ALASKA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Premera Blue Cross Blue Shield of Alaska
Product Name	Alaska Heritage Select Envoy
Plan Name	Heritage Select Envoy
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP) • Mental Health and Substance Use Disorder Services (Largest FEHBP)
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	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						In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
2	**Specialist Visit**	Covered	Specialist Visit	No						In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No						In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Hospital outpatient surgery/ non-surgery facility	No						Applicable deductible & coinsurance apply	No
5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No						Applicable deductible & coinsurance apply	No

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6	**Hospice Services**	Covered	Hospice Services	Yes	6	Other other	6 months lifetime limit		1) Charges in excess of average wholesale price shown in "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions 2) OTC drugs, solutions, and nutritional supplements 3) Drugs and solutions received while an inpatient, except for covered inpatient hospice care 4) Services provided to someone other than the ill or injured member 5) Services of family members or volunteers 6) Services, supplies, or providers not in written plan of care or not named as covered 7) Custodial care, except for hospice care services 8) Non-medical services, such as spiritual, bereavement, legal, or financial counseling 9) Normal living expenses, housekeeping, or transportation services 10)Dietary assistance (e.g. "Meals on Wheels"), or nutritional guidance	Applicable deductible & coinsurance apply	Yes
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No						Applicable cost shares apply	Yes
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)								

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13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No						In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	130	Visits per year			1) Charges in excess of average wholesale price shown in "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions 2) OTC drugs, solutions, and nutritional supplements 3) Drugs and solutions received while an inpatient, except for covered inpatient hospice care 4) Services provided to someone other than the ill or injured member 5) Services of family members or volunteers 6) Services, supplies, or providers not in written plan of care or not named as covered 7) Custodial care, except for hospice care services 8) Non-medical services, such as spiritual, bereavement, legal, or financial counseling 9) Normal living expenses, housekeeping, or transportation services 10)Dietary assistance (e.g. "Meals on Wheels")	Applicable deductible & coinsurance apply	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No					Treatment of chemical dependency/substance abuse, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition	Subject to $100 copay after deductible and preferred coinsurance	No

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16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No						Emergent air & ground: preferred deductible & coinsurance. Non-emergent ground: preferred deductible & coinsurance. Non-emergent air facility to facility: in-network subject to applicable deductible & in-network coinsurance, and out-of-network subject to deductible & 60% coinsurance.	No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					1) Hospital admissions for diagnostic purposes only, unless services can't be provided without use of inpatient hospital facilities, or unless medical condition makes inpatient care medically necessary 2) Any days of inpatient care that exceed length of stay medically necessary to treat your condition 3) Treatment of chemical dependency/ substance abuse, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition	Applicable deductible & coinsurance apply	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No						Applicable deductible & coinsurance apply	No
19	**Bariatric Surgery**	Not Covered	Bariatric Surgery								
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery								
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	60	Days per year			1) Custodial care 2) Care primarily for senile deterioration, mental deficiency, or retardation, or treatment of chemical dependency/substance abuse	Applicable deductible & coinsurance apply	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No						Applicable deductible & coinsurance apply	No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No						Applicable deductible & coinsurance apply	No

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24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental health and substance abuse benefits	No					Services performed and billed by Residential Treatment Centers are not covered.		Yes
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental health and substance abuse benefits	No					Services performed and billed by Residential Treatment Centers are not covered.		No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Mental health and substance abuse benefits	No					Services performed and billed by Residential Treatment Centers are not covered.		Yes
27	**Substance Abuse Disorder Inpatient Services**	Covered	Mental health and substance abuse benefits	No					Services performed and billed by Residential Treatment Centers are not covered.		No
28	**Generic Drugs**	Covered	Generic Drugs								
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs								
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs								
31	**Specialty Drugs**	Covered	Specialty Drugs								
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	45	Visits per year			1) Recreational, vocational, or educational therapy, exercise, or maintenance-level programs 2) Social or cultural therapy 3) Treatment that isn't actively engaged in by the ill, injured, or impaired member 4) Gym or swim therapy 5) Custodial care	Applicable deductible & coinsurance apply. Annual visit limit is combined with the Habilitation benefit.	No
33	**Habilitation Services**	Covered	Habilitation Services	Yes	45	Visits per year			1) Recreational, vocational, or educational therapy, exercise, or maintenance-level programs 2) Social or cultural therapy 3) Treatment that isn't actively engaged in by the ill, injured, or impaired member 4) Gym or swim therapy 5) Custodial care	Applicable deductible & coinsurance apply. Annual visit limit is combined with the Rehabilitation benefit.	No
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	12	Visits per year				In network: subject to applicable copay only.	No

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35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					1) Supplies or equipment not primarily intended for medical use 2) Special or extra-cost convenience features 3) Items such as exercise equipment and weights 4) Orthopedic appliances prescribed primarily for use during participation in sports, recreation, or similar activities 5) Penile prostheses 6) Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices 7) Over bed tables, elevators, vision aids, and telephone alert systems 8) Structural modifications to your home and/or personal vehicle 9) Eyeglasses, contact lenses, and other vision hardware for conditions not listed as a covered medical condition, including routine eye care 10)Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation 11)Hypodermic needles, syringes, lancets, test strips, testing agents, and alcohol swabs used for self-administered medications	Applicable deductible & coinsurance apply	Yes
36	**Hearing Aids**	Not Covered	Hearing Aids								
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No					1) Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy 2) Allergy testing 3) Covered inpatient diagnostic services furnished and billed by inpatient facility 4) Covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services 5) Services relating to testing, diagnosis, or treatment of infertility 6) Mammography services	Applicable deductible & coinsurance apply	No

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38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No					1) Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy 2) Allergy testing 3) Covered inpatient diagnostic services furnished and billed by inpatient facility 4) Covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services 5) Services relating to testing, diagnosis, or treatment of infertility 6) Mammography services	Applicable deductible & coinsurance apply	No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screening/ Immunization	No						Covered in full (no cost shares)	No
40	**Routine Foot Care**	Not Covered	Routine Foot Care								
41	**Acupuncture**	Covered	Acupuncture	Yes	12	Visits per year				In network: subject to applicable copay only.	No
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 other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Limitations, including dollar limits, may apply	No

OTHER BENEFITS

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1	**Hospice Services**	Covered	Respite care	Yes	240	Other other	240 hours within the 6 month lifetime maximum			Applicable deductible and coinsurance apply	No
2	**Hospice Services**	Covered	Inpatient services	Yes	10	Other other	10 days within the 6 month lifetime maximum			Applicable deductible and coinsurance apply	No
3	**Durable Medical Equipment**	Covered	Foot orthotics and orthopedic shoes not related to a diabetic diagnosis	Yes	300	Other other	$300 per calendar year			1) Called BlueCard Worldwide, and available if outside the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands 2) Provides network of contracting inpatient hospitals, but offers only referrals to doctors and other outpatient providers 3) Member will typically have to submit claims for reimbursement themselves	No
4	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No							No
5	**Mental/Behavioral Health Outpatient Services**	Covered	Psychoanalysis	No							No
6	**Mental/Behavioral Health Outpatient Services**	Covered	Psychological testing	No							No
7	**Substance Abuse Disorder Outpatient Services**	Covered	Methadone maintenance	No							No
8	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
9	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
10	**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	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	11
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	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
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	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	27
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
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	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
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	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	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
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	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	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	17
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	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
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	24
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	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	15
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