

## PROPOSED NEVADA 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>	Rocky Mountain Hos&Med Svc (Anthem BCBS)
<b>Product Name</b>	PPO
<b>Plan Name</b>	GenRx PPO 45 Copay
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"><li>• Pediatric Oral (FEDVIP)</li><li>• Pediatric Vision (FEDVIP)</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							No
2	Specialist Visit	Covered	Specialist Visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Services	No					This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Orthognathic surgery. Reversal of sterilization. Services related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation. Treatment of varicose veins or telangiectatic dermal veins when rendered for cosmetic purposes.		No
5	Outpatient Surgery Physician/Surgical Services	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Orthognathic surgery. Reversal of sterilization. Services related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation. Treatment of varicose veins or telangiectatic dermal veins when rendered for cosmetic purposes.		No
6	Hospice Services	Covered	Hospice Services	No					Services of a mental health social worker. Services or supplies for personal comfort or convenience, including homemaker services. Food services, meals, formulas, and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition. · Pastoral and spiritual counseling. Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement, or other legal services.	Hospice includes medical, physical, social and psychological and spiritual services stressing palliative care for patients.	No

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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)	Not Covered	Dental Services						Excluded dental services include, but are not limited to, preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including extraction of impacted wisdom tooth), restoration and replacement of teeth, and services to improve dental clinical outcomes. This exclusion does not apply to services which we are required by law to cover; services to prepare the mouth for radiation therapy to treat head and/or neck cancer; and other services specified as covered		
9	Infertility Treatment	Covered	Infertility Treatment	Yes	2000	Other other	\$2000 limit per lifetime		All services related to artificial conception are not covered	Services to diagnose cause of infertility are covered: limited to \$2000 per lifetime	No
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care						Except as otherwise specifically provided, this coverage does not cover convalescent care from a period of illness, injury, surgery, unless normally received for a specific condition, as determined by Anthem's medical policy. Convalescent care includes the physician's or facilities services. This coverage does not cover care primarily for the purpose of assisting the member in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., hospital or skilled nursing facility) or at home.		
11	Private-Duty Nursing	Not Covered	Private duty nursing services						Coverage does not include private duty nursing services		

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12	Routine Eye Exam (Adult)	Not Covered	Routine Eye Exam						Coverage does not cover any routine eye examinations, routine refractive examinations, eyeglasses, contact lenses, or prescriptions for such services and supplies. This coverage does not cover vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.		
13	Urgent Care Centers or Facilities	Covered	Urgent Care Services in an Urgent Care Center or Facility	No							No
14	Home Health Care Services	Covered	Home Health Care Services	Yes	100	Visits per year			Services of a mental health social worker. Services or supplies for personal comfort or convenience including homemaker services. Food services, meals, formulas, and supplements other than listed above or resulting from dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition. Religious or spiritual counseling. Coverage does not cover care primarily for the purpose of assisting the member in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., hospital or skilled nursing facility) or at home.	Skilled nursing, physical therapy, speech therapy, occupational therapy, infusion therapy and other health-related services provided at home by a certified home health agency.	No
15	Emergency Room Services	Covered	Emergency Room Services	No							No
16	Emergency Transportation/ Ambulance	Covered	Emergency Transportation/ Ambulance	No						Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home	No

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17	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	Covered	Inpatient Hospital Services	No					This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Orthognathic surgery. Reversal of sterilization. Services related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation. Treatment of varicose veins or telangiectatic dermal veins when rendered for cosmetic purposes. Coverage does not cover convalescent care from a period of illness, injury, surgery, unless normally received for a specific condition, as determined by Anthem's medical policy. Convalescent care includes the physician's or facilities services. Coverage does not cover services and supplies used primarily for the member's personal comfort or convenience. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs. Services related to a private room are not covered.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies. Limits applies to Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes
18	<b>Inpatient Physician and Surgical Services</b>	Covered	Inpatient Physician and Surgical Services	No					This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. Orthognathic surgery. Reversal of sterilization. Services related to sex change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation. Treatment of varicose veins or telangiectatic dermal veins when rendered for cosmetic purposes. Coverage does not cover convalescent care from a period of illness, injury, surgery, unless normally received for a specific condition, as determined by Anthem's medical policy. Convalescent care includes the physician's or facilities services.	Physician medical and surgical services while in an inpatient facility. Limits applies to Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes

