HAWAII EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Hawaii Medical Service Association
Product Name	Preferred Provider Plan 2010
Plan Name	HMSA Preferred Provider Plan 2010
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Primary Care Visit to Treat an Injury or Illness	Covered	No					Covered, for an illness or injury, when you are inpatient or outpatient. Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No
Specialist Visit	Yes	Specialist Visit	Covered	No					Covered, for an illness or injury, when you are inpatient or outpatient. Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No					Covered, for an illness or injury, when you are inpatient or outpatient. Coverage includes, but not limited to family planning counseling services. A physician visit may be received in the physician's office, your home, or a facility setting (including, but not limited to: Inpatient visits; inpatient and outpatient surgery; Emergency room services, Laboratory services, diagnostic imaging, treat maternity as any other illness.)	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility	Covered	No					Covered, including but not limited to Recovery and Treatment Rooms for Surgery and Ambulatory Surgery Center (ASC)	No
Outpatient Surgery Physician/ Surgical Services	Yes	Cutting and Non-Cutting Surgery	Covered	No					Includes, but not limited to anesthesia, cutting surgery including preoperative and postoperative care; and non-cutting surgery. Examples of non-cutting surgical procedures include diagnostic and endoscopic procedures; diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. Examples also include orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery; and acne treatment.	No

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Hospice Services	Yes	Hospice	Covered	No				You are not covered for hospice services provided by a hospice not under contract with us.	We follow Medicare guidelines to determine benefits, level of care and eligibility for hospice services. Also, we cover: Residential hospice room and board expenses directly related to the hospice care being provided, and Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.	No
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No						No
Routine Dental Services (Adult)		Routine Dental Services covered under rider	Covered	No				Includes, but not limited to cleaning, exam, pulp vitality test, x-rays, restorative services, endodontic services, periodontic services, surgical services.		No
Infertility Treatment	Yes	In Vitro Fertilization only.	Covered	Yes	1	Procedure per lifetime		Coverage is limited to members who meet the following criteria: The in vitro fertilization is for you or your spouse. In vitro fertilization services are not covered when a surrogate is used; Either of the following two statements is true: You and your spouse have a history of infertility for at least five years; or The infertility is related to one or more of these medical conditions: endometriosis; exposure in utero to diethylstilbestrol (DES); blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility; You have been unable to attain a successful pregnancy through other covered infertility treatments; The in vitro procedures are performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization. Additionally, you are not covered for services or supplies related to the treatment of infertility, including, but not limited to: Collection, storage and processing of semen; Cryopreservation of oocytes, semen and embryos; In vitro fertilization benefits when services of a surrogate are used; Cost of donor-related services, including but not limited to collection, storage and processing of donor oocytes and donor semen; Ovum transplants; Gamete intrafallopian transfer (GIFT); Zygote intrafallopian transfer (ZIFT); Services related to conception by artificial means, including prescription drugs and supplies related to such services except as described Column C.	Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are an HMSA member. If you receive benefits for in vitro fertilization benefits under an HMSA plan, you will not be eligible for in vitro fertilization benefits under any other HMSA plan.	No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)		Routine Eye Exam (Adult). Covered under vision rider.	Covered	Yes	1	Visit per year				No
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No					Covered, for an illness or injury.	No
Home Health Care Services	Yes	Home Health Care Services	Covered	Yes	150	Visits per year				No
Emergency Room Services	Yes	Emergency Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No					Covered, for ground and intra-island or inter-island air ambulance services to the nearest; adequate hospital to treat your illness or injury. Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Hospital Room and Board; and Ancillary Services	Covered	No					Includes, but not limited to coverage for acute inpatient rehabilitation services.	No
