RHODE ISLAND EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross & Blue Shield of Rhode Island
Product Name	Vantage Blue
Plan Name	Vantage Blue BCBSRI
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)	Yes: Habilitative services must be comprehensive and measured as per member per month cost of rehabilitation serviced covered under the plan. Issuer will be required to attach filing as an Exhibit that identifies the habilitative services covered by the plan; includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered; and, includes in the actuarial memo the calculation and analysis used to develop the identified cost. All should happen no later than 90 days after the end of each calendar year. Issuer must also file with OHIC an actuarial memo, using the best available claims data and compare such claims and expense experience with the approved rate factor.

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 Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visits	Covered	No					Other practitioner office visits include nutritional counseling, asthma education, and diabetes management. Nutritional counseling is covered when prescribed by a physician for treatment of illness.	Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Surgery Facility Fee (e.g. Ambulatory Surgery Center)	Covered	No					Outpatient facility fee (e.g., ambulatory surgery center) includes reconstructive surgery to treat functional deformity or impairment, abortion, and surgical sterilization. Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease.	Yes
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician Services	Covered	No					Outpatient surgery physician/surgical services include reconstructive surgery to treat functional deformity or impairment, abortion, and surgical sterilization. Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease.	Yes
Hospice Services	Yes	Hospice Services	Covered	No					Covered when provided by an approved hospice care program.	No
Non-Emergency Care When Traveling Outside the U.S.		Care when Traveling Outside the U.S.	Covered	No						No
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment	Yes	Infertility Treatment	Covered	No				Infertility treatment for a person that previously had a voluntary sterilization procedure is not covered.	Infertility treatment includes assistive reproductive technologies such as invitro fertilization. Coverage is provided when the member is married, unable to conceive or sustain a pregnancy during a one year period and a presumably healthy individual.	Yes
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing	Yes	Private-Duty Nursing	Covered	No					Covered when received in your home when medically necessary, ordered by a physician and performed by a certified home health care agency.	No
Routine Eye Exam (Adult)		Routine Eye Exam	Covered	Yes	1	Visit per year				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?
Urgent Care Centers or Facilities	Yes	Urgent Care Center Visits	Covered	No						No
Home Health Care Services	Yes	Home Health Care Services	Covered	No						No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Ambulance (ground transportation)	Covered	No				This plan does not provide coverage for transportation to a physician's office.	Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No					Inpatient physician and surgical services include reconstructive surgery to treat functional deformity or impairment and surgical sterilization. Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease. Includes mastectomy services.	Yes
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No						No
Cosmetic Surgery			Not Covered						This plan does not cover cosmetic procedures when performed primarily to refine or reshape body structures that are not functionally impaired; to improve appearance or self-esteem or for other psychological, psychiatric or emotional reasons.	
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	No				Custodial Care is not covered.		No
Prenatal and Postnatal Care	Yes	Pregnancy Services and Nursery Care	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and Inpatient Maternity Care	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				This plan does not cover recreation therapy, non-medical self-care, or self-help training, mental health residential treatment programs (including eating disorder residential treatment programs), telephone consultations, therapeutic reaction programs or wilderness programs, behavioral training assessment, education or exercise, including applied behavioral analysis.		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 Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				This plan does not cover recreation therapy, non-medical self-care, or self-help training, mental health residential treatment programs (including eating disorder residential treatment programs), telephone consultations, therapeutic reaction programs or wilderness programs, behavioral training assessment, education or exercise, including applied behavioral analysis.		No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				This plan does not cover methadone clinics and treatments.		No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				This plan does not cover methadone clinics and treatments.		No
Generic Drugs	Yes	Tier 1 lower costs Generic Drugs	Covered	No						No
Preferred Brand Drugs	Yes	Tier 2 Preferred Brand Drugs and high cost Generic Drugs.	Covered	No						No
Non-Preferred Brand Drugs	Yes	Tier 3 Non-Preferred Brand Drugs	Covered	No						No
Specialty Drugs	Yes	Tier 4 Specialty Drugs	Covered	No						No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services including Physical Therapy, Occupational Therapy and Speech Therapy	Covered	No				Maintenance Therapy is not covered.	Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Habilitation Services	Yes	Outpatient Habilitation Services including Physical Therapy, Occupational Therapy and Speech Therapy	Covered	No				Maintenance Therapy is not covered.		Yes
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	12	Visits per year		This plan does not cover massage therapy, aqua therapy, maintenance therapy or aromatherapy, pillows, therapies for the purpose of relieving stress or chiropractic services in the home.		No
Durable Medical Equipment	Yes	Durable Medical Equipment, and Medical Supplies	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	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 (age 19 and older)	Covered	Yes	700	Dollar maximum per ear, per 3 year period, per member age 19 and over			Quantitative limit units apply, see EHB benchmark plan documents. For an eligible person age 19 and over; coverage is limited to the maximum benefit of $700 per ear, per 3 year period, per member. For eligible person under age 19 see "Hearing Aids (Hearing Aids (ages 19 and under)" on Other Tab.	Yes
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No
Routine Foot Care	Yes	Routine Foot Care to treat a systemic condition	Covered	No				Routine foot care is not covered unless to treat a systemic condition.	Routine Foot Care is covered only when performed to treat diabetic related nerve and circulation disorders of the feet.	No
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	Eye Glasses 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			Covered at 100% if the services were provided In Network and at 90% if they were Out of Network subject to the annual $10,000 maximum.	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
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

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?
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						No
Accidental Dental			Not Covered							
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing			Not Covered							
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	Yes	350	Dollars per year			For diabetics only	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	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
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Early Intervention Services	Yes	Early Intervention Services	Covered	No						No
Transplant Surgery - Donor Charges	Yes	Transplant Surgery - Donor Charges	Covered	No						No
Wigs	Yes	Wigs	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?
Durable Medical Equipment	Yes	Enteral Formula or food taken orally	Covered	Yes	2500	Dollar maximum per member per contract year				No
Durable Medical Equipment	Yes	Enteral Formula delivered through a feeding tube	Covered	No					Covered when it is the sole source of nutrition.	No
Outpatient Rehabilitation Services	Yes	Cardiac Rehabilitation	Covered	Yes	18	Weeks (or 36 visits, whichever occurs first) per covered episode				No
Emergency Transportation/ Ambulance	Yes	Air/water Ambulance	Covered	Yes	3000	Dollar maximum per occurrence		This plan does not cover air or water ambulance transportation unless the destination is an acute care hospital or transport from cruise ships when not in US waters.		No
Durable Medical Equipment	Yes	Wigs	Covered	Yes	350	Dollar maximum per calendar year (combined for in and out of network)				No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Physical Rehabilitation	Covered	Yes	45	Days per year				No
Hearing Aids	Yes	Hearing Aids (ages 19 and under)	Covered	Yes	1500	Dollar maximum per ear, per 3 year period, per eligible member under the age of 19				No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Reconstructive Surgery to Treat Functional Deformity or Impairment	Covered	No					Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease. Includes mastectomy services.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Surgical Sterilization	Covered	No						No
Smoking Cessation	Yes	Smoking Cessation	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	9
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	17
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	4
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	27
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	4
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	2
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	8
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	2
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	4
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	4
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	10
ANTIVIRALS	ANTIHERPETIC AGENTS	6
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	20
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
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	7
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	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
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	3
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	2
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	4
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	14

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	2
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	22
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	5
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	13
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	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	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3
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	12