UTAH EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from 3rd largest state employee plan, Health Maintenance Organization
Issuer Name	Public Employee's Health Program
Product Name	Utah Basic Plus
Plan Name	Utah Basic Plus
Supplemented Categories (Supplementary Plan Type)	None
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 visit to treat an injury or illness	No							No
2	**Specialist Visit**	Covered	Specialist visit to treat an injury or illness	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other practitioner office visit to treat an illness or injury	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient facility fee	No							Yes
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient surgery physician/ surgical services	No							Yes
6	**Hospice Services**	Covered	Hospice services	Yes	6	Other	Maximum of 6 months in a 3 year period.				No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-emergency care when traveling outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Not Covered									
10	**Long-Term/Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Not Covered									
13	**Urgent Care Centers or Facilities**	Covered	Urgent care centers or facilities	No							No
14	**Home Health Care Services**	Covered	Home health care services	Yes	30	Days per year	30 days per plan year.				No
15	**Emergency Room Services**	Covered	Emergency room services	No			Medically Necessary emergency room facility services are payable after applicable Coinsurance. Each follow up.				No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency transportation/ ambulance	No							Yes

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient hospital services	No			Charges for Medically Necessary inpatient Hospitalization (semi-private room, ICU, and eligible ancillaries) are payable after applicable Coinsurance.				Yes
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient physician and surgical services	No							Yes
19	**Bariatric Surgery**	Not Covered									
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled nursing facility	Yes	30	Days per month	30 days per plan year				No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and postnatal care	No							No
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	Yes	8	Visits per year	8 visits per plan year/ combined with Substance Abuse outpatient,				No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral health inpatient services	Yes	30	Days per year	30 days per plan year/ combined with Substance Abuse outpatient,				No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance abuse disorder outpatient services	Yes	8	Days per year	8 visits per plan year/ combined with Mental/Behavioral Health Outpatient Services,				No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance abuse disorder inpatient services	Yes	30	Days per year	30 days per plan year/ combined with Mental/Behavioral Health Inpatient Services,				No
28	**Generic Drugs**	Covered	Generic drugs	No							Yes
29	**Preferred Brand Drugs**	Covered	Preferred brand drugs	No							Yes
30	**Non-Preferred Brand Drugs**	Not Covered									
31	**Specialty Drugs**	Covered	Specialty drugs	No							No
32	**Outpatient Rehabilitation Services**	Covered	Physical therapy, speech therapy, occupationally therapy, and habilitative services	Yes	20	Visits per year	Includes habilitative services with a combined limit of 20 visits per plan year.				No

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33	**Habilitation Services**	Covered	Physical therapy, speech therapy, occupationally therapy, and habilitative services.	Yes	20	Visits per year	Includes other outpatient rehabilitation services with a combined limit of 20 visits per plan year.				No
34	**Chiropractic Care**	Not Covered									
35	**Durable Medical Equipment**	Covered	Durable medical equipment	No							Yes
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic test (x-ray and lab work)	No							Yes
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							Yes
40	**Routine Foot Care**	Covered	Routine foot care	No						Visits to a podiatrist are limited to removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. Licensed physician treating a metabolic or peripheral vascular disease.	Yes
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine eye exam for children	Yes	1	Visits per year	One visit per plan year ages 5-18.				No
44	**Eye Glasses for Children**	Covered	Eye glasses for children	Yes	1	Other	One pair of eyeglass lenses per plan year ages 5-18.				No
45	**Dental Check-Up for Children**	Covered	Dental check-up for children	Yes	2	Visits per year	Periodic oral exam fees are allowed twice in a plan year.				Yes

