

MASSACHUSETTS EHB BENCHMARK PLAN

SUMMARY INFORMATION

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| Plan Type | Plan from largest small group product, Health Maintenance Organization |
| Issuer Name | Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. |
| Product Name | HMO Blue With Deductible |
| Plan Name | HMO Blue 2000 Deductible |
| Supplemented Categories (Supplementary Plan Type) | Pediatric Oral (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 Visits to Treat an Injury or Illness | Covered | No | | | | | | No | |
| Specialist Visit | Yes | Specialist Visit | Covered | No | | | | | | No | |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | Yes | Other Practitioner Office Visit (Nurse, Physician Assistant) | Covered | No | | | | | | No | |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Yes | Outpatient Facility Fee (e.g.; Ambulatory Surgery Center) | Covered | No | | | | Removal of wisdom teeth whether or not imbedded in bone. | | No | |
| Outpatient Surgery Physician/Surgical Services | Yes | Outpatient Surgery Physician/Surgical Services | Covered | No | | | | Removal of wisdom teeth whether or not imbedded in bone. | | No | |
| Hospice Services | Yes | Hospice Services | Covered | No | | | | | | No | |
| Non-Emergency Care When Traveling Outside the U.S. | | | Not Covered | | | | | | | | |
| Routine Dental Services (Adult) | | | Not Covered | | | | | | | | |
| Infertility Treatment | Yes | Infertility Treatment | Covered | No | | | | | | No | |
| Long-Term/Custodial Nursing Home Care | | | Not Covered | | | | | | | | |
| Private-Duty Nursing | | | Not Covered | | | | | | | | |
| Routine Eye Exam (Adult) | | Routine Eye Exam (Adult) | Covered | Yes | 1 | Exam every 24 months | | | | No | |
| Urgent Care Centers or Facilities | Yes | Urgent Care Centers or Facilities | Covered | No | | | | | | No | |
| Home Health Care Services | Yes | Home Health Care Services | Covered | No | | | | | | No | |
| Emergency Room Services | Yes | Emergency Room Services | Covered | No | | | | | | No | |
| Emergency Transportation/Ambulance | Yes | Emergency Transportation/Ambulance | Covered | No | | | | | | No | |

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| Inpatient Hospital Services (e.g., Hospital Stay) | Yes | Inpatient Hospital Services (e.g., General Hospital Stay) | Covered | No | | | | | | No | |
| Inpatient Physician and Surgical Services | Yes | Inpatient Physician and Surgical Services | Covered | No | | | | | | No | |
| Bariatric Surgery | Yes | Bariatric Surgery | Covered | No | | | | | | No | |
| Cosmetic Surgery | | | Not Covered | | | | | | | | |
| Skilled Nursing Facility | Yes | Skilled Nursing Facility | Covered | Yes | 100 | Days per year | | | | No | |
| Prenatal and Postnatal Care | Yes | Prenatal and Postnatal Care | Covered | No | | | | Costs that are associated with achieving pregnancy through surrogacy (gestational carrier). | | No | |
| Delivery and All Inpatient Services for Maternity Care | Yes | Delivery and All Inpatient Services for Maternity Care | Covered | No | | | | Costs that are associated with achieving pregnancy through surrogacy (gestational carrier); planned home birth. | | No | |
| Mental/Behavioral Health Outpatient Services | Yes | Mental/Behavioral Health Outpatient Services | Covered | Yes | 24 | Visits per year for certain non-biologically based conditions | | | | No | |
| Mental/Behavioral Health Inpatient Services | Yes | Mental/Behavioral Health Inpatient Services | Covered | Yes | 60 | Days per year for certain non-biologically based conditions | | | | No | |
| Substance Abuse Disorder Outpatient Services | Yes | Substance Abuse Disorder Outpatient Services | Covered | No | | | | | | No | |
| Substance Abuse Disorder Inpatient Services | Yes | Substance Abuse Disorder Inpatient Services | Covered | No | | | | | Residential treatment unless medically necessary. | No | |
| Generic Drugs | Yes | Generic Drugs | Covered | No | | | | | | No | |
| Preferred Brand Drugs | Yes | Preferred Brand Drugs | Covered | No | | | | | | No | |
| Non-Preferred Brand Drugs | Yes | Non-Preferred Brand Drugs | Covered | No | | | | | | No | |
| Specialty Drugs | Yes | Specialty Drugs | Covered | No | | | | | | No | |
| Outpatient Rehabilitation Services | Yes | Outpatient Rehabilitation Services | Covered | No | | | | | Quantitative limit units apply, see EHB benchmark plan documents. | Yes | |
| Habilitation Services | Yes | Habilitation Services | Covered | Yes | 60 | Visits per year | | | Includes Outpatient Physical and Occupational Therapy. No limit applies to autism, home health care, and speech/hearing disorders | Yes | |
| Chiropractic Care | Yes | Chiropractic Care | Covered | Yes | 12 | Visits per year | | Not covered under age 16. | | No | |

