# SOUTH CAROLINA EHB BENCHMARK PLAN

## SUMMARY INFORMATION

| | |
|---|---|
| **Plan Type** | Plan from largest small group product, Preferred Provider Organization |
| **Issuer Name** | BlueCross BlueShield of South Carolina |
| **Product Name** | Business Blue Complete |
| **Plan Name** | Business Blue Complete |
| **Supplemented Categories** (Supplementary Plan Type) | • Pediatric Oral (FEDVIP)<br>• Pediatric Vision (FEDVIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | No |
| **Habilitative Services Defined by State** (Yes/No) | 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 | No | | | | | | | No |
| 4 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | outpatient facility fee | No | | | | | LASIK | Voluntary male sterilization covered. | Yes |
| 5 | **Outpatient Surgery Physician/Surgical Services** | Covered | outpatient surgery/medical services | No | | | | | LASIK | Voluntary male sterilization covered. | Yes |
| 6 | **Hospice Services** | Covered | Hospice services | Yes | 6 | Other | Months per episode | | | | No |
| 7 | **Non-Emergency Care When Traveling Outside the U.S.** | Covered | Care outside the U.S. | No | | | | | | | No |
| 8 | **Routine Dental Services (Adult)** | Not Covered | Routine dental services - adult | | | | | | | | |
| 9 | **Infertility Treatment** | Not Covered | Infertility Treatment | | | | | | | | |
| 10 | **Long-Term/Custodial Nursing Home Care** | Not Covered | Long-term/custodial nursing home care | | | | | | | | |
| 11 | **Private-Duty Nursing** | Not Covered | Private-duty nursing | | | | | | | | |
| 12 | **Routine Eye Exam (Adult)** | Not Covered | Routine eye exam - adult | | | | | | | | |
| 13 | **Urgent Care Centers or Facilities** | Covered | Urgent care centers or facilities | No | | | | | | | No |
| 14 | **Home Health Care Services** | Covered | Home health care | Yes | 60 | Other | Visits per benefit period | | | | No |
| 15 | **Emergency Room Services** | Covered | Emergency room services | No | | | | | | | No |
| 16 | **Emergency Transportation/ Ambulance** | Covered | Air ambulance, transportation to facility/ between facilities | No | | | | | | | No |
| 17 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Inpatient hospital services | No | | | | | | | Yes |
| 18 | **Inpatient Physician and Surgical Services** | Covered | Inpatient physician and surgery | No | | | | | | | Yes |
| 19 | **Bariatric Surgery** | Not Covered | Bariatric surgery | | | | | | | | |
| 20 | **Cosmetic Surgery** | Not Covered | Cosmetic surgery | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 21 | **Skilled Nursing Facility** | Covered | Skilled nursing facility | Yes | 60 | Other | Days per benefit period | | | | Yes |
| 22 | **Prenatal and Postnatal Care** | Covered | Prenatal and postnatal care | No | | | | | Services for surrogate, dependent children. | Includes complications of pregnancy. | Yes |
| 23 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Delivery and all inpatient services for maternity care | No | | | | | Services for surrogate, dependent children. | Includes complications of pregnancy. | Yes |
| 24 | **Mental/Behavioral Health Outpatient Services** | Covered | Mental/behavioral health outpatient | Yes | 25 | Other | Visits per benefit period | | Residential | 25 visit limit is combined mental & substance. | Yes |
| 25 | **Mental/Behavioral Health Inpatient Services** | Covered | Mental/behavioral health inpatient | Yes | 7 | Other | Days per benefit period | | | 7 day limit is combined mental & substance. | No |
| 26 | **Substance Abuse Disorder Outpatient Services** | Covered | Substance abuse disorder outpatient | Yes | 25 | Other | Visits per benefit period | | Residential | 25 visit limit is combined mental & substance. | Yes |
| 27 | **Substance Abuse Disorder Inpatient Services** | Covered | Substance abuse disorder inpatient | Yes | 7 | Other | Days per benefit period | | | 7 day limit is combined mental & substance. | Yes |
| 28 | **Generic Drugs** | Covered | Generic drugs | No | | | | | | | No |
| 29 | **Preferred Brand Drugs** | Covered | Preferred brand drugs | No | | | | | | | No |
| 30 | **Non-Preferred Brand Drugs** | Covered | Non-preferred brand drugs | No | | | | | | | No |
| 31 | **Specialty Drugs** | Covered | Specialty drugs | No | | | | | | | No |
| 32 | **Outpatient Rehabilitation Services** | Covered | Outpatient rehabilitation services | No | | | | | | | Yes |