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19	Bariatric Surgery	Not Covered	Bariatric Surgery						Coverage does not cover bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures.	Not covered, but offered due to mandate	
20	Cosmetic Surgery	Not Covered	Cosmetic Surgery						Coverage does not cover any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).		
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	Yes	100	Days per year			Coverage does not cover care primarily for the purpose of assisting the member in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., hospital or skilled nursing facility) or at home.	Items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.	No

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22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No					Coverage does not cover services including, but not limited to, preconception, paternity testing, court-ordered genetic counseling discussion of family history or testing to determine the sex or physical characteristics of an unborn child). Coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple.	Maternity services include services required by a member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include: Normal vaginal delivery, Cesarean section delivery, Spontaneous termination of pregnancy prior to full term, Therapeutic or elective termination of pregnancy prior to viability, Complications of pregnancy.	No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Facility and Professional Services for Maternity Care	No				48	Coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple.	Maternity services include services required by a member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include: Normal vaginal delivery, Cesarean section delivery, Spontaneous termination of pregnancy prior to full term, Therapeutic or elective termination of pregnancy prior to viability, Complications of pregnancy. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No

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24	<b>Mental/Behavioral Health Outpatient Services</b>	Covered	Mental/Behavioral Health Outpatient Services	No					The following services, supplies or care are not covered: Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, or outward bound programs, even if therapy is included. Private room expenses. Biofeedback. Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education. Hypnotherapy. Religious, marital and social counseling. The cost of any damages to a treatment facility caused by the member. Recreational, sex, primal scream, sleep and Z therapies. Self-help, stress management and weight loss programs. Transactional analysis, encounter groups and transcendental meditation. Sensitivity training, anger management and assertiveness training. Behavior modification programs. Rebirthing therapy. Custodial care. Domiciliary care. Psychosocial rehabilitation.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No
25	<b>Mental/Behavioral Health Inpatient Services</b>	Covered	Mental/Behavioral Health Inpatient Services	No					The following services, supplies or care are not covered: Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, or outward bound programs, even if therapy is included. Private room expenses. Biofeedback. Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education. Hypnotherapy. Religious, marital and social counseling. The cost of any damages to a treatment facility caused by the member. Recreational, sex, primal scream, sleep and Z therapies. Self-help, stress management and weight loss programs. Transactional analysis, encounter groups and transcendental meditation. Sensitivity training, anger management and assertiveness training. Behavior modification programs. Rebirthing therapy. Custodial care. Domiciliary care. Psychosocial rehabilitation. Coverage does not cover care provided in a residential, non-treatment institution, halfway house or school.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No

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26	<b>Substance Abuse Disorder Outpatient Services</b>	Covered	Substance Abuse Disorder Outpatient Services	No					The following services, supplies or care are not covered: Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, or outward bound programs, even if therapy is included. Private room expenses. Biofeedback. Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education. Hypnotherapy. Religious, marital and social counseling. The cost of any damages to a treatment facility caused by the member. Recreational, sex, primal scream, sleep and Z therapies. Self-help, stress management and weight loss programs. Transactional analysis, encounter groups and transcendental meditation. Sensitivity training, anger management and assertiveness training. Behavior modification programs. Rebirthing therapy. Custodial care. Domiciliary care. Psychosocial rehabilitation.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No
27	<b>Substance Abuse Disorder Inpatient Services</b>	Covered	Substance Abuse Disorder Inpatient Services	No					The following services, supplies or care are not covered: Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, or outward bound programs, even if therapy is included. Private room expenses. Biofeedback. Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education. Hypnotherapy. Religious, marital and social counseling. The cost of any damages to a treatment facility caused by the member. Recreational, sex, primal scream, sleep and Z therapies. Self-help, stress management and weight loss programs. Transactional analysis, encounter groups and transcendental meditation. Sensitivity training, anger management and assertiveness training. Behavior modification programs. Rebirthing therapy. Custodial care. Domiciliary care. Psychosocial rehabilitation. Coverage does not cover care provided in a residential, non-treatment institution, halfway house or school.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No

