RHODE ISLAND EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross & Blue Shield of Rhode Island
Product Name	Vantage Blue
Plan Name	Vantage Blue BCBSRI
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	Yes: Habilitative services must be comprehensive and measured as per member per month cost of rehabilitation serviced covered under the plan. Issuer will be required to attach filing as an Exhibit that identifies the habilitative services covered by the plan; includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered; and, includes in the actuarial memo the calculation and analysis used to develop the identified cost. All should happen no later than 90 days after the end of each calendar year. Issuer must also file with OHIC an actuarial memo, using the best available claims data and compare such claims and expense experience with the approved rate factor.

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 Office Visit	No							No
2	**Specialist Visit**	Covered	Specialist Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visits	No							Yes
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Surgery Facility Fee (e.g. Ambulatory Surgery Center)	No							Yes
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician Services	No							Yes
6	**Hospice Services**	Covered	Hospice Services	No						Covered when provided by an approved hospice care program.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Care when Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered	Dental Services								
9	**Infertility Treatment**	Covered	Infertility Treatment	No					Infertility treatment for a person that previously had a voluntary sterilization procedure is not covered.	Coverage is provided when the member is married, unable to conceive or sustain a pregnancy during a one year period and a presumably healthy individual.	Yes
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term Care								

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11	**Private-Duty Nursing**	Covered	Private-Duty Nursing	No						Covered when received in your home when medically necessary, ordered by a physician and performed by a certified home health care agency.	No
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam	Yes	1	Visits per year					No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Center Visits	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No							No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance (ground transportation)	No					This plan does not provide coverage for transportation to a physician's office.		Yes
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No							Yes
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No							Yes
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No							No
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery							This plan does not cover cosmetic procedures when performed primarily to refine or reshape body structures that are not functionally impaired; to improve appearance or self-esteem or for other psychological, psychiatric or emotional reasons.	
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No					Custodial Care is not covered.		No
22	**Prenatal and Postnatal Care**	Covered	Pregnancy Services and Nursery Care	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and Inpatient Maternity Care	No							No

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24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	No					This plan does not cover recreation therapy, non-medical self-care, or self-help training, mental health residential treatment programs (including eating disorder residential treatment programs), telephone consultations, therapeutic reaction programs or wilderness programs, behavioral training assessment, education or exercise, including applied behavioral analysis.		No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					This plan does not cover recreation therapy, non-medical self-care, or self-help training, mental health residential treatment programs (including eating disorder residential treatment programs), telephone consultations, therapeutic reaction programs or wilderness programs, behavioral training assessment, education or exercise, including applied behavioral analysis.		No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No					This plan does not cover methadone clinics and treatments.		No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					This plan does not cover methadone clinics and treatments.		No
28	**Generic Drugs**	Covered	Tier 1 lower costs Generic Drugs	No							No
29	**Preferred Brand Drugs**	Covered	Tier 2 Preferred Brand Drugs and high cost Generic Drugs.	No							No
30	**Non-Preferred Brand Drugs**	Covered	Tier 3 Non-Preferred Brand Drugs	No							No
31	**Specialty Drugs**	Covered	Tier 4 Specialty Drugs	No							No

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32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services including Physical Therapy, Occupational Therapy and Speech Therapy	No							Yes
33	**Habilitation Services**	Covered	Outpatient Habilitation Services including Physical Therapy, Occupational Therapy and Speech Therapy	No							Yes
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	12	Visits per year			This plan does not cover massage therapy, aqua therapy, maintenance therapy or aromatherapy, pillows, therapies for the purpose of relieving stress or chiropractic services in the home.		No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment, and Medical Supplies	No							Yes
36	**Hearing Aids**	Covered	Hearing Aids (age 19 and older)	Yes	700	Other	For an eligible person age 19 and over; coverage is limited to the maximum benefit of $700 per ear, per 3 year period, per member. For eligible person under age 19 see "Hearing Aids (Hearing Aids (ages 19 and under)" on Other Tab.				Yes
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No							No

