UTAH EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from 3rd largest state employee plan, Health Maintenance Organization
Issuer Name	Public Employee's Health Program
Product Name	Utah Basic Plus
Plan Name	Utah Basic Plus
Supplemented Categories (Supplementary Plan Type)	None
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Primary care 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	Other practitioner office visit to treat an illness or injury	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient facility fee	Covered	No				Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Coinsurances.	Charges for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based, are payable after applicable Coinsurance. When emergency room treatment results in an inpatient admission (within 24 hours), benefits are payable as an inpatient stay.	Yes
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient surgery physician/surgical services	Covered	No						Yes
Hospice Services	Yes	Hospice services	Covered	Yes	6	Months per 3 years				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			Not Covered							
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 centers or facilities	Covered	No						No
Home Health Care Services	Yes	Home health care services	Covered	Yes	30	Days per plan year				No

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Emergency Room Services	Yes	Emergency room services	Covered	No					Medically Necessary emergency room facility services are payable after applicable Coinsurance. Each follow up.	No
Emergency Transportation/ Ambulance	Yes	Emergency transportation/ ambulance	Covered	No						Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient hospital services	Covered	No		.		1. Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Coinsurances; 2. Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible; 3. When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, PEHP may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by PEHP; 4. Inpatient benefits for Mental Health require Preauthorization; 5. Only acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Pre-authorization through the inpatient Mental Health benefits; 6. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Pre-authorization; 7. Inpatient Rehabilitation and Skilled Nursing Facility stays are limited to 30 days per plan year combined.	Charges for Medically Necessary inpatient Hospitalization (semi-private room, ICU, and eligible ancillaries) are payable after applicable Coinsurance	Yes
Inpatient Physician and Surgical Services	Yes	Inpatient physician and surgical services	Covered	No				Exclusions apply, see EHB benchmark plan documents.		Yes
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled nursing facility	Covered	Yes	30	30 days per plan year				No
Prenatal and Postnatal Care	Yes	Prenatal and postnatal care	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and all inpatient services for maternity care	Covered	No						No

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Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral health outpatient services	Covered	Yes	8	Visits per plan year/ combined with Substance Abuse outpatient				No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral health inpatient services	Covered	Yes	30	Days per plan year/ combined with Substance Abuse outpatient				No
Substance Abuse Disorder Outpatient Services	Yes	Substance abuse disorder outpatient services	Covered	Yes	8	Visits per plan year/ combined with Mental/Behavioral Health Outpatient Services				No
Substance Abuse Disorder Inpatient Services	Yes	Substance abuse disorder inpatient services	Covered	Yes	30	Days per plan year/ combined with Mental/Behavioral Health Inpatient Services				No
Generic Drugs	Yes	Generic drugs	Covered	No						Yes
Preferred Brand Drugs	Yes	Preferred brand drugs	Covered	No						Yes
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No						No
Specialty Drugs	Yes	Specialty drugs	Covered	No						No
Outpatient Rehabilitation Services	Yes	Physical therapy, speech therapy, occupationally therapy, and habilitative services	Covered	Yes	20	Visits per year Includes habilitative services with a combined limit of 20 visits per plan year.				No

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Habilitation Services	Yes	Physical therapy, speech therapy, occupationally therapy, and habilitative services.	Covered	Yes	20	Visits per year Includes other outpatient rehabilitation services with a combined limit of 20 visits per plan year.				No
Chiropractic Care			Not Covered							
Durable Medical Equipment	Yes	Durable medical equipment	Covered	Yes	1	Breast prosthetic is covered per affected breast every two years. Eye once per affected eye every 5 years. Foot orthotics are not covered.		1. Training and testing in conjunction with Durable Medical Equipment or prosthetics; 2. More than one lens for each affected eye following Surgery for corneal transplant; 3. Durable Medical Equipment that is inappropriate for the patient's medical condition; 4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit; 5. Equipment purchased from non-licensed Providers; 6. Used Durable Medical Equipment; 7. TENS Unit; 8. Neuromuscular Stimulator; 9. H-wave Electronic Device; 10. Sympathetic Therapy Stimulator (STS); 11. Limb prosthetics; 12. Machine rental or purchase for the treatment of sleep disorders; 13. Support hose for phlebitis or other diagnosis.	1. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary; 2. One pair of ear plugs within 60 days following eligible ear Surgery; 3. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty; 4. Artificial eye prosthetic, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Pre-authorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period; 5. Wheelchairs require Pre-authorization through Medical Case Management and are limited to one power wheelchair in any five-year period; 6. Knee braces are limited to one per knee in a three year period.	Yes
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic test (x-ray and lab work)	Covered	No						Yes
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET scans, MRIs)	Covered	No						No
Preventive Care/Screening/ Immunization	Yes	Preventive care/screening/ immunization	Covered	No					Explanations apply, see EHB benchmark plan documents.	Yes
Routine Foot Care		Routine foot care	Covered	No					Visits to a podiatrist are limited to removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. Licensed physician treating a metabolic or peripheral vascular disease.	Yes
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							

