WYOMING EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross Blue Shield of Wyoming
Product Name	Blue Choice Network
Plan Name	Blue Choice Business 1000 80 20
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)	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						No
Specialist Visit	Yes	Specialist Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician/ Surgical Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Hospice Services	Yes	Hospice Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents. Only covered through Case Management.	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				Benefits are not available for donor sperm for artificial insemination or extraordinary procedures to induce fertilization with technical assistance to include surrogate motherhood, gamete intrafallopian transfer, invitro fertilization, peritoneal oocyte and sperm transfer, tubal ovum transfer, artificial insemination, gestational carrier, and preimplantation genetic diagnosis testing.	Surgical and medical to repair or correct the condition causing infertility. Includes DXL, diagnostic, therapeutic, and infertility drugs.	No
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing	Yes	Private-Duty Nursing	Covered	No				Services rendered by a nurse who ordinarily resides in the Member's home or is a member of the Member's immediate family; Services that are provided on an inpatient basis and billed by a hospital; Services which are primarily non-medical in nature, such as bathing, personal grooming, exercising or the administration of medication which can usually be self-administered. Outpatient Private Duty Nursing.	Inpatient Private Duty Nursing is covered for private duty nursing services of an actively practicing Registered Nurse (R.N) when ordered by a physician and rendered within an institution.	No

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Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care Centers	Covered	No						No
Home Health Care Services	Yes	Home Health Care Services	Covered	No				Benefits are not available for services which are primarily non-medical in nature such as bathing, personal grooming, exercising or the administration of medications which can usually be self-administered. Benefits are not available for dietician services, homemaker services, maintenance therapy, food, home delivered meals.	Benefits are available for home health care (HHC) services when rendered to a homebound patient by a home health agency on part-time basis, prescribed by a physician in absence of inpatient or nursing home facility care. Preauthorization of a physician's prescribed plan of treatment is required. The care must begin within 14 days after discharge from the hospital or a SNF. The care received must be directly related to the condition for which hospitalization was required.	No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No					Benefits are available for medically necessary ambulance services from the home, an emergency site, between hospitals, between hospital to home, or between a hospital and nursing home facility. Includes both Ground and Air Ambulance Services.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No				Benefits are NOT available for inpatient services rendered primarily for diagnostic examinations, physical therapy, rest cure, convalescent care, custodial or sanitaria care. Benefits are NOT available for inpatient care rendered primarily for the purpose of administering allergy, sensitivity, food challenge, or related testing, clinical ecology and vitamins or dietary nutritional supplements.	Quantitative limit units apply, see EHB benchmark plan documents. Cover semi private room only and special care unit. When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				Reversals of sterilizations are not covered.	Inpatient physician and surgical services includes voluntary sterilization (male and female). When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	Yes

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Bariatric Surgery	Yes	Bariatric Surgery	Covered	Yes	1	Procedure per lifetime		Benefits are NOT available for the Garren gastric bubble technique relating to morbid obesity.		No
Cosmetic Surgery	Yes	Reconstructive/Cosmetic Surgery	Covered	No				No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	No					No benefits available except through Case Benefit Management.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Services related to surrogacy; maternity services for dependent daughters under their parents' contract.	Includes office visits, appropriate preventive services, and complications.	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No				Services related to surrogacy; maternity services for dependent daughters under their parents' contract.	Includes vaginal delivery, caesarean section, abortions (medically necessary & elective), miscarriage, complications of pregnancy, circumcisions. Benefits are available for midwives if delivery takes place in a licensed facility. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	Yes	25	Visits per year		Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Cover 50% of charge or 50% of allowable, whichever is less. Contract coinsurance does not apply to this benefit. Claims will never be paid at 100%. Note: Visit limit is combined for psychiatric and substance abuse.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	Yes	15	Days per year		Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Note: Visit limit is combined for psychiatric and substance abuse. This includes 15 institutional days and 15 professional visits. Partial Hospitalization is covered subject to the inpatient limit; reduces inpatient days by 1/2 (2 for 1). When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	Yes	25	Visits per year		Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Cover 50% of charge or 50% of allowable, whichever is less. Contract coinsurance does not apply to this benefit. Claims will never be paid at 100%. General history and physical exam is covered prior to admission to an OP substance abuse program. Note: Visit limit is combined for psychiatric and substance abuse.	No

