

PROPOSED WEST VIRGINIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Highmark Blue Cross Blue Shield West Virginia
Product Name	Super Blue Plus 2000
Plan Name	Super Blue Plus 2000 1000 Ded
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none">• Pediatric Oral (FEDVIP)• Pediatric Vision (FEDVIP)
Habilitative Services	No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Visit to Treat an Injury or Illness	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit	No
2	Specialist Visit	Covered	Specialist Visit, including second surgical opinion, therapy modalities	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit	No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit (where the professional may be a Chiropractor, Nurse, Physician Assistant, podiatrist, psychologist or other professional whose services require payment under WV Code or Federal Mandate), and may include covered therapy modalities	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit	No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center but is not an office or clinic used for the private practice of a physician or other provider) and may include Therapy Services such as Radiation, Chemo, dialysis, PT, respiratory, Hyperbaric, pulmonary, speech and occupational modalities.	No					All Covered Services must be Medically Necessary unless otherwise specified.	Non-emergency visits to a Hospital based clinic are paid as an outpatient service and not as an Office Visit. Outpatient facilities may be a part of Facility Other Providers, which include Alcoholism Treatment Center, Ambulatory Medical Facility, Ambulatory Surgical Facility, Birthing Center, Day/Night Psych facility, Dialysis Facility, Drug Abuse treatment facility, Freestanding Renal Dialysis Center, Home Health Agency, Hospice facility, psychiatric facility, psychiatric hospital, Rehabilitation facility, Skilled nursing facility as may be allowed by Federal or State law..	Yes
5	Outpatient Surgery Physician/ Surgical Services	Covered	Outpatient Surgery Physician/ Surgical Services performed within the scope of the provider's license.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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6	Hospice Services	Covered	Hospice Services based on an approved treatment plan when life expectancy is 6 months or less	No					Hospice related prescription drugs are limited to a two week supply and must be for palliative or supportive care. Also excluded are physician visits, volunteer services, spiritual counseling, bereavement counseling, non-palliative chemo or radiation therapy. All Covered Services must be Medically Necessary unless otherwise specified.	Services are similar to home health and include Inpatient hospice care, Respite care, dietary guidance, DME, home health aid visits, prescription drugs,	No
7	Non-Emergency Care When Traveling Outside the U.S.	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
8	Routine Dental Services (Adult)	Not Covered	Routine Dental Services (Adult)								
9	Infertility Treatment	Not Covered	Infertility Treatment						Exclusions include services related to Cloning, reversal of sterilization, In-vitro fertilization, gamete intra fallopian transfer and other ova transfer procedures		
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care								
11	Private-Duty Nursing	Covered	Private-Duty Nursing	Yes	5000	Other other	\$ per year		Inpatient services are available when a provider's regular nursing staff cannot provide them. Non-medical and Custodial services are excluded.		No
12	Routine Eye Exam (Adult)	Not Covered	Routine Eye Exam (Adult)								
13	Urgent Care Centers or Facilities	Covered	Urgent Care Centers or Facilities per the Prudent Layperson standard	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
14	Home Health Care Services	Covered	Homebound patients may receive intermittent skilled care, PT, OT or speech therapy, medical supplies, Oxygen, prescription drugs, medical social services, home health aid visits for skilled nursing or therapy services, laboratory tests, home infusion therapy.	Yes	100	Visits per year			Excluded are dietician services, homemaker services, food or home delivered meals, Custodial Care, maintenance therapy, prenatal care, private duty nursing, personal comfort items. All Covered Services must be Medically Necessary unless otherwise specified.		No

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15	Emergency Room Services	Covered	Emergency Room Services per the Prudent Layperson standard	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
16	Emergency Transportation/Ambulance	Covered	Emergency Transportation/Ambulance	No					Trips must be to the closest facility that can provide Covered Services appropriate for your condition. All Covered Services must be Medically Necessary unless otherwise specified.		No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
19	Bariatric Surgery	Covered	Bariatric Surgery	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
20	Cosmetic Surgery	Covered	Cosmetic Surgery, or reconstructive surgery to restore a body function or malformation caused by disease, trauma, birth defects, growth defects, prior therapeutic processes such as mastectomy; or as a result of an act of family violence	No					Surgery or other services primarily intended to improve appearance in the absence of disease, trauma or causes not defined as Reconstructive are excluded. All Covered Services must be Medically Necessary unless otherwise specified.		No
21	Skilled Nursing Facility	Covered	Providing inpatient services when authorized and based on a physician's Plan of Treatment and recertified every two weeks.	No					Custodial, ambulatory, rest or part-time care and pulmonary tuberculosis treatment is excluded, Benefits expire when the patient cannot present significant improvement. All Covered Services must be Medically Necessary unless otherwise specified.		No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care, including newborn care and circumcision	No					Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No

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23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Services for Maternity Care, when the newborn is added to coverage within 30 days of birth; Care for a covered newborn includes circumcision	No					Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered. except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		Yes
25	Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No

