LOUISIANA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross and Blue Shield of Louisiana
Product Name	GroupCare PPO
Plan Name	GroupCare PPO
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	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 office 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 Fee is covered	No							No

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5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No					Exclusions include: a. rhinoplasty; b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes; c. gynecomastia; d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Benefit Plan; e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants; f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis; g. diastasis recti; h. biofeedback; i. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies. j. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP). k. Reversal of a voluntary sterilization procedure.	Surgical services Include: 1. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and postoperative medical visits. 2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting 3. Assistant Surgeon 4. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Outpatient Medical and Surgical Services include: 1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care. 2. Services of an Ambulatory Surgical Center 3. Consultation (as defined in this Benefit Plan).	No
6	**Hospice Services**	Covered	Hospice Services	No							No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care when traveling outside the U.S.	No							No

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8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Not Covered									
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Covered	Coverage is available to a Member for Private Duty Nursing Services as shown in the Schedule of Benefits, when performed on an Outpatient basis and when the nurse is not related to the Member by blood, marriage, or adoption.	Yes	5000	Other other	$5000.00 each benefit period			Inpatient Private Duty Nursing Services are not covered.	No
12	**Routine Eye Exam (Adult)**	Not Covered									
13	**Urgent Care Centers or Facilities**	Covered	Services for Urgent Care Centers are covered.	No							No
14	**Home Health Care Services**	Covered	Home Health Care	No						As shown on the Schedule of Benefits	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No						Emergency Room Services - Network benefits- The member must pay an Emergency Room Copayment as shown in the Schedule of Benefits, for each visit to an Emergency Room for treatment. The ER copayment is waived if the visit results in an Inpatient Admission.	No

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16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No					No benefits are available if transportation is provided for the Member's comfort or convenience, or when a hospital transports members between parts of its own campus.	Emergency Transportation/ Ambulance Includes: To or from the nearest Hospital (when medically necessary); Benefits for air ambulance services are available only if this type of ambulance service is requested by policing or medical authorities at the site in an emergency situation or if the member is in a location that cannot be reached for a ground ambulance.	No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No						Inpatient Bed, Board and General Nursing Services include: 1. Hospital room and board and general nursing services. 2. In a Special Care Unit for a critically ill Member requiring an intensive level of care. 3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital, for the maximum number of days per Benefit Period shown in the Schedule of Benefits. 4. In a Residential Treatment Center for Members with Mental Disorders and Alcohol and/or Drug Abuse Benefits. B. Other Hospital Services (Inpatient and Outpatient) 1. Use of operating, delivery, recovery and treatment rooms and equipment. 2. Drugs and medicines including take-home Prescription Drugs. 3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies. 4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee. 5. Medical and surgical supplies, casts, and splints. 6. Diagnostic Services rendered by a Hospital employee. 7. Physical Therapy provided by a Hospital employee. 8. Psychological testing when ordered by the attending Physician and performed by an employee of the hospital.	No

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18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No						Surgical services Include: 1. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and postoperative medical visits. 2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting 3. Assistant Surgeon 4. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Inpatient Medical Services - Subject to provisions in the sections pertaining to Surgery and Pregnancy Care in this Benefit Plan, Inpatient Medical Services include: 1. Inpatient medical care visits; 2. Concurrent Care; 3. Consultation (as defined in this Benefit Plan).	No
19	**Bariatric Surgery**	Not Covered									
20	**Cosmetic Surgery**	Not Covered								Unless required for a Congenital Anomaly.	
21	**Skilled Nursing Facility**	Covered	Skill Nursing Facility	No							No
22	**Prenatal and Postnatal Care**	Covered	Pregnancy Care Benefits are as follows: 1. Surgical and Medical Services a. Initial office visit and visits during the term of the pregnancy. b. Diagnostic Services. c. Delivery, including necessary pre-natal and post-natal care. d. Medically Necessary	No					Exclusions are: Services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these	An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An authorization is required if a newborn's stay exceeds that of the mother.	No

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			abortion required in order to save the life of the mother. 2. Facility Services Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care. 3. Benefits a. Network Benefits: A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to each pregnancy for Covered Services rendered by Network Providers.						procedures are not available for Benefits. 21. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild; abortion other than to save a life of the mother:		
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Pregnancy Care Benefits are as follows: 1. Surgical and Medical Services a. Initial office visit and visits during the term of the pregnancy. b. Diagnostic Services. c. Delivery, including necessary pre-natal and post-natal care. d. Medically Necessary abortion required in order to save the life of the mother.	No				48		An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother.	No

