

## MONTANA EHB BENCHMARK PLAN

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### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Preferred Provider Organization
<b>Issuer Name</b>	Blue Cross and Blue Shield of Montana
<b>Product Name</b>	Blue Dimensions
<b>Plan Name</b>	Blue Dimensions
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"> <li>• Pediatric Oral (FEDVIP)</li> <li>• Pediatric Vision (FEDVIP)</li> </ul>
<b>Habilitative Services</b> <b>Included Benchmark</b> (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 visit to treat an injury or illness.	Covered	No						No
Specialist Visit	Yes	Specialist visit to treat an injury or illness.	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Primary Care visit to treat an injury or illness	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility and Ambulatory Surgery Center services for illness and injuries. Services of a surgical facility or freestanding facility (surgery centers).	Covered	No				Reconstructive surgery for cosmetic purposes (improve appearance), reconstructive cosmetic procedures.		No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician and Surgery Center services for illness and injuries. Services by a professional provider	Covered	No				Reconstructive surgery for cosmetic purposes (improve appearance), reconstructive cosmetic procedures.		No
Hospice Services	Yes	Hospice Services - Inpatient and outpatient care, home care, skilled nursing, counseling and other support services	Covered	No				Services that do not require skilled nursing care, including custodial care or care for the convenience of the patient or family member.		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)			Not Covered							
Infertility Treatment	Yes	Infertility Treatment	Covered	No				Invitro fertilization.	Infertility Treatment includes services to diagnose infertility, services related to artificial insemination, medical care needed to correct an underlying cause of infertility.	No

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Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care visit to treat and Injury or Illness	Covered	No						No
Home Health Care Services	Yes	Home health care services	Covered	Yes	180	Visits per year		Maintenance or custodial care visits; domestic or housekeeping services; "Meals on Wheels" or similar food.	Home Health Care Services prescribed and supervised by the attending physician provided in the member's home by a licensed Home Health Agency and are part of the member's treatment plan. Services include: nursing services; home health aide services; hospice services; physical, occupational and speech therapy; medical social worker; medical supplies and equipment suitable for use in the home; medically necessary personal hygiene, grooming and dietary assistance.	No
Emergency Room Services	Yes	Emergency Room Services for the treatment of accidental injury and emergency services.	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation or Ambulance	Covered	No					Provided by a licensed ambulance and required for an emergency medical condition to the nearest hospital with appropriate facilities.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services for illness and injuries.	Covered	Yes	365	Days per year		Does not include the following: a nursing home; a rest home; hospice; a rehabilitation facility; a skilled nursing facility; a convalescent home; a long-term, chronic-care institution or facility providing the type of care listed above.	Includes room and board accommodations and miscellaneous hospital services including: laboratory procedures; operating room, delivery room, recovery room; anesthetic supplies; surgical supplies; oxygen and use of equipment for its administration; x-ray, intravenous injections and setup; special diets; respiratory therapy, chemotherapy, radiation therapy, dialysis and physical therapy, speech therapy and occupational therapy.	No
Inpatient Physician and Surgical Services	Yes	Inpatient physician and surgical services for illness or injury.	Covered	No						No
Bariatric Surgery			Not Covered							
Cosmetic Surgery	Yes	Cosmetic surgery	Covered	No					Cosmetic services when provided to correct a condition resulting from an accident, a condition resulting from an injury or to treat a congenital anomaly.	No
Skilled Nursing Facility	Yes	Skilled Nursing Facility or Convalescent Home Services	Covered	Yes	60	Days per year		Custodial care.	Services of a Skilled Nursing facility as an alternative to Hospital Inpatient Care.	No

