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

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Primary Care Visit to Treat an Injury or Illness	Covered	No					Physician Office Service.	No
Specialist Visit	Yes	Specialist Visit	Covered	No					Physician Specialist Office Service.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Allied Primary Care Health Professional Office Visit (Nurse Practitioner, Nurse Midwife, and Physician's Assistant)	Covered	No					Allied Primary Care Health Professional Office Service.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	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	Yes	Outpatient Surgery Physician/Surgical Services	Covered	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
Hospice Services	Yes	Hospice Services	Covered	Yes	6	Months per lifetime			Hospice Care.	No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered							
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No					Urgent Care Centers.	No
Home Health Care Services	Yes	Home Health Care Services	Covered	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

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Emergency Room Services	Yes	Emergency Room Services	Covered	No					Emergency room services to include physician, facility fee and supplies in providing treatment for members for covered emergency care.	No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	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)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	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
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	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
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility			Not Covered							
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	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

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	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
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	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
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	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
Substance Abuse Disorder Outpatient Services	Yes	Alcohol and Drug Abuse Outpatient Services	Covered	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

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Substance Abuse Disorder Inpatient Services	Yes	Alcohol and Drug Abuse Inpatient Services	Covered	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
Generic Drugs	Yes	Prescription Drug	Covered	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
Preferred Brand Drugs	Yes	Prescription Drug	Covered	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
Non-Preferred Brand Drugs	Yes	Prescription Drug	Covered	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
Specialty Drugs	Yes	Prescription Drug	Covered	No				Exclusions and Network requirements.	Prescription Drug.	No
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	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
Habilitation Services	Yes	Habilitation Services	Covered	No					Covered as defined by Rehabilitation Services.	No
Chiropractic Care	Yes	Chiropractic Care	Covered	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
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	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
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No				Hearing exams are excluded with the exception of children’s 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

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	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
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/ Immunization	Covered	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
Routine Foot Care	Yes	Routine Foot Care	Covered	Yes	1	Visit per year		Palliative and cosmetic foot care.	Covered for certain individuals with Diabetes based on Medical Policy.	No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year			Supplemented using Mississippi CHIP.	No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of eyeglasses per year			Supplemented using Mississippi CHIP.	No
Dental Check-Up for Children	Yes	Dental Check-Up for Children	Covered	Yes	1	Visit per 6 months			Supplemented using Mississippi CHIP.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	20	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	20	Visits per year				No
Well Baby Visits and Care			Not Covered							
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child			Not Covered							
Orthodontia - Child			Not Covered							
Major Dental Care - Child			Not Covered							
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant			Not Covered							
Accidental Dental			Not Covered							
Dialysis			Not Covered							
Allergy Testing			Not Covered							
Chemotherapy			Not Covered							
Radiation			Not Covered							
Diabetes Education	Yes	Diabetes Education	Covered	Yes	1	Visit per year				No
Prosthetic Devices			Not Covered							
Infusion Therapy	Yes	Infusion Therapy	Covered	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
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No					5000 Dollars	No
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Mental Health Other	Yes	Mental Health Other	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Mental/ Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health	Covered	Yes	60	Days per year			Mental/Behavioral Health Partial Hospitalization.	No
Inpatient Rehabilitation Services	Yes	Inpatient Rehabilitation Services	Covered	Yes	30	Days per year			Inpatient rehabilitation services that cannot be adequately performed in an outpatient setting.	No
Other Women's Health	Yes	Other Women's Health	Covered	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
Sleep Studies	Yes	Sleep Studies	Covered	No					Services must be provided by a sleep disorder center accredited by the American Academy of Sleep Medicine.	No
Diabetes Self-Management Training	Yes	Diabetes Self-Management Training	Covered	Yes	1	Visit per year			Self-management training for the control of Diabetes.	No
Diabetes Equipment	Yes	Diabetes Equipment	Covered	Yes	1	Unit per 2 years			Equipment and supplies for monitoring blood glucose and insulin administration	No
Diabetes Dilated Eye Exam	Yes	Diabetes Dilated Eye Exam	Covered	Yes	1	Exam per year			Dilated eye exam for members with Diabetes.	No
Diabetes Preventive Foot Care	Yes	Diabetes Preventive Foot Care	Covered	Yes	1	Visit 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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/ SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
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

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
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	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

CATEGORY	CLASS	SUBMISSION COUNT
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
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