OTHER BENEFITS

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1	**Substance Abuse Disorder Inpatient Services**	Covered	Substance abuse disorder inpatient services	Yes	30	Days per year				30 days per plan year/combined with Mental/Behavioral Health Inpatient Services.	No
2	**Routine Foot Care**	Covered	Routine foot care	No						Visits to a podiatrist are limited to removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease.	No
3	**Durable Medical Equipment**	Covered	Durable medical equipment	Yes	1	Other	Breast prosthetics are covered one per affected breast every two years. Eyes once per affected eye every 5 years. Foot orthotics are not covered.		1. Training and testing in conjunction with Durable Medical Equipment or prosthetics; 2. More than one lens for each affected eye following Surgery for corneal transplant; 3. Durable Medical Equipment that is inappropriate for the patient's medical condition; 4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit; 5. Equipment purchased from non-licensed Providers; 6. Used Durable Medical Equipment; 7. TENS Unit; 8. Neuromuscular Stimulator; 9. H-wave Electronic Device; 10. Sympathetic Therapy Stimulator (STS); 11. Limb prosthetics; 12. Machine rental or purchase for the treatment of sleep disorders; 13. Support hose for phlebitis or other diagnosis.	1. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary; 2. One pair of ear plugs within 60 days following eligible ear Surgery; 3. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty; 4. Artificial eye prosthetic, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Pre-authorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period; 5. Wheelchairs require Pre-authorization through Medical Case Management and are limited to one power wheelchair in any five-year period; 6. Knee braces are limited to one per knee in a three year period.	No

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4	**Generic Drugs**	Covered	Generic drugs	No					1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on PEHP's Preferred Drug List or website; 2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy); 3. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old). PEHP Utah Basic Plus » Medical Master Policy » Covered Benefits 4. Hair growth and hair loss products; 5. Medications or nutritional supplements for weight loss or weight gain; 6. Investigational and non-FDA Approved medications; 7. Medications needed to participate in any drug research or medication study; 8. FDA-approved medication for Experimental or Investigational indications; 9. Non-approved indications determined by PEHP's Pharmacy and Therapeutics Committee and the PEHP Master Policy; 10. Drugs for athletic and mental performance; 11. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by PEHP; 12. Oral infant and medical formulas; 13. Therapeutic Devices or appliances unless listed in PEHP's Preferred Drug List; 14. Diagnostic agents; 15. Over-the-counter medications and products unless listed in PEHP's Preferred Drug List; 16. Take-home prescriptions from a Hospital or Skilled Nursing Facility; 17. Biological serum, blood, or blood plasma; 18. Medications and	1. Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines, or PEHP's Pharmacy and Therapeutics Committee; 2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting; 3. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage; 4. When a medication is dispensed in two different strengths or dosage forms, a separate Coinsurance will be required for each dispensed prescription; 5. Preferred generic prescription prenatal vitamins are covered at 100% when a female Member enrolls in WeeCare and uses their pharmacy card to obtain their prescription within the first or second trimester. Members who enroll after the first or second trimester are responsible for applicable Coinsurances; 6. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation; 7. Medication quantities and availability may be restricted to a lower allowed day supply when a manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply; 8. Cash paid and Coordination of Benefits claims will be subject to PEHP's Pre-authorization, step therapy, Benefit Coverage and quantity levels. PEHP will reimburse up to Medco's	No

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									injectables prescribed for Industrial Claims and Worker's Compensation; 19. Medications dispensed from an institution or substance abuse clinic when the Member does not use their pharmacy card at a PEHP Contracted pharmacy are not payable as a pharmacy claim; 20. Compounding fees, powders, and non-covered medications used in compounded preparations; 21. Medications used for Cosmetic indications; 22. Replacement of lost, stolen or damaged medications; 23. Nasal immunizations unless listed in the PEHP Preferred Drug List; 24. Medications for Elective abortions except in accordance with Utah State Law; 25. Drugs for the treatment of nail fungus; 26. Medications for sex change operations; 27. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services; 28. Hypodermic needles; 29. Oral and nasal antihistamines for allergies; 30. Drugs used for sexual dysfunction or enhancement; 31. Medications for the treatment of infertility; 32. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP; 33. Medications not listed on the PEHP website. For a complete list of covered drugs, refer to the PEHP website; 34. Drugs purchased from non-participating Providers over the Internet.	Contracted rate and PEHP's benefit rules; 9. PEHP will have the ability to limit the availability and filling of any medication, Device or supply. The Pharmacy or Case Management Department may require the following tools: (a) Require prescriptions to be filled at a specified pharmacy; (b) Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by PEHP; (c) Obtain services and medications from only a specified Provider; (d) Require participation in a specified treatment for any underlying medical conditional; (e) Require completion of a drug treatment program; (f) Adhere to a PEHP Limitation or program to help reduce or eliminate drug abuse or dependence; (g) Deny medications or quantities needed to support any dependence, addiction or abuse if a Member misuses the health care system to obtain drugs in excess of what is Medically Necessary. 10. Fluoride tablets are limited to children up to the age of 12 years old; 11. Enteral formula requires Pre-authorization and is limited to the pharmacy network for Coverage; 12. Retail prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used. Twenty-three days must pass at a local pharmacy before a prescription can be refilled.	
5	**Preferred Brand Drugs**	Covered	Preferred brand drugs	No					1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on	1. Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines,	No

