MISSISSIPPI EHB BENCHMARK PLAN

SUMMARY INFORMATION

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)Pediatric Vision (State CHIP)
Habilitative Services Included Benchmark (Yes/No)	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	Stay	l 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
	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	•	Covered	Allied Primary Care Health Professional Office Visit (Nurse Practitioner, Nurse Midwife, and Physican's Assistant)	No						Allied Primary Care Health Professional Office Service.	
	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
	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.	
	Hospice Services	Covered	Hospice Services	Yes	6	Other	Months per lifetime			Hospice Care.	No
	Non-Emergency Care When Traveling Outside the U.S.	Not Covered									
	Services (Adult)	Not Covered									
10	Infertility Treatment Long-Term/ Custodial Nursing Home Care	Not Covered									
	Nursing	Not Covered									
	Routine Eye Exam (Adult)	Not Covered									

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	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
	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
	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
	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No						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

Row	Α	В	С	D	Е	F	G	н	1	1	К
Number		Covered	Benefit Description	Quantitative	Limit	Limit Units	Other Limit	Minimum	Exclusions	Explanation:	Does this
		(Required):	(Required if benefit is	Limit on	Quantity	(Required if	Units	Stay	(Optional):	(Optional)	benefit have
		Is benefit	Covered):	Service?	(Required if	Quantitative	Description	(Optional):	Enter any Exclusions for this	Enter an Explanation for anything not	additional
		Covered or	Enter a Description, it may	(Required if	Quantitative	Limit is	(Required if	Enter the	benefit	listed	limitations or
		Not Covered	be the same as the Benefit	benefit is	Limit is	"Yes"):	"Other" Limit	Minimum			restrictions?
			name	Covered):	"Yes"):	Select the	Unit):	Stay			(Required if
				Select "Yes"	Enter Limit	correct limit	If a Limit Unit	(in hours)			benefit is
				if	Quantity	units	of "Other"	as a whole			Covered):
				Quantitative			was selected				Select "Yes" if
				Limit applies			in Limit Units,				there are
							enter a				additional
							description				limitations or
											restrictions
											that need to be described
18	Inpatient Physician	Covered	Inpatient Physician and	No					Exclusions: weight reduction	Inpatient Physician and Surgical	No
10	and Surgical Services		Surgical Services	IVO					programs or treatment for	Services as described above.	NO
	and surgicul services		Sargical Scriness						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		
19	Bariatric Surgery	Not Covered							acuity.		
20		Not Covered									
21		Not Covered									
22	Prenatal and	Covered	Prenatal and Postnatal Care	No						Prenatal and Postnatal care includes:	No
	Postnatal Care									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).	

