

PROPOSED MARYLAND EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Largest state employee plan, Preferred Provider Organization
Issuer Name	CareFirst of Maryland, Inc.
Product Name	State of Maryland Preferred Provider Organization
Plan Name	CareFirst State of Maryland PPO
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none">• Pediatric Oral (State CHIP)• Pediatric Vision (FEDVIP)
Habilitative Services	Yes

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 Treatment	No						A Primary Care Medical Home Program is available for qualifying patients (generally those with chronic conditions)	No
2	Specialist Visit	Covered	Outpatient Specialist Services	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Primary Care Treatment	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Ambulatory Surgical Center Services	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery and Physician/Surgical Services	No						If multiple surgical procedures are performed during the same operative session, services that are integral to the main surgical procedure will not be covered as a separate benefit.	No
6	Hospice Services	Covered	Respite Care	Yes	14	Days per year			Excludes any services other than palliative care	An approved plan of treatment is required and must be accepted in writing by the Member or the family.	No
7	Non-Emergency Care When Traveling Outside the U.S.	Covered	Non-Emergency Care when Traveling Outside the U.S.	No							No
8	Routine Dental Services (Adult)	Not Covered									
9	Infertility Treatment	Covered	Infertility Services	Yes	100000	Other other	Benefits for IVF are limited to a \$100,000 lifetime benefit		When the member or partner has undergone sterilization with or without reversal; when a surrogate is used; when donor sperm, eggs, or embryos are used; when the services involve a domestic partner or common law spouse (except when the legality of those relationships is recognized); does not cover cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s)		Yes
10	Long-Term/Custodial Nursing Home Care	Not Covered									
11	Private-Duty Nursing	Covered	Outpatient Private Duty Nursing	No						An approved plan of treatment is required; coverage comes as a rider	No

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12	Routine Eye Exam (Adult)	Covered	Routine Eye Exam (Adult)	Yes	1	Visits per year			Orthoptics, vision training, and low vision aids; Cision care services for cosmetic use	A second exam is covered within 60 days of an optometrist's exam, when an optometrist suspects a problem and refers a Member to an ophthalmologist; coverage comes as a rider	No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Facility	No							No
14	Home Health Care Services	Covered	Hospital/Home Health Agency Services	Yes	120	Days per year			Rental or purchase of renal dialysis equipment and supplies	Up to 2 home health visits are covered following both child delivery and a mastectomy; these visits do not count toward the visit limitation	Yes
15	Emergency Room Services	Covered	Emergency Services	No							No
16	Emergency Transportation/ Ambulance	Covered	Ambulance Services	No						Limited to licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No					Medical care for inpatient stays that are primarily for any diagnostic service and/or observation or for rehabilitation services; only covers private rooms when medically necessary		No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No							No
19	Bariatric Surgery	Covered	Surgical Treatment of Morbid Obesity	No						Patient must meet clinical definition of morbidly obese	No
20	Cosmetic Surgery	Not Covered								Coverage for cosmetic surgery is only provided for reconstructive surgery following a mastectomy or for treatment of a cleft lip and/or palate	
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility Services	Yes	180	Days per year				Hospital precertification and review is required.	No
22	Prenatal and Postnatal Care	Covered	Prenatal and post natal care for mother	No							No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and Inpatient Services for Maternity Care	No				48		1 home health visit is covered following hospital discharge (an additional is covered for patients that leave the hospital early if prescribed); this visit does not count toward the home health limit	No