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									PEHP's Preferred Drug List or website; 2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy); 3. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old). PEHP Utah Basic Plus » Medical Master Policy » Covered Benefits 4. Hair growth and hair loss products; 5. Medications or nutritional supplements for weight loss or weight gain; 6. Investigational and non-FDA Approved medications; 7. Medications needed to participate in any drug research or medication study; 8. FDA-approved medication for Experimental or Investigational indications; 9. Non-approved indications determined by PEHP's Pharmacy and Therapeutics Committee and the PEHP Master Policy; 10. Drugs for athletic and mental performance; 11. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by PEHP; 12. Oral infant and medical formulas; 13. Therapeutic Devices or appliances unless listed in PEHP's Preferred Drug List; 14. Diagnostic agents; 15. Over-the-counter medications and products unless listed in PEHP's Preferred Drug List; 16. Take-home prescriptions from a Hospital or Skilled Nursing Facility; 17. Biological serum, blood, or blood plasma; 18. Medications and injectables prescribed for Industrial Claims and Worker's Compensation; 19. Medications dispensed from an institution or substance abuse clinic	or PEHP's Pharmacy and Therapeutics Committee; 2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting; 3. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage; 4. When a medication is dispensed in two different strengths or dosage forms, a separate Coinsurance will be required for each dispensed prescription; 5. Preferred generic prescription prenatal vitamins are covered at 100% when a female Member enrolls in WeeCare and uses their pharmacy card to obtain their prescription within the first or second trimester. Members who enroll after the first or second trimester are responsible for applicable Coinsurances; 6. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation; 7. Medication quantities and availability may be restricted to a lower allowed day supply when a manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply; 8. Cash paid and Coordination of Benefits claims will be subject to PEHP's Pre-authorization, step therapy, Benefit Coverage and quantity levels. PEHP will reimburse up to Medco's Contracted rate and PEHP's benefit rules; 9. PEHP will have the ability to limit the availability and filling of any medication, Device or supply. The	

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									when the Member does not use their pharmacy card at a PEHP Contracted pharmacy are not payable as a pharmacy claim; 20. Compounding fees, powders, and non-covered medications used in compounded preparations; 21. Medications used for Cosmetic indications; 22. Replacement of lost, stolen or damaged medications; 23. Nasal immunizations unless listed in the PEHP Preferred Drug List; 24. Medications for Elective abortions except in accordance with Utah State Law; 25. Drugs for the treatment of nail fungus; 26. Medications for sex change operations. 27. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services; 28. Hypodermic needles; 29. Oral and nasal antihistamines for allergies; 30. Drugs used for sexual dysfunction or enhancement; 31. Medications for the treatment of infertility; 32. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP; 33. Medications not listed on the PEHP website. For a complete list of covered drugs, refer to the PEHP website; 34. Drugs purchased from non-participating Providers over the Internet.	Pharmacy or Case Management Department may require the following tools: (a) Require prescriptions to be filled at a specified pharmacy; (b) Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by PEHPl (c) Obtain services and medications from only a specified Provider; (d) Require participation in a specified treatment for any underlying medical condition; (e) Require completion of a drug treatment program; (f) Adhere to a PEHP Limitation or program to help reduce or eliminate drug abuse or dependence; (g) Deny medications or quantities needed to support any dependence, addiction or abuse if a Member misuses the health care system to obtain drugs in excess of what is Medically Necessary. 10. Fluoride tablets are limited to children up to the age of 12 years old; 11. Enteral formula requires Pre-authorization and is limited to the pharmacy network for Coverage; 12. Retail prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used. Twenty-three days must pass at a local pharmacy before a prescription can be refilled.	