Row	Α	В	С	D	E	F	G	н	I	J	К
Numbei	r Benefit	Covered (Required): Is benefit Covered or Not Covered	Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	units	Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	Stay (in hours) as a whole number	Exclusions (Optional): Enter any Exclusions for this benefit	Explanation: (Optional) Enter an Explanation for anything not listed	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
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, 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			environmental change; admittance into a mental	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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Row	Α	В	C	D	E	F	G	H	'.	J	K
Number	Benefit	Covered	Benefit Description	Quantitative	Limit	Limit Units	Other Limit	Minimum	Exclusions	Explanation:	Does this
		(Required):	(Required if benefit is	Limit on	Quantity	(Required if	Units	Stay	(Optional):	(Optional)	benefit have
		Is benefit	Covered):	Service?	(Required if	Quantitative		(Optional):	Enter any Exclusions for this	Enter an Explanation for anything not	
		Covered or	Enter a Description, it may	(Required if	Quantitative	Limit is	(Required if	Enter the	benefit	listed	limitations or
		Not Covered	be the same as the Benefit	benefit is	Limit is	"Yes"):	"Other" Limit	Minimum			restrictions?
			name	Covered):	"Yes"):	Select the	Unit):	Stay			(Required if
				Select "Yes"	Enter Limit	correct limit	If a Limit Unit	(in hours)			benefit is
				if	Quantity	units	of "Other"	as a whole			Covered):
				Quantitative			was selected	number			Select "Yes" if
				Limit applies			in Limit Units,				there are
							enter a				additional
							description				limitations or
							u.cocipu.c				restrictions
											that need to
											be described
25	Mental/Behavioral	Covered	Mental/Behavioral Health	Yes	30	Days per year			Marital, family, career,	Benefits for treatment of	Yes
25	-	Covered	· ·	162	30	Days per year			1 1		res
	Health Inpatient		Inpatient Services						behavioral, or other counseling	Nervous/Mental conditions are limited	
	Services								services; treatment or testing	to benefits for conditions which are	
									related to autistic disease,	manifested in a disturbance of	
									learning disabilities, mental	intellectual and emotional functions to	
										a degree of severity where; 1) the	
									environmental change;	presence of anxiety and/or depression	
									admittance into a mental	is significantly beyond minor behavior	
									institution or sanatorium, except	aberrations, or 2) the patient's mental	
									where enforcement of the	state is such that there has been a	
									exclusion is prohibited by law;	break with reality. The company	
									treatment in connection with	provides benefits based on the	
									involuntary commitment.	allowable charge for covered services	
									,	provided to a member for inpatient	
										services and partial hospitalization.	
26	Substance Abuse	Covered	Alcohol and Drug Abuse	Yes	20	Visits per year			Marital, family, career,	Services and partial neophanization	No
	Disorder Outpatient	2010.00	Outpatient Services	. 63		riores per year			behavioral, or other counseling		
	Services		Suspanient Services						services; treatment or testing		
	JCI VICCS								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		
27	Substance Abuse	Covered	Alcohol and Drug Abuse	Yes	7	Days per year]	Marital, family, career,		No
	Disorder Inpatient		Inpatient Services						behavioral, or other counseling		
	Services								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.		

Row	Α	В	С	D	Е	F	G	н		J	К
Numb		Covered	Benefit Description	Quantitative	Limit	Limit Units	Other Limit	Minimum	Exclusions	Explanation:	Does this
	Denene	(Required):	(Required if benefit is	Limit on	Quantity	(Required if	Units	Stay	(Optional):	(Optional)	benefit have
		Is benefit	Covered):	Service?	(Required if	Quantitative		(Optional):	` ' '	Enter an Explanation for anything not	
		Covered or	Enter a Description, it may	(Required if	Quantitative	Limit is	(Required if	Enter the	benefit	listed	limitations or
		Not Covered	be the same as the Benefit	benefit is	Limit is	"Yes"):	"Other" Limit		Denent	listed	restrictions?
		Not covered	name	Covered):	"Yes"):	Select the	Unit):	Stay			(Required if
			name	Select "Yes"	Enter Limit		•				benefit is
				if	Quantity	units	of "Other"	as a whole			Covered):
				Quantitative			was selected	number			Select "Yes" if
				Limit applies			in Limit Units,				there are
							enter a				additional
							description				limitations or
											restrictions
											that need to
											be described
28	Generic Drugs	Covered	Prescription Drug	No					Formulary exclusions include	Prescription Drug.	No
									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.		
29	Preferred Brand	Covered	Prescription Drug	No					Formulary exclusions include	Prescription Drug.	No
	Drugs								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.		
30	Non-Preferred	Covered	Prescription Drug	No					Formulary exclusions include	Prescription Drug.	No
	Brand Drugs								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.		
31	Specialty Drugs	Covered	Prescription Drug	No					Exclusions and Network	Prescription Drug.	No
22			0	<u></u>	20				requirements.		
32	Outpatient	Covered	Outpatient Rehabilitation	Yes	20	Visits per year			Therapy services related to	Benefits for the coordinated use of	Yes
	Rehabilitation		Services						general conditioning of the	medical, social, educational or	
	Services								patient; therapies rendered	vocational services, beyond the acute	
									primarily for job training;	care stage of disease or injury, for the	
										purpose of upgrading the physical	
									therapy for learning disabilities	functional ability of a patient disabled	
									and developmental problems;	by disease or injury so that the patient	
									Physical Therapy/Occupational	may independently carry out ordinary	
									Therapy: combined 20 visit limit;	daily activities.	
									Speech Therapy: separate 20		
									visit limit.		
33	Habilitation Services	Covered	Habilitation Services	No						Covered as defined by Rehabilitation	No
1	[Services.	

