NORTHERN MARIANA ISLANDS EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest national FEHBP, Preferred Provider Organization
Issuer Name	Blue Cross Blue Shield
Product Name	Blue Cross and Blue Shield Service Benefit Plan
Plan Name	Standard Option
Supplemented Categories (Supplementary Plan Type)	Pediatric Vision (FEDVIP)
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							No
2	**Specialist Visit**	Covered	Specialist Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Services	No							No
5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No							No
6	**Hospice Services**	Covered	Hospice care	Yes	7	Days per admission	Inpatient hospice stays limited to up to 7 consecutive days, separated by at least 21 days of traditional home hospice.				Yes
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Covered	Dental Benefits	Yes	2	Other	2 eval/prophylaxis per year.				No
9	**Infertility Treatment**	Covered	Diagnosis and treatment of infertility	No					Assistive reproductive technology (ART) procedures, drugs, services and supplies are not covered.		No

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10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Not Covered									
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No							No
14	**Home Health Care Services**	Covered	Home health services	Yes	25	Visits per year	25 visits per year.			Covered only when performed by RN or LPN.	Yes
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance	No						Wheelchair van services and gurney van services; Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care.	Yes
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No							No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No							No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No						Stringent pre-surgical criteria must satisfied for coverage to be provided.	No
20	**Cosmetic Surgery**	Not Covered									

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21	**Skilled Nursing Facility**	Not Covered								Only Standard Option members with primary Medicare Part A are eligible for SNF benefit, limited to secondary coverage for first 30 days only.	
22	**Prenatal and Postnatal Care**	Covered	Maternity care	No					Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest; Genetic testing/screening of the baby's father (see page 33 for our coverage of medically necessary diagnostic genetic testing) - Maternity care for women not enrolled in this Plan.		Yes
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Maternity care	No							No
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.		No
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

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28	**Generic Drugs**	Covered	Prescription benefits	No						Service Benefit Plan covers a comprehensive set of drugs - for non-covered drugs see NDC list.	No
29	**Preferred Brand Drugs**	Covered	Prescription benefits	No						Service Benefit Plan covers a comprehensive set of drugs - for non-covered drugs see NDC list.	No
30	**Non-Preferred Brand Drugs**	Covered	Prescription benefits	No						Service Benefit Plan covers a comprehensive set of drugs - for non-covered drugs see NDC list.	No
31	**Specialty Drugs**	Covered	Prescription benefits	No						Service Benefit Plan covers a comprehensive set of drugs - for non-covered drugs see NDC list.	No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient rehabilitation services	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				Yes
33	**Habilitation Services**	Covered	Outpatient rehabilitation services	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				Yes

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34	**Chiropractic Care**	Covered	Manipulative treatment	Yes	12	Treatments per year				Members only receive benefits for one office visit and one set of x-rays per calendar year, when billed by a chiropractor.	Yes
35	**Durable Medical Equipment**	Covered	Durable medical equipment	No							Yes
36	**Hearing Aids**	Covered	Hearing aids	Yes	1	Other	Limited to $1,250 per ear per calendar year for children; $1,250 per ear per 36-month period for adults.				Yes
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic tests	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Diagnostic tests	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive care	Yes	1	Other	Cancer screenings, STI screenings, lab screenings, and other preventive care services are limited to one per member per calendar year.		Genetic testing/screening, group nutritional counseling, self-administered health risk assessments, screening services requested solely by the member.	Certain services will be paid more than once per year per preventive benefits (i.e., office visits, exams), based on ACA requirement to pay in full any office visit/exam where the primary purpose of the visit was for preventive care.	No
40	**Routine Foot Care**	Covered	Foot care	No					Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot.	Covered when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	No
41	**Acupuncture**	Covered	Alternative treatments	Yes	24	Treatments per year					No
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No

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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 Benefits	Yes	2	Other	2 eval/prophylaxis per year.				Yes