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6	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient hospital services	No					1. Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Coinsurances; 2. Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible; 3. When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, PEHP may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by PEHP; 4. Inpatient benefits for Mental Health require Preauthorization; 5. Only acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Pre-authorization through the inpatient Mental Health benefits; 6. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Pre-authorization; 7. Inpatient Rehabilitation and Skilled Nursing Facility stays are limited to 30 days per plan year combined.		No

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7	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient facility fee	No					Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Coinsurances.	Charges for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based, are payable after applicable Coinsurance. When emergency room treatment results in an inpatient admission (within 24 hours), benefits are payable as an inpatient stay.	No
8	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient surgery physical/surgical services	No					1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes; 2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery; 3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future Complications; 4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions: (a) Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes; and (b) Reconstructive Surgery made necessary by an Accidental injury in the preceding five years. 5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years; 6. Assisted reproductive technologies: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or	Medically Necessary Surgical Procedures are payable, after applicable Coinsurance when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility. 1. Multiple Surgical Procedures during the same operative session are allowable at 100% of Maximum Allowable Fee for the primary procedure and 50% of Maximum Allowable Fee for all additional eligible procedures. Incidental procedures are excluded; 2. Surgical benefits are payable based on surgical Package Fees to include the Surgery and post-operative care per CPT guidelines and RBRVS guidelines; 3. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Pre-authorization through Medical Case Management; 4. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, PEHP may allow payment for the standard Calcitite placement	No

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									any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded. 7. Surgical treatment for correction of refractive errors; 8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible; 9. Reversal of sterilization; 10. Gender reassignment Surgery; 11. Rhytidectomy; 12. Surgery that is dental in origin, including care and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care; 13. Complications as a result of non-covered or ineligible Surgery; 14. Injection of collagen, except as approved for urological procedures; 15. Lipectomy, abdominoplasty, panniculectomy; 16. Repair of diastasis recti; 17. Sperm banking system, storage, treatment, or other such services; 18. Non-FDA Approved or Experimental or Investigational procedures, drugs and Devices; 19. Hair transplants or other treatment for hair loss or restoration; 20. Chemical peels; 21. Treatment for spider or reticular veins; 22. Liposuction; 23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery; 24. Chin implant, genioplasty	towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible. Pre-authorization is required.	

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									or horizontal symphyseal osteotomy; 25. Unbundling or fragmentation of surgical codes; 26. Any Surgery solely for snoring; 27. Otoplasty; 28. Abortions, except as in accordance with Utah State Law; 29. Surgical treatment for sexual dysfunction; 30. Subtalar implants; 31. Additional fees charged because a robotic surgical system was used during surgery; 32. Mastectomy for gynecomastia; 33. All treatment of infertility; 34. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery; 35. Breast Reduction; 36. Blepharoplasty (or other eyelid Surgery); 37. Circumcision; 38. Infertility surgery; 39. Sclerotherapy of varicose veins; 40. Microphlebectomy (stab phlebectomy); 41. TMJ/TMD/Myofacial Pain.		
9	**Inpatient Physician and Surgical Services**	Covered	Inpatient physician and surgical services	No					1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes; 2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery; 3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future Complications; 4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions: (a) Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes; and (b)		No