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	Chiropractic Care	Covered	Chiropractic Care		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
	Durable Medical Equipment	Covered	Durable Medical Equipment	No					changes to the member's home, auto, or personal property to accommodate any DME; benefits	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
37	Hearing Aids Diagnostic Test (X-Ray and Lab Work)	Not Covered 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 deficit illness or injury.	No
	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs)	No						definite illness or injury. 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
	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.	
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								Diabetes based on Medical Folicy.	
	Weight Loss Programs	Not Covered									

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		(Required):	(Required if benefit is	Limit on	Quantity	(Required if	Units	Stay	(Optional):	(Optional)	benefit have
		Is benefit	Covered):	Service?	(Required if	Quantitative	Description	(Optional):	Enter any Exclusions for this	Enter an Explanation for anything not	additional
		Covered or	Enter a Description, it may	(Required if	Quantitative	Limit is	(Required if	Enter the	benefit	listed	limitations or
		Not Covered	be the same as the Benefit	benefit is	Limit is	"Yes"):	"Other" Limit	Minimum			restrictions?
			name	Covered):	"Yes"):	Select the	Unit):	Stay			(Required if
				Select "Yes"	Enter Limit	correct limit	If a Limit Unit	(in hours)			benefit is
				if	Quantity	units	of "Other"	as a whole			Covered):
				Quantitative			was selected	number			Select "Yes" if
				Limit applies			in Limit Units,				there are
							enter a				additional
							description				limitations or
											restrictions
											that need to
											be described
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year				Supplemented using Mississippi CHIP.	No
44	Eye Glasses for	Covered	Eyeglasses for adults and	Yes	1	Other	1 pair of			Supplemented using Mississippi CHIP.	No
	Children		children				eyeglasses				
							per year				
45	Dental Check-Up for	Covered	Dental Check-Up for	Yes	1	Other	1 every 6		·	Supplemented using Mississippi CHIP.	No
	Children		Children				months				

