered	Oral Chemotherapy Drugs	No							No

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20	**Other**	Covered	Outpatient Infusion Therapy	No							No
21	**Other**	Covered	Renal Dialysis/Hemodialysis	No						Covered as an inpatient in a hospital setting or in a Medicare approved dialysis center.	No
22	**Other**	Covered	Dental Services Resulting From Accident	Yes	12	Other	Care must be completed within 12 months of the injury.				No
23	**Other**	Covered	TMJ	No					Dental restorations/extractions, and orthodontic treatment related to TMJ.		No
24	**Other**	Covered	Organ Transplants	No					Expenses of transporting a living donor, expenses related to the purchase of any organ, services or supplies related to mechanical or non-human organs associated with transplants.	Includes certain bone marrow/stem cell transfers, heart, heart and lung, kidney, liver, lung, pancreas, and small bowel.	No
25	**Other**	Covered	Diabetes Education	Yes	10	Hours per year	10 hours per year in the first year and two hours follow-up annually.			Training and education for the self-management of all types of diabetes mellitus when the training or education is prescribed by a licensed physician and provided by a state-certified program.	No
26	**Other**	Covered	Reconstructive Breast Surgery	No						Reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses.	No
27	**Other**	Covered	Reconstructive Surgery	No						Primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect.	No

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28	**Other**	Covered	Dental Anesthesia	No						Dental anesthesia for children who are under age 14 or severely disabled/ developmentally disabled for services performed in a hospital or dental care office.	No
29	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care - Cesarean Section	No				96	Maternity services and newborn care if the mother is a surrogate mother.	Minimum maternity stay of 96 hours following a cesarean section unless attending provider and mother choose otherwise. Includes delivery and complications of pregnancy.	No
30	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
31	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
32	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply.	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	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	11
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
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	16
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	1
ANTIMYCOBACTERIALS	ANTITUBERCULARS	2
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	0
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	1
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	0
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	1
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	10
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
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	3
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	1
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	4
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
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	5
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
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	0
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	32
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	7
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
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	2
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	0
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	0
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	3
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	2
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	9
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	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	8
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	1
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	2
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	3
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4