VERMONT EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	The Vermont Health Plan, LLC
Product Name	CDHP-HMO
Plan Name	BlueCare, The Vermont Health Plan, LLC, CDHP
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							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							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No							Yes
6	**Hospice Services**	Covered	Hospice Services	No						Must meet hospice requirements for benefit eligibility.	Yes
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					Excluded UNLESS member qualifies for coverage due to sabbatical or attending college in a foreign country.		No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Not Covered								Refer to Infertility Drug limitation in Generic, Preferred and Non-Preferred Prescription Drug categories.	
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Covered	Private-Duty Nursing	Yes	2000	Other	Covered up to $2,000 per plan year			Requires prior approval and recertification of treatment plan every 60 days.	No

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12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam (Adult)	Yes	1	Other	1 routine eye exam per calendar year		Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.		No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No							No
15	**Emergency Room Services**	Covered	Emergency Room Services	No					Excludes benefits for an emergency room services that does not meet definition of Emergency Service.		Yes
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No					Insured's condition must meet the criteria for an emergency medical condition. Insured must get approval within 48 hours after emergency air or water transport.		No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	1	Other	Coverage for either day of admission OR day of discharge but not both.				No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	Yes	1	Other	May limit the number of visits covered by one Provider in a given day.				Yes
19	**Bariatric Surgery**	Covered	Bariatric Surgery	Yes	1	Other	Covered up to $10,000 per lifetime.				No
20	**Cosmetic Surgery**	Covered	Cosmetic Surgery	No					Cosmetic Surgery is an excluded benefit except for prior approval for reconstruction as detailed in certificate of coverage.		No

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21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No						Covered by participating facility only for Acute Care. Includes room, board, general nursing care, medication and drugs given by SNF during a covered stay and medical services included in the rates of a SNF.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No						See Maternity Office Visits and Inpatient Hospital Services for additional benefit information.	Yes
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No						Covered as an Inpatient Hospital Stay.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	No						Includes individual and group psychotherapy, family and couples therapy, intensive programs, partial hospital day treatment, psychological testing when integral to treatment, psychotherapy programs to improve compliance with prescribed medical treatment regimens for diabetes, hypertension, ischemic heart disease and emphysema.	Yes
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes hospitalization, residential treatment programs.	No

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26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No						Includes detoxification in outpatient rehab facility (including services for the patient's family when necessary).	Yes
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes detoxification in an inpatient rehabilitation facility.	No
28	**Generic Drugs**	Covered	Generic Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.				Yes
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
31	**Specialty Drugs**	Covered	Specialty Drugs	Yes	30	Other	Limited to a 30-day supply.		ONLY Participating Specialty pharmacies may be utilized for Specialty drugs.		Yes

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32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	30	Other	Up to 30 outpatient sessions combined per plan year.			Cardiac Rehabilitation is covered up to 36 visits per cardiac event. Typically include physical, occupational and speech therapy but may also include radiation therapy, chemotherapy, dialysis, infusion therapy.	Yes
33	**Habilitation Services**	Covered	Habilitation Services	No						Autism Coverage per Vermont State Mandate for ages zero to six years.	No
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	12	Other	Prior Approval is required after the 12th visit.			Prior approval required after 12 visits; includes treatment for neuromusculoskeletal conditions by a network provider working within the scope of their license.	No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No						Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, and devices. Threshold applies.	Yes
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No							No
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							No
40	**Routine Foot Care**	Covered	Routine Foot Care	No					Covered for Diabetics ONLY; excluded for all other members.		No
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	Yes	1	Other	1 routine eye exam per member per calendar year.		Does not cover the evaluation and fitting of contact lenses or other supplemental tests.		No
44	**Eye Glasses for Children**	Covered	Eye Glasses for Children	No						Refer to "Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery" on Other tab for more information.	No
45	**Dental Check-Up for Children**	Covered	Dental Check-Up for Children	Yes	2	Treatments per year					No

