ILLINOIS EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross Blue Shield of Illinois
Product Name	BlueAdvantage Entrepreneur PPO
Plan Name	BlueCross BlueShield of Illinois BlueAdvantage
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Benefit Information			General Information								
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	Physician Office Visits	Covered	No						No
Specialist Visit	Yes	Specialty Provider Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Provider office Visit	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Hospital Services	Covered	No						No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient or ambulatory surgical procedures	Covered	No						No
Hospice Services	Yes	Hospice Care	Covered	No				Exclusions: 1. Durable medical equipment; 2. Home delivered meals; 3. Homemaker services; 4. Traditional medical services provided for the direct care of the terminal illness, disease or condition; 5. Transportation, including, but not limited to, Ambulance Transportation. Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.	You must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Coverage includes: 1. Coordinated Home Care; 2. Medical supplies and dressings; 3. Medication; 4. Nursing Services – Skilled and non-Skilled; 5. Occupational Therapy; 6. Pain management services; 7. Physical Therapy; 8. Physician visits; 9. Social and spiritual services; 10. Respite Care Service. Charges for DME may be separated from the hospice benefit because: - DME is usually outsourced and billed accordingly; or - You could possibly have different coverage amounts.	No
Non-Emergency Care When Traveling Outside the U.S.		Service outside of plan service area	Covered	No						No
Routine Dental Services (Adult)			Not Covered							

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Infertility Treatment	Yes	Infertility Treatment	Covered	Yes	6	Completed oocyte retrievals/ lifetime		Benefits will not be provided for the following: 1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, Sperm or embryos from you will be covered if you choose to use a surrogate. 2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term. 3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. 4. Non-medical costs of an egg or sperm donor. 5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield. 6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists. 7. Infertility treatment rendered to your dependents under age 18. In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization. Benefits for treatments that include oocyte retrievals will be provided only when: 1) You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and 2) You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered. Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory	Quantity limit is 4 with an additional 2 only following a live birth and under certain conditions. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.	Yes

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								screenings, psychological screenings and prescription drugs. The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.		
Long-Term/Custodial Nursing Home Care			Not Covered						Long Term Care and Custodial Care are excluded regardless of setting.	
Private-Duty Nursing	Yes	Private Duty Nursing Service	Covered	No				Private Duty Nursing requires Medical Services Advisory (MSA) review including case management. Private Duty Nursing is excluded when you are an Inpatient. Custodial Care services are excluded. Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available nonprofessional personnel.		No
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care Services	Covered	No						No
Home Health Care Services	Yes	Coordinated Home Care Program	Covered	No				The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).	Needs Medical Services Advisory (MSA) review in order to maximize benefits for services received in a Coordinated Home Care Program. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies.	No
Emergency Room Services	Yes	Emergency Room Visit	Covered	No					Includes out-of-country emergencies.	No

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Emergency Transportation/ Ambulance	Yes	Ambulance Transportation	Covered	No				Not covered under the hospice program. Not provided for long distance trips because it is more convenient than other transportation.		No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No					Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Hospital Services	Covered	No					Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	Yes
Bariatric Surgery	Yes	Bariatric Surgical Procedures	Covered	No						No
Cosmetic Surgery	Yes	Cosmetic Surgery	Covered	No				Covered only for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.		No
Skilled Nursing Facility	Yes	Skilled Nursing Facility Services	Covered	No				No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.	Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.	No
Prenatal and Postnatal Care	Yes	Maternity Service	Covered	No					Includes lactation support.	No
Delivery and All Inpatient Services for Maternity Care	Yes	Maternity Service	Covered	No					Needs Medical Services Advisory (MSA) review in order to avoid penalty and receive maximum benefits.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental health and substance abuse services	Covered	No				Residential treatment centers are a general exclusion, except for Substance Use Disorders. Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: Residential treatment centers, except for Substance Use Disorders; Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders; Investigational treatments (see Other Exclusions below); Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions). Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological	No

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									and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.	
Mental/Behavioral Health Inpatient Services	Yes	Mental health and substance abuse services	Covered	No				Residential treatment centers are a general exclusion, except for Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: Residential treatment centers, except for Substance Use Disorders; Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders. Investigational treatments (see Other Exclusions below); Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions). Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health	No

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									Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.	
Substance Abuse Disorder Outpatient Services	Yes	Mental health and substance abuse services	Covered	No				Residential treatment centers are a general exclusion, except for Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: Residential treatment centers, except for Substance Use Disorder; Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders. - Investigational treatments (see Other Exclusions below) - Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions). - Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. - Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.	No