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									Reconstructive Surgery made necessary by an Accidental injury in the preceding five years. 5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years; 6. Assisted reproductive technologies: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded; 7. Surgical treatment for correction of refractive errors; 8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible; 9. Reversal of sterilization; 10. Gender reassignment Surgery; 11. Rhytidectomy; 12. Surgery that is dental in origin, including care and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care; 13. Complications as a result of non-covered or ineligible Surgery; 14. Injection of collagen, except as approved for urological procedures; 15. Lipectomy, abdominoplasty, panniculectomy; 16. Repair of diastasis		

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									recti; 17. Sperm banking system, storage, treatment, or other such services; 18. Non-FDA Approved or Experimental or Investigational procedures, drugs and Devices; 19. Hair transplants or other treatment for hair loss or restoration; 20. Chemical peels; 21. Treatment for spider or reticular veins; 22. Liposuction; 23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery; 24. Chin implant, genioplasty or horizontal symphyseal osteotomy; 25. Unbundling or fragmentation of surgical codes; 26. Any Surgery solely for snoring; 27. Otoplasty; 28. Abortions, except as in accordance with Utah State Law; 29. Surgical treatment for sexual dysfunction; 30. Subtalar implants; 31. Additional fees charged because a robotic surgical system was used during surgery; 32. Mastectomy for gynecomastia; 33. All treatment of infertility; 34. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery; 35. Breast Reduction; 36. Blepharoplasty (or other eyelid Surgery); 37. Circumcision; 38. Infertility surgery; 39. Sclerotherapy of varicose veins; 40. Microphlebectomy (stab phlebectomy); 41. TMJ/TMD/ Myofacial Pain.		
10	**Other**	Covered	Limitations and exclusions from coverage relating to medical visits	No					1. Hospital visits the same day as Surgery or following a Surgical Procedure except for treatment of a diagnosis unrelated to the Surgery; 2. Examinations made in connection with a hearing aid; 3. Services for weight loss or in conjunction with weight loss programs regardless of the	1. Physical therapy visits may be payable up to plan limits when Medically Necessary; 2. Pelvic floor therapy visits may be payable up to plan limits when Medically Necessary. See applicable Benefits Summary for plan limits; 3. Outpatient occupational therapy for fine motor function may	No

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									medical indications except as allowed under the Affordable Care Act Preventive Services; 4. Sublingual antigens; 5. Services that are dental in origin, including care and treatment of the teeth, gums, alveolar process, extraction of teeth, re-implantation or splinting, endodontia, periodontia, orthodontia, prosthetics, dental implants, crowns or pontics over implants, anesthesia or supplies used in such care; 6. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluations; 7. Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services; 8. Acupuncture treatment; 9. Physical or occupational therapy primarily for maintenance care; 10. Occupational therapy for activities of daily living, academic learning, vocational or life skills, drivers evaluation or training, developmental delay and recreational therapy; 11. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school; 12. Hypnotherapy or biofeedback. 13. Hair transplants or other treatment for hair loss or restoration. 14. Treatment of TMJ/TMD or Myofacial Pain; 15. Vision therapy; 16. Testing and treatment therapies for developmental delay or child developmental programs; 17. Rolfing or massage therapy; 18. Training and testing in conjunction with Durable	be payable up to plan limits when Medically Necessary. See applicable Benefits Summary for plan limits; 4. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same-day visits by a multi-disciplinary team are eligible with applicable Coinsurance(s) per Provider; 5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative; 6. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses; 7. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on-call" or shift work requirements; 8. Cardiac Rehabilitation, Phase 2, following heart attack, cardiac Surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year; 9. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.	

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									Medical Equipment or prosthetics; 19. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services; 20. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations, or for legal purposes such as custodial rights, paternity suits, etc.; 21. Visits in conjunction with palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. See applicable Benefits Summary for Eligible Benefits; 22. Cardiac Rehabilitation, Phases 3 and 4; 23. Pulmonary Rehabilitation, Phase 3; 24. Chelation therapy; 25. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection; 26. Fitness programs; 27. Charges for special medical equipment, machines, or Devices in the Provider's office used to enhance diagnostic or therapeutic services in a Provider's practice; 28. Childbirth education classes; 29. Topical hyperbaric oxygen treatment; 30. Chiropractic treatment.		

