VIRGINIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Anthem Health Plans of VA (Anthem BCBS)
Product Name	PPO
Plan Name	KeyCare 30 with KC30 Rx Plan 10 30 50 OR 20
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (CHIP) • Pediatric Vision (FEDVIP)
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				Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
Specialist Visit	Yes	Specialist Visit	Covered	No				Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit	Covered	No				Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Services	Covered	No				Oral surgery that is dental in origin; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.		No
Outpatient Surgery Physician/Surgical Services	Yes	Physician Medical and Surgical Services in an Outpatient Facility	Covered	No				Oral surgery that is dental in origin; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.		No
Hospice Services	Yes	Hospice Services	Covered	No						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					Treatment of natural teeth due to diseases; treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 60 days after the injury and you submitted a treatment plan to Anthem for prior approval; dental care, treatment, supplies, or dental x-rays; damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered; oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures; appliances for temporomandibular joint pain dysfunction; or periodontal care, prosthodontal care or orthodontic care; removal of impacted wisdom teeth.		
Infertility Treatment		Infertility Treatment	Covered	No				Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.	Includes services to diagnose and treat conditions resulting in infertility.	No

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Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing	Yes	Private duty nursing services	Covered	Yes	500	Dollars per year		Excludes coverage for private duty nursing services provided in an inpatient setting.	Services of an RN or LPN in the home. Nurse must not be a relative. Doctor must certify that private duty nursing services are medically necessary and not merely custodial. Home nursing services provided through home health care are not subject to this limit.	No
Routine Eye Exam (Adult)		Routine Eye Exam	Covered	Yes	1	Visit per year		Services for vision training and orthoptics; services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; eyeglasses and eyewear.	Includes routine eye exam and refraction.	No
Urgent Care Centers or Facilities	Yes	Urgent Care Services in an Urgent Care Center or Facility	Covered	No						No
Home Health Care Services	Yes	Home Health Care Services	Covered	Yes	100	Visits per year		Homemaker services; maintenance therapy; food and home-delivered meals; custodial care and services.	Medical treatment provided in the home on a part time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy. When these therapy services are provided as part of home health they are not subject to separate visit limits for therapy services.	No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	No					Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home.	No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No				Convenience items; Private room unless medically necessary; Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				Care by interns, residents, house physicians or other facility employees that is billed separately from the facility; Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.	Physician medical and surgical services while in an inpatient facility.	No

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Bariatric Surgery			Not Covered					Services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.		
Cosmetic Surgery			Not Covered					Cosmetic surgery or procedures, including complications that directly result from such surgeries and/or procedures.	Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment.	
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	100	Days per admission		Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.	Items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Services related to surrogacy is member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered.	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Facility and Professional Services for Maternity Care	Covered	No			48	Services related to surrogacy is member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No

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Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
Generic Drugs	Yes	Generic Prescription Drugs	Covered	No				Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
Preferred Brand Drugs	Yes	Preferred Brand Prescription Drugs	Covered	No				Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Prescription Drugs	Covered	No				Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
Specialty Drugs	Yes	Specialty Prescription Drugs	Covered	No				Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	Yes	30	Visits per year		Physical therapy or occupational therapy to maintain or preserve current function if there is no chance or improvement or reversal; Group or individual exercise classes or personal training sessions; Recreational therapy including but not limited to sleep, dance, arts, crafts, aquatic, gambling and nature therapy.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 30 visit/year limit for physical and occupational therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	Yes
Habilitation Services	Yes	Habilitation Services	Covered	Yes	30	Visits per year		Physical therapy or occupational therapy to maintain or preserve current function if there is no chance or improvement or reversal; Group or individual exercise classes or personal training sessions; Recreational therapy including but not limited to sleep, dance, arts, crafts, aquatic, gambling and nature therapy.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 30 visit/year limit for physical and occupational therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	Yes
Chiropractic Care	Yes	Spinal manipulation and manual medical intervention services	Covered	Yes	30	Visits per year		Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions.	Benefit limit applies for spinal manipulation and manual medical intervention services.	No

