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

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					In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
Specialist Visit	Yes	Specialist Visit	Covered	No					In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No					In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Hospital outpatient surgery/ non-surgery facility	Covered	No					Applicable deductible & coinsurance apply	No
Outpatient Surgery Physician/ Surgical Services	Yes	Outpatient Surgery Physician/Surgical Services	Covered	No					Applicable deductible & coinsurance apply	No
Hospice Services	Yes	Hospice Services	Covered	Yes	6	Month 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
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No					Applicable cost shares apply. 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	Yes

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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					In network: first 6 visits subject to applicable copay only. Subsequent visits subject to applicable deductible and coinsurance.	No
Home Health Care Services	Yes	Home Health Care Services	Covered	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
Emergency Room Services	Yes	Emergency Room Services	Covered	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
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/ Ambulance	Covered	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

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Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	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
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No					Applicable deductible & coinsurance apply	No
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	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
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No					Applicable deductible & coinsurance apply	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No					Applicable deductible & coinsurance apply	No
Mental/Behavioral Health Outpatient Services	Yes	Mental health and substance abuse benefits	Covered	No				Services performed and billed by Residential Treatment Centers are not covered.		Yes
Mental/Behavioral Health Inpatient Services	Yes	Mental health and substance abuse benefits	Covered	No				Services performed and billed by Residential Treatment Centers are not covered.		No
Substance Abuse Disorder Outpatient Services	Yes	Mental health and substance abuse benefits	Covered	No				Services performed and billed by Residential Treatment Centers are not covered.		Yes
Substance Abuse Disorder Inpatient Services	Yes	Mental health and substance abuse benefits	Covered	No				Services performed and billed by Residential Treatment Centers are not covered.		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

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Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	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
Habilitation Services	Yes	Habilitation Services	Covered	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
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	12	Visits per year			In network: subject to applicable copay only.	No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	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
Hearing Aids			Not Covered							

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Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	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
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	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
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/ Screening/ Immunization	Covered	No					Covered in full (no cost shares)	No
Routine Foot Care			Not Covered							
Acupuncture	Yes	Acupuncture	Covered	Yes	12	Visits per year			In network: subject to applicable copay only.	No
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No
Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit per 6 months			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy			Not Covered							
Rehabilitative Occupational and Rehabilitative Physical Therapy			Not Covered							
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No

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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	Yes	Basic Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Basic Dental Care - Adult			Not Covered							
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			Not Covered							
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorders (PKU)	Yes	Inherited Metabolic Disorders (PKU)	Covered	No						No

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Newborn Hearing Screening	Yes	Newborn Hearing Screening	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?
Hospice Services	Yes	Respite care	Covered	Yes	240	Hours within the 6 month lifetime maximum			Applicable deductible and coinsurance apply	No
Hospice Services	Yes	Inpatient services	Covered	Yes	10	Days within the 6 month lifetime maximum			Applicable deductible and coinsurance apply	No
Durable Medical Equipment	Yes	Foot orthotics and orthopedic shoes not related to a diabetic diagnosis	Covered	Yes	300	Dollars per calendar year				No
Mental/Behavioral Health Outpatient Services	Yes	Psychoanalysis	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Psychological testing	Covered	No						No
Substance Abuse Disorder Outpatient Services	Yes	Methadone maintenance	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	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
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	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

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
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
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