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24	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Facility Services	No					marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, comat-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
25	Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient and Residential Crisis Facility and Professional Services	No					marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, comat-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
26	Substance Abuse Disorder Outpatient Services	Covered	Mental/Behavioral Health Outpatient Facility Services	No							No
27	Substance Abuse Disorder Inpatient Services	Covered	Mental/Behavioral Health Inpatient and Residential Crisis Facility and Professional Services	No							No
28	Generic Drugs	Covered	Generic Drugs	No					Weight loss products other than appetite suppressants; Adrogen and estrogen endocrine medications; OTC drugs; cosmetic agents; Serums/Toxoids/Vaccines (Synagis/Rhogam) (Rabbies vaccine covered until 7/1/12); homeopathic drugs; vitamins except prenatal viatamins and select therapeutic agents like Rocaltrol, Calcitriol, Niacin, Potaba, Deplin		No
29	Preferred Brand Drugs	Covered	Preferred Brand Drugs	No					Weight loss products other than appetite suppressants; Adrogen and estrogen endocrine medications; OTC drugs; cosmetic agents; Serums/Toxoids/Vaccines (Synagis/Rhogam) (Rabbies vaccine covered until 7/1/12); homeopathic drugs; vitamins except prenatal viatamins and select therapeutic agents like Rocaltrol, Calcitriol, Niacin, Potaba, Deplin		No

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30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Drugs	No					Weight loss products other than appetite suppressants; Adrogen and estrogen endocrine medications; OTC drugs; cosmetic agents; Serums/Toxoids/Vaccines (Synagis/Rhogam) (Rabbies vaccine covered until 7/1/12); homeopathic drugs; vitamins except prenatal vitamins and select therapeutic agents like Rocaltrol, Calcitriol, Niacin, Potaba, Deplin		No
31	Specialty Drugs	Covered	Specialty drugs	No					Injectable dermatologicals		No
32	Outpatient Rehabilitation Services	Covered	Physical, Occupational, and Speech Therapy	Yes	50	Visits per year			Vocational rehabilitation; comprehensive rehabilitation services	Rehabilitative services for otological, audiological, and speech/language treatment does not count toward the speech therapy visit limit	No
33	Habilitation Services	Covered	Physical, Occupational, and Speech Therapy	Yes	50	Visits per year			Early intervention and school services; services for members 19 years of age or older	Visit limit does not apply to otological, audiological and speech/language treatment for Cleft Lip or Cleft Palate, or Both	No
34	Chiropractic Care	Covered	Spinal Manipulations by a Chiropractor or Doctor of Osteopathy	No					Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine	Benefits are only provided for medically necessary for pain management spinal manipulations and for evaluation of the musculoskeletal conditions of the spine when provided by a qualified chiropractor or DO; Plan of Treatment must be submitted	No
35	Durable Medical Equipment	Covered	Includes medical devices and supplies, orthotic and prosthetic devices, and medical foods	No							No
36	Hearing Aids	Covered	Hearing Aids	Yes	1	Other other	1 for each hearing impaired ear every 36 months			Only the least expensive medically necessary model is covered for adults; adult coverage comes as a rider	No
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Services	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Diagnostic Imaging Services	No							No

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39	Preventive Care/ Screening/ Immunization	Covered	Preventative Screenings	No						There are age or condition limitations for coverage of certain screenings and immunizations (e.g. PSA tests for prostate cancer screenings are limited to 1. Men between 40-75 years old; 2. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3. When used for staging in determining the need for a bone scan for patients with prostate cancer; or 4. When used for male Members who are at high risk for prostate cancer.)	No
40	Routine Foot Care	Covered	Routine Foot Care	No						Only covered for conditions it is determined to be medically necessary for such as for diabetics	No
41	Acupuncture	Covered	Acupuncture	No						Only covered for medically necessary pain management; Plan of Treatment must be submitted	No
42	Weight Loss Programs	Not Covered									
43	Routine Eye Exam for Children	Covered	Routine Eye Exam for Children	Yes	1	Visits per year				FEDVIP BlueVision High	No
44	Eye Glasses for Children	Covered	Glasses and Frames or Contact Lenses	Yes	1	Other other	1 pair of eyeglasses or 1 pair contact lenses per year			FEDVIP BlueVision High	No
45	Dental Check-Up for Children	Covered	Clinical Oral Exam	Yes	2	Visits per year	Only fluoride from PCP, exam covered under dental plan			MCHP Healthy Smiles	No
46	Other										

