# NORTH DAKOTA EHB BENCHMARK PLAN

## SUMMARY INFORMATION

| | |
|---|---|
| **Plan Type** | Largest HMO Plan, Health Maintenance Organization |
| **Issuer Name** | Sanford Health Plan |
| **Product Name** | Sanford Health Plan HMO |
| **Plan Name** | Sanford Health Plan HMO |
| **Supplemented Categories** (Supplementary Plan Type) | • Pediatric Oral (State CHIP)<br>• Pediatric Vision (State CHIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | No |
| **Habilitative Services Defined by State** (Yes/No) | No |

## BENEFITS AND LIMITS

| Row Number | A<br>Benefit | B<br>Covered (Required): Is benefit Covered or Not Covered | C<br>Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name | D<br>Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies | E<br>Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity | F<br>Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units | G<br>Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description | H<br>Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number | I<br>Exclusions (Optional): Enter any Exclusions for this benefit | J<br>Explanation: (Optional) Enter an Explanation for anything not listed | K<br>Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Primary Care Visit to Treat an Injury or Illness** | Covered | Primary Care Visit to Treat an Injury or Illness | No | | | | | | | No |
| 2 | **Specialist Visit** | Covered | Specialist Visit | No | | | | | | | No |
| 3 | **Other Practitioner Office Visit (Nurse, Physician Assistant)** | Covered | Other Practitioner Office Visit (Nurse, Physician Assistant) | No | | | | | | | No |
| 4 | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Covered | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | No | | | | | Surgical procedures that can be done in a Practitioner office setting (i.e., vasectomy, toe nail removal).<br>Blood and blood derivatives replaced by the Member.<br>Take-home drugs. | | No |
| 5 | **Outpatient Surgery Physician/Surgical Services** | Covered | Outpatient Surgery Physician/Surgical Services | No | | | | | | | No |
| 6 | **Hospice Services** | Covered | Hospice Services | No | | | | | Independent nursing, homemaker services. | | No |
| 7 | **Non-Emergency Care When Traveling Outside the U.S.** | Not Covered | Non-Emergency Care When Traveling Outside the U.S. | | | | | | | | |
| 8 | **Routine Dental Services (Adult)** | Not Covered | Routine Dental Services (Adult) | | | | | | | | |
| 9 | **Infertility Treatment** | Not Covered | Infertility Treatment | | | | | | | | |
| 10 | **Long-Term/ Custodial Nursing Home Care** | Not Covered | Long-Term/Custodial Nursing Home Care | | | | | | | | |
| 11 | **Private-Duty Nursing** | Not Covered | Private-Duty Nursing | | | | | | | | |
| 12 | **Routine Eye Exam (Adult)** | Not Covered | Routine Eye Exam (Adult) | | | | | | | | |
| 13 | **Urgent Care Centers or Facilities** | Covered | Urgent Care Centers or Facilities | No | | | | | | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | **Home Health Care Services** | Covered | Home Health Care Services | Yes | 40 | Visits per year | | | Nursing care requested by, or for the convenience of the patient or the patient's family (rest cures).<br>Custodial or convalescent care. | | No |
| 15 | **Emergency Room Services** | Covered | Emergency Room Services | No | | | | | | | No |
| 16 | **Emergency Transportation/ Ambulance** | Covered | Emergency Transportation/ Ambulance | No | | | | | Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other healthcare services.<br>Transfers performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider.<br>Services and/or travel expenses relating to a Non-Emergency Medical Condition. | | No |
| 17 | **Inpatient Hospital Services (e.g., Hospital Stay)** | Covered | Inpatient Hospital Services (e.g., Hospital Stay) | No | | | | | Take-home drugs.<br>Personal comfort items (telephone, television, guest meals and beds).<br>Private nursing care.<br>Costs associated with private rooms.<br>Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider.<br>Custodial care.<br>Convalescent care.<br>Intermediate level or Domiciliary care.<br>Residential care (except for the treatment of mental disorders or substance abuse disorders).<br>Rest cures.<br>Services to assist in activities of daily living. | | No |
| 18 | **Inpatient Physician and Surgical Services** | Covered | Inpatient Physician and Surgical Services | No | | | | | | | No |
| 19 | **Bariatric Surgery** | Covered | Bariatric Surgery | Yes | 1 | Procedures per lifetime | | | | | No |
| 20 | **Cosmetic Surgery** | Not Covered | Cosmetic Surgery | | | | | | | | |
| 21 | **Skilled Nursing Facility** | Covered | Skilled Nursing Facility | Yes | 30 | Days per year | | | Custodial care; Convalescent care; Intermediate level or Domiciliary care; Residential care; Rest cures; Services to assist in activities of daily living. | | No |