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Routine Eye Exam for Children	Yes	Routine eye exam for children	Covered	Yes	1	Visit per plan year, ages 5-18				No
Eye Glasses for Children	Yes	Eye glasses for children	Covered	Yes	1	Pair of eyeglass lenses per plan year ages 5-18				No
Dental Check-Up for Children	Yes	Dental check-up for children	Covered	Yes	2	Visits per year, periodic oral exam fees are allowed twice in a plan year			Oral Examinations: Periodic oral exam fees are allowed twice in a plan year age 3-18. A re-evaluation is considered included in the primary procedure and is not payable separately. Diagnostic X-rays/Services: 1. Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period for members age 13-18, in lieu of panorex x-ray; 2. Full series bitewing x-rays (4) are allowed only twice in a plan year; 3. A panorex is allowable once during any three-year period in lieu of complete mouth x-ray; 4. Vertical bitewings are payable up to eight films. Preventive: 1. Prophylaxis (cleaning) is allowed twice in a plan year. A child Prophylaxis will be allowed through age 13. An adult Prophylaxis will be allowed for age 14-18; 2. Sealants on permanent molars are allowed once during any five-year period for eligible Dependents through 17 years of age. Permanent molars include teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32. (Permanent molars with occlusal restoration are ineligible.)	Yes
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			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			Not Covered							
Orthodontia - Child			Not Covered							

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Major Dental Care - Child			Not Covered							
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	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			Not Covered							
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
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
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Generic Drugs	Yes	Generic drugs	Covered	No				Exclusions apply, see EHB benchmark plan documents.	Explanations apply, see EHB benchmark plan documents.	No
Preferred Brand Drugs	Yes	Preferred brand drugs	Covered	No				Exclusions apply, see EHB benchmark plan documents.	Explanations apply, see EHB benchmark plan documents.	No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient surgery physician/surgical services	Covered	No				Exclusions apply, see EHB benchmark plan documents.	Medically Necessary Surgical Procedures are payable, after applicable Coinsurance when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility. 1. Multiple Surgical Procedures during the same operative session are allowable at 100% of Maximum Allowable Fee for the primary procedure and 50% of Maximum Allowable Fee for all additional eligible procedures. Incidental procedures are excluded; 2. Surgical benefits are payable based on surgical Package Fees to include the Surgery and post-operative care per CPT guidelines and RBRVS guidelines; 3. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Pre-authorization through Medical Case Management; 4. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, PEHP may allow payment for the standard Calcitite placement towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible. Pre-authorization is required.	No

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Limitations and exclusions from coverage relating to medical visits	Yes	Limitations and exclusions from coverage relating to medical visits	Covered	No				Exclusions apply, see EHB benchmark plan documents.	1. Physical therapy visits may be payable up to plan limits when Medically Necessary; 2. Pelvic floor therapy visits may be payable up to plan limits when Medically Necessary. See applicable Benefits Summary for plan limits; 3. Outpatient occupational therapy for fine motor function may be payable up to plan limits when Medically Necessary. See applicable Benefits Summary for plan limits; 4. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same-day visits by a multi-disciplinary team are eligible with applicable Coinsurance(s) per Provider; 5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative; 6. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses; 7. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on-call" or shift work requirements; 8. Cardiac Rehabilitation, Phase 2, following heart attack, cardiac Surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year; 9. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.	No

