# Mississippi EHB Benchmark Plan

## Summary Information

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| **Plan Type** | Plan from largest small group product, Preferred Provider Organization |
| **Issuer Name** | Blue Cross & Blue Shield of Mississippi |
| **Product Name** | Network Blue |
| **Plan Name** | Network Blue |
| **Supplemented Categories** (Supplementary Plan Type) | • Pediatric Oral (State CHIP)<br>• Pediatric Vision (State CHIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | Yes |

## BENEFITS AND LIMITS

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>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 | | | | | | Physician Office Service. | No |
| 2 | **Specialist Visit** | Covered | Specialist Visit | No | | | | | | Physician Specialist Office Service. | No |
| 3 | **Other Practitioner Office Visit (Nurse, Physician Assistant)** | Covered | Allied Primary Care Health Professional Office Visit (Nurse Practitioner, Nurse Midwife, and Physican's Assistant) | No | | | | | | Allied Primary Care Health Professional Office Service. | No |
| 4 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | No | | | | | | Covered Services to Patients in Ambulatory Surgical Facility includes: Pre-op labs directly related to surgical procedure; Pre-op preparation; Use of facility (operating rooms, recovery rooms & surgical equipment); Anesthesia, drugs, & surgical supplies; Implants, prostheses & nourishments. | No |
| 5 | **Outpatient Surgery Physician/Surgical Services** | Covered | Outpatient Surgery Physician/Surgical Services | No | | | | | Other dental surgery; Oral surgery dental in origin; Elective Abortion; Lasik or any eye surgery to repair visual acuity. | Outpatient Surgery - Physician/Surgical Services including dental or oral surgery services related to an accident. | No |
| 6 | **Hospice Services** | Covered | Hospice Services | Yes | 6 | Other | Months per lifetime | | | Hospice Care. | No |
| 7 | **Non-Emergency Care When Traveling Outside the U.S.** | Not Covered | | | | | | | | | |
| 8 | **Routine Dental Services (Adult)** | Not Covered | | | | | | | | | |
| 9 | **Infertility Treatment** | Not Covered | | | | | | | | | |
| 10 | **Long-Term/ Custodial Nursing Home Care** | Not Covered | | | | | | | | | |
| 11 | **Private-Duty Nursing** | Not Covered | | | | | | | | | |
| 12 | **Routine Eye Exam (Adult)** | Not Covered | | | | | | | | | |

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| 13 | **Urgent Care Centers or Facilities** | Covered | Urgent Care Centers or Facilities | No | | | | | | Urgent Care Centers. | No |
| 14 | **Home Health Care Services** | Covered | Home Health Care Services | No | | | | | | Health services rendered in the individual's place of residence by an organization licensed as a home health Provider by the appropriate state agency and/or approved by Company. | No |
| 15 | **Emergency Room Services** | Covered | Emergency Room Services | No | | | | | | Emergency room services to include physician, facility fee and supplies in providing treatment for members for covered emergency care. | No |
| 16 | **Emergency Transportation/ Ambulance** | Covered | Emergency Transportation/ Ambulance | No | | | | | Transportation for comfort or convenience. | Medically necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured; includes transportation by air ambulance when condition or urgency of needed medical care precludes travel by surface transportation. | No |
| 17 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Inpatient Hospital Services (e.g., Hospital Stay) | No | | | | | Exclusions: weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss; cosmetic surgery and any complications resulting from cosmetic surgery; other dental surgery; oral surgery dental in origin; elective abortion; Lasik or any eye surgery to repair visual acuity. | Inpatient bed, board, and general nursing service; operating, delivery, recovery and treatment rooms and equipment; drugs and medicine; blood; anesthesia; medical and surgical supplies; diagnostic and therapy services; and psychological testing and psychotherapy. Reconstructive breast surgery: includes reconstruction on breast on which mastectomy performed; surgery and reconstruction to produce symmetry; and prostheses and care for complications of mastectomy. Transplants to include renal transplants, other solid organ transplants (liver, heart, lung), tissue transplants, and donor benefits. *Subject to prior approval and some limitations.* | No |