| 33 | **Habilitation Services** | Not Covered | Habilitation services | | | | | | | Physical therapy only; subject to physical therapy limit. | |
| 34 | **Chiropractic Care** | Covered | Chiropractic care | No | | | | | Spinal subluxation services. | | Yes |
| 35 | **Durable Medical Equipment** | Covered | Durable medical equipment | No | | | | | TENS unit | Orthotics, medical equipment and supplies. | Yes |
| 36 | **Hearing Aids** | Not Covered | Hearing aids | | | | | | | | |
| 37 | **Diagnostic Test (X-Ray and Lab Work)** | Covered | Diagnostic test | No | | | | | | | No |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 38 | **Imaging (CT/PET Scans, MRIs)** | Covered | Imaging | No | | | | | | | No |
| 39 | **Preventive Care/ Screening/Immunization** | Covered | Preventive care/screening/ immunization | No | | | | | | As required by USPSTF, CDC and HRSA eff 9/23/10. | No |
| 40 | **Routine Foot Care** | Not Covered | Routine foot care | | | | | | | Exception is made for diabetes related. | |
| 41 | **Acupuncture** | Not Covered | Acupuncture | | | | | | | | |
| 42 | **Weight Loss Programs** | Not Covered | Weight loss programs | | | | | | | | |
| 43 | **Routine Eye Exam for Children** | Covered | Routine eye exam | Yes | 1 | Visits per year | | | | | No |
| 44 | **Eye Glasses for Children** | Covered | Eyeglasses for adults and children | Yes | 1 | Other | 1 pair of glasses (lenses and frames per year) | | | | No |
| 45 | **Dental Check-Up for Children** | Covered | Dental Exams | Yes | 1 | Other | 1 every 6 months | | | Limitations, including dollar limits, may apply. | No |

## 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 | 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 | **Other** | Covered | Radiation therapy | No | | | | | | | No |
| 2 | **Other** | Covered | Chemotherapy | No | | | | | | | No |
| 3 | **Other** | Covered | Outpatient and home infusion therapy | No | | | | | | | No |
| 4 | **Other** | Covered | Renal dialysis/ hemodialysis | No | | | | | | | No |
| 5 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | Reconstructive surgery or procedures | No | | | | | | Must be to correct a functional disorder or result of injury. | No |
| 6 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | Reconstructive breast surgery/breast prosthesis | No | | | | | | If after a mastectomy. | No |
| 7 | **Outpatient Surgery Physician/Surgical Services** | Covered | Reconstructive surgery or procedures | No | | | | | | Must be to correct a functional disorder or result of injury. | Yes |
| 8 | **Outpatient Surgery Physician/Surgical Services** | Covered | Reconstructive breast surgery/breast prosthesis | No | | | | | | If after a mastectomy. | No |
| 9 | **Cosmetic Surgery** | Covered | Reconstructive surgery | No | | | | | | If to correct a functional disorder. | No |
| 10 | **Cosmetic Surgery** | Covered | Services result of injury | No | | | | | | | No |
| 11 | **Prenatal and Postnatal Care** | Covered | Pregnancy testing when performed in physician's office | No | | | | | | | No |
| 12 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Anesthesia, | No | | | | | | | No |
| 13 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Newborn nursery and care, neonatal intensive care, circumcision | No | | | | | | | No |
| 14 | **Mental/Behavioral Health Outpatient Services** | Covered | Group therapy, psychological testing, psychoanalysis | No | | | | | | | No |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | **Substance Abuse Disorder Outpatient Services** | Covered | Partial day hospitalization | No | | | | | | | No |
| 16 | **Substance Abuse Disorder Outpatient Services** | Covered | Freestanding rehab facilities | No | | | | | | | No |
| 17 | **Substance Abuse Disorder Inpatient Services** | Covered | Partial day hospitalization | No | | | | | | | No |
| 18 | **Substance Abuse Disorder Inpatient Services** | Covered | Freestanding rehab facilities | No | | | | | | | No |
| 19 | **Outpatient Rehabilitation Services** | Covered | Pulmonary rehab | No | | | | | | Only when part of covered lung transplant. | No |
| 20 | **Outpatient Rehabilitation Services** | Covered | Physical therapy | Yes | 30 | Other | Visits per benefit period | | | | No |