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Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	Yes	15	Days per year		Benefits are NOT available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are NOT available for the treatment of codependency.	Note: Visit limit is combined for psychiatric and substance abuse. This includes 15 institutional days and 15 professional visits. Partial Hospitalization is covered subject to the inpatient limit; reduces inpatient days by 1/2 (2 for 1). When an eligible Professional recommends an inpatient (IP) admission, notification to BCBSWY is required prior to services being rendered. Although, emergency and maternity admissions ARE NOT subject to a sanction, notification to BCBSWY is encouraged. The preadmission authorization and admission notification provisions do not apply when secondary to Medicare, other health insurance or 3rd party coverage. A sanction of $200 (maximum) per admission will be applied before the cost sharing and is the member's responsibility.	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	Yes	20	Visits per year		No coverage for hypnosis, cardiac rehabilitation, pulmonary rehabilitation, biofeedback, or pain treatment/therapy.	Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury.	Yes
Habilitation Services			Not Covered							
Chiropractic Care	Yes	Chiropractic Care/Spinal Manipulations	Covered	Yes	15	Visits per year				No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No				Benefits are not available for support devices for the foot, including flat foot conditions. There are no benefits for shoe inserts. Benefits are not available for deluxe motorized equipment, electronic speech aids; robotization devices, robotic prosthetics, dental appliances and artificial organs. Benefits are not available for personal hygiene and convenience items such as air conditioner, humidifiers or physical fitness equipment. Benefits are not available for wigs or artificial hairpieces, or hair transplants or implants, regardless of whether or not there is a medical reason for hair loss.	Includes but not limited to Diabetic supplies, therapeutic devices (e.g., hypodermic needles & syringes), oxygen, onsite and take-home medical/surgical supplies. Benefits are available for rental or purchase, initial fitting/adjustments, repair and replacement, used and refurbished equipment.	Yes
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-ray and Lab Work)	Covered	No				Benefits are not available for all forms of thermography for all uses and indicators.		No

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Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No					When multiple MRI/MRT/MRA's are performed on the same day, benefits for the technical component will be limited to 50% of the maximum allowance for each MRI/MRT/MRA after the first. Pet Scans must be authorized by Medical Review.	Yes
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/Immunization	Covered	No				Only covered when services are rendered by a participating provider.	Quantitative limit units apply, see EHB benchmark plan documents. Preventive care benefits are covered as required under PPACA.	No
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	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			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	20	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	60	Visits per year				No
Well Baby Visits and Care			Not Covered							
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					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
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							

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Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Organ Transplants	Covered	No				Transportation of the recipient to the location of the transplant surgery. Benefits are NOT available for small intestine, spleen transplantation or donor organs or tissue other than human donor organ or tissue. Covered but not limited to the following: liver, heart, heart-lung, kidney, pancreas, bone marrow and cornea transplant.	Includes evaluation, preparation & delivery of the donor organ; removal of the donor organ; transportation of the donor organ to the location of the transplant surgery; donor search costs.	No
Accidental Dental			Not Covered							
Dialysis	Yes	Dialysis	Covered	No					Dialysis includes hemodialysis.	No
Allergy Testing	Yes	Allergy Testing	Covered	No				Benefits are not available for clinical ecology, orthomolecular therapy, vitamins, dietary nutritional supplements, or related testing rendered on an outpatient basis. Benefits are not available for the following allergy testing modalities: nasal challenge testing, provocative/neutralization testing, leukocyte; histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis; hypersensitivity syndrome testing, IgE level testing for food allergies; general volatile organic screening test and mauve urine test. Benefits are not available for the following methods of desensitization: provocation/neutralization therapy by sublingual (drops) intradermal and subcutaneous routes, urine autoinjections, repository emulsion therapy, candidiasis hypersensitivity syndrome treatment or IV vitamin C therapy.	Allergy testing includes allergy treatment.	No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	Yes	1	Time evaluation per 3 hours			Covered when billed by a participating provider.	No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No				Benefits are not available for deluxe motorized equipment, electronic speech aids; robotization devices, robotic prosthetics, dental appliances and artificial organs.	Prosthetic devices include breast prostheses.	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No					Infusion therapy includes outpatient infusion therapy and IV home therapy/enteral nutrition. Only covered through Case Management.	No
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling			Not Covered							