| 22 | **Prenatal and Postnatal Care** | Covered | Prenatal and Postnatal Care | No | | | | | Amniocentesis or chorionic villi sampling (CVS) solely for sex determination. | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 23 | **Delivery and All Inpatient Services for Maternity Care** | Covered | Delivery and All Inpatient Services for Maternity Care | No | | | | | | | No |
| 24 | **Mental/Behavioral Health Outpatient Services** | Covered | Mental/Behavioral Health Outpatient Services | No | | | | | Convalescent care.<br>Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling.<br>Learning disabilities.<br>Behavioral problems.<br>Mental disability or mental disorder services that, according to generally accepted professional standards, is not amenable to favorable modification (except for initial evaluation, diagnosis or crisis intervention).<br>Services related to environmental change.<br>Behavioral therapy, modification, or training.<br>Milieu therapy.<br>Sensitivity training.<br>Conduct Disorder. | | No |
| 25 | **Mental/Behavioral Health Inpatient Services** | Covered | Mental/Behavioral Health Inpatient Services | No | | | | | Mental health Services received in a Residential Treatment Facility for Members ages 21 and older. | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | **Substance Abuse Disorder Outpatient Services** | Covered | Substance Abuse Disorder Outpatient Services | No | | | | | Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are required, regardless of where the services are received (e.g. detoxification centers).<br>Detoxification Services and other services related to Methadone or Cyclazocine therapy.<br>Long term care in a mental health facility.<br>Convalescent care.<br>Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling.<br>Learning disabilities.<br>Behavioral problems.<br>Services related to environmental change.<br>Behavioral therapy, modification, or training.<br>Milieu therapy.<br>Sensitivity training.<br>Conduct Disorder.<br>Custodial Care.<br>Intermediate level or Domiciliary care. | | No |
| 27 | **Substance Abuse Disorder Inpatient Services** | Covered | Substance Abuse Disorder Inpatient Services | No | | | | | Substance abuse health Services received in a Residential Treatment Facility for Members ages 21 and older. | | No |
| 28 | **Generic Drugs** | Covered | Generic Drugs | No | | | | | Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;<br>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).<br>Medications that are used to treat infertility;<br>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan (e.g., Xenical, diethlypropion, and phenteramine);<br>Replacement of a prescription drug due to loss, | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | damage, or theft;<br>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;<br>Experimental or Investigational drugs;<br>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;<br>B-12 Injections, except for pernicious anemia;<br>Immunological agents (allergy shot extracts);<br>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);<br>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;<br>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;<br>Smoking deterrent products such as Chantix;<br>Drug Efficacy Study Implementation ("DESI") drugs;<br>Drugs that may be received without charge under a Federal, State, or Local program;<br>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or antipigmenting of the skin (e.g., Latisse, Propecia, and Vaniqa);<br>Refills of any prescription older than one year;<br>Unit dose packaging;<br>Compound medications containing no legend (prescription) medication; and<br>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature). | | |
| 29 | **Preferred Brand Drugs** | Covered | Preferred Brand Drugs | No | | | | | Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;<br>Drugs and associated expenses and devices not approved by the FDA for a particular use except as | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).<br>Medications that are used to treat infertility;<br>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan (e.g., Xenical, diethlypropion, and phenteramine);<br>Replacement of a prescription drug due to loss, damage, or theft;<br>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;<br>Experimental or Investigational drugs;<br>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;<br>B-12 Injections, except for pernicious anemia;<br>Immunological agents (allergy shot extracts);<br>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);<br>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;<br>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;<br>Smoking deterrent products such as Chantix;<br>Drug Efficacy Study Implementation ("DESI") drugs;<br>Drugs that may be received without charge under a Federal, State, or Local program;<br>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or antipigmenting of the skin (e.g., Latisse, Propecia, and Vaniqa);<br>Refills of any prescription older than one year;<br>Unit dose packaging;<br>Compound medications containing no legend (prescription) medication; and<br>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature). | | |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 30 | **Non-Preferred Brand Drugs** | Covered | Non-Preferred Brand Drugs | No | | | | | Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g. syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;<br>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).