

## PROPOSED VERMONT EHB BENCHMARK PLAN

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### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Health Maintenance Organization
<b>Issuer Name</b>	The Vermont Health Plan, LLC
<b>Product Name</b>	CDHP-HMO
<b>Plan Name</b>	BlueCare, The Vermont Health Plan, LLC, CDHP
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"><li>• Pediatric Oral (State CHIP)</li><li>• Pediatric Vision (FEDVIP)</li></ul>
<b>Habilitative Services</b>	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							No
2	Specialist Visit	Covered	Specialist Visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery Physician/Surgical Services	No							Yes
6	Hospice Services	Covered	Hospice Services	No						Must meet hospice requirements for benefit eligibility.	Yes
7	Non-Emergency Care When Traveling Outside the U.S.	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					Excluded UNLESS member qualifies for coverage due to sabbatical or attending college in a foreign country.		No
8	Routine Dental Services (Adult)	Not Covered									
9	Infertility Treatment	Not Covered								Refer to Infertility Drug limitation in Generic, Preferred and Non-Preferred Prescription Drug categories.	
10	Long-Term/Custodial Nursing Home Care	Not Covered									
11	Private-Duty Nursing	Covered	Private-Duty Nursing	Yes	2000	Other other	Covered up to \$2,000 per plan year			Requires prior approval and recertification of treatment plan every 60 days.	No
12	Routine Eye Exam (Adult)	Covered	Routine Eye Exam (Adult)	Yes	1	Other other	1 routine eye exam per calendar year		Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.		No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Centers or Facilities	No							No
14	Home Health Care Services	Covered	Home Health Care Services	No							No

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15	Emergency Room Services	Covered	Emergency Room Services	No					Excludes benefits for an emergency room services that does not meet definition of Emergency Service.		Yes
16	Emergency Transportation/ Ambulance	Covered	Emergency Transportation/ Ambulance	No					Insured's condition must meet the criteria for an emergency medical condition. Insured must get approval within 48 hours after emergency air or water transport.		No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	1	Other other	Coverage for either day of admission OR day of discharge but not both.				No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	Yes	1	Other other	May limit the number of visits covered by one Provider in a given day.				Yes
19	Bariatric Surgery	Covered	Bariatric Surgery	Yes	1	Other other	Covered up to \$10,000 per lifetime.				No
20	Cosmetic Surgery	Covered	Cosmetic Surgery	No					Cosmetic Surgery is an excluded benefit except for prior approval for reconstruction as detailed in certificate of coverage.		No
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	No						Covered by participating facility only for Acute Care. Includes room, board, general nursing care, medication and drugs given by SNF during a covered stay and medical services included in the rates of a SNF.	No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No						See Maternity Office Visits and Inpatient Hospital Services for additional benefit information.	Yes
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Services for Maternity Care	No						Covered as an Inpatient Hospital Stay.	No

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24	<b>Mental/Behavioral Health Outpatient Services</b>	Covered	Mental/Behavioral Health Outpatient Services	No						Includes individual and group psychotherapy, family and couples therapy, intensive programs, partial hospital day treatment, psychological testing when integral to treatment, psychotherapy programs to improve compliance with prescribed medical treatment regimens for diabetes, hypertension, ischemic heart disease and emphysema.	Yes
25	<b>Mental/Behavioral Health Inpatient Services</b>	Covered	Mental/Behavioral Health Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes hospitalization, residential treatment programs.	No
26	<b>Substance Abuse Disorder Outpatient Services</b>	Covered	Substance Abuse Disorder Outpatient Services	No						Includes detoxification in outpatient rehab facility (including services for the patient's family when necessary)	Yes
27	<b>Substance Abuse Disorder Inpatient Services</b>	Covered	Substance Abuse Disorder Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes detoxification in an inpatient rehabilitation facility.	No
28	<b>Generic Drugs</b>	Covered	Generic Drugs	Yes	90	Other other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.				Yes

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29	Preferred Brand Drugs	Covered	Preferred Brand Drugs	Yes	90	Other other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Drugs	Yes	90	Other other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
31	Specialty Drugs	Covered	Specialty Drugs	Yes	30	Other other	Limited to a 30-day supply.		ONLY Participating Specialty pharmacies may be utilized for Specialty drugs.		Yes
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	Yes	30	Other other	Up to 30 outpatient sessions combined per plan year			Cardiac Rehabilitation is covered up to 36 visits per cardiac event. Typically include physical, occupational and speech therapy but may also include radiation therapy, chemotherapy, dialysis, infusion therapy.	Yes
33	Habilitation Services	Covered	Habilitation Services	No						Autism Coverage per Vermont State Mandate for ages zero to six years.	No
34	Chiropractic Care	Covered	Chiropractic Care	Yes	12	Other other	Prior Approval is required after the 12th visit.			Prior approval required after 12 visits; includes treatment for neuromusculoskeletal conditions by a network provider working within the scope of their license.	No
35	Durable Medical Equipment	Covered	Durable Medical Equipment	No						Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, devices. Threshold applies.	Yes
36	Hearing Aids	Not Covered									
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Test (X-Ray and Lab Work)	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/ Screening/Immunization	No							No
40	Routine Foot Care	Covered	Routine Foot Care	No					Covered for Diabetics ONLY; excluded for all other members.		No
41	Acupuncture	Not Covered									