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			2. Facility Services Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care. 3. Benefits a. Network Benefits: A Pregnancy Care Copayment, if shown in the Schedule of Benefits, applies to each pregnancy for Covered Services rendered by Network Providers.								
24	**Mental/ Behavioral Health Outpatient Services**	Covered	Benefits for the treatment of Mental Health are available subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.	No					Coverage for treatment of Mental Disorders does NOT include conseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.		No

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25	**Mental/ Behavioral Health Inpatient Services**	Covered	Benefits for the treatment of Mental Health are available subject to any limitations shown in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional.	No					Coverage for treatment of Mental Disorders does NOT include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.		No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Coverage for treatment of Substance Abuse is available only if shown as Covered Services in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Covered Services will be only those, which are for treatment for abuse of alcohol, drugs or other chemicals, and the resultant physiological and/or psychological dependency, which develops with continued use.	No							No

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27	**Substance Abuse Disorder Inpatient Services**	Covered	Coverage for treatment of Substance Abuse is available only if shown as Covered Services in the Schedule of Benefits. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Covered Services will be only those, which are for treatment for abuse of alcohol, drugs or other chemicals, and the resultant physiological and/or psychological dependency, which develops with continued use.	No							No
28	**Generic Drugs**	Covered	Generic Drugs	No					Exclusions are: Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits: a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance; b. any medication not proven effective in general medical practice; c. Investigational drugs and drugs used other than for the FDA	Applicable prescription drug deductible applies; Generic drugs are primarily on Tier 1, but may also be on Tier 3. Injectable generic drugs are on Tier 5. In addition, quantity per dispensing (QPD) limits/allowances are placed on certain medications and are based on the manufacturer's recommended dosage and duration of therapy, common usage for episodic or intermittent treatment, FDA-approved recommendations and/or clinical studies, and/or as determined by Blue Cross and Blue Shield of Louisiana	No

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									approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug; d. fertility drugs; e. minerals and vitamins, except for vitamins requiring a prescription for dispensation; f. nutritional or dietary supplements, or herbal supplements and treatments; g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available; h. contraceptive drugs; i. drugs for non-covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®); j. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®); k. Prescription Drugs for and/or treatment of idiopathic short stature.		
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No					Exclusions are: Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits: a. lifestyle-enhancing drugs including but not	Applicable prescription drug deductible applies; Preferred Brand drugs (oral) are on Tier 2, Preferred Brand drugs (injectable) are included on Tier 5; Select Preferred Brand Drugs (oral or injectable) may be on Tier 1. In addition, quantity per dispensing (QPD) limits/allowances are placed on certain	No

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									limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance; b. any medication not proven effective in general medical practice; c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug; d. fertility drugs; e. minerals and vitamins, except for vitamins requiring a prescription for dispensation; f. nutritional or dietary supplements, or herbal supplements and treatments; g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available; h. contraceptive drugs; i. drugs for non-covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®); j. Prescription Drugs, equipment or substances to treat	medications and are based on the manufacturer's recommended dosage and duration of therapy, common usage for episodic or intermittent treatment, FDA-approved recommendations and/or clinical studies, and/or as determined by Blue Cross and Blue Shield of Louisiana	

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									sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®); k. Prescription Drugs for and/or treatment of idiopathic short stature.		
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand drugs	No					Exclusions are: Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits: a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance; b. any medication not proven effective in general medical practice; c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug; d. fertility drugs; e. minerals and vitamins, except for vitamins requiring a prescription for dispensation; f. nutritional or	Applicable prescription drug deductible applies; Non-Preferred Brand Drugs (oral) are included on Tier 3 and Tier 4; Non-Preferred Brand Drugs (injectable) are included on Tier 5. In addition, quantity per dispensing (QPD) limits/allowances are placed on certain medications and are based on the manufacturer's recommended dosage and duration of therapy, common usage for episodic or intermittent treatment, FDA-approved recommendations and/or clinical studies, and/or as determined by Blue Cross and Blue Shield of Louisiana	No

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									dietary supplements, or herbal supplements and treatments; g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available; h. contraceptive drugs; i. drugs for non-covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®); j. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®); k. Prescription Drugs for and/or treatment of idiopathic short stature.		
31	**Specialty Drugs**	Covered	Specialty drugs	No					Exclusions are: Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits: a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance; b. any medication not proven effective in general medical practice; c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are	Applicable prescription drug deductible applies; Specialty drugs can appear on all Tiers depending on drug status: Generic Drug (Tier 1, Tier 3), Brand-Name Drug (Tier 2, Tier 3, Tier 4), Injectable drugs (Tier 5). In addition, quantity per dispensing (QPD) limits/allowances are placed on certain medications and are based on the manufacturer's recommended dosage and duration of therapy, common usage for episodic or intermittent treatment, FDA-approved recommendations and/or clinical studies, and/or as determined by Blue Cross and Blue Shield of Louisiana	No

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
									recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug; d. fertility drugs; e. minerals and vitamins, except for vitamins requiring a prescription for dispensation; f. nutritional or dietary supplements, or herbal supplements and treatments; g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available; h. contraceptive drugs; i. drugs for non-covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®); j. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®); k. Prescription Drugs for and/or treatment of idiopathic short stature.		