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11	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic test (x-ray and lab work)	No					1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations; 2. Routine drug screening, except when ordered by a treating physician; 3. Sublingual or colorimetric allergy testing; 4. Charges in conjunction with weight loss programs regardless of Medical Necessity; 5. Epidemiological and predictive genetic counseling except in conjunction with the Affordable Care Act; 6. Probability and predictive analysis and testing; 7. Unbundling of lab charges or panels; 8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations; 9. Hair analysis, trace elements, or dental filling toxicity; 10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded; 11. Sleep Studies for sleep disorders; 12. Services in conjunction with diagnosing infertility; 13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services; 14. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease.	1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis; 2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.	No

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12	**Other**	Covered	Mental health and substance abuse	No					1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan; 2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances; 3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions; 4. Wilderness programs; 5. Inpatient treatment for behavior modification, enuresis, or encopresis; 6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations; 7. Occupational or recreational therapy; 8. Hospital leave of absence charges; 9. Sodium amobarbital interviews; 10. Residential treatment programs; 11. Tobacco abuse; 12. Routine drug screening, except when ordered by a treating physician.	1. Benefits for group family counseling will be payable under Mental Health for the primary patient. Benefits will not be considered separate for each individual family Member; 2. When an inpatient stay spans an old and new plan year, hospital benefits will be based on the old plan year provisions. Actual number of days used, however, will apply to specific plan years; 3. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed; 4. Only one visit per Provider of the same specialty per day is payable; 5. Outpatient visits are limited to 8 per plan year.	No
13	**Emergency Transportation/ Ambulance**	Covered	Emergency transportation/ambulance	No					1. Charges for common or private aviation services; 2. Services for the convenience of the patient or family; 3. After-hours charges; 4. Charges for ambulance waiting time.	1. Benefits are only eligible when ambulance services are necessary due to a medical emergency; 2. Only services to transport to the nearest Hospital where proper medical care is available are eligible; 3. Benefits will be payable for air ambulance only in Life-threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available.	No

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14	**Other**	Covered	Home health and hospice care	No					1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider; 2. Private duty nursing; 3. Home health aide; 4. Custodial Care; 5. Respite Care; 6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services; 7. Total Parenteral Nutrition through Hospice; 8. Enteral Nutrition, unless obtained through the pharmacy card.	1. Total Enteral Nutrition (TEN) formula requires Pre-authorization and must be obtained through the pharmacy card; 2. Physical and/or occupational therapy performed in the home is subject to the outpatient plan limits. See applicable Benefits Summary for details; 3. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits. See applicable Benefits Summary for details; 4. Skilled Nursing visits are subject to plan Limitations. See applicable Benefits Summary for details; 5. Hospice services are subject to plan Limitations. See applicable Benefits Summary for details.	No
15	**Preventive Care/ Screening/ Immunization**	Covered	Preventive care/screening/ immunizations	No						COVERED PREVENTIVE SERVICES FOR ADULTS: Preventive office visits including the following services, once per plan year; Blood pressure screening; Immunizations vaccines for adults-doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diptheria, Pertussis, Varicella; Abdominal aortic aneurysm one-time screening for men aged 65-75 who have ever smoked; Alcohol misuse screening and counseling; Anemia screening on a routine basis for pregnant women; Bacteriuria urinary tract or other infection screening for pregnant women; BRCA counseling about genetic testing for women at higher risk; Breast cancer	No