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28	Generic Drugs	Covered	Generic Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No
29	Preferred Brand Drugs	Covered	Preferred Brand Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No
30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No
31	Specialty Drugs	Covered	Specialty Drugs, generally understood to be drugs not covered under the pharma benefit but furnished on an outpatient basis such as infusion therapy and some injectable drugs	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services to treat Stroke, Spinal cord injury, Congenital deformity, Amputation, Major multiple traumas, Fracture of femur, brain injury, Polyarthritis, including rheumatoid arthritis, Neurological disorders, Cardiac disorders and Burns when there is a reasonable likelihood services will restore optimal physical, medical, psychological, social, emotional, vocational and economic status.	No					Excluded services are those associated with Mental conditions, chemical dependency, vocational rehabilitation, long term maintenance, custodial services. All Covered Services must be Medically Necessary unless otherwise specified.		Yes
33	Habilitation Services	Not Covered	Habilitation Services							This service is not defined by applicable State Code or in the Certificate of Coverage.	
34	Chiropractic Care	Covered	Chiropractic Care manipulations are considered same as Physical therapy	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
35	Durable Medical Equipment	Covered	Durable Medical Equipment purchase or rental at our option when prescribed by a provider practicing within the scope of their license, including orthotics, prosthetics.	No					Excluding dental appliances, elastic bandages, garter belts or similar supplies, orthopedic shoes, items not serving a medical purpose, items not able to withstand repeated use, All Covered Services must be Medically Necessary unless otherwise specified.		No
36	Hearing Aids	Not Covered	Hearing Aids								
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Test (X-Ray and Lab Work) when ordered by a physician or qualified provider operating within the scope of their licence, includes pre-admission testing	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
38	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs) ordered by a physician or other qualified provider operating within the scope of their license	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/Screening/ Immunization to the extent mandated by State and Federal Code.	No							No
40	Routine Foot Care	Not Covered	Routine Foot Care								
41	Acupuncture	Not Covered	Acupuncture								
42	Weight Loss Programs	Not Covered	Weight Loss Programs								
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year					No
44	Eye Glasses for Children	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Limitations, including dollar limits, may apply	No
46	Other										

OTHER BENEFITS

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1	Other	Covered	Abortion, elective and therapeutic	No					Partial Birth abortion		No
2	Mental/ Behavioral Health Outpatient Services	Covered	Applied Behavioral Analysis (ABA) for Autism	Yes	30000	Other other	Annual \$30k limit for ABA therapy during first 3 years DX'd. \$2000/month thereafter to age 18.		All Covered Services must be Medically Necessary unless otherwise specified.		No
3	Other	Covered	Oral Surgery for boney tooth impaction	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
4	Other	Covered	Allergy tests and treatment; includes desensitization treatment	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
5	Other	Covered	temporo and crano mandibular disorder treatment; "TMJ"	Yes	1	Other other	Orthotics, splints and appliances are limited to one every 3 years.		Treatment to alter vertical dimension is excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Exam, DX, imaging, injections, PT and physiotherapy, Surgery when needed due to physical trauma or organic disease are COVERED	No
6	Other	Covered	Clinical Trials Coverage	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
7	Other	Covered	Sterilization surgery not subject to Medical Necessity	No					Reversal of sterilization is excluded		No
8	Other	Covered	Human Organ Transplants including Heart, Heart/lung, Lung, Liver, pancreas	Yes	150	Other other	\$150 per day for meal, transportation and lodging up to \$10,000 for recipient and one additional adult (or 2 adults if patient is a minor)		All Covered Services must be Medically Necessary unless otherwise specified.	Includes expenses of recipient, pre/post operative care and immunosuppressant drugs.	No
9	Other	Covered	Bone Marrow procedures	Yes	150	Other other	\$150 per day for meal, transportation and lodging up to \$10,000 for recipient and one additional adult (or 2 adults if patient is a minor)		Procedures to treat T-Cell leukemia virus and AIDS are excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Coverage is provided for 4 listed types of transplants for 5 listed covered diseases (page 28 of benefit booklet)	No
10	Other	Covered	Assistant at Surgry, A Physician's help to a surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
11	Other	Covered	Diabetes Education & Control	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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12	Outpatient Rehabilitation Services	Covered	Speech therapy	No					Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified		No
13	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Speech therapy	No					Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified		No
14	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
15	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
16	Other	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply	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	13
ANESTHETICS	LOCAL ANESTHETICS	2
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	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	23
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	9
ANTIBACTERIALS	MACROLIDES	6
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	BARBITURIC ACID DERIVATIVE	1
ANTICONVULSANTS	BENZODIAZEPINE DERIVATIVE	4
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
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	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	ANTIFUNGALS	24
ANTIGOUT AGENTS	ANTIGOUT AGENTS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

Category	Class	Submission Count
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS	52
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	4
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
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	ANTISPASTICITY AGENTS	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	8
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
ANXIOLYTICS	SELECTIVE SEROTONIN REUPTAKE INHIBITORS /SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4

Category	Class	Submission Count
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	9
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	9
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	6
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
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	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	2
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	5
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	DENTAL AND ORAL AGENTS	7
DERMATOLOGICAL AGENTS	DERMATOLOGICAL AGENTS	27
ENZYME REPLACEMENT/MODIFIERS	ENZYME REPLACEMENT/MODIFIERS	18
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

Category	Class	Submission Count
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	4
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	24
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	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	2
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	13
IMMUNOLOGICAL AGENTS	VACCINES	16
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	8
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	METABOLIC BONE DISEASE AGENTS	13
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	8
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES	1
OTIC AGENTS	OTIC AGENTS	4
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	7
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3

Category	Class	Submission Count
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	6
SKELETAL MUSCLE RELAXANTS	SKELETAL MUSCLE RELAXANTS	8
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	10
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	5