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									- Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.	
Substance Abuse Disorder Inpatient Services	Yes	Mental health and substance abuse services	Covered	No				Residential treatment centers are a general exclusion, except for Substance Use Disorders. - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders.	Exclusions include but may not be limited to: - Residential treatment centers, except for Substance Use Disorders - Subject to Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Abuse disorders. - Investigational treatments (see Other Exclusions below) - Services provided that are not for the treatment of a Mental Illness, defined as illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions). - Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner. - Substance Abuse Rehabilitation Treatment does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats. - Substance Abuse Treatment Facility does not include half-way houses, boarding houses or other facilities that provide primarily a supportive	No

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									environment, even if counseling is provided in such facilities.	
Generic Drugs	Yes	Generic Drugs	Covered	No						Yes
Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No					Prescription tobacco cessation drugs are covered. Self-injectables are covered.	No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No						No
Specialty Drugs	Yes	Specialty Drugs	Covered	No					Biologics are covered. Growth Hormone Therapy is covered.	No
Outpatient Rehabilitation Services	Yes	Rehabilitation Services	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	Yes
Habilitation Services	Yes	Habilitation Services	Covered	No				Benefit available only for Congenital, Genetic or Early Acquired Disorders diagnoses. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services are excluded.	Your benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met: 1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and 2. Treatment is administered by a licensed speech–language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and; 3. Treatment must be Medically Necessary and therapeutic and not Investigational.	No
Chiropractic Care	Yes	Chiropractic Manipulation	Covered	Yes	1000	Dollars per benefit period			Currently limited to $1,000 per benefit period. It is anticipated that this will be converted to a quantitative limit on visits.	No
Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No				Implants are covered separately. Prosthetic Devices: Benefits will be provided for prosthetic devices, special appliances and surgical implants when: 1. they are required to replace all or part of an organ or tissue of the human body, or 2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue. Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required). Orthotic Devices: Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited	Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Insulin pumps are covered. CPAPs are covered. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.	No

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								to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities. Except as specifically mentioned in this Certificate, special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, and wigs (also referred to as cranial prostheses) are excluded.		
Hearing Aids	Yes	Hearing Aids	Covered	No				Not covered except for bone anchored hearing aids (osseointegrated auditory implants). Examinations for the prescription or fitting of hearing aids are excluded, except for one inpatient hearing screening for a newborn.		No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Diagnostic Test	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care	Covered	No				Immunizations are excluded except for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved.		No
Routine Foot Care	Yes	Routine Foot Care	Covered	No					Only covered for individuals with diabetes.	No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year			Supplemented using FEDVIP.	No
Eye Glasses for Children	Yes	Eyeglasses for children	Covered	Yes	1	Pair of glasses (lenses and frames) per year			Supplemented using FEDVIP.	No
Dental Check-Up for Children	Yes	Dental Check-Up for Children	Covered	Yes	3	Visits per year			One visit every 6 months and one visit every 12 months in a school setting. Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using Illinois CHIP.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No				Covered when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.		No
Rehabilitative Occupational and	Yes	Rehabilitative Occupational and	Covered	No				Covered when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a		No

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Rehabilitative Physical Therapy		Rehabilitative Physical Therapy						written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis. Preventive physical therapy for Multiple Sclerosis patients is covered as mandated. Covered when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment begins and must relate to the type, frequency and duration of therapy and indicate anticipated goals and diagnosis.		
Well Baby Visits and Care			Not Covered							
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using Illinois CHIP.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using Illinois CHIP.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using Illinois CHIP.	No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No					Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate are excluded. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that	No

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									will be provided for lodging is $50 per person per day. In addition, the following are excluded: Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery; travel time and related expenses required by a Provider; drugs which do not have approval of the Food and Drug Administration; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; meals.	
Accidental Dental	Yes	Accidental Dental	Covered	No				Dental services that are not required as a result of an accidental injury are excluded. Coverage is provided only for sound, natural teeth. If an injury or breakage is to a tooth with a previous weakness, such as one with a cavity or crown, it would not be considered a sound natural tooth and would not be covered.		No
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No					Both in-patient and out-patient as medically necessary.	No
Radiation	Yes	Radiation	Covered	No					Both in-patient and out-patient as medically necessary.	No
Diabetes Education			Not Covered							
Prosthetic Devices			Not Covered							
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No						No
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes[5]	Clinical Trials	Covered	No						No
Diabetes Care Management	Yes[5]	Diabetes Care Management	Covered	No						No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Prescription Drugs Other	Yes	Prescription Drugs Other	Covered	No						No
Organ Transplants	Yes	Organ Transplants	Covered	No					Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate are excluded. Benefits for transportation and lodging are limited to a combined maximum of	No