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										mammography screenings for women age 40 and over, once per plan year; Breast cancer chemoprevention counseling for women at higher risk; Breast feeding interventions to support and promote breast feeding; Cervical cancer screening, once per plan year; Chlamydia infection screening; Cholesterol screening, once per plan year; Colorectal cancer screening for adults aged 50-75; Depression screening; Diabetes screening; Diet counseling for adults at higher risk for chronic disease; Gonorrhea screening; Hepatitis B screening for pregnant women at their first prenatal visit; HIV screening; Obesity screening and counseling; Osteoporosis screening for women age 60 and older; Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk; Sexually transmitted infection prevention counseling; Syphilis screening; Tobacco use screening; Type 2 Diabetes screening for adults with high blood pressure COVERED PREVENTIVE SERVICES FOR CHILDREN Preventive office visits with medical history for all children throughout development (as recommended by the American Academy of Pediatrics); Immunizations, vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Diptheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus,	

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										Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella; Alcohol and drug use assessments; Autism screening for children at 18 and 24 months; Behavioral assessments; Cervical dysplasia screening; Congenital hypothyroidism screening for newborns; Developmental screening for children under age 3, and surveillance throughout childhood; Dyslipidemia screening for children at higher risk of lipid disorders; Gonorrhea preventive medication for the eyes of all newborns; Hearing screening; Height, weight and Body Mass Index measurements for children; Hematocrit or hemoglobin screening; Hemoglobinopathies or sickle cell screening for newborns; HIV screening; Lead screening; Obesity screening and counseling; Oral health risk assessment for young children; Phenylketonuria (PKU) screening for this genetic disorder in newborns; Sexually transmitted infection (STI) prevention counseling; Tuberculin testing for children at higher risk of tuberculosis; Routine vision exam for children between age 3 and 5, once per plan year; Vision acuity screening for all children. COVERAGE FOR SPECIFIC DRUGS Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over the counter purchases are not covered. See applicable Benefits Summary for coverage information: Aspirin use for men and women of certain ages; Folic	

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										acid supplements for women who may become pregnant; Fluoride chemoprevention supplements for children without fluoride in their water source; Iron supplements for children ages 6 to 12 months at risk for anemia; Tobacco use cessation interventions.	
16	**Dental Check-Up for Children**	Covered	Dental check-up for children	No						Oral Examinations: Periodic oral exam fees are allowed twice in a plan year age 3-18. A re-evaluation is considered included in the primary procedure and is not payable separately. Diagnostic X-rays/Services: 1. Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period for members age 13-18, in lieu of panorex x-ray; 2. Full series bitewing x-rays (4) are allowed only twice in a plan year; 3. A panorex is allowable once during any three-year period in lieu of complete mouth x-ray; 4. Vertical bitewings are payable up to eight films. Preventive: 1. Prophylaxis (cleaning) is allowed twice in a plan year. A child Prophylaxis will be allowed through age 13. An adult Prophylaxis will be allowed for age 14-18; 2. Sealants on permanent molars are allowed once during any five-year period for eligible Dependents through 17 years of age. Permanent molars include teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32. (Permanent molars with occlusal restoration are ineligible.)	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	8
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	2
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	9
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	8
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	3
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	3
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	0
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	5
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	7
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	8
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3
ANTIFUNGALS	NO USP CLASS	13
ANTIGOUT AGENTS	NO USP CLASS	3
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	0
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	2
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	0
ANTIMYCOBACTERIALS	ANTITUBERCULARS	5
ANTINEOPLASTICS	ALKYLATING AGENTS	2
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	1
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	1
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	1
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	8
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	1
ANTIPARASITICS	ANTHELMINTICS	0
ANTIPARASITICS	ANTIPROTOZOALS	5
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	3
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	1
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	4
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	0
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	4
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	2
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	3
ANTIVIRALS	ANTIHERPETIC AGENTS	4
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	4

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	4
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	10
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	0
BLOOD GLUCOSE REGULATORS	INSULINS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	3
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	8
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	11
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	5
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	2
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	0
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	3
DENTAL AND ORAL AGENTS	NO USP CLASS	5
DERMATOLOGICAL AGENTS	NO USP CLASS	15
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	2
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	3
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	0
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	3
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	6
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	1
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	20
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	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	3
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	8
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
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	5
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	1
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	3

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	7
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	10
OTIC AGENTS	NO USP CLASS	3
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	3
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	5
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	1
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	5
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	2
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	2