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<b>Prenatal and Postnatal Care</b>	Yes	Prenatal and postnatal care	Covered	No						No	
<b>Delivery and All Inpatient Services for Maternity Care</b>	Yes	Delivery and all inpatient services for maternity care	Covered	No					Delivery of one or more newborns. Includes the initial care of a newborn at birth provided by a physician; standby care provided by a pediatrician at a cesarean section and Nursery care (hospital nursery care of newborn infants).	No	
<b>Mental/Behavioral Health Outpatient Services</b>	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				Marriage counseling, hypnotherapy and services given by a staff member of a school or halfway house.	The care and treatment of mental illness provided by a hospital; a physician or prescribed by a physician; a mental health treatment center; a chemical dependency treatment center; a psychologist, a licensed social worker; a licensed professional addiction counselor or a licensed psychiatrist. Outpatient benefits must be provided to diagnose and treat recognized mental illness and treatment must be reasonably expected to improve and restore the level of functioning that has been affected by the mental illness.	No	
<b>Mental/Behavioral Health Inpatient Services</b>	Yes	Mental/Behavioral Health Inpatient Services	Covered	No					Care must be provided in or by a hospital; a freestanding inpatient facility or a physician. Medically monitored and medically managed intensive inpatient care and clinically managed high-intensity residential services are covered. Partial Hospitalization services must be provided by a hospital, a freestanding inpatient facility or a physician.	No	
<b>Substance Abuse Disorder Outpatient Services</b>	Yes	Substance Abuse Disorder Outpatient Services - Chemical Dependency	Covered	No				Marriage counseling, hypnotherapy and services given by a staff member of a school or halfway house.	The care and treatment for Chemical Dependency provided by a hospital; a mental health treatment center; a chemical dependency treatment center; a physician or prescribed by a physician; a psychologist; a licensed social worker; a licensed professional counselor, or an addiction counselor licensed by the state or a licensed psychiatrist. Outpatient services must be provided to diagnose and treat a recognized chemical dependency and treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the chemical dependency.	No	
<b>Substance Abuse Disorder Inpatient Services</b>	Yes	Substance Abuse Disorder Inpatient Services – Chemical Dependency	Covered	No					Care must be provided in or by: a hospital; a freestanding inpatient facility or a physician. Medically monitored and medically managed intensive inpatient care services and clinically managed high-intensity residential services are covered.	No	
<b>Generic Drugs</b>	Yes	Generic Drugs	Covered	No						No	
<b>Preferred Brand Drugs</b>	Yes	Preferred Brand Drugs	Covered	No						No	
<b>Non-Preferred Brand Drugs</b>	Yes	Non-Preferred Brand Drugs	Covered	No						No	
<b>Specialty Drugs</b>	Yes	Specialty Drugs	Covered	No						No	

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<b>Outpatient Rehabilitation Services</b>	Yes	Outpatient Rehabilitation Services	Covered	No					Services provided for: physical therapy; speech therapy; cardiac therapy and occupational therapy.	No
<b>Habilitation Services</b>	Yes	Habilitation Services	Covered	Yes	50000	Dollars for ABA services for members 0 through 8 years of age and 20,000 dollars for ABA services for members 9 through 18 years of age		Custodial care, diagnostic admissions, maintenance, nonmedical self-help or vocational educational therapy, social or cultural rehabilitation, learning and developmental disabilities and visual, speech or auditory disorders because of learning and developmental disabilities.	A specialized, intense and comprehensive program of therapies and treatment services, including but not limited to physical, occupational and speech therapy, provided by a multidisciplinary team for treatment of an injury or physical deficit. A Rehabilitation Therapy program is provided by a rehabilitation facility in an inpatient care or outpatient setting; provided under the direction of a qualified physician and according to a formal written treatment plan with specific goals; designed to restore the patient's maximum function and independence; and medically necessary to improve or restore bodily function and the member must continue to show measurable progress. For Autism Spectrum Disorders (autistic disorder, Asperger's Disorder, Pervasive Developmental Disorder) covered services include: habilitative or rehabilitative care, including, but not limited to professional, counseling and guidance services and treatment programs; Applied Behavioral Analysis (ABA): discrete trail training, pivotal response training, intensive intervention programs and early intensive behavioral intervention; medications; psychiatric or psychological care; and therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.	No
<b>Chiropractic Care</b>	Yes	Chiropractic care including spinal manipulations	Covered	Yes	10	Visits per year; \$600 maximum per benefit period for treatments; \$100 maximum for office visit x-rays.				No
<b>Durable Medical Equipment</b>	Yes	Durable Medical Equipment	Covered	No				Exclusions include exercise equipment; car lifts or stair lifts; whirlpool baths, hot tubs, saunas, - waterbeds; computerized or deluxe equipment; computer-assisted communication devices; durable medical equipment required primarily for use in athletics; replacement of lost or stolen durable medical equipment; repair or rental equipment; deluxe equipment and duplicate equipment purchased primarily as a convenience.	Includes appropriate equipment used for therapeutic purposes where the member resides. The equipment must be able to withstand repeated use; primarily used to serve a medical purpose rather than for comfort or convenience; generally not useful to a personal who is not ill or injured and prescribed by a physician. One insulin pump each warranty period.	No
<b>Hearing Aids</b>			Not Covered							

