OREGON EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from 3rd largest small group product, Preferred Provider Organization
Issuer Name	PacificSource Health Plans
Product Name	Preferred CoDeduct Value
Plan Name	Preferred CoDeduct Value 3000 35 70
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	Yes: For purposes of the essential health benefits benchmark plan for the State of Oregon, and subject to carrier-specific requirements; including eligibility, medical necessity, preauthorization, provider credentialing/accreditation standards, etc.; the provisions of the EHB Benchmark Plan relating to rehabilitation medical services define the coverage requirements for habilitation medical services when such services are medically necessary for the maintenance, learning, or improving skills and function for daily living.

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	Office and home visits	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No
Specialist Visit	Yes	Office and home visits	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Office and home visits	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient surgery/services	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient surgery/services	Covered	No						No

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	Hospice services	Covered	No					Hospice services require preauthorization and are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative or friend, or private duty nursing. The following criteria to determine eligibility for hospice benefits: The member's physician must certify that the member is terminally ill with a life expectancy of less than six months; The member must be living at home; A non-salaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms. Only the following hospice services are covered: Home nursing visits; Home health aides when necessary to assist in personal care; Home visits by a medical social worker; Home visits by the hospice physician; Prescription medications for the relief of symptoms manifested by the terminal illness; Medically necessary physical, occupational, and speech therapy provided in the home; Home infusion therapy; Durable medical equipment, oxygen, and medical supplies; Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits; Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary; Pastoral care and bereavement services.	No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered							
Infertility Treatment			Not Covered							
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							

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?
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent care center visits	Covered	No						No
Home Health Care Services	Yes	Office and home visits	Covered	No				Private duty nursing is not covered.	Covered services require preauthorization and include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Benefit includes home infusion services including parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered.	No
Emergency Room Services	Yes	Emergency room visits	Covered	No					In a medical emergency, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient. An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to): Unusual or heavy bleeding; Sudden abdominal or chest pains; Suspected heart attacks; Major traumatic injuries; Serious burns; Poisoning; Unconsciousness; Convulsions or seizures; Difficulty breathing; Sudden fevers.	No
Emergency Transportation/ Ambulance	Yes	Ambulance, ground and air	Covered	No						No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient room and board	Covered	No				The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.		No
Inpatient Physician and Surgical Services	Yes	Professional services	Covered	No						No
Bariatric Surgery			Not Covered							

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?
Cosmetic Surgery	Yes	Cosmetic or reconstructive surgery	Covered	Yes	1	Attempt at cosmetic or reconstructive surgery within 18 months after the injury, surgery, scar, or defect first occurred			This plan covers one attempt at cosmetic or reconstructive surgery in the following situations: When necessary to correct a functional disorder; or When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization is required for all cosmetic and reconstructive surgeries. For information on breast reconstruction, see 'breast reconstruction' benefit.	No
Skilled Nursing Facility	Yes	Skilled nursing facility care	Covered	No				Confinement for custodial care is not covered.	Benefit requires preauthorization.	No
Prenatal and Postnatal Care	Yes	Prenatal and postnatal care	Covered	No						No
Delivery and All Inpatient Services for Maternity Care	Yes	Maternity care	Covered	No						No
Mental/Behavioral Health Outpatient Services	Yes	Mental health office visits	Covered	No				This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider: Treatment for the following diagnosis: Mental retardation; Paraphilias; Learning disorders; Gender Identity Disorders in Adults (GID); Urinary incontinence; Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger; Food dependencies; Nicotine-related disorders; Treatment programs, training, or therapy as follows: Residential mental health programs exceeding 45 days of treatment per year; Educational or correctional services or sheltered living provided by a school or halfway house; Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; Court-ordered sex offender treatment programs; Court-ordered screening interviews or drug or alcohol treatment programs; Marital/partner counseling; Support groups; Sensory integration training; Biofeedback (other than as specifically noted); Hypnotherapy; Academic skills training; Equine/ animal therapy; Narcosynthesis; Aversion therapy; Social skill training; Recreation therapy outside an inpatient or residential treatment setting.	As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these.	No