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32	**Outpatient Rehabilitation Services**	Covered	Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/ Language Pathology Therapy, and/or Chiropractic Services. The Member must be able to tolerate a minimum of three (3) hours of active therapy per day.	No					Other exclusions: Visual therapy; lifestyle/habit changing clinics and/or programs; recreational therapy; primarily to enhance athletic abilities; and/or Inpatient pain rehabilitation and pain control programs.	An Inpatient rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition. Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.	No
33	**Habilitation Services**	Covered	Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/ Language Pathology Therapy, and/or Chiropractic Services. The Member must be able to tolerate a minimum of three (3) hours of active therapy per day.	No					Other exclusions: Visual therapy; lifestyle/habit changing clinics and/or programs; recreational therapy; primarily to enhance athletic abilities; and/or Inpatient pain rehabilitation and pain control programs.	An Inpatient rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition. Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.	No
34	**Chiropractic Care**	Covered	Chiropractic Care	No							No

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35	**Durable Medical Equipment**	Covered	Includes: Durable Medical Equipment, Orthotics Devices, and Prosthetic Appliances and Devices (Limb and non-limb). Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered; Medical equipment and supplies	No					Exclusions are: hairpieces, wigs, hair growth, and/or hair implants; Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.	Limitations in connection with Durable Medical Equipment. (1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier. (2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose. (3) There is no coverage for the repair or replacement of equipment lost or damaged due to neglect or misuse. (4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by Us. 2. Orthotic Devices, Prosthetic Appliances and Devices (non-limb) and Posthetic Appliances and Devices and Prosthetic Services of the Limb Limitations: a. There is no coverage for fitting, or adjustments as this is, included in the Allowable Charge b. Repair or replacement is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. We will determine this time period. c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when the Member selects a deluxe device solely for his comfort or convenience. d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented	No

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										to be Medically Necessary. e. No Orthodics Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.	
36	**Hearing Aids**	Covered	Hearing Aids	Yes	1	Other other	Benefits are available for hearing aids for covered Members age seventeen (17) and under. This Benefit is limited to one (1) hearing aid, per ear, in a thirty-six (36) month period. We will pay up to our Allowable Charge for this Benefit. We may increase Our Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will We pay more than one thousand, four hundred dollars ($1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If the Member purchases a hearing aid that costs more than one-thousand, four hundred dollars ($1,400.00), the Member is responsible for all amounts above one-thousand, four		Hearing aids or for examinations for the prescribing or fitting of hearing aids		No

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							hundred dollars ($1,400.00). This Benefit is not subject to Coinsurance or Deductible Amounts.				
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-rays and lab work)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET scans, MRI)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screening/ Immunization	Yes	1	Other other	Prostate Cancer Screening – One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a			EXAMINATIONS AND TESTING: Routine Wellness Physical Examination–Certain routine wellness diagnostic tests ordered by Your Physician are covered. Well Baby Care; Prostate Cancer Screening; Colorectal Cancer Screening; IMMUNIZATION: All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6). SCREENING AND COUNSELING: Abdominal Aortic Aneurysm Screening; Alcohol Misuse Screening and Counseling; Aspirin Counseling; Blood Pressure Screening; Cholesterol Screening; Depression Screening; Type 2 Diabetes Screening; Diet Counseling; HIV Screening; Obesity Screening and Counseling; Sexually Transmitted Infection Counseling; Tobacco Use Screening; Syphilis Screening; COVERED SERVICES FOR WOMEN: Counseling for - BRCA genetic testing and breast cancer chemoprevention; Routine Gynecologist/Obstetrician Visits; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap	No