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Durable Medical Equipment	Yes	Medical Equipment and Supplies	Covered	No				Those items that have both a therapeutic and non-therapeutic use including exercise equipment; air conditioners, dehumidifiers, humidifiers and purifiers; hypoallergenic bed linens; whirlpool baths; handrails, ramps, elevators, stair glides; telephones; adjustments made to a vehicle; foot orthotics; changes made to home or place of business; repair or replacement of equipment lost or damaged through neglect. Over the counter convenience and hyenic items that include but are not limited to adhesive removers, cleansers, underpads, ice bags.	Durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants.	No
Hearing Aids			Not Covered					Hearing aids, fittings and exams for hearing aids.		
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Tests	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Advanced Diagnostic Imaging Services	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screenings and Immunizations	Covered	No					Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012.	No
Routine Foot Care		Routine Foot Care	Covered	No					Routine or palliative foot care is covered for treatment of patients with diabetes or vascular disease only; Treatment of bunions only covered when associated with capsular or bone surgery.	No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered					Weight loss programs; Services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.		
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			Supplemented by VA CHIP. Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	30	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	30	Visits per year				No

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Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No					Supplemented by VA CHIP. Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Supplemented by VA CHIP. Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Members must have a severe, dysfunctional, handicapping malocclusion.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Supplemented by VA CHIP. 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	Human Organ and Tissue Transplant Services	Covered	No				Benefits for donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, and sibling).	Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. Specific limited transportation/lodging costs and donor costs are also covered.	No

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Accidental Dental	Yes	Dental Services for Accidental Injury and Other Related Medical Services	Covered	No				Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Dental services resulting from an accidental injury provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. The cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth; the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face; dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.	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						No
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No					Palliative foot care, medical supplies, equipment, and education for diabetes care for all diabetics.	No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Mental Health Other	Yes	Mental Health Other	Covered	No						No

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Early Intervention Services	Yes	Early Intervention Services	Covered	No					Early intervention services for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of: speech and language therapy; occupational therapy; physical therapy; and assistive technology services and devices.	No
Bones/Joints	Yes	Bones/Joints	Covered	No						No
Blood and Blood Services	Yes	Blood and Blood Services	Covered	No						No
Rape and Incest Coverage	Yes	Rape and Incest Coverage	Covered	No						No

OTHER BENEFITS

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Allergy Treatment	Yes	Allergy Treatment	Covered	No						No
Injectable drugs and other drugs administered in a provider's office or other outpatient setting	Yes	Injectable drugs and other drugs administered in a provider's office or other outpatient setting	Covered	No						No
Vision Correction After Surgery or Accident	Yes	Vision Correction After Surgery or Accident	Covered	No				Sunglasses or safety glasses and accompanying frames of any type; any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power; any lost or broken lenses or frames; any blended lenses (no line), oversize lenses, polycarbonate lenses (for dependents over the age of19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for dependents over the age of 19 and adults), tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses; any frame in which the manufacturer has imposed a no discount policy	Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury. Includes cost of materials and fitting as well as exams and replacement of these eyeglasses or contact lenses if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if: prescribed to replace the human lens lost due to surgery or injury; "pinhole" glasses are prescribed for use after surgery for a detached retina; or lenses are prescribed instead of surgery in the following situations: contact lenses are used for the treatment of infantile glaucoma; corneal or scleral lenses are prescribed in connection with keratoconus; scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.	No
Outpatient Rehabilitation Services	Yes	Speech Therapy	Covered	Yes	30	Visits per year			Includes physical therapy, occupational therapy and speech therapy. 30 visit/year speech therapy limit is shared between rehabilitation and habilitation services.	No
Habilitation Services	Yes	Speech Therapy	Covered	Yes	30	Visits per year			Includes physical therapy, occupational therapy and speech therapy. 30 visit/year speech therapy limit is shared between rehabilitation and habilitation services.	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	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
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	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	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	25
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	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	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	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	4
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

CATEGORY	CLASS	SUBMISSION COUNT
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	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
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	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	16
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	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6

CATEGORY	CLASS	SUBMISSION COUNT
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	23
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	4
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	15
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

CATEGORY	CLASS	SUBMISSION COUNT
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	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	11