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| 18 | **Inpatient Physician and Surgical Services** | Covered | Inpatient Physician and Surgical Services | No | | | | | Exclusions: weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss; cosmetic surgery and any complications resulting from cosmetic surgery; transportation of the recipient to the location of the transplant surgery; other dental surgery; oral surgery dental in origin; elective abortion; Lasik or any eye surgery to repair visual acuity. | Inpatient Physician and Surgical Services as described above. | No |
| 19 | **Bariatric Surgery** | Not Covered | | | | | | | | | |
| 20 | **Cosmetic Surgery** | Not Covered | | | | | | | | | |
| 21 | **Skilled Nursing Facility** | Not Covered | | | | | | | | | |
| 22 | **Prenatal and Postnatal Care** | Covered | Prenatal and Postnatal Care | No | | | | | | Prenatal and Postnatal care includes: surgical and Medical Services: initial office visit, diagnostic services, delivery (including pre-natal and post-natal care), interruptions of pregnancy (miscarriage and medically necessary abortion required in order to preserve the life or physical health of the mother). | No |

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| 23 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Delivery and All Inpatient Services for Maternity Care | No | | | | | Maternity and newborn care for dependent children. | Delivery and all inpatient services for maternity care: hospital services required in connection with the pregnancy and interruptions of pregnancy. Newborn: treatment of illness, prematurity, postmaturity, or congenital condition for ill new born, circumcision, initial examinations of a well newborn or, when delivery is by C-section, one consultation for standby resuscitation and infant care in OR by a physician other than the operating surgeon. Benefits will be provided for subsequent visits by the physician while the well newborn is in the hospital with the mother. These benefits will not extend beyond the mother's stay; routine hospital nursery care of a well newborn for the mother's authorized routine length of stay. | No |
| 24 | **Mental/Behavioral Health Outpatient Services** | Covered | Mental/Behavioral Health Outpatient Services | Yes | 52 | Visits per year | | | Marital, family, career, behavioral, or other counseling services; treatment or testing related to autistic disease, learning disabilities, mental retardation, or hospitalization for environmental change; admittance into a mental institution or sanatorium, except where enforcement of the exclusion is prohibited by law; treatment in connection with involuntary commitment. | Benefits for treatment of Nervous/Mental conditions are limited to benefits for conditions which are manifested in a disturbance of intellectual and emotional functions to a degree of severity where; 1) the presence of anxiety and/or depression is significantly beyond minor behavior aberrations, or 2) the patient's mental state is such that there has been a break with reality. The company provides benefits based on the allowable charge for covered services provided to a member for outpatient services. Outpatient services are those services which are received in a hospital, an outpatient treatment facility, or another appropriate setting licensed by the state of Mississippi and approved by the company. | No |

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| 25 | **Mental/Behavioral Health Inpatient Services** | Covered | Mental/Behavioral Health Inpatient Services | Yes | 30 | Days per year | | | Marital, family, career, behavioral, or other counseling services; treatment or testing related to autistic disease, learning disabilities, mental retardation, or hospitalization for environmental change; admittance into a mental institution or sanatorium, except where enforcement of the exclusion is prohibited by law; treatment in connection with involuntary commitment. | Benefits for treatment of Nervous/Mental conditions are limited to benefits for conditions which are manifested in a disturbance of intellectual and emotional functions to a degree of severity where; 1) the presence of anxiety and/or depression is significantly beyond minor behavior aberrations, or 2) the patient's mental state is such that there has been a break with reality. The company provides benefits based on the allowable charge for covered services provided to a member for inpatient services and partial hospitalization. | Yes |
| 26 | **Substance Abuse Disorder Outpatient Services** | Covered | Alcohol and Drug Abuse Outpatient Services | Yes | 20 | Visits per year | | | Marital, family, career, behavioral, or other counseling services; treatment or testing related to autistic disease, learning disabilities, mental retardation, or hospitalization for environmental change; admittance into a mental institution or sanatorium, except where enforcement of the exclusion is prohibited by law; treatment in connection with involuntary commitment | | No |
| 27 | **Substance Abuse Disorder Inpatient Services** | Covered | Alcohol and Drug Abuse Inpatient Services | Yes | 7 | Days per year | | | Marital, family, career, behavioral, or other counseling services; treatment or testing related to autistic disease, learning disabilities, mental retardation, or hospitalization for environmental change; admittance into a mental institution or sanatorium, except where enforcement of the exclusion is prohibited by law; treatment in connection with involuntary commitment. | | No |