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							condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic			Smear - One (1) per Benefit Period; Screenings – Chlamydia Infection and Gonorrhea; COVERED SERVICES FOR PREGNANT WOMEN: Anemia Screening; Bacteriuria Screening; Breast Feeding Intervention; Folic Acid Supplements; Hepatitis B Screening; Rh Incompatibility Screening; COVERED SERVICES FOR CHILDREN: Alcohol and Drug Use Assessments; Autism Screening: Ages 1-2; Behavioral Assessments; Cervical Dysplasia Screening; Congenital Hypothyroidism Screening; Developmental Screening: Ages 0-3; Dyslipidemia Screening; Hearing Screening: One per Benefit Period for Children Ages 0-21; Height, Weight and Body Mass Index Measurements; Hematocrit or Hemoglobin Screening' Sickle Cell Screening for Newborns; HIV Screening; Lead Screening: One per Benefit Period for Ages 0-6; Obesity Screening and Counseling; Oral Health Assessment; Phenylketonuria (PKU) for Newborn; Sexually Transmitted Infection Counseling; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21;	

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							Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21.				
40	**Routine Foot Care**	Not Covered								Except for persons who have been diagnosed with diabetes; cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot.	
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									

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43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply	No

OTHER BENEFITS

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1	**Other**	Covered	Interpreter Expenses for the Hearing Impaired:	No					Services rendered by a family Member are not covered.	Interpreter Expenses for the Hearing Impaired: Services performed by a qualified interpreter/transliterator are covered when the Member needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of the Member's hearing impairment or his failure to understand or otherwise communicate in spoken language.	No
2	**Other**	Covered	Low Protein Food Products for Treatment of Inherited Metabolic Diseases. Benefits are available for low protein food products for treatment of certain Inherited Metabolic Diseases.	Yes	200	Other	Low Protein Food Products shall not include natural foods that are naturally low in protein. Benefits for Low Protein Food Products are limited to the treatment of the following diseases: Phenylketonuria (PKU); Maple Syrup Urine Disease (MSUD); Methylmalonic Acidemia (MMA); Isovaleric Acidemia (IVA); Propionic Acidemia; Glutaric Acidemia; Urea Cycle Defects; Tyrosinemia. Limitation: Benefits shall not exceed two-hundred dollars ($200.00) per month. The Member is responsible for all amounts above two-hundred dollars ($200.00) per month. Charges over two-hundred dollars ($200.00) per month are non-covered charges and do not accrue to the Member's Out-of-Pocket Amount.		Exclusions: Food or food supplements, formulas and medical foods, including those used for gastric tube feedings.	Benefits for Low Protein Food Products are mited to the treatment of the following diseases: Phenylketonuria (PKU); Maple Syrup Urine Disease (MSUD); Methylmalonic Acidemia (MMA); Isovaleric Acidemia (IVA); Propionic Acidemia; Gultaric Acidemia; Urea Cycle Defects; Tyrosinemia	No

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3	**Other**	Covered	Permanent Sterilization Procedures and Contraceptive Devices	No						Permanent Sterilization Procedures and Contraceptive Devices: Benefits are available for surgical procedures and/or contraceptive devices that result in permanent sterilization, including tubal ligation, vasectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes. Benefits are available for contraceptive intrauterine devices (IUDs), including the insertion and removal of such devices.	No
4	**Other**	Covered	Sleep Studies	No						Sleep Studies: Medically Necessary sleep studies and associated professional claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM).	No
5	**Other**	Covered	Oral Surgery Benefits	No						Oral Surgery Benefits Coverage is provided only for the following services or procedures: A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth; B. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those, which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.); C. Excision of exostoses or tori of the jaws and hard palate; D. Incision and drainage of abscess and treatment of cellulitis; E. Incision of accessory sinuses, salivary glands, and salivary ducts; F. Anesthesia for the above services or procedures when rendered by an oral surgeon; G. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia; H. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders; I. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.	No
6	**Other**	Covered	Attention Deficit/ Hyperactivity Disorder	No							No

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7	**Other**	Covered	Autism Spectrum Disorders (ASD) ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis, when Company determines it is Medically Necessary	No					ABA is NOT covered for members age seventeen (17) and older.	Autism Spectrum Disorders (ASD) ASD Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis, when Company determines it is Medically Necessary	No

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8	**Other**	Covered	Bone Mass Measurement Benefits are available for scientifically proven Bone Mass Measurement tests for the diagnosis and treatment of osteoporosis if a Member: 1. is an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment; 2. is an individual receiving long-term steroid therapy; or 3. is an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies	No							No
9	**Other**	Covered	Breast Reconstructive Surgical Services	No						Breast Reconstructive Surgical Services include: the Member will also receive Benefits for the following Covered Services: a. reconstruction of the breast on which the mastectomy has been performed; b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.	No