OTHER BENEFITS

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1	Other	Covered	Circumcision	No						Includes circumcision performed by a mohel recognized under the laws of Judaism	No
2	Habilitation Services	Covered	Occupational, Physical, and Speech Therapy	No					Excludes benefits for those over 19 years old		No
3	Other	Covered	Organ and Tissue Transplant	No					Travel expenses are not covered for the recipient and companion for kidney, cornea, and bone marrow transplants; coverage is not provided for expenses related to finding a donor	Covered for kidney, cornea, bone marrow, liver, heart, pancreas, single/double-lung, and heart-lung transplants for both the donor and recipient. Coverage includes immunosuppressant maintenance drugs. Travel experiences are covered for the organ transplant team when needed and for the recipient and companion(s), including lodging expense and meals, when the organ transplant hospital is over 50 miles from the recipient's home.	No
4	Other	Covered	Elective abortions	No							No
5	Other	Covered	Mastectomy Related Services	No						Provides for up to 2 home health visits following a mastectomy, but these visits do not count toward the total covered home health visit limitation	No
6	Other	Covered	Outpatient Cardiac Rehabilitation	Yes	36	Other other	Sessions within a 12 week period per medical event			Physician referral is required; coverage comes as a rider	No
7	Infertility Treatment	Covered	Infertility Services	Yes	3	Other other	Artificial insemination (AI)/intrauterine insemination (IUI) and IVF are limited to 3 attempts per live birth				No

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8	Hospice Services	Covered	Respite Care	Yes	5	Other other	At the carrier's discretion, may limit benefit to 5 consecutive days for each inpatient stay				Yes
9	Hospice Services	Covered	Bereavement counseling	Yes	15	Other other	Limited to the 6 month period following the Member's death or 15 visits, whichever occurs 1st.				No
10	Home Health Care Services	Covered	Home Health Aid Visits	Yes	40	Visits per year				Up to 2 home health visits are covered following both child delivery and a mastectomy; these visits do not count toward the visit limitation	No
11	Other	Covered	Clinical Trial Patient Cost Services	No							No
12	Other	Covered	Diabetes equipment, supplies, and self-management	No							No
13	Other	Covered	General anesthesia and associated hospital or ambulatory surgical facility services for dental care	No					Does not provide coverage for dental services oral anesthesia or facility and provider charges related to temporomandibular joint disorders; does not provide coverage for the dental services where general anesthesia is provided	Provided for individuals 17 years of age or younger when medically necessary under certain circumstances	No
14	Other	Covered	Contraceptive Services, Devices, and Drugs	No					Excludes over the counter contraceptive devices	Includes coverage for all FDA approved devices and drugs (including injectables); includes coverage for the exam, insertion, and removal of devices; and elective sterilization and reversal of elective sterilization	No
15	Other	Covered	Hair Prosthesis	Yes	1	Other other	1 hair prosthesis per benefit period				No
16	Other	Covered	Medical Foods	No						Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease	No

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17	Other	Covered	Administration of injectable Prescription Drugs by a Health Care Provider	No						Covered as part of inpatient/outpatient provider services	No
18	Other	Covered	Allergy Related Services	No						Includes allergen immunotherapy (allergy injections) and allergy testing	No
19	Other	Covered	Mental/Behavioral Health Partial Hospitalization Services	No					marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
20	Other	Covered	Mental/Behavioral Health Intensive Outpatient Services	No					marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
21	Other	Covered	Mental/Behavioral Health Office and Professional Services	No					Intensive outpatient services, marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
22	Other	Covered	Mental/Behavioral Health Outpatient Medication Management Services	No					Intensive outpatient services, marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
23	Other	Covered	Mental/Behavioral Health Emergency Room Services	No					Intensive outpatient services, marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, recreational therapy, smoking cessation, weight loss programs		No
24	Other	Covered	Routine Gynecological Care (For a member 22 years of age or older)	Yes	1	Visits per year					No