| 21 | **Durable Medical Equipment** | Covered | Durable medical equipment | No | | | | | Such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners, air filters, common first aid supplies. Manual or motorized wheelchairs or power operated scooters for mobility outside the home setting. | Have exclusive medical use and medical in nature; such as wheelchairs, hospital-type beds, prosthetic devices, walkers, oxygen, respirators, etc. | No |
| 22 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Reconstructive surgery or procedures | No | | | | | | Must be to correct a functional disorder or result of injury. | No |
| 23 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Reconstructive breast surgery/breast prosthesis | No | | | | | | If after a mastectomy. | No |
| 24 | **Inpatient Physician and Surgical Services** | Covered | Reconstructive surgery or procedures | No | | | | | | Must be to correct a functional disorder or result of injury. | No |
| 25 | **Inpatient Physician and Surgical Services** | Covered | Reconstructive breast surgery/breast prosthesis | No | | | | | | If after a mastectomy. | No |
| 26 | **Other** | Covered | Allergy treatment and testing | No | | | | | | | No |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 27 | **Other** | Covered | Organ transplants: heart, lung, heart/lung, cornea, kidney, liver, pancreas, pancreas/kidney, bone marrow | No | | | | | Transplants involving mechanical or animal organ. Allogenic or syngenic bone marrow transplants and other forms of stem cell transplant; where less than four of six complex antigens match or case in which mixed leukocyte culture is reactive or in AIDS and HIV. Adrenal tissue to brain transplants. | | No |
| 28 | **Other** | Covered | Cochlear implants | No | | | | | | | No |
| 29 | **Durable Medical Equipment** | Covered | Prosthetic devices | Yes | 50000 | Other | Dollars per benefit period | | | | No |
| 30 | **Skilled Nursing Facility** | Covered | Skilled nursing facility | No | | | | | | If admitted after 14 days of approved hospitalization. | No |
| 31 | **Chiropractic Care** | Covered | Chiropractic care | No | | | | | | Services limited to covered benefits as allowed by scope of practice. | No |
| 32 | **Durable Medical Equipment** | Covered | Durable medical equipment | No | | | | | Adjustable cranial orthosis as referenced in contract; bioelectric, microprocessor or computer programmed prosthetic components. | | No |
| 33 | **Other** | Covered | Basic Dental Care – Child | No | | | | | | Limitations, including dollar limits, may apply. | No |
| 34 | **Other** | Covered | Major Dental Care – Child | No | | | | | | Limitations, including dollar limits, may apply. | No |
| 35 | **Other** | Covered | Orthodontia - Child | No | | | | | | Limitations, including dollar limits, may apply. | No |

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

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANALGESICS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 19 |
| ANALGESICS | OPIOID ANALGESICS, LONG-ACTING | 10 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 9 |
| 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 | 19 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 9 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 20 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 18 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 5 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 11 |
| ANTIBACTERIALS | MACROLIDES | 5 |
| ANTIBACTERIALS | QUINOLONES | 8 |
| ANTIBACTERIALS | SULFONAMIDES | 4 |
| ANTIBACTERIALS | TETRACYCLINES | 4 |
| ANTICONVULSANTS | ANTICONVULSANTS, OTHER | 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 | 8 |
| ANTIDEPRESSANTS | MONOAMINE OXIDASE INHIBITORS | 4 |
| ANTIDEPRESSANTS | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 9 |
| ANTIDEPRESSANTS | TRICYCLICS | 9 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 10 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 8 |
| ANTIFUNGALS | NO USP CLASS | 25 |
| ANTIGOUT AGENTS | NO USP CLASS | 5 |
| ANTIMIGRAINE AGENTS | ERGOT ALKALOIDS | 2 |
| ANTIMIGRAINE AGENTS | PROPHYLACTIC | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANTIMIGRAINE AGENTS | SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS | 6 |
| 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 | 3 |
| ANTIPARKINSON AGENTS | DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS | 2 |
| ANTIPARKINSON AGENTS | MONOAMINE OXIDASE B (MAO-B) INHIBITORS | 2 |
| ANTIPSYCHOTICS | 1ST GENERATION/TYPICAL | 10 |