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28	Generic Drugs	Covered	Generic Prescription Drugs	No					Nutritional and/or dietary supplements. Prescription drugs for the treatment of sexual dysfunction or impotence. Smoking Cessation drugs. Drugs for hair loss. Coverage does not cover any service, supply, or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning. Over the counter items.		No
29	Preferred Brand Drugs	Not Covered	Preferred Brand Prescription Drugs						Plan covers generic drugs only		
30	Non-Preferred Brand Drugs	Not Covered	Non-Preferred Brand Prescription Drugs						Plan covers generic drugs only		
31	Specialty Drugs	Not Covered	Specialty Prescription Drugs						Plan covers generic drugs only		
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			Coverage does not cover any treatment that does not significantly enhance or increase the member's function or productivity, or care provided after the member has reached his/her maximum medical improvement. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	Yes
33	Habilitation Services	Covered	Habilitation Services	Yes	20	Visits per year			Coverage does not cover any treatment that does not significantly enhance or increase the member's function or productivity, or care provided after the member has reached his/her maximum medical improvement. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.	Includes physical therapy, occupational therapy and speech therapy. 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No
34	Chiropractic Care	Covered	Spinal manipulation and manual medical intervention services	Yes	12	Visits per year				Visit limit is combined with acupuncture limit.	No

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35	<b>Durable Medical Equipment</b>	Covered	Medical Equipment and Supplies	No					The following services, supplies or care are not covered: Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances that the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters). Any items available without a prescription such as over the counter items and items usually stocked in the home for general use, including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, and biofeedback equipment. Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition. These include, but are not limited to, bath accessories, home modifications to accommodate wheelchairs, wheel chair convenience items, wheel chair lifts, or vehicle modifications. Dental prosthesis, hair/cranial prosthesis, penile prosthesis or other prosthesis for cosmetic purpose. Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide. Home exercise and therapy equipment. Hearing aids and related services and supplies. Consumer beds or water beds. Repair or replacement needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section. Orthopedic shoes not attached to a brace (except for members with diabetes). Coverage does not include supplies for the treatment of sexual dysfunction or impotence.	Includes medical supplies, durable medical equipment, oxygen, appliances, prostheses and orthopedic appliances.	No
36	<b>Hearing Aids</b>	Not Covered	Hearing Aids						Coverage is excluded for hearing aids and routine hearing tests		

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37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Tests	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Advanced Diagnostic Imaging Services	No							No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/ Screenings and Immunizations	No						Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012	No
40	Routine Foot Care	Not Covered	Routine Foot Care						Routine foot care such as care for corns, toenails and calluses (except for members with diabetes).		
41	Acupuncture	Covered	Acupuncture	Yes	12	Visits per year				Visit limit is combined with spinal manipulation limit.	No
42	Weight Loss Programs	Not Covered	Weight Loss Programs						coverage does not cover weight loss programs whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting 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	Other	Covered	Radiation Therapy	No							No
2	Other	Covered	Chemotherapy	No							No
3	Other	Covered	Infusion Therapy	No							No
4	Other	Covered	Renal Dialysis/Hemodialysis	No							No
5	Other	Covered	Allergy Treatment	No							No
6	Other	Covered	Injectable Drugs and Other Drugs Provided/ Administered During an Office Visit	No							No
7	Other	Covered	Autism Services	No					Services for autism spectrum disorders are subject to the same general exclusions or limitations as other medical services or prescription drugs covered under this plan.	Coverage is provided for the screening, diagnosis, and treatment of autism spectrum disorder to members under 18 years of age or, if enrolled in high school, until the member reaches 22 years of age. Screening for autism spectrum disorders means medically necessary assessments, evaluations or tests to screen and diagnose whether a member has an autism spectrum disorder. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:  (a) Prescribed for a member diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and (b) Provided for a member diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.	No
8	Other	Covered	Applied Behavior Analysis (ABA)	Yes	36000	Other other	Dollar Limit per year			Applied behavior analysis treatment for autism spectrum disorder is limited for members under 18 years of age or, if enrolled in high school, until the member reaches 22 years of age.	No