OTHER BENEFITS

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	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	as a whole	this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed Mental/Behavioral Health Partial	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
	Mentaly Behavioral Health Inpatient Services	Covered	iviental/Benavioral Health	res	60	Days per year				Hospitalization.	NO .
2	Inpatient Rehabilitation Services		Inpatient Rehabilitation Services			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
	Other	Covered	Infusion Therapy Other Women's Health	No					Services and supplies	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. Treatment to correct an underlying cause	No
5	Other	Covered	Other Women's Health	NO					related to infertility, artificial insemination, intrauterine insemination and in-vitro fertilization regardless of any claim of medical necessity.	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		Diabetes Self- Management Training	Yes	1	Visits per year				Self-management training for the control of Diabetes.	No
			Diabetes Equipment	Yes		Other	Per 2 years			Equipment and supplies for monitoring blood glucose and insulin administration	No
			Diabetes Dilated Eye Exam	Yes		Other	Exam per year			Dilated eye exam for members with Diabetes.	No
10	Other		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	5	
ANTIVIRALS	INHIBITORS ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE	11	
	TRANSCRIPTASE INHIBITORS		
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 (5 BIPOLAR AGENTS) (5 BIPOLAR AGENTS) (5 BIPOLAR AGENTS) (5 BIODG GLUCOSE REGULATORS) (5 BICODG GLUCOSE REGULATORS) (5 BICODG GLUCOSE REGULATORS) (7 BILODG GLUCOSE REGULATORS) (10 BILODG BROUNDERS) (11 BILODG BROUNDERS)	CATEGORY	CLASS	SUBMISSION COUNT
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BLOOD GLUCOSE REGULATORS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS ANTICOAGULANTS 7 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS 1 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS 1 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS 1 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS PLATELET MODIFYING AGENTS 8 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS PLATELET MODIFYING AGENTS 8 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS PLATELET MODIFYING AGENTS 8 BCARDIOVASCULAR AGENTS ALPHA-ADRENERGIC AGONISTS 5 CARDIOVASCULAR AGENTS ALPHA-ADRENERGIC BLOCKING AGENTS 4 CARDIOVASCULAR AGENTS ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS 10 CARDIOVASCULAR AGENTS ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS 10 CARDIOVASCULAR AGENTS ANTIARRIN-THIMICS 11 CARDIOVASCULAR AGENTS DIURETICS, CARDIOVASCULAR AGENTS 10 CARDIOVASCULAR AGENTS DIURETICS, CARDIOVASCULAR AGENTS 11 CARDIOVASCULAR AGENTS DIURETICS, CARDIOVASCULAR AGENTS 12 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 14 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 14 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 15 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 16 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 17 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 18 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 18 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 18 CARDIOVASCULAR AGE	BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD FOULTS/MODIFIERS/VOLUME EXPANDERS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS CARDIOVASCULAR AGENTS ALPHA-ADRENERGIC AGONISTS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS CARDIOVASCULAR AGENTS ALPHA-ADRENERGIC BLOCKING AGENTS SALPHA-ADRENERGIC BLOCKING AGENTS ALPHA-ADRENERGIC BLOCKING AGENTS ALPHA-ADRENERGIC BLOCKING AGENTS ARDIOVASCULAR AGENTS ANGIOTENSIN IN EXCEPTOR ANTAGONISTS 7 CARDIOVASCULAR AGENTS ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS 10 CARDIOVASCULAR AGENTS ANTARRHYTHMICS 110 CARDIOVASCULAR AGENTS ANTARRHYTHMICS 110 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 4 CARDIOVASCULAR AGENTS DIURETICS	BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS BLOOD FORMATION MODIFIERS 1 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS PLATELET MODIFYING AGENTS SERVICE AND STATE AN	BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS LOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS CARDIOVASCULAR AGENTS ALPHA ADRENERGIC AGORISTS 8 ALPHA ADRENERGIC AGORISTS 5 CARDIOVASCULAR AGENTS ALPHA ADRENERGIC BLOCKING AGENTS 4 CARDIOVASCULAR AGENTS ALPHA ADRENERGIC BLOCKING AGENTS 7 CARDIOVASCULAR AGENTS ANGIOTENSIN I RECEPTOR ANTAGONISTS 7 CARDIOVASCULAR AGENTS ANGIOTENSIN I RECEPTOR ANTAGONISTS 10 CARDIOVASCULAR AGENTS ANGIOTENSIN I RECEPTOR