<br>Medications that are used to treat infertility;<br>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan(e.g.Xenical, diethlypropion, and phenteramine);<br>Replacement of a prescription drug due to loss, damage, or theft;<br>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;<br>Experimental or Investigational drugs;<br>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;<br>B-12 Injections, except for pernicious anemia;<br>Immunological agents (allergy shot extracts);<br>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);<br>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;<br>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;<br>Smoking deterrent products such as Chantix;<br>Drug Efficacy Study Implementation ("DESI") drugs;<br>Drugs that may be received without charge under a Federal, State, or Local program;<br>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or antipigmenting of the skin (e.g,. Latisse, Propecia, | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | and Vaniqa);<br>Refills of any prescription older than one year;<br>Unit dose packaging;<br>Compound medications containing no legend (prescription) medication; and<br>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature). | | |
| 31 | **Specialty Drugs** | Covered | Specialty Drugs | No | | | | | Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g. syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;<br>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).<br>Medications that are used to treat infertility;<br>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan(e.g. Xenical, diethlypropion, and phenteramine);<br>Replacement of a prescription drug due to loss, damage, or theft;<br>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;<br>Experimental or Investigational drugs;<br>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;<br>B-12 Injections, except for pernicious anemia;<br>Immunological agents (allergy shot extracts);<br>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);<br>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;<br>Whole Blood and Blood Components Not Classified | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | as Drugs in the United States Pharmacopoeia;<br>Smoking deterrent products such as Chantix;<br>Drug Efficacy Study Implementation ("DESI") drugs;<br>Drugs that may be received without charge under a Federal, State, or Local program;<br>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or antipigmenting of the skin (e.g., Latisse, Propecia, and Vaniqa);<br>Refills of any prescription older than one year;<br>Unit dose packaging;<br>Compound medications containing no legend (prescription) medication; and<br>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature). | | |
| 32 | **Outpatient Rehabilitation Services** | Covered | Outpatient Rehabilitation Services | Yes | 30 | Treatments per year | | | Services provided in the Members' home for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time including therapy for chronic and/or recurring symptoms including but not limited to arthritis, back pain, and fibromyalgia; hot/cold pack therapy including polar ice therapy and water circulating devices; Speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal facility or clarity; voice training and voice therapy. | | No |
| 33 | **Habilitation Services** | Not Covered | Habilitation Services | | | | | | | | |
| 34 | **Chiropractic Care** | Covered | Chiropractic Care | Yes | 20 | Visits per year | | | Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack therapy including polar ice therapy and water circulating devices. | | No |
| 35 | **Durable Medical Equipment** | Covered | Durable Medical Equipment | Yes | 1 | Other | Unit limits unique to type of DME defined per medical coverage policy | | Home Traction Units.<br>DME replacements due to physical growth.<br>DME to aid in the correction of congenital anomalies over the age of five (5) years.<br>Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances.<br>Disposable supplies (including diapers) or non- | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.<br>Revision of durable medical equipment, except when made necessary by normal wear or use.<br>Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness, lost, or stolen.<br>Duplicate or similar items<br>Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates.<br>Items which are primarily educational in nature or for vocation, comfort, convenience or recreation.<br>Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication.<br>Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools.<br>Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.<br>Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment.<br>Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier.<br>Remote control devices as optional accessories.<br>Any other equipment and supplies which the Plan determines is not eligible for coverage. | | |