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9	Other	Covered	Vision Correction After Surgery or Accident	No						Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia. Replacements are only covered if a physician recommends a change in prescription.	No

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10	<b>Other</b>	Covered	Dental Services for Accidental Injury and Other Related Medical Services	No					Restoring the mouth, teeth, or jaws because of injuries resulting from biting, chewing, or an accident or injury principally damaging the teeth. Restorations, supplies, or appliances. Examples of such non-covered items include but are not limited to: cosmetic restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are not medically necessary to stabilize damaged teeth. Inpatient or outpatient services required due to the age of the member, medical condition and/or nature of the dental services except as described above. Upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic, congenital or acquired characteristic. Artificially implanted devices and bone graft for denture wear. Administration of anesthesia for dental services, operating and recovery room charges, surgeon services except as allowed above.	Benefits are provided for accident-related dental expenses when the member meets all of the following criteria: Dental services, supplies and appliances are needed because of an accident in which the member sustained other significant bodily injuries outside the mouth or oral cavity. Treatment must be for injuries to the member's sound natural teeth. Treatment must be necessary to restore the member's teeth to the condition they were in immediately before the accident. The first dental services must be performed within 90 days after the member's accident. Related services must be performed within six months after the member's accident. Services after six months are not covered even if coverage is still in effect. Benefits for restorations are limited to those services, supplies, and appliances Anthem determines to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. Dental Anesthesia: Benefits are provided for general anesthesia, when provided in a hospital, outpatient surgical facility or other facility, and for associated hospital or facility charges for dental care provided to a dependent child who 1) has a physical, mental or medically compromising condition; 2) has dental needs for which local anesthesia is not effective because of acute infection, or allergy; 3) is extremely uncooperative, unmanageable, uncommunicative; or 4) has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation. Inpatient Admission for Dental Care: Benefits are provided for inpatient facility services including room and board, but not including charges for the dental services, only if the member has a non-dental-related physical condition, such as bleeding disorders or heart condition that makes the hospitalization medically necessary.	No

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11	Other	Covered	Human Organ and Tissue Transplant Services	No					<p>Human Organ and Tissue Transplant Exclusions — The following services, supplies or care are not covered:</p> <ul style="list-style-type: none"> <li>Performed at any hospital that is not designated or approved by Anthem to provide covered transplant procedures for the organ or tissue being transplanted.</li> <li>Benefits for services if the member is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide the organ or stem cell/bone marrow transplant service.</li> <li>Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends except as provided above.</li> <li>Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service or supply. Any service or supply associated with or provided in follow-up to any of the above.</li> <li>Any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires Federal or other governmental agency approval and such approval is not granted at the time services are provided.</li> <li>Any service or supply associated with or provided in follow-up to any of the above.</li> <li>Transplants of organs other than those listed above, including non-human organs.</li> <li>Procurement of a donor organ which has been sold rather than donated.</li> <li>Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices long as any of the above devices remain in place.</li> </ul> <p>This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant. Blood, blood plasma and blood derivatives received from community sources or replaced through donor credit. For non-covered transportation and lodging related but not</p>		

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11 (cont.)	<b>Other (cont.)</b>								limited to the following: Alcohol, tobacco, other non food items; Child care; Mileage within the medical transplant facility city; Rental care, buses, taxis, or shuttle services, except as specifically approved by Anthem; Frequent Flyer miles; Coupons, vouchers, or travel tickets; Prepayment or deposits; Services for a condition that is not directly related, or a direct result, of the transplant; Telephone calls; Laundry; Postage; Entertainment; Interim visits to a medical care facility while waiting for the actual transplant procedure; Travel expenses for donor companion/caregiver; Return visits for the donor for a treatment of a condition found during the evaluation.	Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.	Yes
12	<b>Other</b>	Covered	Transportation of the recipient to the location of the transplant surgery and Lodging for Living Donors	Yes	10000	Other other	\$10000 limit per transplant		Human Organ and Tissue Transplant Exclusions — The following services, supplies or care are not covered: Performed at any hospital that is not designated or approved by Anthem to provide covered transplant procedures for the organ or tissue being transplanted. Benefits for services if the member is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide the organ or stem cell/bone marrow transplant service. Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends except as provided above. Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service or supply. Any service or supply associated with or provided in follow-up to any of the above. Any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires Federal or other governmental agency approval and such approval is not granted at the time services are provided. Any service or supply associated with or provided in follow-up to any of the above. Transplants of organs other than those listed above, including non-human organs. Procurement of a donor organ which has been sold rather than donated. Services		

