WYOMING EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross Blue Shield of Wyoming
Product Name	Blue Choice Network
Plan Name	Blue Choice Business 1000 80 20
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • 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							No
2	**Specialist Visit**	Covered	Specialist Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No							Yes
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/ Surgical Services	No							Yes
6	**Hospice Services**	Covered	Hospice Services	No						Only covered through Case Management.	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									

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9	**Infertility Treatment**	Covered	Infertility Treatment	No					Benefits are not available for donor sperm for artificial insemination or extraordinary procedures to induce fertilization with technical assistance to include surrogate motherhood, gamete intrafallopian transfer, invitro fertilization, peritoneal oocyte and sperm transfer, tubal ovum transfer, artificial insemination, gestational carrier, and preimplantation genetic diagnosis testing.	Surgical and medical to repair or correct the condition causing infertility. Includes DXL, diagnostic, therapeutic, and infertility drugs.	No
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care								
11	**Private-Duty Nursing**	Covered	Private-Duty Nursing	No					Services rendered by a nurse who ordinarily resides in the Member's home or is a member of the Member's immediate family; Services that are provided on an inpatient basis and billed by a hospital; Services which are primarily non-medical in nature, such as bathing, personal grooming, exercising or the administration of medication which can usually be self-administered. Outpatient Private Duty Nursing.	Inpatient Private Duty Nursing is covered for private duty nursing services of an actively practicing Registered Nurse (R.N) when ordered by a physician and rendered within an institution.	No
12	**Routine Eye Exam (Adult)**	Not Covered									

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13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No					Benefits are not available for services which are primarily non-medical in nature such as bathing, personal grooming, exercising or the administration of medications which can usually be self-administered. Benefits are not available for dietician services, homemaker services, maintenance therapy, food, home delivered meals.	Benefits are available for home health care (HHC) services when rendered to a homebound patient by a home health agency on part-time basis, prescribed by a physician in absence of inpatient or nursing home facility care. Preauthorization of a physician's prescribed plan of treatment is required. The care must begin within 14 days after discharge from the hospital or a SNF. The care received must be directly related to the condition for which hospitalization was required.	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No						Benefits are available for medically necessary ambulance services from the home, an emergency site, between hospitals, between hospital to home, or between a hospital and nursing home facility. Includes both Ground and Air Ambulance Services.	No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					Benefits are NOT available for inpatient services rendered primarily for diagnostic examinations, physical therapy, rest cure, convalescent care, custodial or sanitaria care. Benefits are NOT available for inpatient care rendered primarily for the purpose of administering allergy, sensitivity, food challenge, or related testing, clinical ecology and vitamins or dietary nutritional supplements.	Cover semi private room only and special care unit. When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No						When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	Yes
19	**Bariatric Surgery**	Covered	Bariatric Surgery	Yes	1	Procedures per lifetime			Benefits are NOT available for the Garren gastric bubble technique relating to morbid obesity.		No
20	**Cosmetic Surgery**	Covered	Reconstructive/Cosmetic Surgery	No					No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No

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21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No						No benefits available except through Case Benefit Management.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No					Services related to surrogacy; maternity services for dependent daughters under their parents' contract.	Includes office visits, appropriate preventive services, and complications.	No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No					Services related to surrogacy; maternity services for dependent daughters under their parents' contract.	Includes vaginal delivery, caesarean section, abortions (medically necessary & elective), miscarriage, complications of pregnancy, circumcisions. Benefits are available for midwives if delivery takes place in a licensed facility. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	Yes	25	Visits per year			Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Cover 50% of charge or 50% of allowable, whichever is less. Contract coinsurance does not apply to this benefit. Claims will never be paid at 100%. Note: Visit limit is combined for psychiatric and substance abuse.	No

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25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	Yes	15	Days per year			Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Note: Visit limit is combined for psychiatric and substance abuse. This includes 15 institutional days and 15 professional visits. Partial Hospitalization is covered subject to the inpatient limit; reduces inpatient days by 1/2 (2 for 1). When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	25	Visits per year			Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Cover 50% of charge or 50% of allowable, whichever is less. Contract coinsurance does not apply to this benefit. Claims will never be paid at 100%. General history and physical exam is covered prior to admission to an OP substance abuse program. Note: Visit limit is combined for psychiatric and substance abuse.	No