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| 28 | **Generic Drugs** | Covered | Prescription Drug | No | | | | | Formulary exclusions include certain quantity limits based upon clinical guidelines, compound prescription drugs, investigative drugs with exceptions, and prescription drugs if there is an equivalent over the counter product. | Prescription Drug. | No |
| 29 | **Preferred Brand Drugs** | Covered | Prescription Drug | No | | | | | Formulary exclusions include certain quantity limits based upon clinical guidelines, compound prescription drugs, investigative drugs with exceptions, and prescription drugs if there is an equivalent over the counter product. | Prescription Drug. | No |
| 30 | **Non-Preferred Brand Drugs** | Covered | Prescription Drug | No | | | | | Formulary exclusions include certain quantity limits based upon clinical guidelines, compound prescription drugs, investigative drugs with exceptions, and prescription drugs if there is an equivalent over the counter product. | Prescription Drug. | No |
| 31 | **Specialty Drugs** | Covered | Prescription Drug | No | | | | | Exclusions and Network requirements. | Prescription Drug. | No |
| 32 | **Outpatient Rehabilitation Services** | Covered | Outpatient Rehabilitation Services | Yes | 20 | Visits per year | | | Therapy services related to general conditioning of the patient; therapies rendered primarily for job training; pulmonary rehabilitation; speech therapy for learning disabilities and developmental problems; Physical Therapy/Occupational Therapy: combined 20 visit limit; Speech Therapy: separate 20 visit limit. | Benefits for the coordinated use of medical, social, educational or vocational services, beyond the acute care stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities. | Yes |
| 33 | **Habilitation Services** | Covered | Habilitation Services | No | | | | | | Covered as defined by Rehabilitation Services. | No |

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| 34 | **Chiropractic Care** | Covered | Chiropractic Care | Yes | 20 | Visits per year | | | | Physical/medicinal benefits as to the modalities, therapeutic procedures, tests and measurements used to evaluate and treat acute musculoskeletal conditions. | No |
| 35 | **Durable Medical Equipment** | Covered | Durable Medical Equipment | No | | | | | Benefits will not be provided for hot tubs, swimming pools, whirlpools, lift chairs, air purifiers; alterations or structural changes to the member's home, auto, or personal property to accommodate any DME; benefits only provided when equipment is prescribed by a physician and is not a comfort or convenience item. | Items which are used to serve a medical purpose, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home. This includes orthotic devices and prosthetic appliances. | No |
| 36 | **Hearing Aids** | Not Covered | | | | | | | | | |
| 37 | **Diagnostic Test (X-Ray and Lab Work)** | Covered | Diagnostic Test (X-Ray and Lab Work) | No | | | | | Hearing exams are excluded with the exception of childrens' wellness exams. | Radiology, laboratory, and pathology services and other tests or procedures rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite illness or injury. | No |
| 38 | **Imaging (CT/PET Scans, MRIs)** | Covered | Imaging (CT/PET Scans, MRIs) | No | | | | | | Radiology services and other tests or procedures rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite illness or injury. | No |
| 39 | **Preventive Care/ Screening/ Immunization** | Covered | Preventive Care/Screening/ Immunization | No | | | | | | Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage, including but not limited to preventive services mandated by ACA. | No |
| 40 | **Routine Foot Care** | Covered | Routine Foot Care | Yes | 1 | Visits per year | | | Palliative and cosmetic foot care. | Covered for certain individuals with Diabetes based on Medical Policy. | No |
| 41 | **Acupuncture** | Not Covered | | | | | | | | | |
| 42 | **Weight Loss Programs** | Not Covered | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 43 | **Routine Eye Exam for Children** | Covered | Routine eye exam | Yes | 1 | Visits per year | | | | Supplemented using Mississippi CHIP. | No |
| 44 | **Eye Glasses for Children** | Covered | Eyeglasses for adults and children | Yes | 1 | Other | 1 pair of eyeglasses per year | | | Supplemented using Mississippi CHIP. | No |
| 45 | **Dental Check-Up for Children** | Covered | Dental Check-Up for Children | Yes | 1 | Other | 1 every 6 months | | | Supplemented using Mississippi CHIP. | No |