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?
Mental/Behavioral Health Inpatient Services	Yes	Mental health inpatient and residential care	Covered	Yes	45	Days per year		This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider. Treatment for the following diagnosis: Mental retardation; Paraphilias; Learning disorders; Gender Identity Disorders in Adults (GID); Urinary incontinence; Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger: Food dependencies; Nicotine-related disorders. Treatment programs, training, or therapy as follows: Residential mental health programs exceeding 45 days of treatment per year; Educational or correctional services or sheltered living provided by a school or halfway house; Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; Court-ordered sex offender treatment programs; Court-ordered screening interviews or drug or alcohol treatment programs; Marital/partner counseling; Support groups; Sensory integration training; Biofeedback (other than as specifically noted); Hypnotherapy; Academic skills training; Equine/ animal therapy; Narcosynthesis; Aversion therapy; Social skill training; Recreation therapy outside an inpatient or residential treatment setting.	As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these.	No

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?
Substance Abuse Disorder Outpatient Services	Yes	Chemical dependency office visits	Covered	No				This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider. Treatment for the following diagnosis: Mental retardation; Paraphilias; Learning disorders; Gender Identity Disorders in Adults (GID); Urinary incontinence; Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger; Food dependencies; Nicotine-related disorders. Treatment programs, training, or therapy as follows: Residential mental health programs exceeding 45 days of treatment per year; Educational or correctional services or sheltered living provided by a school or halfway house; Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; Court-ordered sex offender treatment programs; Court-ordered screening interviews or drug or alcohol treatment programs; Marital/partner counseling; Support groups; Sensory integration training; Biofeedback (other than as specifically noted); Hypnotherapy; Academic skills training; Equine/ animal therapy; Narcosynthesis; Aversion therapy; Social skill training; Recreation therapy outside an inpatient or residential treatment setting.	Quantitative limit units apply, see EHB benchmark plan documents. Treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine. As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these.	No

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?
Substance Abuse Disorder Inpatient Services	Yes	Chemical dependency inpatient and residential care	Covered	No				This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider. Treatment for the following diagnosis: Mental retardation; Paraphilias; Learning disorders; Gender Identity Disorders in Adults (GID); Urinary incontinence; Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger; Food dependencies; Nicotine-related disorders. Treatment programs, training, or therapy as follows: Residential mental health programs exceeding 45 days of treatment per year; Educational or correctional services or sheltered living provided by a school or halfway house; Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; Court-ordered sex offender treatment programs; Court-ordered screening interviews or drug or alcohol treatment programs; Marital/partner counseling; Support groups; Sensory integration training; Biofeedback (other than as specifically noted); Hypnotherapy; Academic skills training; Equine/ animal therapy; Narcosynthesis; Aversion therapy; Social skill training; Recreation therapy outside an inpatient or residential treatment setting.	Treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine. As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these.	No
Generic Drugs	Yes	Generic drugs	Covered	No				This plan does not cover the following: Drugs and biologicals that can be self-administered (including injectable), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered; Growth hormone injections or treatments, except to treat documented growth hormone deficiencies; Immunizations or other medications or supplies for protection while traveling or at work; Over-the-counter medications or nonprescription drugs		No
Preferred Brand Drugs	Yes	Preferred brand drugs	Covered	No				This plan does not cover the following: Drugs and biologicals that can be self-administered (including injectable), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered; Growth hormone injections or treatments, except to treat documented growth hormone deficiencies; Immunizations or other medications or supplies for protection while traveling or at work; Over-the-counter medications or nonprescription drugs.		No

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?
Non-Preferred Brand Drugs	Yes	Non-preferred brand drugs	Covered	No				This plan does not cover the following: Drugs and biologicals that can be self-administered (including injectable), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered; Growth hormone injections or treatments, except to treat documented growth hormone deficiencies; Immunizations or other medications or supplies for protection while traveling or at work; Over-the-counter medications or nonprescription drugs		No
Specialty Drugs	Yes	Specialty drugs	Covered	No				This plan does not cover the following: Drugs and biologicals that can be self-administered (including injectable), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered; Growth hormone injections or treatments, except to treat documented growth hormone deficiencies; Immunizations or other medications or supplies for protection while traveling or at work; Over-the-counter medications or nonprescription drugs	Specialty drugs must be distributed by the contracted mail-order vendor to be covered.	No
Outpatient Rehabilitation Services	Yes	Outpatient rehabilitation services	Covered	Yes	30	Visits per year			Services provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Only treatment of neurologic conditions (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met. Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury.	No