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38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Services	No							No
40	**Routine Foot Care**	Not Covered	Routine Foot Care, unless to treat a systemic condition.						Routine foot care is not covered unless to treat a systemic condition.	Routine Foot Care is covered only when performed to treat diabetic related nerve and circulation disorders of the feet.	
41	**Acupuncture**	Not Covered	Acupuncture								
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs								
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year)				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Covered at 100% if the services were provided In Network and at 90% if they were Out of Network subject to the annual $10,000 maximum.	No

OTHER BENEFITS

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1	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Nutritional Counseling	No						When prescribed by a physician for treatment of illness.	No
2	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Asthma Education	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Diabetes Management	No							No
4	**Durable Medical Equipment**	Covered	Enteral Formula or food taken orally	Yes	2500	Other	Limited to a maximum benefit of $2,500 per member per contract year.				No
5	**Durable Medical Equipment**	Covered	Enteral Formula delivered through a feeding tube	No						Covered when it is the sole source of nutrition.	No
6	**Outpatient Rehabilitation Services**	Covered	Physical Therapy	No					Maintenance Therapy is not covered.		No
7	**Outpatient Rehabilitation Services**	Covered	Occupational Therapy	No					Maintenance Therapy is not covered.		No
8	**Outpatient Rehabilitation Services**	Covered	Speech Therapy	No					Maintenance Therapy is not covered.		No
9	**Habilitation Services**	Covered	Physical Therapy	No					Maintenance Therapy is not covered.		No
10	**Habilitation Services**	Covered	Occupational Therapy	No					Maintenance Therapy is not covered.		No
11	**Habilitation Services**	Covered	Speech Therapy	No					Maintenance Therapy is not covered.		No
12	**Outpatient Rehabilitation Services**	Covered	Cardiac Rehabilitation	Yes	18	Other	Coverage is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode.				No

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13	**Emergency Transportation/ Ambulance**	Covered	Air/water Ambulance	Yes	3000	Other	Coverage is limited to a maximum benefit of $3,000 per occurrence.		This plan does not cover air or water ambulance transportation unless the destination is an acute care hospital or transport from cruise ships when not in US waters.		No
14	**Durable Medical Equipment**	Covered	Wigs	Yes	350	Other	Up to $350 benefit maximum per calendar year (combined for in and out of network).				No
15	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Physical Rehabilitation	Yes	45	Days per year					No
16	**Hearing Aids**	Covered	Hearing Aids (ages 19 and under)	Yes	1500	Other	Coverage is limited to the maximum benefit of $1500 per ear, per 3 year period, per member (for an eligible person under the age of 19).				No
17	**Infertility Treatment**	Covered	Assistive Reproductive Technologies such as Invitro fertilization	No							No
18	**Outpatient Surgery Physician/Surgical Services**	Covered	Reconstructive Surgery to Treat Functional Deformity or Impairment	No						Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease.	No

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19	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Reconstructive Surgery to Treat Functional Deformity or Impairment	No						Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease. Includes mastectomy services.	No
20	**Inpatient Physician and Surgical Services**	Covered	Reconstructive Surgery to Treat Functional Deformity or Impairment	No						Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease. Includes mastectomy services.	No
21	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Reconstructive Surgery to Treat Functional Deformity or Impairment	No						Reconstructive surgery and procedures are covered when performed to correct a functional deformity due to a previous therapeutic process or a documented functional impairment caused by trauma, congenital anomaly or disease.	No
22	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Abortion	No							No
23	**Outpatient Surgery Physician/Surgical Services**	Covered	Abortion	No							No
24	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Surgical Sterilization	No							No
25	**Inpatient Physician and Surgical Services**	Covered	Surgical Sterilization	No							No
26	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Surgical Sterilization	No							No
27	**Outpatient Surgery Physician/Surgical Services**	Covered	Surgical Sterilization	No							No
28	**Other**	Covered	Smoking Cessation	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	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	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	17
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	4
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
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	4
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	2
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	8
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	2
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	4
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	4
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	10
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	20
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	6
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	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	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	4
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	14
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	2
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	22
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	5
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	13
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	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3
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	12