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<b>Diagnostic Test (X-Ray and Lab Work)</b>	Yes	Diagnostic Test (X-Ray and Lab work)	Covered	No					Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures.	No	
<b>Imaging (CT/PET Scans, MRIs)</b>	Yes	Imaging (CT/PET Scans, MRI's)	Covered	No					Diagnostic x-ray and imaging. Tests include Computerized tomography scan (CT scan), MRI's, Ultrasound.	No	
<b>Preventive Care/ Screening/ Immunization</b>	Yes	Preventive Care/ Screening/ Immunization	Covered	Yes	1	Purchase of one breast pump per birth event			Preventive Health Care services include, but are not limited to: services that have an "A" or "B" rating in the United States Preventive Services Task Force's current recommendations; immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women; and current recommendation of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to November 2009. As of 8/1/2012 Women's Preventive as outlined by ACA.	No	
<b>Routine Foot Care</b>	Yes	Routine Foot Care	Covered	No						No	
<b>Acupuncture</b>			Not Covered								
<b>Weight Loss Programs</b>	Yes	Weight Loss Programs	Covered	No						No	
<b>Routine Eye Exam for Children</b>	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No	
<b>Eye Glasses for Children</b>	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No	
<b>Dental Check-Up for Children</b>	Yes	Dental Exams	Covered	Yes	1	Visit per 6 months			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	
<b>Rehabilitative Speech Therapy</b>	Yes	Rehabilitative Speech Therapy	Covered	No						No	
<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No						No	
<b>Well Baby Visits and Care</b>	Yes	Well Baby Visits and Care	Covered	No						No	
<b>Laboratory Outpatient and Professional Services</b>	Yes	Laboratory Outpatient and Professional Services	Covered	No						No	
<b>X-rays and Diagnostic Imaging</b>	Yes	X-rays and Diagnostic Imaging	Covered	No						No	
<b>Basic Dental Care - Child</b>	Yes	Basic Dental Care – Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No	

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Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Major Dental Care - Child	Yes	Major Dental Care – Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	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				Exclusions include: experimental or investigational procedures, transplants of a nonhuman organ or artificial organ implant and donor searches.	Organ Transplant. Includes heart, heart/lung, single lung/double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplant.	No
Accidental Dental	Yes	Accidental Dental	Covered	No				Exclusions include: orthodontics, dentofacial orthopedics or related appliances even if related to the accident. Services for the repair of teeth which are damaged as the result of biting and chewing.	Dental Services Resulting from an Accident. Medically necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an accident.	No
Dialysis	Yes	Dialysis	Covered	No					Dialysis includes renal dialysis and hemodialysis.	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						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No				Nonsurgical treatment for malocclusion of the jaw, including services for TMJ, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances.		No
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Diabetes Care Management	Yes <sup>(5)</sup>	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Mental Health Other	Yes	Mental Health Other	Covered	No						No

## OTHER BENEFITS

Benefit Information			General Information							
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Dental Surgery	Yes	Dental Surgery	Covered	No						No
Dental Services Resulting from an Accident. Medically necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an accident.	Yes	Dental Services Resulting from an Accident. Medically necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an accident.	Covered	No				Exclusions include: orthodontics, dentofacial orthopedics or related appliances even if related to the accident. Services for the repair of teeth which are damaged as the result of biting and chewing.		No
Alternative Medicine	Yes	Alternative Medicine	Covered	No				Acupressure, homeopathy, hypnotherapy, rolfing, holistic medicine.		No
Allergy Treatment	Yes	Allergy Treatment	Covered	No						No
Diabetic Supplies	Yes	Diabetic Supplies	Covered	Yes	1	Insulin pump each warranty period				No
Cochlear Implants if medically necessary.	Yes	Cochlear Implants if medically necessary.	Covered	No						No
ABA Therapy is available for members with an Autism, Asperger's or Pervasive Developmental Disorder and are under 19 years of age	Yes	ABA Therapy is available for members with an Autism, Asperger's or Pervasive Developmental Disorder and are under 19 years of age	Covered	Yes	50000	Dollar maximum per benefit period. \$50,000 for members 0 through 8 years of age and \$20,000 for members 9 through 18 years of age.				No
Individual Educational Services, other than diabetic education, that are related to a medical condition.	Yes	Individual Educational Services, other than diabetic education, that are related to a medical condition.	Covered	Yes	5	Visits per year				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	9
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	1
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	11
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	7
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	25
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	3
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	9
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	3

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	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
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	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	6
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	33
ENZYME REPLACEMENT/ MODIFIERS	NO USP CLASS	11
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6

CATEGORY	CLASS	SUBMISSION COUNT
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	6
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	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	21
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
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

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
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	5
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	11