ANTAGONISTS 10 CARDIOVASCULAR AGENTS ANTARRHYTHMICS 10 CARDIOVASCULAR AGENTS ANTARRHYTHMICS 10 CARDIOVASCULAR AGENTS CALCIUM CHANNEL BLOCKING AGENTS 13 CARDIOVASCULAR AGENTS COMBINETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 4 CARDIOVASCULAR AGENTS DIURETICS, THIAZIDE 6 CARDIOVASCULAR AGENTS DIURETICS, THIAZIDE 6 CARDIOVASCULAR AGENTS DIURETICS, THIAZIDE 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HIRAZIDE 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HIRAZIDE 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HIRAZIDE 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, OTHER 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, OTHER 7 CAR	BLOOD GLUCOSE REGULATORS	INSULINS	10
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CARDIOVASCULAR AGENTS ANGIOTENSIN II RECEPTOR ANTAGONISTS 7 CARDIOVASCULAR AGENTS ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS 10 CARDIOVASCULAR AGENTS ANTIARHYTHMICS 110 CARDIOVASCULAR AGENTS BETA-ADRENERGIC BLOCKING AGENTS 13 CARDIOVASCULAR AGENTS CALCIUM CHANNEL BLOCKING AGENTS 9 CARDIOVASCULAR AGENTS CARDIOVASCULAR AGENTS CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, LOOP 4 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 4 CARDIOVASCULAR AGENTS DIURETICS, HIAZIDE 6 CARDIOVASCULAR AGENTS DIURETICS, HIAZIDE 6 CARDIOVASCULAR AGENTS DIVERTICS, HIAZIDE 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HIBRIC ACID DERIVATIVES 2 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HIBRIC ACID DERIVATIVES 2 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, SIBRIC ACID DERIVATIVES 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, MIGC COA REDUCTASE INHIBITORS 6 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, DIRECT-ACTING ARTERIAL 2 CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL 2 CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL 2 CARDIOVASCULAR AGENTS ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES 4 CENTRAL NERVOUS SYSTEM AGENTS ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES CENTRAL NERVOUS SYSTEM AGENTS ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES CENTRAL NERVOUS SYSTEM AGENTS FIRROMYALGIA AGENTS NO USP CLASS 3 ENZYME REPLACEMENT/MODIFIERS NO USP CLASS NO USP CLASS ANTISPASMODICS, GASTROINTESTINAL 3 CASTROINTESTINAL AGENTS ANTISPASMODICS, GASTROINTESTINAL 4 CASTROINTESTINAL AGENTS ANTISPASMODICS, GASTROINTESTINAL 5 CASTROINTESTINAL AGENTS HISTAMINES (HISTAMINES (HISTAMINES) CENTRAL NERVOUS SYSTEM AGENTS ANTISPASMODICS, GASTROINTESTINAL 5 CASTROINTESTINAL AGENTS ANTISPASMODICS, GASTROINTESTINAL 5 CASTROINTESTINAL AGENTS ANTISPASMODICS, CASTROINTESTINAL 5 CASTROINTESTINAL AGENTS ANTISPASMODICS CASTROINTESTINAL AGENTS ANTISPASMODICS CA	CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
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HORMONES/MODIFIERS) HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS 1 HORMONES/MODIFIERS) HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) NO USP CLASS HORMONAL AGENTS, SUPPRESSANT (ADRENAL) NO USP CLASS 1 HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) NO USP CLASS 1 HORMONAL AGENTS, SUPPRESSANT (PITUITARY) 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	· · · · · · · · · · · · · · · · · · ·	FCTDOCENIC	-
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HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) HORMONAL AGENTS, SUPPRESSANT (PITUITARY) NO USP CLASS HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) HORMONAL AGENTS, SUPPRESSANT (THYROID) ANTITHYROID AGENTS IMMUNOLOGICAL AGENTS 22			
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HORMONAL AGENTS, SUPPRESSANT (THYROID) ANTITHYROID AGENTS 2 IMMUNOLOGICAL AGENTS IMMUNE SUPPRESSANTS 22	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
IMMUNOLOGICAL AGENTS IMMUNE SUPPRESSANTS 22	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	IMMUNIZING AGENTS, PASSIVE	4
IMMUNOLOGICAL AGENTS IMMUNOMODULATORS 10	IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS AMINOSALICYLATES 3	INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS GLUCOCORTICOIDS 5	INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS SULFONAMIDES 1	INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS NO USP CLASS 14	METABOLIC BONE DISEASE AGENTS	NO USP CLASS	14
OPHTHALMIC AGENTS OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS 3	OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS OPHTHALMIC AGENTS, OTHER 4	OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS OPHTHALMIC ANTI-ALLERGY AGENTS 9	OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS OPHTHALMIC ANTI-INFLAMMATORIES 11	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