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?
Habilitation Services	Yes	Defined by the State of Oregon. Parity with rehabilitation services. See "other" for inpatient habilitation services.	Covered	Yes	30	Visits per year		Habilitation: Functional capacity evaluations, work hardening programs, vocational habilitation, community reintegration services, and driving evaluations and training programs. Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including physician review.	For purposes of the essential health benefits benchmark plan for the State of Oregon, and subject to carrier-specific requirements; including eligibility, medical necessity, preauthorization, provider credentialing/accreditation standards, etc.; the provisions of the PacificSource Preferred CoDeduct Value Plan relating to rehabilitation medical services define the coverage requirements for habilitation medical services when such services are medically necessary for the maintenance, learning, or improving skills and function for daily living. Services provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Only treatment of neurologic conditions (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met. Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury.	Yes
Chiropractic Care			Not Covered							

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?
Durable Medical Equipment	Yes	Durable medical equipment	Covered	Yes	5000	Dollars per year Exceptions to this limitation are essential health benefits, such as prosthetics and orthotic devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs, and breast pumps. Medical foods for the treatment of inborn errors of metabolism are also exempt from this limitation.		Hospital-grade breast pumps are excluded under preventive care and regular benefits.	Explanations apply, see EHB benchmark plan documents.	No
Hearing Aids	Yes	Hearing aids	Covered	Yes	4000	Dollar maximum benefit every 48 months.			As part of the durable medical equipment benefit, hearing aids are covered for members 18 years of age and younger, or 25 years of age and younger if the member is enrolled in a secondary school or an accredited educational institution. The benefit amount shall be adjusted on January 1 of each year to reflect the U.S. City Average Consumer Price Index in accordance with ORS 743A.141.	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic and therapeutic radiology and lab	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Advanced diagnostic imaging	Covered	No						No

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?
Preventive Care/ Screening/ Immunization	Yes	Routine physicals for adults	Covered	Yes	1	Exam every four years for members 22-34; Exam every two years for members 35-39; Exam every year for members over 60		Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit.	Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit.	Yes
Routine Foot Care	Yes	Routine foot care	Covered	No					Covered only for patients with diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet.	No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	FEDVIP (Federal BlueVision High)	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	FEDVIP (Federal BlueVision High)	Covered	Yes	1	Pair of glasses per year			Collection frames (up to $250) are covered in full. Non-collection lenses are covered up to $150 and then 20% off. Standard lenses are covered in full.	No
Dental Check-Up for Children	Yes	CHIP (OHP Plus)	Covered	Yes	1	Periodic: 2 times per year. Comprehensive: 1 time per year with the same provider; 2 times per year with different providers.				No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No					Limited to children under the age of 18 with pervasive developmental disorders.	No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No						No
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	Yes	31	Exams per child		Only laboratory tests and other diagnostic testing procedures related to a well baby child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/child care exam are not covered by this preventive care benefit.	At birth: One standard in-hospital exam. Ages 0-2: 12 additional exams during the first 36 months of life. Ages 3-21: One exam per year.	No

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?
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			Not Covered							
Orthodontia - Child			Not Covered							
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No						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							

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?
Transplant	Yes	Transplant Services	Covered	No				This plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.	You must have been covered under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. This plan covers the following medically necessary organ and tissue transplants: Kidney; Kidney-Pancreas; Pancreas whole organ transplantation (under certain criteria); Heart; Heart- Lung; Lung; Liver (under certain criteria); Bone marrow and peripheral blood stem cell; Pediatric bowel. Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations: Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient. Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same maximum dollar limitation, if any, as the transplant itself. Medical services required for the removal and transportation of organs or tissues from living donors are covered. Transplant related services, including HLA typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to provider contractual agreements. Coverage of the organ or tissue donation is covered up to $8,000 per transplant. Travel and housing expenses for the recipient and one caregiver are limited to $5,000 per transplant. If transplant services are available through a contracted facility and performed by choice at a non-contracted facility, benefits are limited to $100,000 per transplant.	No
Accidental Dental			Not Covered							
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No

