IOWA EHB BENCHMARK PLAN

SUMMARY INFORMATION

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

BENEFITS AND LIMITS

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 Office Visit	Covered	No						No
Specialist Visit	Yes	Specialist Office Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Surgery and Ancillary Supplies/Services	Covered	No					Includes voluntary male sterilization, and abortion.	No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery and Physician/Surgical Services	Covered	No					Includes voluntary male sterilization, and abortion.	No
Hospice Services	Yes	Hospice Services	Covered	Yes	5	Hospice respite care must be used in increments of not more than 5 days at a time, 15 days per lifetime for inpatient and 15 days per lifetime for outpatient.			Short-term, temporary relief to those who are caring for family members	Yes
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)			Not Covered							
Infertility Treatment	Yes	Infertility Treatment	Covered	No				Artificial insemination and in vitro fertilization; including forms of in vitro fertilization, or any treatment related to those procedures. Infertility treatment if the result of voluntary sterilization, collection or purchase of semen or oocytes, or reversal of tubal ligation or vasectomy.	Infertility treatment limited to diagnosis; benefits will end beginning on the day any non-covered procedures are received.	No
Long-Term/ Custodial Nursing Home Care			Not Covered						This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel therefore it is not a covered benefit.	

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Private-Duty Nursing	Yes	Private Duty Nursing In the Home	Covered	No						No
Routine Eye Exam (Adult)			Not Covered						Vision examination is only covered when related to an illness or injury.	
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No						No
Home Health Care Services	Yes	Home Health Services	Covered	No				Custodial home care.	In order for the care to be approved, it must be approved by a physician.	No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No				Professional Air Ambulance Transportation is excluded if interfacility transport as a result of convenience to any party involved and deceased individuals who were pronounced dead at the scene. Professional Ground Ambulance Transportation is excluded if transportation is for convenience.	Air ambulance transport service to the nearest hospital/nursing facility or from a current facility to another facility/hospital. Professional ground ambulance transportation to a hospital or nursing facility if medically necessary.	Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No					Includes voluntary male sterilization and abortion.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No					Includes voluntary male sterilization and abortion.	No
Bariatric Surgery	Yes	Morbid Obesity Treatment	Covered	No				Weight reduction programs or supplies including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs.		No
Cosmetic Surgery			Not Covered						Cosmetic services, supplies, or drugs, if provided primarily to improve physical appearance; including treatment for complications resulting from a non-covered cosmetic procedure.	
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	90	Days per year			90 days per benefit year in a hospital or nursing facility.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Maternity services and newborn care if the mother is a surrogate mother.	Prenatal and postnatal care includes complications of pregnancy, and pregnancy testing when performed in physician's office.	Yes
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care - Vaginal Delivery	Covered	No			48	Hours for maternity services and newborn care if the mother is a surrogate mother.	Delivery and All Inpatient Services for Maternity Care includes anesthesia for inpatient maternity care, newborn nursery and care, and Neonatal Intensive Care Unit. Minimum maternity stay requirements of 48 hours for vaginal delivery unless attending provider and mother choose otherwise. Includes delivery and complications of pregnancy. Minimum maternity stay of 96 hours following a cesarean section unless attending provider and mother choose otherwise. Includes delivery and complications of pregnancy.	Yes

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Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	Yes	52	Visits per year, this limit is combined with Substance Abuse Disorder Outpatient Services.		Communication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services.	Treatment for certain psychiatric, psychological, or emotional conditions as an outpatient; includes schizophrenia, bipolar disorder, and autistic disorders.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	Yes	30	Days per year, this limit is combined with Substance Abuse Disorder Inpatient Services.		Communication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services.	Treatment for certain psychiatric, psychological, or emotional conditions as an outpatient; includes schizophrenia, bipolar disorder, and autistic disorders.	No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	Yes	52	Visits per year, this limit is combined with Mental/ Behavioral Health Outpatient Services.		Residential facility services.	Treatment for a condition with physical or psychological symptoms, produced by habitual use of certain drugs.	No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	Yes	30	Days per year, this limit is combined with Mental/ Behavioral Health Inpatient Services.		Residential facility services.	Treatment for a condition with physical or psychological symptoms, produced by habitual use of certain drugs.	No
Generic Drugs	Yes	Generic Drugs	Covered	No						No
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No						No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No						No
Specialty Drugs	Yes	Specialty Drugs	Covered	No						No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	No				Occupational therapy supplies and occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization. Speech therapy services not provided by a licensed or certified Speech Pathologist. Speech therapy to treat certain developmental, learning, or communication disorders such as: stuttering and stammering. Physical therapy as provided as an inpatient in the absence of a separate medical condition that requires hospitalization.	This includes cardiac rehabilitation. Services to treat the upper extremities, which mean the arms from the shoulders to the finders. Rehabilitative Speech Therapy services when related to a specific illness, injury, or impairment.	Yes