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Reconstructive Surgery			Not Covered							
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
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Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Colonoscopy	Covered	Yes	1	Procedure every 10 years at age 50 through 75				Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Sigmoidoscopy	Covered	Yes	1	Procedure every 5 years at age 50 through 75				Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Voluntary Sterilization (Male and Female)	Covered	No				Reversals of sterilizations are not covered.		Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Eye Refractive Surgery	Covered	No				Not covered when used in otherwise healthy eyes to replace eyeglasses or contact lenses.		Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Reconstructive/Cosmetic Surgery	Covered	No				No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No
Outpatient Surgery Physician/ Surgical Services	Yes	Colonoscopy	Covered	Yes	1	Procedure every 10 years at age 50 through 75				Yes
Outpatient Surgery Physician/ Surgical Services	Yes	Sigmoidoscopy	Covered	Yes	1	Procedure every 5 years at age 50 through 75				Yes
Outpatient Surgery Physician/ Surgical Services	Yes	Voluntary Sterilization (Male and Female)	Covered	No				Reversals of sterilizations are not covered.		Yes
Outpatient Surgery Physician/ Surgical Services	Yes	Eye Refractive Surgery	Covered	No				Not covered when used in otherwise healthy eyes to replace eyeglasses or contact lenses.		Yes
Outpatient Surgery Physician/ Surgical Services	Yes	Reconstructive/Cosmetic Surgery	Covered	No				No coverage for cosmetic surgery and related services intended primarily to improve appearance.	Cover expenses related to cosmetic surgery only when restorative surgery is required as the result of a birth defect, accidental injury or a malignant disease process or its treatment. Prior approval is necessary.	No
Hospice Services	Yes	Bereavement Services	Covered	Yes	12	Sessions per period of bereavement			Limited to $25 paid per session. Must be completed during the 12 months following the death of the terminally ill patient.	No
Outpatient Rehabilitation Services	Yes	Physical Therapy	Covered	Yes	40	Visits per year		No coverage for maintenance physical therapy.		Yes

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Outpatient Rehabilitation Services	Yes	Speech Therapy	Covered	Yes	20	Visits per year			Not covered, except when related to rehabilitative care. Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury. Combined benefit limit with other rehabilitative care services (e.g., occupational therapy).	Yes
Outpatient Rehabilitation Services	Yes	Occupational Therapy	Covered	Yes	20	Visits per year			Not covered, except when related to rehabilitative care. Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.). The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury. Combined benefit limit with other rehabilitative care services (e.g., speech therapy).	No
Durable Medical Equipment	Yes	Prosthetics/Orthotics	Covered	No					Covered when related to a covered medical condition. Orthopedic appliances which are rigid or semi-rigid support items only.	No
Accidental Dental	Yes	Accidental Dental	Covered	Yes	1500	Dollars per member per calendar year for services within 90 days of the accident			Includes accident related dental and TMJ.	No
Anesthesia	Yes	Anesthesia	Covered	No				Benefits are not available for acupuncture or hypnosis for anesthetic purposes.		No
Hearing Exams/Testing	Yes	Hearing Exams/Testing	Covered	No					Covered for medical diagnosis when appropriate and necessary.	No
Blood, Blood Processing, Blood Substitutions and Derivatives	Yes	Blood, Blood Processing, Blood Substitutions and Derivatives	Covered	No				Benefits are not available for donated blood.		No
Genetic Testing	Yes	Genetic Testing	Covered	No					Covered if within the guidelines of the medical policy.	No
Cochlear Implants	Yes	Cochlear Implants	Covered	No					Covered if approved through Case Management.	No
Inpatient Rehabilitation	Yes	Inpatient Rehabilitation	Covered	Yes	45	Days per year			Covered for accidental or medical injury (e.g., stroke, spinal cord injury, closed or open head injury).	No
Second Surgical Opinion	Yes	Second Surgical Opinion	Covered	No					Benefits are available for second surgical opinion (voluntary) on covered elective surgery recommended by an eligible professional.	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	10
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	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	11
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	20
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	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	3
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	5
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
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	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

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	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
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	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	15
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5

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	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	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	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	20
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	13

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	14
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)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4