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10	**Other**	Covered	Cleft Lip and Cleft Palate Services	No						Cleft Lip and Cleft Palate Services include: 1. Oral and facial Surgery, surgical management, and follow-up care; 2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances; 3. Orthodontic treatment and management; 4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy. 5. Speech-language evaluation and therapy; 6. Audiological assessments and amplification devices; 7. Otolaryngology treatment and management; 8. Psychological assessment and counseling; 9. Genetic assessment and counseling for patient and parents.	No
11	**Other**	Covered	Diabetes coverage	No						Diabetes coverage 1. Coverage is available for the equipment, supplies, and Outpatient self-treatment training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Member's Physician.	No
12	**Other**	Covered	Dietician Visits	Yes	250	Other	$250.00 in allowable charges per benefit period				No
13	**Other**	Covered	Organ, Tissue and Bone Marrow Transplant Benefits.	No					Exclusions are: any costs of donating an organ or tissue for transplant when a Member is a donor; the transplant of any non-human organ or tissue; or bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan. If any organ, tissue	Organ, Tissue and Bone Marrow Transplant Benefits. A. Acquisition Expenses If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Benefit Plan. B. Organ, Tissue and Bone Marrow Transplant Benefits 1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or an HMO Louisiana, Inc. (HMOLA) Network facility, unless otherwise approved by Us in writing. 2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services and for Dependent Out-of-Area services. 3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).	No

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
									or bone marrow is sold rather than donated to a Member, the purchase price of such organ, tissue or bone marrow is not covered.	C. Solid Human Organ Transplants of the: 1. Liver; 2. Heart; 3. Lung; 4. Kidney; 5. Pancreas; 6. Small bowel; and 7. Other solid organ transplant procedures, which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case by case basis. D. Tissue Transplant Procedures (Autologous and Allogeneic), as specified below: Tissue transplants (other than bone marrow) are covered under regular Benefits and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the Article on Care Management. These following tissue transplants are covered: 1. Blood transfusions; 2. Autologous parathyroid transplants; 3. Corneal transplants; 4. Bone and cartilage grafting; 131HR 01228 R01/12 40 5. Skin grafting; 6. Autologous islet cell transplants; and 7. Other tissue transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis. E. Bone Marrow Transplants 1. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.	

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
14	**Other**	Covered	Inpatient Rehabilitation Services - Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/ Language Pathology Therapy, and/or Chiropractic Services. The Member must be able to tolerate a minimum of three (3) hours of active therapy per day.	No					Other exclusions: Visual therapy; lifestyle/habit changing clinics and/or programs; recreational therapy; primarily to enhance athletic abilities; and/or Inpatient pain rehabilitation and pain control programs.	Rehabilitative Care Benefits will be available for Services provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. The Member must be able to tolerate a minimum of three (3) hours of active therapy per day. An Inpatient rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition. Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition.	No
15	**Other**	Covered	Clinical Trial Participation	No					The following services are not covered: a. Non-healthcare services provided as part of the clinical trial; b. Costs for managing research data associated with the clinical trial; c. Investigational drugs or devices; and/or d. Services, treatment or supplies not otherwise covered under this Benefit Plan.	Clinical Trial Participation 1. Patient costs are covered when incurred for treatment provided in a clinical trial for cancer, as described in this paragraph. Coverage will be subject to any applicable Copayment, Deductible, and/or Coinsurance amounts shown in the Schedule of Benefits. 2. The following services are not covered: a. Non-healthcare services provided as part of the clinical trial; b. Costs for managing research data associated with the clinical trial; c. Investigational drugs or devices; and/or d. Services, treatment or supplies not otherwise covered under this Benefit Plan. 3. Investigational treatments and associated protocol related patient care not excluded in this paragraph shall be covered if all of the following criteria are met: a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer. b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer. c. The treatment is being provided in accordance with a	No

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
										clinical trial approved by one of the following entities: (1) One of the United States National Institutes of Health. (2) A cooperative group funded by one of the National Institutes of Health. (3) The FDA, in the form of an investigational new drug application. (4) The United States Department of Veterans Affairs. (5) The United States Department of Defense. (6) A federally funded general clinical research center. (7) The Coalition of National Cancer Cooperative Groups. d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks. e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise. f. There must be no clearly superior, non-investigational approach. g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative. h. The patient has signed an institutional review board approved consent form.	
16	**Other**	Covered	Accidental Injury	Yes	350	Other	$350 Per member each benefit period				No
17	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
18	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
19	**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	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	1
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	7
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	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	26
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

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	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
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	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	3
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	11
ANTIVIRALS	ANTIHERPETIC AGENTS	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	3
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	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	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	34
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	6
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

CATEGORY	CLASS	SUBMISSION COUNT
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	8
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	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
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	6
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	17
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	1
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
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	11
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

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
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	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	4
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	11