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Habilitation Services	Yes	Habilitation Services	Covered	No				Therapies rendered primarily for job training and therapy services related to general conditioning of the patient. Any habilitation not related to developmental delay is not covered.	Habilitative services driven by congenital disorders/ developmental delays are covered.	No
Chiropractic Care	Yes	Chiropractic Care Office Services	Covered	No						No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No				Orthotics, wigs or hair pieces, pools, whirlpools, spas, common first-aid supplies, and health club memberships.	Equipment that is primarily and customarily manufactured to serve a medical purpose including diabetic supplies and prosthetic limbs.	No
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No				Genetic testing for purely informational purposes.	Tests, screenings, imagings, and evaluation procedures as medically necessary. Includes allergy testing and genetic testing in the following situations: The member is an appropriate candidate for a test under medically recognized standards, and the outcome of the test is expected to result in a covered course of treatment. Includes hearing exams only in the case of an illness or injury.	Yes
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/Immunization	Covered	No				Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.	Preventive care such as immunizations and medical evaluations related to nicotine dependence.	Yes
Routine Foot Care			Not Covered							
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	Eyeglasses for children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No
Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit every 6 months			Limitations, including dollar limits, may apply.	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
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

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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						Limitations, including dollar limits, may apply.	
Orthodontia - Adult			Not Covered						Limitations, including dollar limits, may apply.	
Major Dental Care – Adult			Not Covered						Limitations, including dollar limits, may apply.	
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No				Expenses of transporting a living donor, expenses related to the purchase of any organ, services or supplies related to mechanical or non-human organs associated with transplants.	Includes certain bone marrow/stem cell transfers, heart, heart and lung, kidney, liver, lung, pancreas, and small bowel.	No
Accidental Dental	Yes	Accidental Dental	Covered	No					Care must be completed within 12 months of the injury.	No
Dialysis	Yes	Dialysis	Covered	No					Dialysis includes renal dialysis and hemodialysis. Covered as an inpatient in a hospital setting or in a Medicare approved dialysis center.	No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No					Use of a chemical agent to treat or control a serious illness.	No
Radiation	Yes	Radiation	Covered	No					Use of radiation to treat or control a serious illness.	No
Diabetes Education	Yes	Diabetes Education	Covered	No					10 hours per year in the first year and two hours follow-up annually. Training and education for the self-management of all types of diabetes mellitus when the training or education is prescribed by a licensed physician and provided by a state-certified program.	No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy	Yes	Infusion Therapy	Covered	No					Infusion Therapy includes outpatient infusion therapy.	No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No				Dental restorations/extractions, and orthodontic treatment related to TMJ.		No
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No

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Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No					Reconstructive Surgery includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses. Primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect.	No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No					Dental anesthesia for children who are under age 14 or severely disabled/ developmentally disabled for services performed in a hospital or dental care office.	No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Autism Spectrum Disorders	Yes[(S)]	Autism Spectrum Disorders	Covered	No					Coverage is provided for autistic disorders for small group plans covering mental illness or substance abuse.	No

OTHER BENEFITS

Benefit Information			General Information							
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Preventive Care/ Screening/Immunization	Yes	Preventive Physical Examination	Covered	Yes	1	Visit per year			Preventive gynecological exam is covered as part of preventive physical examination.	No
Preventive Care/ Screening/Immunization	Yes	Mammogram	Covered	Yes	1	Visit per year			Mammography benefits are covered once per year.	No
Preventive Care/ Screening/Immunization	Yes	Well-Child Care	Covered	No					AAP recommended schedule of well-child visits covered through age 6. Well-child care includes newborn care, physical examinations, development assessments, immunizations, and laboratory services.	No
Preventive Care/ Screening/Immunization	Yes	Contraceptives	Covered	No					Injected, implanted and devices are covered under health policy. Contraceptive drugs (oral) and contraceptive drug delivery devices like insertable rings and patches are covered under drug.	No
Oral Chemotherapy Drugs	Yes	Oral Chemotherapy Drugs	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	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	11
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	16
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

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

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	1
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	4
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	5
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	0
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	32
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	7

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

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	9
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	8
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	1
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	2
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	3
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4