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42	Weight Loss Programs	Not Covered									
43	Routine Eye Exam for Children	Covered	Routine Eye Exam for Children	Yes	1	Other other	1 routine eye exam per member per calendar year.		Does not cover the evaluation and fitting of contact lenses or other supplemental tests.		No
44	Eye Glasses for Children	Covered		No						Refer to "Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery" on Other tab for more information.	No
45	Dental Check-Up for Children	Covered		Yes	2	Treatments per year					No
46	Other										

## OTHER BENEFITS

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1	Other	Covered	Nutritional Counseling	Yes	3	Visits per year	3 visits per plan year		Visits for treatment of diabetes do not count toward this visit limit		No
2	Outpatient Surgery Physician/Surgical Services	Covered	Neuropsychological Testing	Yes	8	Hours per year					No
3	Hospice Services	Covered	Home Health Aide	Yes	100	Hours per month				For personal care services only	No
4	Outpatient Rehabilitation Services	Covered	Outpatient physical, speech and occupational therapy	Yes	30	Visits per year	Up to 30 outpatient sessions combined per plan year			Covered up to 30 visits combined per plan year.	No
5	Other	Covered	Preventive Care	No						Includes routine physical examinations, immunizations, well-child care, screening mammogram, screening colonoscopy, preventive GYN	No
6	Other	Covered	Dental Services (not Routine)	No						Includes treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started with six months of the accident; also includes surgery to correct gross deformity from major disease or surgery with service occurring within six months of the onset of disease or within six months of surgery.	No
7	Inpatient Physician and Surgical Services	Covered	Sterilization Reversal	Yes	1	Other other	Procedures per lifetime			Covers only one attempt at reversal of sterilization.	No
8	Durable Medical Equipment	Covered	Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery.	Yes	1	Other other	1 set of accompanying eyeglasses or contact lenses for the original prescription and one set for each new prescription				Yes

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9	Durable Medical Equipment	Covered	Dental prosthetics	No					Repair or replacement of dental appliances or dental prosthetics	With prior approval and only of required to treat an accidental injury (except injury as a result of chewing or biting); or to correct gross deformity resulting from major disease or Surgery; to treat obstructive sleep apnea; or to treat craniofacial disorders, including temporomandibular joint syndrome	No
10	Generic Drugs	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
11	Preferred Brand Drugs	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
12	Non-Preferred Brand Drugs	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
13	Other	Covered	Nutritional Formulae or supplements	Yes	2500	Other other	Up to \$2,500 per year for medical foods prescribed for the medically necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.				No
14	Prenatal and Postnatal Care	Covered	Maternity Office Visits	No						Includes coverage by a Physician or other Professional during a woman's pregnancy for pre-natal visits and other care and post-natal visits.	No

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15	Other	Covered	Transplant Services - deceased donor	Yes	35000	Other other	For transplants using a deceased donor, benefits are limited to \$35,000 per solid organ transplant for search, removal, storage, and transportation of the organ.				No
16	Emergency Room Services	Covered	Emergency room physician services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
17	Emergency Room Services	Covered	Emergency mental health and substance use physician and facility services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
18	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral health office visits	No							No
19	Substance Abuse Disorder Outpatient Services	Covered	Substance use disorder office visits	No							No
20	Outpatient Rehabilitation Services	Covered	Cardiac rehabilitation services	Yes	36	Other other	36 visits per cardiac event; three supervised exercise sessions per week up to total of 36 sessions for cardiac and pulmonary rehab programs.				No
21	Hospice Services	Covered	Hospice Services Homemaker Services	Yes	100	Hours per month					No
22	Hospice Services	Covered	Hospice Continuous Care Services in Home	Yes	5	Days per admission	OR 120 hours of continuous care			for in home care	No
23	Hospice Services	Covered	Hospice Respite Care	Yes	72	Hours per month					No
24	Hospice Services	Covered	Hospice Social Services Visits	Yes	6	Visits per lifetime					No
25	Hospice Services	Covered	Hospice Bereavement visits	Yes	2	Visits per lifetime				2 bereavement visits following death	No
26	Generic Drugs	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No

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27	Preferred Brand Drugs	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
28	Non-Preferred Brand Drugs	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
29	Specialty Drugs	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
30	Other	Covered	Transplant Services - Live donor	Yes	65000	Other other	For transplants using a live donor, benefits are limited to \$65,000 for the live donor's surgical expenses and storage and transportation of the organ for each covered organ transplant procedure completed. Costs for a donor must be incurred within 120 days from the date of the donor's surgery.				No
31	Other	Covered	Transplant Recipient - Benefit Coverage Time Period	Yes	1	Other other	From 30 days before the transplant to 365 days after the transplant for bone marrow transplants OR From five days before the transplant to 365 days after the transplant.				No
32	Durable Medical Equipment	Covered	Pre-fabricated knee braces	No					Custom-fabricated or custom-molded knee braces		No

**PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS**

<b>Category</b>	<b>Class</b>	<b>Submission Count</b>
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-AMINO BUTYRIC 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

Category	Class	Submission Count
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
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

Category	Class	Submission Count
ANXIOLYTICS	SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4
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

Category	Class	Submission Count
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
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

Category	Class	Submission Count
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
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	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	3
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	3