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27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	15	Days per year			Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Note: Visit limit is combined for psychiatric and substance abuse. This includes 15 institutional days and 15 professional visits. Partial Hospitalization is covered subject to the inpatient limit; reduces inpatient days by 1/2 (2 for 1). When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	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	Yes	20	Visits per year			No coverage for hypnosis, cardiac rehabilitation, pulmonary rehabilitation, biofeedback, or pain treatment/therapy.	Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury.	Yes
33	**Habilitation Services**	Not Covered									
34	**Chiropractic Care**	Covered	Chiropractic Care/Spinal Manipulations	Yes	15	Visits per year					No

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35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					Benefits are not available for support devices for the foot, including flat foot conditions. There are no benefits for shoe inserts. Benefits are not available for deluxe motorized equipment, electronic speech aids; robotization devices, robotic prosthetics, dental appliances and artificial organs. Benefits are not available for personal hygiene and convenience items such as air conditioner, humidifiers or physical fitness equipment. Benefits are not available for wigs or artificial hairpieces, or hair transplants or implants, regardless of whether or not there is a medical reason for hair loss.	Includes but not limited to Diabetic supplies, therapeutic devices (e.g., hypodermic needles & syringes), oxygen, onsite and take-home medical/surgical supplies. Benefits are available for rental or purchase, initial fitting/adjustments, repair and replacement, used and refurbished equipment.	Yes
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-ray and Lab Work)	No					Benefits are not available for all forms of thermography for all uses and indicators.		No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No						When multiple MRI/MRT/MRA's are performed on the same day, benefits for the technical component will be limited to 50% of the maximum allowance for each MRI/MRT/MRA after the first.	Yes
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/Immunization	No					Only covered when services are rendered by a participating provider.	Preventive care benefits are covered as required under PPACA.	No
40	**Routine Foot Care**	Not Covered									
41	**Acupuncture**	Not Covered									

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42	**Weight Loss Programs**	Not Covered									
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	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Colonoscopy	Yes	1	Other	1 every 10 years at age 50 through 75				Yes
2	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Sigmoidoscopy	Yes	1	Other	1 every 5 years at age 50 through 75				Yes
3	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Voluntary Sterilization (Male and Female)	No					Reversals of sterilizations are not covered.		Yes
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Eye Refractive Surgery	No					Not covered when used in otherwise healthy eyes to replace eyeglasses or contact lenses.		Yes
5	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Reconstructive/Cosmetic Surgery	No					No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No
6	**Outpatient Surgery Physician/ Surgical Services**	Covered	Colonoscopy	Yes	1	Other	1 every 10 years at age 50 through 75				Yes
7	**Outpatient Surgery Physician/ Surgical Services**	Covered	Sigmoidoscopy	Yes	1	Other	1 every 5 years at age 50 through 75				Yes
8	**Outpatient Surgery Physician/ Surgical Services**	Covered	Voluntary Sterilization (Male and Female)	No					Reversals of sterilizations are not covered.		Yes

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9	**Outpatient Surgery Physician/ Surgical Services**	Covered	Eye Refractive Surgery	No					Not covered when used in otherwise healthy eyes to replace eyeglasses or contact lenses.		Yes
10	**Outpatient Surgery Physician/ Surgical Services**	Covered	Reconstructive/Cosmetic Surgery	No					No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No
11	**Hospice Services**	Covered	Bereavement Services	Yes	12	Other	Sessions per period of bereavement			Limited to $25 paid per session. Must be completed during the 12 months following the death of the terminally ill patient.	No
12	**Inpatient Physician and Surgical Services**	Covered	Voluntary Sterilization (Male and Female)	No					Reversals of sterilizations are not covered.		No
13	**Outpatient Rehabilitation Services**	Covered	Physical Therapy	Yes	40	Visits per year			No coverage for maintenance physical therapy.		Yes
14	**Outpatient Rehabilitation Services**	Covered	Speech Therapy	Yes	20	Visits per year				Not covered, except when related to rehabilitative care. Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury. Combined benefit limit with other rehabilitative care services (e.g., occupational therapy).	Yes
15	**Outpatient Rehabilitation Services**	Covered	Occupational Therapy	Yes	20	Visits per year				Not covered, except when related to rehabilitative care. Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury. Combined benefit limit with other rehabilitative care services (e.g., speech therapy).	No