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| Durable Medical Equipment | Yes | Durable Medical Equipment | Covered | No | | | | Foot orthotics; medical supplies; equipment not designed to serve medical purpose. | Quantitative limit units apply, see EHB benchmark plan documents. | Yes | |
| Hearing Aids | | | Not Covered | | | | | | | | |
| Diagnostic Test (X-Ray and Lab Work) | Yes | Diagnostic Test (X-Ray and Lab Work) | Covered | No | | | | | | No | |
| Imaging (CT/PET Scans, MRIs) | Yes | Imaging (CT/PET Scans, MRIs) | Covered | No | | | | | | No | |
| Preventive Care/Screening/Immunization | Yes | Preventive Care/Screening/Immunization | Covered | No | | | | | | No | |
| Routine Foot Care | Yes | Routine Foot Care | Covered | No | | | | Routine Foot Care except for patients with systemic circulatory disease. | | No | |
| Acupuncture | | | Not Covered | | | | | | | | |
| Weight Loss Programs | Yes | Weight Loss Programs | Covered | Yes | 150 | Dollar reimbursement per contract per calendar year | | | | No | |
| Routine Eye Exam for Children | Yes | Routine Eye Exam for Children | Covered | Yes | 1 | Visit every 24 months | | | | No | |
| Eye Glasses for Children | | | Not Covered | | | | | | | | |
| Dental Check-Up for Children | Yes | Pediatric Dental Care (excluding orthodontia) | Covered | Yes | 2 | Oral exams, cleanings, fluoride every 12 months | | Orthodontia is excluded (other than medically necessary orthodontia). | | No | |
| Rehabilitative Speech Therapy | Yes | Rehabilitative Speech Therapy | Covered | No | | | | | | No | |
| Rehabilitative Occupational and Rehabilitative Physical Therapy | Yes | Rehabilitative Occupational and Rehabilitative Physical Therapy | Covered | Yes | 60 | Visits per year | | | No limit applies to autism, home health care, and speech/hearing disorders | No | |
| Well Baby Visits and Care | Yes | Well Baby Visits and Care | Covered | No | | | | | | No | |
| 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 | | | | | | | | |

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| Orthodontia - Adult | | | Not Covered | | | | | | | |
| Major Dental Care – Adult | | | Not Covered | | | | | | | |
| 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 | | | Not Covered | | | | | | | |
| Prosthetic Devices | Yes | Prosthetic Devices | Covered | Yes | 500 | Dollars per year | | | | No |
| Infusion Therapy | | | Not Covered | | | | | | | |
| Treatment for Temporomandibular Joint Disorders | | | Not Covered | | | | | | | |
| Nutritional Counseling | | | Not Covered | | | | | | | |
| Reconstructive Surgery | | | Not Covered | | | | | | | |
| Clinical Trials | Yes | Clinical Trials | 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 |
| Congenital Anomaly, including Cleft Lip/Palate | Yes | Congenital Anomaly, including Cleft Lip/Palate | Covered | No | | | | | | No |
| Early Intervention Services | Yes | Early Intervention Services | Covered | No | | | | | | No |
| Nutrition/Formulas | Yes | Nutrition/Formulas | Covered | No | | | | | | No |
| Bone Marrow Transplants for Treatment of Breast Cancer | Yes | Bone Marrow Transplants for Treatment of Breast Cancer | Covered | No | | | | | | No |
| Cardiac Rehabilitation | Yes | Cardiac Rehabilitation | Covered | No | | | | | | No |
| Contraceptive Services | Yes | Contraceptive Services | Covered | No | | | | | | No |