OTHER BENEFITS

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1	**Hospice Services**	Covered	Home Infusion Therapy	No							No
2	**Emergency Transportation/ Ambulance**	Covered	Air Ambulance	No							No
3	**Mental/Behavioral Health Outpatient Services**	Covered	Group therapy	No							No
4	**Mental/Behavioral Health Outpatient Services**	Covered	Psychoanalysis	No							No
5	**Mental/Behavioral Health Outpatient Services**	Covered	Psychological testing	No							No
6	**Substance Abuse Disorder Outpatient Services**	Covered	Methadone maintenance	No							No
7	**Outpatient Rehabilitation Services**	Covered	Cardiac rehabilitation	No							No
8	**Outpatient Rehabilitation Services**	Covered	Pulmonary rehabilitation	No							No
9	**Outpatient Rehabilitation Services**	Covered	Physical therapy	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				No
10	**Outpatient Rehabilitation Services**	Covered	Occupational therapy	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				No

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11	**Outpatient Rehabilitation Services**	Covered	Speech therapy	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				No
12	**Habilitation Services**	Covered	PT, OT and ST for a person with autism or other congenital defect when service is medically necessary and patient is demonstrating improvement	Yes	75	Other	PT/OT/ST limited to 75 visits per member, per calendar year, in any combination of services regardless of whether the condition was present at birth and as long as medically necessary and therapies are improving functionality.				No
13	**Durable Medical Equipment**	Covered	Orthotics and special footwear	No					Do not cover shoes and over-the-counter orthotics, arch supports, heel pads and heel cups.		No
14	**Durable Medical Equipment**	Covered	Cochlear implants	No							No
15	**Durable Medical Equipment**	Covered	Prosthetics	No							No
16	**Durable Medical Equipment**	Covered	Speech-generating devices	Yes	1250	Other	$1,250 per calendar year.				No
17	**Hearing Aids**	Covered	Hearing exams related to illness or injury	No							No
18	**Dental Check-Up for Children**	Covered	Prophylaxis	Yes	2	Other	2 evals/prophylaxis per calendar year.				No

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19	**Dental Check-Up for Children**	Covered	Restorative services	No						Limited to certain restorative services up to a fee schedule amount.	No
20	**Chiropractic Care**	Covered	Chiropractic office visits	Yes	1	Visits per year					No
21	**Chiropractic Care**	Covered	Set of x-rays	Yes	1	Visits per year					No
22	**Home Health Care Services**	Covered	Home Health Care Services	Yes	2	Other	2 hours per day.				No
23	**Prenatal and Postnatal Care**	Covered	Pregnancy related depression	Yes	4	Other	Up to 4 visits to a mental health professional.				No
24	**Prenatal and Postnatal Care**	Covered	Tocolytic therapy	Yes	25	Visits per year	Up to 25 visits (2 hours per day) per calendar year.		Oral tocolytic agents not covered.		Yes
25	**Prenatal and Postnatal Care**	Covered	Tocolytic therapy	Yes	2	Other	2 hours per day.				No
26	**Reconstructive Surgery**	Covered	Reconstructive surgery to restore bodily function or correct deformity resulting from disease, trauma, or previous therapeutic process	No							No
27	**Reconstructive Surgery**	Covered	Reconstructive procedures to correct congenital or developmental anomalies if the anomaly results in functional impairment	No							No
28	**Reconstructive Surgery**	Covered	Reconstructive breast surgery	No							No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSIONCOUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
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	11
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	26
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3

CATEGORY	CLASS	SUBMISSIONCOUNT
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	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
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

CATEGORY	CLASS	SUBMISSIONCOUNT
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	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	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	7
DERMATOLOGICAL AGENTS	NO USP CLASS	33
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
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

CATEGORY	CLASS	SUBMISSIONCOUNT
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
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	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2

CATEGORY	CLASS	SUBMISSIONCOUNT
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	9