## OTHER BENEFITS

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Mental/ Behavioral Health Inpatient Services** | Covered | Mental/Behavioral Health | Yes | 60 | Days per year | | | | Mental/Behavioral Health Partial Hospitalization. | No |
| 2 | **Inpatient Rehabilitation Services** | Covered | Inpatient Rehabilitation Services | Yes | 30 | Days per year | | | | Inpatient rehabilitation services that cannot be adequately performed in an outpatient setting. | No |
| 3 | **Other** | Covered | TMJ | Yes | 5000 | Other | Dollars | | | TMJ. | No |
| 4 | **Other** | Covered | Infusion Therapy | No | | | | | | Limited to drugs, intravenous solutions, Durable Medical Equipment, pharmacy compounding and dispensing services, fees associated with drawing blood for the purpose of monitoring response to therapy, therapist services, ancillary medical supplies, and nursing visits, including initiation of infusion therapy, intravenous restarts and emergency care when medical necessary to provide infusion therapy. | No |
| 5 | **Other** | Covered | Other Women's Health | No | | | | | Services and supplies related to infertility, artificial insemination, intrauterine insemination and in-vitro fertilization regardless of any claim of medical necessity. | Treatment to correct an underlying cause of infertility. | No |
| 6 | **Other** | Covered | Sleep Studies | No | | | | | | Services must be provided by a sleep disorder center accredited by the American Academy of Sleep Medicine. | No |
| 7 | **Other** | Covered | Diabetes Self-Management Training | Yes | 1 | Visits per year | | | | Self-management training for the control of Diabetes. | No |
| 8 | **Other** | Covered | Diabetes Equipment | Yes | 1 | Other | Per 2 years | | | Equipment and supplies for monitoring blood glucose and insulin administration | No |
| 9 | **Other** | Covered | Diabetes Dilated Eye Exam | Yes | 1 | Other | Exam per year | | | Dilated eye exam for members with Diabetes. | No |
| 10 | **Other** | Covered | Diabetes Preventive Foot Care | Yes | 1 | Visits per year | | | | Preventive foot care for members with Diabetes. | 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 | 9 |
| 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 | 19 |
| 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 | 1 |
| 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 | 7 |
| 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 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANTIMIGRAINE AGENTS | SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS | 7 |
| ANTIMYASTHENIC AGENTS | PARASYMPATHOMIMETICS | 3 |
| 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 | 5 |
| ANTINEOPLASTICS | AROMATASE INHIBITORS, 3RD GENERATION | 3 |
| ANTINEOPLASTICS | ENZYME INHIBITORS | 3 |
| ANTINEOPLASTICS | MOLECULAR TARGET INHIBITORS | 12 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 3 |
| ANTINEOPLASTICS | RETINOIDS | 3 |
| ANTIPARASITICS | ANTHELMINTICS | 3 |
| 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 | 4 |
| 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 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| BIPOLAR AGENTS | BIPOLAR AGENTS, OTHER | 6 |
| BIPOLAR AGENTS | MOOD STABILIZERS | 5 |
| BLOOD GLUCOSE REGULATORS | ANTIDIABETIC AGENTS | 21 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 2 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 10 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | ANTICOAGULANTS | 7 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | BLOOD FORMATION MODIFIERS | 7 |
| 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 | 7 |
| 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 | 6 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, OTHER | 6 |
| 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 | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 3 |
| 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 | 33 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 15 |
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 5 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 6 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 4 |
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 2 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| GASTROINTESTINAL AGENTS | LAXATIVES | 3 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 6 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 7 |
| GENITOURINARY AGENTS | BENIGN PROSTATIC HYPERTROPHY AGENTS | 8 |
| 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 | 3 |
| 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 | 4 |
| 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 | 22 |
| 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 | 14 |
| 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 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 13 |
| OTIC AGENTS | NO USP CLASS | 6 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 6 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 11 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 2 |
| 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 | 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 | 6 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 7 |