OTHER BENEFITS

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	**Other**	Covered	Nutritional Counseling	Yes	3	Visits per year	3 visits per plan year		Visits for treatment of diabetes do not count toward this visit limit.		No
2	**Outpatient Surgery Physician/ Surgical Services**	Covered	Neuropsychological Testing	Yes	8	Hours per year					No
3	**Hospice Services**	Covered	Home Health Aide	Yes	100	Hours per month				For personal care services only.	No
4	**Outpatient Rehabilitation Services**	Covered	Outpatient physical, speech and occupational therapy	Yes	30	Visits per year	Up to 30 outpatient sessions combined per plan year.			Covered up to 30 visits combined per plan year.	No
5	**Other**	Covered	Preventive Care	No						Includes routine physical examinations, immunizations, well-child care, screening mammogram, screening colonoscopy, preventive GYN.	No
6	**Other**	Covered	Dental Services (not Routine)	No						Includes treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started with six months of the accident; also includes surgery to correct gross deformity from major disease or surgery with service occurring within six months of the onset of disease or within six months of surgery.	No
7	**Inpatient Physician and Surgical Services**	Covered	Sterilization Reversal	Yes	1	Other	Procedures per lifetime			Covers only one attempt at reversal of sterilization.	No

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8	**Durable Medical Equipment**	Covered	Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery.	Yes	1	Other	1 set of accompanying eyeglasses or contact lenses for the original prescription and one set for each new prescription.				Yes
9	**Durable Medical Equipment**	Covered	Dental prosthetics	No					Repair or replacement of dental appliances or dental prosthetics.	With prior approval and only of required to treat an accidental injury (except injury as a result of chewing or biting); or to correct gross deformity resulting from major disease or Surgery; to treat obstructive sleep apnea; or to treat craniofacial disorders, including temporomandibular joint syndrome.	No
10	**Generic Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
11	**Preferred Brand Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
12	**Non-Preferred Brand Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
13	**Other**	Covered	Nutritional Formulae or supplements	Yes	2500	Other	Up to $2,500 per year for medical foods prescribed for the medically necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.				No
14	**Prenatal and Postnatal Care**	Covered	Maternity Office Visits	No						Includes coverage by a Physician or other Professional during a woman's pregnancy for pre-natal visits and other care and post-natal visits.	No
15	**Other**	Covered	Transplant Services - deceased donor	Yes	35000	Other	For transplants using a deceased donor, benefits are limited to $35,000 per solid organ transplant for search, removal, storage, and transportation of the organ.				No

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16	**Emergency Room Services**	Covered	Emergency room physician services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
17	**Emergency Room Services**	Covered	Emergency mental health and substance use physician and facility services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
18	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral health office visits	No							No
19	**Substance Abuse Disorder Outpatient Services**	Covered	Substance use disorder office visits	No							No
20	**Outpatient Rehabilitation Services**	Covered	Cardiac rehabilitation services	Yes	36	Other	36 visits per cardiac event; three supervised exercise sessions per week up to total of 36 sessions for cardiac and pulmonary rehab programs.				No
21	**Hospice Services**	Covered	Hospice Services Homemaker Services	Yes	100	Hours per month					No
22	**Hospice Services**	Covered	Hospice Continuous Care Services in Home	Yes	5	Days per admission	OR 120 hours of continuous care.			For in home care.	No
23	**Hospice Services**	Covered	Hospice Respite Care	Yes	72	Hours per month					No
24	**Hospice Services**	Covered	Hospice Social Services Visits	Yes	6	Visits per lifetime					No
25	**Hospice Services**	Covered	Hospice Bereavement visits	Yes	2	Visits per lifetime				Two bereavement visits following death.	No

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26	**Generic Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
27	**Preferred Brand Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
28	**Non-Preferred Brand Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
29	**Specialty Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
30	**Other**	Covered	Transplant Services - Live donor	Yes	65000	Other	For transplants using a live donor, benefits are limited to $65,000 for the live donor's surgical expenses and storage and transportation of the organ for each covered organ transplant procedure completed. Costs for a donor must be incurred within 120 days from the date of the donor's surgery.				No
31	**Other**	Covered	Transplant Recipient - Benefit Coverage Time Period	Yes	1	Other	From 30 days before the transplant to 365 days after the transplant for bone marrow transplants OR From five days before the transplant to 365 days after the transplant.				No
32	**Durable Medical Equipment**	Covered	Pre-fabricated knee braces	No					Custom-fabricated or custom-molded knee braces.		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	26
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	3
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	14
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	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4