

## PROPOSED ALASKA EHB BENCHMARK PLAN

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### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Preferred Provider Organization
<b>Issuer Name</b>	Premera Blue Cross Blue Shield of Alaska
<b>Product Name</b>	Alaska Heritage Select Envoy
<b>Plan Name</b>	Heritage Select Envoy
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"><li>• Pediatric Oral (FEDVIP)</li><li>• Pediatric Vision (FEDVIP)</li><li>• Mental Health and Substance Abuse Disorder Services (Largest FEHBP)</li></ul>
<b>Habilitative Services</b>	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		<ul style="list-style-type: none"> <li>1) Charges in excess of average wholesale price shown in "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions</li> <li>2) OTC drugs, solutions, and nutritional supplements</li> <li>3) Drugs and solutions received while an inpatient, except for covered inpatient hospice care</li> <li>4) Services provided to someone other than the ill or injured member</li> <li>5) Services of family members or volunteers</li> <li>6) Services, supplies, or providers not in written plan of care or not named as covered</li> <li>7) Custodial care, except for hospice care services</li> <li>8) Non-medical services, such as spiritual, bereavement, legal, or financial counseling</li> <li>9) Normal living expenses, housekeeping, or transportation services</li> <li>10) Dietary assistance (e.g. "Meals on Wheels"), or nutritional guidance</li> </ul>	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)								
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

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14	Home Health Care Services	Covered	Home Health Care Services	Yes	130	Visits per year			<ul style="list-style-type: none"> <li>1) Charges in excess of average wholesale price shown in "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions</li> <li>2) OTC drugs, solutions, and nutritional supplements</li> <li>3) Drugs and solutions received while an inpatient, except for covered inpatient hospice care</li> <li>4) Services provided to someone other than the ill or injured member</li> <li>5) Services of family members or volunteers</li> <li>6) Services, supplies, or providers not in written plan of care or not named as covered</li> <li>7) Custodial care, except for hospice care services</li> <li>8) Non-medical services, such as spiritual, bereavement, legal, or financial counseling</li> <li>9) Normal living expenses, housekeeping, or transportation services</li> <li>10) Dietary assistance (e.g. "Meals on Wheels")</li> </ul>	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
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					<ul style="list-style-type: none"> <li>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</li> <li>2) Any days of inpatient care that exceed length of stay medically necessary to treat your condition</li> <li>3) Treatment of chemical dependency/substance abuse, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition</li> </ul>	Applicable deductible & coinsurance apply	No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No						Applicable deductible & coinsurance apply	No

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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
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	Not Covered	Generic Drugs								
29	Preferred Brand Drugs	Not Covered	Preferred Brand Drugs								
30	Non-Preferred Brand Drugs	Not Covered	Non-Preferred Brand Drugs								
31	Specialty Drugs	Not 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

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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
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
46	Other										

**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	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	13
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	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	23
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	9
ANTIBACTERIALS	MACROLIDES	6
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	BARBITURIC ACID DERIVATIVE	1
ANTICONVULSANTS	BENZODIAZEPINE DERIVATIVE	4
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
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	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	ANTIFUNGALS	24
ANTIGOUT AGENTS	ANTIGOUT AGENTS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7

Category	Class	Submission Count
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS	52
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	4
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
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	ANTISPASTICITY AGENTS	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	8
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	SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4

Category	Class	Submission Count
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	9
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	9
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	6
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
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	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	2
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	5
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	DENTAL AND ORAL AGENTS	7
DERMATOLOGICAL AGENTS	DERMATOLOGICAL AGENTS	27
ENZYME REPLACEMENT/MODIFIERS	ENZYME REPLACEMENT/MODIFIERS	18
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	2
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6

Category	Class	Submission Count
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	4
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	24
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
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	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	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	2
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	13
IMMUNOLOGICAL AGENTS	VACCINES	16
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	8
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	METABOLIC BONE DISEASE AGENTS	13
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	8
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES	1
OTIC AGENTS	OTIC AGENTS	4
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	7

<b>Category</b>	<b>Class</b>	<b>Submission Count</b>
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	6
SKELETAL MUSCLE RELAXANTS	SKELETAL MUSCLE RELAXANTS	8
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	10
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	5