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| Hormone Replacement Therapy (HRT) | Yes | Hormone Replacement Therapy (HRT) | Covered | No | | | | | | No |
| Human Leukocyte Antigen Testing | Yes | Human Leukocyte Antigen Testing | Covered | No | | | | | | No |
| Hypodermic Syringes or Needles | Yes | Hypodermic Syringes or Needles | Covered | No | | | | | | No |

OTHER BENEFITS

| Benefit Information | | | General Information | | | | | | | |
|--|----------|--|------------------------------------|---|------------------------|--|----------------------|-----------------|-------------------|--|
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| All Massachusetts Mandated Benefits and other benefits covered by the benchmark plan | Yes | All Massachusetts Mandated Benefits and other benefits covered by the benchmark plan | Covered | No | | | | | | 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 | 7 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 11 |
| ANESTHETICS | LOCAL ANESTHETICS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | ALCOHOL DETERRENTS/ANTI-CRAVING | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | OPIOID ANTAGONISTS | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | SMOKING CESSATION AGENTS | 3 |
| ANTI-INFLAMMATORY AGENTS | GLUCOCORTICOIDS | 1 |
| ANTI-INFLAMMATORY AGENTS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 20 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 9 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 16 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 16 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 4 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 11 |
| ANTIBACTERIALS | MACROLIDES | 4 |
| ANTIBACTERIALS | QUINOLONES | 4 |
| ANTIBACTERIALS | SULFONAMIDES | 4 |
| ANTIBACTERIALS | TETRACYCLINES | 4 |
| ANTICONVULSANTS | ANTICONVULSANTS, OTHER | 2 |
| 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 | 3 |
| ANTIDEPRESSANTS | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 9 |
| ANTIDEPRESSANTS | TRICYCLICS | 9 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 10 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 7 |
| ANTIFUNGALS | NO USP CLASS | 20 |
| 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 | 4 |
| 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 | 6 |
| ANTINEOPLASTICS | AROMATASE INHIBITORS, 3RD GENERATION | 3 |
| ANTINEOPLASTICS | ENZYME INHIBITORS | 3 |
| ANTINEOPLASTICS | MOLECULAR TARGET INHIBITORS | 12 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 2 |
| ANTINEOPLASTICS | RETINOIDS | 3 |
| ANTIPARASITICS | ANTHELMINTICS | 4 |
| 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 | 8 |
| 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 |

| 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 | 20 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 2 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 9 |
| 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 | 6 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC BLOCKING AGENTS | 4 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN II RECEPTOR ANTAGONISTS | 6 |
| 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 | 4 |
| 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 | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 2 |
| CENTRAL NERVOUS SYSTEM AGENTS | FIBROMYALGIA AGENTS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | MULTIPLE SCLEROSIS AGENTS | 6 |
| DENTAL AND ORAL AGENTS | NO USP CLASS | 7 |
| DERMATOLOGICAL AGENTS | NO USP CLASS | 28 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 9 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|--|------------------|
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 6 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 5 |
| 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 | 4 |
| 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 | 4 |
| 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 | 20 |
| IMMUNOLOGICAL AGENTS | IMMUNIZING AGENTS, PASSIVE | 0 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 9 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 2 |
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|------------------|
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 13 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 3 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 4 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 6 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 9 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 12 |
| OTIC AGENTS | NO USP CLASS | 6 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 4 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 9 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 7 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 6 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 4 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 6 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 3 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 3 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 7 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 11 |