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?
Treatment for Temporomandibular Joint Disorders			Not Covered							
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes	Clinical Trials	Covered	No					Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. PacificSource is not, based on the coverage provided, liable for any adverse effects of a clinical trial.	No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No					This plan covers treatment involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subject benefits listed for durable medical equipment.	No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Mastectomy-Related Coverage	Yes	Mastectomy-Related Coverage	Covered	No					Mastectomy-related coverage includes breast reconstruction. Reconstruction must be in connection with a medically necessary mastectomy. Preauthorization is required. Coverage is provided in a manner determined in consultation with the attending physician and patient for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema.	No
Brain Injury	Yes	Brain Injury	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?
Grade A and B USPSTF Preventive Services, Bright Futures Recommended Medical Screenings for Children, and ACIP Recommended Immunizations for Children	Yes	Grade A and B USPSTF Preventive Services, Bright Futures Recommended Medical Screenings for Children, and ACIP Recommended Immunizations for Children	Covered	Yes	1	Multiple				No
Immunizations	Yes	Immunizations	Covered	No				Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g., travel).	Standard age-appropriated childhood and adult immunizations for primary prevention of infectious diseases as recommended by and adopted the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body.	No
Well Woman Visits	Yes	Well Woman Visits	Covered	Yes	1	Routine gynecological exam each year for women 18 and over			Routine preventive mammograms for women as recommended. Pelvic exams and Pap smear exams at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.	No
Colorectal Cancer Screening	Yes	Colorectal Cancer Screening	Covered	No					Routine Colonoscopy applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.	No
Prostate Cancer Screening	Yes	Prostate Cancer Screening	Covered	No						No

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?
Tobacco Use Cessation Program Services	Yes	Tobacco Use Cessation Program Services	Covered	Yes	2	Quit attempts per lifetime for members 15 and over			Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older. Covered only when provided by a PacificSource approved program. Specific nicotine replacement therapy will only be covered according to the program's description. If this policy includes benefits for prescription drugs, tobacco use cessation related medication prescribed in conjunction with an approved tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.	No
Telemedical Health Services	Yes	Telemedical Health Services	Covered	No					Medically necessary telemedical health services for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, or co-insurance requirements that apply to comparable health services provided in person.	No
Biofeedback	Yes	Biofeedback	Covered	Yes	10	Treatments per lifetime			Benefit is limited for treatment of migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner.	No
Cardiac Rehabilitation	Yes	Cardiac Rehabilitation	Covered	Yes	36	Sessions		Phase III (long-term outpatient) services are not covered.	Phase I (inpatient) services are covered under inpatient hospital benefits. Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.	No

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?
Hospitalization for Dental Procedures	Yes	Hospitalization for Dental Procedures	Covered	No				Hospitalization because of the patient's apprehension or convenience is not covered.	Only covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered.	No
Maxillofacial Prosthetic Services	Yes	Maxillofacial Prosthetic Services	Covered	No				Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions and artificial larynx are also not covered.	Covered when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician.	No
Pediatric Dental Care	Yes	Pediatric Dental Care	Covered	Yes	2000	Dollar lifetime maximum			Preauthorization is required. Limited to services requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center.	No
Sleep Studies	Yes	Sleep Studies	Covered	No					Covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.	No
Tubal Ligation and Vasectomy	Yes	Tubal Ligation and Vasectomy	Covered	No				Procedures performed during the member's first six months of coverage under the plan. (Exception for coverage of tubal ligations performed at the time of a covered newborn delivery.) Surgery to reverse voluntary sterilization is not covered.		No
Allergy Injections	Yes	Allergy Injections	Covered	No						No

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?
Habilitation Services	Yes	Inpatient Habilitation Services	Covered	Yes	30	Days per year		Exclusions: Habilitation. Functional capacity evaluations, work hardening programs, vocational habilitation, community reintegration services, and driving evaluations and training programs. Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including physician review.	For purposes of the essential health benefits benchmark plan for the State of Oregon, and subject to carrier-specific requirements; including eligibility, medical necessity, preauthorization, provider credentialing/accreditation standards, etc.; the provisions of the PacificSource Preferred CoDeduct Value Plan relating to rehabilitation medical services define the coverage requirements for habilitation medical services when such services are medically necessary for the maintenance, learning, or improving skills and function for daily living. Covered services are limited to a maximum of 30 days per calendar year except in cases of head or spinal cord injury. Covered services for rehabilitation after a head or spinal cord injury is limited to 60 days per calendar year. Services are subject to preauthorization. Recreation therapy is only covered as part of an inpatient rehabilitation admission.	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	9
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	0
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	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	26
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

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	5
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	9
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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
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	5

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0
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	8
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
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	12