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

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	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
2	**Specialist Visit**	Covered	Specialist Visit, including second surgical opinion, therapy modalities	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
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	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	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
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	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.	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

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5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services performed within the scope of the provider's license.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
6	**Hospice Services**	Covered	Hospice Services based on an approved treatment plan when life expectancy is 6 months or less.	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
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
8	**Routine Dental Services (Adult)**	Not Covered	Routine Dental Services (Adult).								
9	**Infertility Treatment**	Not Covered	Infertility Treatment.						Exclusions include services related to Cloning, reversal of sterilization, In-vitro fertilization, gamete intra fallopian transfer and other ova transfer procedures.		
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care.								
11	**Private-Duty Nursing**	Covered	Private-Duty Nursing.	Yes	5000	Other	$ per year		Inpatient services are available when a provider's regular nursing staff cannot provide them. Non-medical and Custodial services are excluded.		No
12	**Routine Eye Exam (Adult)**	Not Covered	Routine Eye Exam (Adult).								
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities per the Prudent Layperson standard.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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14	**Home Health Care Services**	Covered	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.	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
15	**Emergency Room Services**	Covered	Emergency Room Services per the Prudent Layperson standard	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	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
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
20	**Cosmetic Surgery**	Covered	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.	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

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21	**Skilled Nursing Facility**	Covered	Providing inpatient services when authorized and based on a physician's Plan of Treatment and recertified every two weeks.	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
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care, including newborn care and circumcision.	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
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	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	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
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	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.		Yes

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25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	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
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	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
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	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

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28	**Generic Drugs**	Covered	Generic Drugs	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
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	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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30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	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
31	**Specialty Drugs**	Covered	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.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
32	**Outpatient Rehabilitation Services**	Covered	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.	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

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33	**Habilitation Services**	Not Covered	Habilitation Services							This service is not defined by applicable State Code or in the Certificate of Coverage.	
34	**Chiropractic Care**	Covered	Chiropractic Care manipulations are considered same as Physical therapy	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment purchase or rental at our option when prescribed by a provider practicing within the scope of their license, including orthotics, prosthetics.	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
36	**Hearing Aids**	Not Covered	Hearing Aids								
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	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	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs) ordered by a physician or other qualified provider operating within the scope of their license	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/ Immunization to the extent mandated by State and Federal Code.	No							No
40	**Routine Foot Care**	Not Covered	Routine Foot Care								
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

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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	Every 6 months			Supplemented using WV CHIP. Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

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1	**Other**	Covered	Abortion, elective and therapeutic	No					Partial Birth abortion.		No
2	**Mental/Behavioral Health Outpatient Services**	Covered	Applied Behavioral Analysis (ABA) for Autism	Yes	30000	Other	Annual $30k limit 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
3	**Other**	Covered	Oral Surgery for boney tooth impaction	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
4	**Other**	Covered	Allergy tests and treatment; includes desensitization treatment	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
5	**Other**	Covered	Temporo and Cranio mandibular disorder treatment; "TMJ"	Yes	1	Other	Orthotics, splints and appliances are limited to one every 3 years.		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
6	**Other**	Covered	Clinical Trials Coverage	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
7	**Other**	Covered	Sterilization surgery not subject to Medical Necessity	No					Reversal of sterilization is excluded.		No
8	**Other**	Covered	Human Organ Transplants including Heart, Heart/lung, Lung, Liver, pancreas	Yes	150	Other	$150 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.	Includes expenses of recipient, pre/post-operative care and immunosuppressant drugs.	No
9	**Other**	Covered	Bone Marrow procedures	Yes	150	Other	$150 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).		Procedures to treat T-Cell leukemia virus and AIDS are excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Coverage is provided for 4 listed types of transplants for 5 listed covered diseases (page 28 of benefit booklet).	No

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10	**Other**	Covered	Assistant at Surgery, A Physician's help to a surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
11	**Other**	Covered	Diabetes Education & Control	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
12	**Outpatient Rehabilitation Services**	Covered	Speech therapy	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
13	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Speech therapy	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
14	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
15	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
16	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply. Covered only if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development.	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
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	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
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
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