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12 (cont.)	Other (cont.)								and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant. Blood, blood plasma and blood derivatives received from community sources or replaced through donor credit. For non-covered transportation and lodging related but not limited to the following: Alcohol, tobacco, other non food items; Child care; Mileage within the medical transplant facility city; Rental care, buses, taxis, or shuttle services, except as specifically approved by Anthem; Frequent Flyer miles; Coupons, vouchers, or travel tickets; Prepayment or deposits; Services for a condition that is not directly related, or a direct result, of the transplant; Telephone calls; Laundry; Postage; Entertainment; Interim visits to a medical care facility while waiting for the actual transplant procedure; Travel expenses for donor companion/caregiver; Return visits for the donor for a treatment of a condition found during the evaluation.	Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.	No
13	Other	Covered	Donor Search Costs	Yes	30000	Other other	\$30000 limit per lifetime		Human Organ and Tissue Transplant Exclusions — The following services, supplies or care are not covered: Performed at any hospital that is not designated or approved by Anthem to provide covered transplant procedures for the organ or tissue being transplanted. Benefits for services if the member is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide the organ or stem cell/bone marrow transplant service. Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends except as provided above. Any		

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13 (cont.)	Other (cont.)								<p>experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service or supply. Any service or supply associated with or provided in follow-up to any of the above. Any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires Federal or other governmental agency approval and such approval is not granted at the time services are provided. Any service or supply associated with or provided in follow-up to any of the above. Transplants of organs other than those listed above, including non-human organs. - Procurement of a donor organ which has been sold rather than donated. Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant. Blood, blood plasma and blood derivatives received from community sources or replaced through donor credit. For non-covered transportation and lodging related but not limited to the following: Alcohol, tobacco, other non food items; Child care; Mileage within the medical transplant facility city; Rental care, buses, taxis, or shuttle services, except as specifically approved by Anthem; Frequent Flyer miles; Coupons, vouchers, or travel tickets; Prepayment or deposits; Services for a condition that is not directly related, or a direct result, of the transplant; Telephone calls; Laundry; Postage; Entertainment; Interim visits to a medical care facility while waiting for the actual transplant procedure; Travel expenses for donor companion/caregiver; Return visits for the donor for a treatment of a condition found during the evaluation.</p>	<p>Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.</p>	No

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14	Outpatient Rehabilitation Services	Covered	Cardiac Rehabilitation	Yes	36	Days per year					No
15	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Rehabilitation	Yes	30	Days per year					No
16	Inpatient Physician and Surgical Services	Covered	Inpatient Rehabilitation	Yes	30	Days per year					No
17	Other	Covered	Diabetic Care	No						Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the member's disease course when provided by a certified, registered, or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. Replacement of pumps that are out of warranty and are malfunctioning and cannot be refurbished would be a covered service. In situations where new models or upgrades to the latest insulin pump are requested, coverage would not be available.	No
18	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
19	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
20	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	0
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	8
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	22
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-AMINOBTYRIC 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

Category	Class	Submission Count
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS	5
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
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

Category	Class	Submission Count
BIPOLAR AGENTS	MOOD STABILIZERS	4
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	6
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	8
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	6
DENTAL AND ORAL AGENTS	DENTAL AND ORAL AGENTS	6
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

Category	Class	Submission Count
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
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)	4
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	4
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)	7
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	20
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
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

<b>Category</b>	<b>Class</b>	<b>Submission Count</b>
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	7
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	9
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	5