| 36 | **Hearing Aids** | Not Covered | Hearing Aids | | | | | | | | |
| 37 | **Diagnostic Test (X-Ray and Lab Work)** | Covered | Diagnostic Test (X-Ray and Lab Work) | No | | | | | | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 38 | **Imaging (CT/PET Scans, MRIs)** | Covered | Imaging (CT/PET Scans, MRIs) | No | | | | | | | No |
| 39 | **Preventive Care/ Screening/ Immunization** | Covered | Preventive Care/Screening/Immunization | No | | | | | School physicals, sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses). | | No |
| 40 | **Routine Foot Care** | Covered | Routine Foot Care | No | | | | | Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (except as stated above).<br>Diagnosis and treatment of weak, strained, or flat feet. | | No |
| 41 | **Acupuncture** | Not Covered | Acupuncture | | | | | | | | |
| 42 | **Weight Loss Programs** | Not Covered | Weight Loss Programs | | | | | | | | |
| 43 | **Routine Eye Exam for Children** | Covered | CHIP- Pediatric Vision- Routine Eye Exam for Children | Yes | 1 | Visits per year | | | | | No |
| 44 | **Eye Glasses for Children** | Covered | CHIP- Pediatric Vision- Eye Glasses for Children | Yes | 1 | Other | 1 pair of glasses every other year | | | | No |
| 45 | **Dental Check-Up for Children** | Covered | CHIP-Pediatric Dental- Dental Check-up | Yes | 2 | Visits per year | | | | | No |

## OTHER BENEFITS

| 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 | **Other** | Covered | Family Planning | No | | | | | | | No |
| 2 | **Other** | Covered | Family Planning Services include consultations, and pre-pregnancy planning; Voluntary Sterilizations include tubal ligations and vasectomies; Mirena IUD device is covered every five (5) years | No | | | | | Genetic counseling or testing, elective abortion services, Implanon implantable contraceptive device, sterilization of Dependent children, reversal of voluntary sterilization. | | No |
| 3 | **Other** | Covered | Allergy Care | No | | | | | Provocative food testing and sublingual allergy desensitization. | | No |
| 4 | **Other** | Covered | Diagnostic Testing and Treatment of hearing illness or injury | No | | | | | Gradual hearing loss that occurs with aging and related adult hearing screening services, testing and supplies; Hearing aids; Tinnitus Maskers; All other hearing related supplies, purchases, examinations, testing or fittings. | | No |
| 5 | **Other** | Covered | Vision Services | No | | | | | Vision exams (routine); Refractive errors of the eye; Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere; Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; Replacement of lost, stolen, broken, or damaged lenses or glasses; Bifocal contact lenses; Special lens coating or lens treatments for prosthetic eyewear; Glasses and/or contacts after cataract surgery; Routine cleaning of Scleral Shells. | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | **Other** | Covered | Transplant Services | No | | | | | Transplant evaluations with no end organ complications; Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use; Artificial organs, any transplant or transplant services not listed above; Expenses incurred by a Participant as a donor, unless the recipient is also a Participant Costs related to locating organ donors; Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless if the donor is covered as a Participant under this Plan or not; Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies, drugs and aftercare for or related to artificial or non-human organ transplants; Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by Sanford Health Plan's medical director or its designee; Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Provider or non-center of excellence; Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria. | | No |
| 7 | **Other** | Covered | Dental Benefits | No | | | | | Routine dental care and treatment; Natural teeth replacements including crowns, bridges, braces or implants; Osseointegrated implant surgery (dental implants); Extraction of wisdom teeth; Hospitalization for extraction of teeth; Dental x-rays or dental appliances; Shortening of the mandible or maxillae for cosmetic purposes; Services and supplies related to ridge augmentation, implantology, and preventive vestivuloplasty; Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD). | | No |
| 8 | **Other** | Covered | CHIP-Pediatric Dental-Dental Check-up | Yes | 2 | Visits per year | | | | | No |
| 9 | **Other** | Covered | CHIP- Pediatric Vision-Eye Glasses for Children | Yes | 1 | Other | 1 pair of glasses every other year | | | | No |
| 10 | **Other** | Covered | CHIP- Pediatric Vision-Routine Eye Exam for Children | Yes | 1 | Visits per year | | | | | No |

## PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANALGESICS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 20 |
| ANALGESICS | OPIOID ANALGESICS, LONG-ACTING | 10 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 9 |