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									$10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day. In addition, the following are excluded: Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery; travel time and related expenses required by a Provider; drugs which do not have approval of the Food and Drug Administration; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; meals.	
Bones/Joints	Yes	Bones/Joints	Covered	No						No
Autism Spectrum Disorders	Yes	Autism Spectrum Disorders	Covered	No					Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is medically necessary, or, (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist: psychiatric care, including diagnostic services; psychological assessments and treatments; habilitative or rehabilitative treatments; therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.	No
Breast Implant Removal	Yes	Breast Implant Removal	Covered	No						No
Multiple Sclerosis	Yes	Multiple Sclerosis	Covered	No						No

OTHER BENEFITS

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Additional Surgical Opinion	Yes	Additional Surgical Opinion	Covered	No				Following a recommendation for elective surgery. Covered at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation.		No
Outpatient Rehabilitation Services	Yes	Cardiac Rehabilitation Services	Covered	Yes	36	Treatments		Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.		No
Generic Drugs	Yes	Outpatient Prescription Drug Program	Covered	No				The following are excluded from the Outpatient Prescription Drug Program but may be payable under other benefit sections of the Certificate: 1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels,); and drugs or covered devices for which no valid Prescription Order is obtained. 2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies). 3. Administration or injection of any drugs. 4. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative). 5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility. 6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers'	These exclusions are generally applicable to all categories of drugs -- Generic, Preferred Brand, Non-preferred Brand and Specialty.	Yes

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
								Compensation law. 7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. 8. Drugs which are repackaged by a company other than the original manufacturer. 9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date. 10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. 11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. 12. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not medically Necessary, or otherwise improper. 13. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card. 14. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted. 15. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise. 16. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Section or that are determined to be high-risk compounds. 17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging. 18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise		

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								determined by Blue Cross and Blue Shield. 19. Athletic performance enhancement drugs. 20. Allergy serum and allergy testing materials. 21. Some equivalent drugs manufactured under multiple brand names. Benefits may be limited to only one of the brand equivalents available. 22. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives. 23. Medications in depot or long acting formulations that are intended for use longer than the covered days' supply amount.		
Generic Drugs	Yes	Outpatient Prescription Drug Program	Covered	No				Prior authorization, step therapy, maximum day supply and/or quantity limitations may apply. See EHB benchmark plan documents.	These exclusions are generally applicable to all categories of drugs -- Generic, Preferred Brand, Non-preferred Brand and Specialty.	No
Naprapathic Service	Yes	Naprapathic Service	Covered	Yes	1000	Dollars per benefit period			Currently limited to $1,000 per benefit period. It is anticipated that this will be converted to a quantitative limit on visits. Massage therapy is a covered service but massage therapists are not eligible providers.	No
Infertility Treatment	Yes	Infertility Treatment	Covered	Yes	6	Completed oocyte retrievals		Benefits for treatments that include oocyte retrievals will be provided only when: 1) You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and 2) You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered. Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs. The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.		No
Oral Surgery/TMJ	Yes	Oral Surgery/TMJ	Covered	No					Benefits limited to: surgical removal of complete bony impacted teeth; excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; excision of exostoses of the jaws	No

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
									and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.	
Pulmonary Rehabilitation Therapy	Yes	Pulmonary Rehabilitation Therapy	Covered	No					Based on medical necessity.	No
Nutrition	Yes	Nutrition	Covered	No				Excludes: Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.		No
Blood and blood components	Yes	Blood and blood components	Covered	No					Covered at 80% instead of 90%. Includes clotting factors necessary for the treatment of blood disorders, such as hemophilia. Excludes blood derivatives not classified as drugs in the official formularies.	No
Emergency medical care resulting from a criminal sexual assault or abuse	Yes	Emergency medical care resulting from a criminal sexual assault or abuse	Covered	No					Covered at 100% with no cost sharing.	No
End Stage Renal Disease	Yes	End Stage Renal Disease	Covered	No					Both in-patient and out-patient as medically necessary.	No
Detoxification	Yes	Detoxification	Covered	No					Based on medical necessity for the particular addictive substance.	No
Electroconvulsive Therapy	Yes	Electroconvulsive Therapy	Covered	No						No
Inpatient Physician and Surgical Services	Yes	Assistant Surgeon	Covered	No					Follow Medicare guidelines as to whether reimbursement is available.	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	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
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	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	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	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	8
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	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
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	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
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

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	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	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	34
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	16
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	1
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	12
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	10
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4