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16	**Durable Medical Equipment**	Covered	Prosthetics/Orthotics	No						Covered when related to a covered medical condition. Orthopedic appliances which are rigid or semi-rigid support items only.	No
17	**Other**	Covered	Accidents	Yes	1500	Other	Dollars per member per calendar year for services within 90 days of the accident.			Includes accident related dental and TMJ.	No

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18	**Other**	Covered	Allergy Testing and Treatment	No					Benefits are not available for clinical ecology, orthomolecular therapy, vitamins, dietary nutritional supplements, or related testing rendered on an outpatient basis. Benefits are not available for the following allergy testing modalities: nasal challenge testing, provocative/neutralization testing, leukocyte; histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis; hypersensitivity syndrome testing, IgE level testing for food allergies; general volatile organic screening test and mauve urine test. Benefits are not available for the following methods of desensitization: provocation/neutralization therapy by sublingual (drops) intradermal and subcutaneous routes, urine autoinjections, repository emulsion therapy, candidiasis hypersensitivity syndrome treatment or IV vitamin C therapy.		No
19	**Other**	Covered	Anesthesia	No					Benefits are not available for acupuncture or hypnosis for anesthetic purposes.		No
20	**Other**	Covered	Hearing Exams/Testing	No						Covered for medical diagnosis when appropriate and necessary.	No

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21	**Other**	Covered	Blood, Blood Processing, Blood Substitutions and Derivatives	No					Benefits are not available for donated blood.		No
22	**Other**	Covered	Chemotherapy/Radiation	No							No
23	**Other**	Covered	Genetic Testing	No						Covered if within the guidelines of the medical policy.	No
24	**Other**	Covered	Dialysis/Hemodialysis	No							No
25	**Other**	Covered	Cochlear Implants	No						Covered if approved through Case Management.	No
26	**Other**	Covered	Prosthetics to include Breast Prosthesis	No					Benefits are not available for deluxe motorized equipment, electronic speech aids; robotization devices, robotic prosthetics, dental appliances and artificial organs.		No
27	**Other**	Covered	Diabetic Education Services	Yes	1	Other	Time Evaluation/3 Hours			Covered when billed by a participating provider.	No
28	**Other**	Covered	Outpatient Infusion Therapy	No						Only covered through Case Management.	No
29	**Other**	Covered	Inpatient Rehabilitation	Yes	45	Days per year				Covered for accidental or medical injury (e.g., stroke, spinal cord injury, closed or open head injury).	No
30	**Other**	Covered	IV Home Therapy/Enteral Nutrition	No						Only covered through Case Management.	No
31	**Other**	Covered	Organ Transplants	No					Transportation of the recipient to the location of the transplant surgery. Benefits are NOT available for small intestine, spleen transplantation or donor organs or tissue other than human donor organ or tissue. Covered but not limited to the following: liver, heart, heart-lung, kidney, pancreas, bone marrow and cornea transplant.	Includes evaluation, preparation & delivery of the donor organ; removal of the donor organ; transportation of the donor organ to the location of the transplant surgery; donor search costs.	No

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
32	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No			Pet Scans must be authorized by Medical Review				No
33	**Other**	Covered	Second Surgical Opinion	No						Benefits are available for second surgical opinion (voluntary) on covered elective surgery recommended by an eligible professional.	No
34	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
35	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
36	**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	10
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	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	11
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	20
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	3
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	5
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	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	20
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	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	15
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

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	0
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	20
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
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	13
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	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	4