Inpatient Physician and Surgical Services	Yes	Cutting and Non-cutting Surgery	Covered	No					Includes, but not limited to cutting surgery including preoperative and postoperative care; and non-cutting surgery. Examples of non-cutting surgical procedures include diagnostic and endoscopic procedures; diagnostic and therapeutic injections including catheters injections into joints, muscles, and tendons. Examples also include orthopedic castings; destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery; and acne treatment.	No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No						No
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	120	Days per year			Room and board is covered, but only for semi-private rooms. Services and supplies are covered, including routine surgical supplies, drugs, dressing, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.	No
Prenatal and Postnatal Care	Yes	Maternity Care	Covered	No					Covered for physician services, including prenatal, false labor, delivery, and postnatal services.	No
Delivery and All Inpatient Services for Maternity Care	Yes	Maternity Care	Covered	No					Covered for maternity related services such as nursery care, labor room, hospital room and board, and ancillary services.	No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Mental/ Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No					Covered in accordance with Federal Mental Health Parity for Hospital and Facility, and Physician services. The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.	No
Mental/ Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No					Covered in accordance with Federal Mental Health Parity for Hospital and Facility, and Physician services.	No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.	Coverage includes Hospital and Facility, and Physician services. The services are provided by a licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, licensed mental health counselor, or advanced practice registered nurse.	No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				You are not covered for detoxification services and educational programs to which drinking or drugged drivers are referred by the judicial system solely because you have been referred or services performed by mutual self-help groups.	Coverage includes Hospital and Facility, and Physician services.	No
Generic Drugs	Yes	Generic Drugs	Covered	No					Covered for A drug that is prescribed or dispensed under its commonly used generic name rather than a brand name. Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No					Covered for Brand name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary. Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No					Covered for Brand name drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary. Includes, but not limited to Smoking and Tobacco Cessation Prescription Drugs.	No
Specialty Drugs	Yes	Specialty Drugs	Covered	No					Covered for high cost drugs that are used to treat chronic, potentially life threatening diseases and are listed in the HMSA Select Prescription Drug Formulary.	No
Outpatient Rehabilitation Services	Yes	Physical and Occupational Therapy; and Speech Therapy	Covered	No				Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.		No
Habilitation Services	Yes	Habilitation Services	Covered	No						No
Chiropractic Care			Not Covered							
Durable Medical Equipment	Yes	Durable Medical Equipment and Supplies	Covered	No				Supplies and accessories necessary for the effective functioning of the equipment are covered subject to certain limitations and exclusions. Contact HMSA for details.	Durable medical equipment can be rented or purchased; however, certain items are covered only as rentals.	Yes

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Hearing Aids	Yes	Hearing Aids	Covered	Yes	1	Hearing aid per ear every 60 months		Fitting adjustment, repair and batteries are not covered.		No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Testing	Covered	No					Includes, but not limited to Allergy Testing, Diagnostic Colonoscopy, routine hearing exam, and Genetic Screening and Testing.	Yes
Imaging (CT/PET Scans, MRIs)	Yes	Radiology	Covered	No					Includes, but not limited to Nuclear Medicine.	No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/ Immunizations	Covered	No					Covered in accordance with the Affordable Care Act (ACA) and guidelines set by the Advisory Committee on Immunization Practices (ACIP). Screening Services and Preventive Counseling. Covered, for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as the following: Preventive Counseling Services; Screening Laboratory Services; Screening Radiology Services. Covered for recommended preventive services for women developed by Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA). Covered, including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care; Immunizations. Covered, for standard immunizations and immunizations for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory committee on Immunization Practices (ACIP).	Yes
Routine Foot Care			Not Covered						Routine foot care for diabetics is covered.	