| ANESTHETICS | LOCAL ANESTHETICS | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | ALCOHOL DETERRENTS/ANTI-CRAVING | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | OPIOID ANTAGONISTS | 2 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | SMOKING CESSATION AGENTS | 0 |
| ANTI-INFLAMMATORY AGENTS | GLUCOCORTICOIDS | 2 |
| ANTI-INFLAMMATORY AGENTS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 20 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 5 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 14 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 10 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 1 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 5 |
| ANTIBACTERIALS | MACROLIDES | 5 |
| ANTIBACTERIALS | QUINOLONES | 6 |
| 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 | 6 |
| 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 | 3 |
| ANTIDEPRESSANTS | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 9 |
| ANTIDEPRESSANTS | TRICYCLICS | 9 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 9 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 6 |
| ANTIFUNGALS | NO USP CLASS | 19 |
| 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 | 9 |
| ANTINEOPLASTICS | ALKYLATING AGENTS | 6 |
| ANTINEOPLASTICS | ANTIANGIOGENIC AGENTS | 0 |
| 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 | 2 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 1 |
| ANTINEOPLASTICS | RETINOIDS | 2 |
| ANTIPARASITICS | ANTHELMINTICS | 4 |
| ANTIPARASITICS | ANTIPROTOZOALS | 12 |
| ANTIPARASITICS | PEDICULICIDES/SCABICIDES | 6 |
| ANTIPARKINSON AGENTS | ANTICHOLINERGICS | 2 |
| 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 | 6 |
| ANTIPSYCHOTICS | TREATMENT-RESISTANT | 1 |
| ANTISPASTICITY AGENTS | NO USP CLASS | 4 |
| ANTIVIRALS | ANTI-CYTOMEGALOVIRUS (CMV) AGENTS | 2 |
| 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 | 5 |
| 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 | 5 |
| BIPOLAR AGENTS | MOOD STABILIZERS | 5 |
| BLOOD GLUCOSE REGULATORS | ANTIDIABETIC AGENTS | 18 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 2 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 9 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | ANTICOAGULANTS | 7 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | BLOOD FORMATION MODIFIERS | 6 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | COAGULANTS | 0 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | PLATELET MODIFYING AGENTS | 7 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC AGONISTS | 5 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC BLOCKING AGENTS | 4 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN II RECEPTOR ANTAGONISTS | 4 |
| CARDIOVASCULAR AGENTS | ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS | 10 |
| CARDIOVASCULAR AGENTS | ANTIARRHYTHMICS | 9 |
| 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 | 6 |
| 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 | 3 |
| 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 | 32 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 5 |
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 5 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 5 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 3 |
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 2 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| GASTROINTESTINAL AGENTS | LAXATIVES | 3 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 4 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 5 |
| GENITOURINARY AGENTS | BENIGN PROSTATIC HYPERTROPHY AGENTS | 7 |
| GENITOURINARY AGENTS | GENITOURINARY AGENTS, OTHER | 3 |
| GENITOURINARY AGENTS | PHOSPHATE BINDERS | 2 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL) | GLUCOCORTICOIDS/MINERALOCORTICOIDS | 23 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY) | NO USP CLASS | 1 |
| 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 | 3 |
| 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 | 4 |
| 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 | 0 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 6 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 2 |
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 9 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 2 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 4 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 4 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 9 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 13 |
| OTIC AGENTS | NO USP CLASS | 6 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 6 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 7 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 8 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 5 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 3 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 6 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 2 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 4 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 6 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 7 |