| ANTIPSYCHOTICS | 2ND GENERATION/ATYPICAL | 9 |
| ANTIPSYCHOTICS | TREATMENT-RESISTANT | 1 |
| ANTISPASTICITY AGENTS | NO USP CLASS | 5 |
| ANTIVIRALS | ANTI-CYTOMEGALOVIRUS (CMV) AGENTS | 4 |
| ANTIVIRALS | ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS | 5 |
| ANTIVIRALS | ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS | 11 |
| ANTIVIRALS | ANTI-HIV AGENTS, OTHER | 3 |
| ANTIVIRALS | ANTI-HIV AGENTS, PROTEASE INHIBITORS | 9 |
| ANTIVIRALS | ANTI-INFLUENZA AGENTS | 4 |
| ANTIVIRALS | ANTIHEPATITIS AGENTS | 12 |
| ANTIVIRALS | ANTIHERPETIC AGENTS | 6 |
| ANXIOLYTICS | ANXIOLYTICS, OTHER | 4 |
| ANXIOLYTICS | SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS) | 5 |

| 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 | 8 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | COAGULANTS | 1 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | PLATELET MODIFYING AGENTS | 7 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC AGONISTS | 5 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC BLOCKING AGENTS | 4 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN II RECEPTOR ANTAGONISTS | 8 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS | 10 |
| CARDIOVASCULAR AGENTS | ANTIARRHYTHMICS | 10 |
| CARDIOVASCULAR AGENTS | BETA-ADRENERGIC BLOCKING AGENTS | 13 |
| CARDIOVASCULAR AGENTS | CALCIUM CHANNEL BLOCKING AGENTS | 9 |
| CARDIOVASCULAR AGENTS | CARDIOVASCULAR AGENTS, OTHER | 3 |
| CARDIOVASCULAR AGENTS | DIURETICS, CARBONIC ANHYDRASE INHIBITORS | 2 |
| CARDIOVASCULAR AGENTS | DIURETICS, LOOP | 4 |
| CARDIOVASCULAR AGENTS | DIURETICS, POTASSIUM-SPARING | 4 |
| CARDIOVASCULAR AGENTS | DIURETICS, THIAZIDE | 6 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES | 2 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS | 7 |
| CARDIOVASCULAR AGENTS | DYSLIPIDEMICS, OTHER | 6 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL | 3 |
| CARDIOVASCULAR AGENTS | VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | FIBROMYALGIA AGENTS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | MULTIPLE SCLEROSIS AGENTS | 7 |
| DENTAL AND ORAL AGENTS | NO USP CLASS | 8 |
| DERMATOLOGICAL AGENTS | NO USP CLASS | 35 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 16 |
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 6 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 6 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 2 |
| GASTROINTESTINAL AGENTS | LAXATIVES | 3 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 6 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 6 |
| 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 | 4 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS) | NO USP CLASS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANABOLIC STEROIDS | 2 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ANDROGENS | 4 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ESTROGENS | 6 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | PROGESTINS | 5 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) | NO USP CLASS | 3 |
| HORMONAL AGENTS, SUPPRESSANT (ADRENAL) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PITUITARY) | NO USP CLASS | 9 |
| HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) | ANTIANDROGENS | 5 |
| HORMONAL AGENTS, SUPPRESSANT (THYROID) | ANTITHYROID AGENTS | 2 |
| IMMUNOLOGICAL AGENTS | IMMUNE SUPPRESSANTS | 23 |
| IMMUNOLOGICAL AGENTS | IMMUNIZING AGENTS, PASSIVE | 4 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 10 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 3 |
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 15 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 3 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 9 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 11 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 14 |
| OTIC AGENTS | NO USP CLASS | 6 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 6 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 11 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 10 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 6 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 5 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 6 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 3 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 5 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 7 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 11 |