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine Eye Exam for Children	Covered	No					Covered in accordance with Bright Futures Recommendations for Preventive Pediatric Health Care.	No
Eye Glasses for Children	Yes	Eye glasses for Children	Covered	Yes	1	Pair of lenses per calendar year. Frames limited to one every 2 years.			Covered under Vision Rider.	No
Dental Check-Up for Children	Yes	Dental Check-up for Children	Covered	Yes	2	Visits per year			Covered under Dental Rider. Clinical oral exams.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No						No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No						No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No						No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No						No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No						No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No					Covered for Corneal, Kidney, Heart, Heart and Lung, Liver, Lung, Pancreas, Simultaneous Kidney/Pancreas, Small Bowel and Multivisceral, and Stem-Cell Transplants (including Bone Marrow transplants).	No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis	Yes	Dialysis	Covered	No					Dialysis & Supplies	No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No					Diabetes Education & Counseling	No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No					Orthotics & External Prosthetics .Orthotics are covered when prescribe by your treating provider to provide therapeutic support or restore function such as braces, orthopedic footwear, and shoe inserts. External prosthetics are covered when prescribed by your treating provider to replace absent or non-functioning parts of the human body with an artificial substitute such as artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No					IV/Infusion Therapy & Injectables	No
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No				Complications of a non-covered cosmetic reconstructive surgery are not covered.	Covered, but only for corrective surgery required to restore, reconstruct or correct: Any bodily function that was lost, impaired, or damaged as a result of an illness or injury; Developmental abnormalities when present from birth and that severely impair or impede normal, essential bodily functions; The breast on which a mastectomy was performed, and surgery for the reconstruction of the other breast to produce a symmetrical appearance (including prostheses). Treatment for complications of mastectomy and reconstruction, including lymphedema, is also covered.	No
Cochlear Implants	Yes	Cochlear Implants	Covered	No						No
Services required by Affordable Care Act (ACA)	Yes	Services required by Affordable Care Act (ACA)	Covered	No					All services required by the Affordable Care Act is covered by this plan including, but not limited to: Routing Mammography Screening, HPV/Cervical Cancer Screening, Newborn Screening (other than hearing); Pediatric Hearing Screening; Colorectal Cancer screening; Depression Screening (Adolescents and Adults); Diagnostic Bone Mass Measurement/Density Testing; Screening Colonoscopy; Diabetes Screening; Screening for Sexually Transmitted Infections - HIV; Screening for Sexually Transmitted Infections - Other; Anemia Screening for Pregnant Women; Bacteriuria Urinary Tract Screening for Pregnant Women; Bacteriuria Urinary Tract Screening for Pregnant Women; BRCA Screening and Counseling About Genetic Testing; Folic Acid Supplements for Women Who May Become Pregnant; Hepatitis B Screening for Newly Pregnant Women; Smoking and Tobacco Cessation Counseling; Diabetes Education and Counseling; Diabetes Monitoring; Breastfeeding/Lactation Counseling; Nutritional Counseling; Genetic Counseling.	No
Prostate Cancer Screening	Yes	Prostate Cancer Screening	Covered	Yes	1	Procedures per year for men age 50 or older				No
Blood & Blood Products	Yes	Blood & Blood Products	Covered	No					Includes, but not limited to plasma.	No
Voluntary Sterilization	Yes	Voluntary Sterilization	Covered	No					Includes, but not limited to tubal ligation and male vasectomy.	No
Pulmonary Rehab	Yes	Pulmonary Rehab	Covered	No						No
Hyperbaric Oxygen Therapy	Yes	Hyperbaric Oxygen Therapy	Covered	No						No
Oxygen	Yes	Oxygen	Covered	No						No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
HIV/AIDS Treatment	Yes	HIV/AIDS Treatment	Covered	No					Refer to drug rider.	No
Diagnosis & Treatment of Lymphedema	Yes	Diagnosis & Treatment of Lymphedema	Covered	No						No
Termination of Pregnancy	Yes	Termination of Pregnancy	Covered	No						No
Coverage for Certain Clinical Trials -in accordance with Medicare guidelines	Yes	Coverage for Certain Clinical Trials -in accordance with Medicare guidelines	Covered	No						No
Medical Foods	Yes	Medical Foods	Covered	No					To treat inborn errors of metabolism in accord with Hawaii Law and HMSA guidelines.	No
Vision Benefits covered under Vision Rider	Yes	Vision Benefits covered under Vision Rider	Covered	No						No
Dental Benefits covered under Dental Rider	Yes	Dental Benefits covered under Dental Rider	Covered	No						No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	10
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	22
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	2
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	8
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	3
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	2
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	2
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	33
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	11
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	10
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	15
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	7