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25	Other	Covered	Child Preventive and Routine Care (newborn through age 2)	Yes	12	Visits per lifetime			Benefit for newborns through 2 years		No
26	Other	Covered	Child Preventive and Routine Care (for members age 3 through 21)	Yes	1	Visits per year					No
27	Other	Covered	Immunizations	No						Benefits are available for immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.	No
28	Other	Covered	Chlamydia and Human Papillomavirus Screening	Yes	1	Visits per year				Benefit for Female Members who are under the age of 20 years if they are sexually active; and at least 20 years old if they have Multiple Risk Factors; male members if they have Multiple Risk Factors; and A human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.	No
29	Other	Covered	Colorectal Cancer Screening	No						Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.	No
30	Other	Covered	Mammography/Breast Cancer Screening	No						At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.	No

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31	Other	Covered	Osteoporosis Prevention	No						Bone Mass Measurement for the prevention and diagnosis of osteoporosis when requested by a Health Care Provider for a Qualified Individual.	No
32	Other	Covered	Prostate Cancer Screening	No						PSA tests for prostate cancer screenings are limited to 1. Men between 40-75 years old; 2. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3. When used for staging in determining the need for a bone scan for patients with prostate cancer; or 4. When used for male Members who are at high risk for prostate cancer.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

Category	Class	Submission Count
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	17
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	8
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	12
ANESTHETICS	LOCAL ANESTHETICS	1
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	1
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	2
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	17
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	17
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	15
ANTIBACTERIALS	BETA-LACTAM, OTHER	3
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	8
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	5
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	BARBITURIC ACID DERIVATIVE	1
ANTICONVULSANTS	BENZODIAZEPINE DERIVATIVE	3
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	3
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	2
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	5
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	0
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	0
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	1
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	8
ANTIDEPRESSANTS	TRICYCLICS	8
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3
ANTIFUNGALS	ANTIFUNGALS	15
ANTIGOUT AGENTS	ANTIGOUT AGENTS	2

Category	Class	Submission Count
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	3
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	1
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	5
ANTINEOPLASTICS	ALKYLATING AGENTS	3
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	1
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS	35
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	5
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	2
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	8
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	2
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	0
ANTIPARASITICS	ANTIPROTOZOALS	5
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	3
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	0
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	4
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	ANTISPASTICITY AGENTS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	0
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	7
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	0
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	4
ANTIVIRALS	ANTI-INFLUENZA AGENTS	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	10
ANTIVIRALS	ANTIHERPETIC AGENTS	4

Category	Class	Submission Count
ANXIOLYTICS	ANXIOLYTICS, OTHER	3
ANXIOLYTICS	SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	4
BIPOLAR AGENTS	MOOD STABILIZERS	3
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	10
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	1
BLOOD GLUCOSE REGULATORS	INSULINS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	3
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	2
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	9
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	7
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	12
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	7
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	6
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	3
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	4
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	2
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	2
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	2
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	4
DENTAL AND ORAL AGENTS	DENTAL AND ORAL AGENTS	6
DERMATOLOGICAL AGENTS	DERMATOLOGICAL AGENTS	17
ENZYME REPLACEMENT/MODIFIERS	ENZYME REPLACEMENT/MODIFIERS	12
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3

Category	Class	Submission Count
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	1
GASTROINTESTINAL AGENTS	LAXATIVES	2
GASTROINTESTINAL AGENTS	PROTECTANTS	1
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	3
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	5
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	6
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	1
GENITOURINARY AGENTS	PHOSPHATE BINDERS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	20
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	3
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	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	0
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	6
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	14
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	1
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	6
IMMUNOLOGICAL AGENTS	VACCINES	5
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	1
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	6
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	METABOLIC BONE DISEASE AGENTS	9

Category	Class	Submission Count
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	7
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	8
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	7
OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES	1
OTIC AGENTS	OTIC AGENTS	1
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	9
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	0
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	5
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	3
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3
SKELETAL MUSCLE RELAXANTS	SKELETAL MUSCLE RELAXANTS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	1
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	5