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Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic test (x-ray and lab work)	Covered	No				1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations; 2. Routine drug screening, except when ordered by a treating physician; 3. Sublingual or colorimetric allergy testing; 4. Charges in conjunction with weight loss programs regardless of Medical Necessity; 5. Epidemiological and predictive genetic counseling except in conjunction with the Affordable Care Act; 6. Probability and predictive analysis and testing; 7. Unbundling of lab charges or panels; 8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations; 9. Hair analysis, trace elements, or dental filling toxicity; 10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded; 11. Sleep Studies for sleep disorders; 12. Services in conjunction with diagnosing infertility; 13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services; 14. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease.	1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis; 2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.	No
Mental health and substance abuse	Yes	Mental health and substance abuse	Covered	No				1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan; 2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances; 3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions; 4. Wilderness programs; 5. Inpatient treatment for behavior modification, enuresis, or encopresis; 6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations; 7. Occupational or recreational therapy; 8. Hospital leave of absence charges; 9. Sodium amobarbital interviews; 10. Residential treatment programs; 11. Tobacco abuse; 12. Routine drug screening, except when ordered by a treating physician.	1. Benefits for group family counseling will be payable under Mental Health for the primary patient. Benefits will not be considered separate for each individual family Member; 2. When an inpatient stay spans an old and new plan year, hospital benefits will be based on the old plan year provisions. Actual number of days used, however, will apply to specific plan years; 3. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed; 4. Only one visit per Provider of the same specialty per day is payable; 5. Outpatient visits are limited to 8 per plan year.	No

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Emergency Transportation/ Ambulance	Yes	Emergency transportation/ambulance	Covered	No				1. Charges for common or private aviation services; 2. Services for the convenience of the patient or family; 3. After-hours charges; 4. Charges for ambulance waiting time.	1. Benefits are only eligible when ambulance services are necessary due to a medical emergency; 2. Only services to transport to the nearest Hospital where proper medical care is available are eligible; 3. Benefits will be payable for air ambulance only in Life-threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available.	No
Home health and hospice care	Yes	Home health and hospice care	Covered	No				1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider; 2. Private duty nursing; 3. Home health aide; 4. Custodial Care; 5. Respite Care; 6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services; 7. Total Parenteral Nutrition through Hospice; 8. Enteral Nutrition, unless obtained through the pharmacy card.	1. Total Enteral Nutrition (TEN) formula requires Pre-authorization and must be obtained through the pharmacy card; 2. Physical and/or occupational therapy performed in the home is subject to the outpatient plan limits. See applicable Benefits Summary for details; 3. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits. See applicable Benefits Summary for details; 4. Skilled Nursing visits are subject to plan Limitations. See applicable Benefits Summary for details; 5. Hospice services are subject to plan Limitations. See applicable Benefits Summary for details.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	8
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	2
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	9
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	8
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	3
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	3
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	0
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	5
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	7
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	8
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3
ANTIFUNGALS	NO USP CLASS	13
ANTIGOUT AGENTS	NO USP CLASS	3
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	0
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	2
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	0
ANTIMYCOBACTERIALS	ANTITUBERCULARS	5
ANTINEOPLASTICS	ALKYLATING AGENTS	2
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	1
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	1
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	1
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	8
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	1
ANTIPARASITICS	ANTHELMINTICS	0
ANTIPARASITICS	ANTIPROTOZOALS	5
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	3
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	1
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	4
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	0
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	2
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	3
ANTIVIRALS	ANTIHERPETIC AGENTS	4
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	4
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	4
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	10
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	0
BLOOD GLUCOSE REGULATORS	INSULINS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	3
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	8
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	11
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	5
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	2
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	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	2
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	0
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	3
DENTAL AND ORAL AGENTS	NO USP CLASS	5
DERMATOLOGICAL AGENTS	NO USP CLASS	15
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	2

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	3
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	0
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	3
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	6
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	1
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	20
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	1
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	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	3
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	8
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	5
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	1
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	7
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	10
OTIC AGENTS	NO USP CLASS	3
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	3
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	5
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	1
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	5
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	2
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	2