

NORTH DAKOTA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Largest HMO Plan, Health Maintenance Organization
Issuer Name	Sanford Health Plan
Product Name	Sanford Health Plan HMO
Plan Name	Sanford Health Plan HMO
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none"> • Pediatric Oral (State CHIP) • Pediatric Vision (State CHIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

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	Primary Care Visit to Treat an Injury or Illness	Covered	No						No	
Specialist Visit	Yes	Specialist Visit	Covered	No						No	
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	No						No	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	No				Surgical procedures that can be done in a Practitioner office setting (i.e., vasectomy, toe nail removal). Blood and blood derivatives replaced by the Member. Take-home drugs.		No	
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Surgery Physician/Surgical Services	Covered	No						No	
Hospice Services	Yes	Hospice Services	Covered	No				Independent nursing, homemaker services.		No	
Non-Emergency Care When Traveling Outside the U.S.			Not Covered								
Routine Dental Services (Adult)			Not Covered								
Infertility Treatment			Not Covered								
Long-Term/Custodial Nursing Home Care			Not Covered								
Private-Duty Nursing	Yes	Private-Duty Nursing	Covered	No						No	
Routine Eye Exam (Adult)			Not Covered								
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No						No	
Home Health Care Services	Yes	Home Health Care Services	Covered	Yes	40	Visits per year		Nursing care requested by, or for the convenience of the patient or the patient's family (rest cures). Custodial or convalescent care.		No	
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No	

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Emergency Transportation/Ambulance	Yes	Emergency Transportation/Ambulance	Covered	No				Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other healthcare services. Transfers performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider. Services and/or travel expenses relating to a Non-Emergency Medical Condition.		No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	No				Take-home drugs. Personal comfort items (telephone, television, guest meals and beds). Private nursing care. Costs associated with private rooms. Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider. Custodial care. Convalescent care. Intermediate level or Domiciliary care. Residential care (except for the treatment of mental disorders or substance abuse disorders). Rest cures. Services to assist in activities of daily living.		No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No						No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	Yes	1	Procedure per lifetime				No
Cosmetic Surgery			Not Covered							
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	30	Days per year		Custodial care; Convalescent care; Intermediate level or Domiciliary care; Residential care; Rest cures; Services to assist in activities of daily living.		No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.		No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No						No

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Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				<p>Convalescent care.</p> <p>Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling.</p> <p>Learning disabilities.</p> <p>Behavioral problems.</p> <p>Mental disability or mental disorder services that, according to generally accepted professional standards, is not amenable to favorable modification (except for initial evaluation, diagnosis or crisis intervention).</p> <p>Services related to environmental change.</p> <p>Behavioral therapy, modification, or training.</p> <p>Milieu therapy.</p> <p>Sensitivity training.</p> <p>Conduct Disorder.</p>		No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				Mental health Services received in a Residential Treatment Facility for Members ages 21 and older.		No
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				<p>Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are required, regardless of where the services are received (e.g. detoxification centers).</p> <p>Detoxification Services and other services related to Methadone or Cyclazocine therapy.</p> <p>Long term care in a mental health facility.</p> <p>Convalescent care.</p> <p>Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling.</p> <p>Learning disabilities.</p> <p>Behavioral problems.</p> <p>Services related to environmental change.</p> <p>Behavioral therapy, modification, or training.</p> <p>Milieu therapy.</p> <p>Sensitivity training.</p> <p>Conduct Disorder.</p> <p>Custodial Care.</p> <p>Intermediate level or Domiciliary care.</p>		No
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				Substance abuse health Services received in a Residential Treatment Facility for Members ages 21 and older.		No

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Generic Drugs	Yes	Generic Drugs	Covered	No				<p>Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;</p> <p>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).</p> <p>Medications that are used to treat infertility;</p> <p>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan (e.g., Xenical, diethylpropion, and phenteramine);</p> <p>Replacement of a prescription drug due to loss, damage, or theft;</p> <p>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;</p> <p>Experimental or Investigational drugs;</p> <p>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;</p> <p>B-12 Injections, except for pernicious anemia;</p> <p>Immunological agents (allergy shot extracts);</p> <p>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);</p> <p>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;</p> <p>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;</p> <p>Smoking deterrent products such as Chantix;</p> <p>Drug Efficacy Study Implementation ("DESI") drugs;</p> <p>Drugs that may be received without charge under a Federal, State, or Local program;</p> <p>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmentation or antipigmenting of the skin (e.g., Latisse, Propecia, and Vaniqa);</p> <p>Refills of any prescription older than one year;</p> <p>Unit dose packaging;</p> <p>Compound medications containing no legend (prescription) medication; and</p> <p>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature).</p>		No

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Preferred Brand Drugs	Yes	Preferred Brand Drugs	Covered	No				<p>Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;</p> <p>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).</p> <p>Medications that are used to treat infertility;</p> <p>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan (e.g., Xenical, diethylpropion, and phenteramine);</p> <p>Replacement of a prescription drug due to loss, damage, or theft;</p> <p>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;</p> <p>Experimental or Investigational drugs;</p> <p>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;</p> <p>B-12 Injections, except for pernicious anemia;</p> <p>Immunological agents (allergy shot extracts);</p> <p>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);</p> <p>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;</p> <p>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;</p> <p>Smoking deterrent products such as Chantix;</p> <p>Drug Efficacy Study Implementation ("DESI") drugs;</p> <p>Drugs that may be received without charge under a Federal, State, or Local program;</p> <p>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmentation or antipigmentation of the skin (e.g., Latisse, Propecia, and Vaniqa);</p> <p>Refills of any prescription older than one year;</p> <p>Unit dose packaging;</p> <p>Compound medications containing no legend (prescription) medication; and</p> <p>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature).</p>		No

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Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Drugs	Covered	No				<p>Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g. syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;</p> <p>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).</p> <p>Medications that are used to treat infertility;</p> <p>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan(e.g. Xenical, diethylpropion, and phenteramine);</p> <p>Replacement of a prescription drug due to loss, damage, or theft;</p> <p>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;</p> <p>Experimental or Investigational drugs;</p> <p>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;</p> <p>B-12 Injections, except for pernicious anemia;</p> <p>Immunological agents (allergy shot extracts);</p> <p>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);</p> <p>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;</p> <p>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;</p> <p>Smoking deterrent products such as Chantix;</p> <p>Drug Efficacy Study Implementation ("DESI") drugs;</p> <p>Drugs that may be received without charge under a Federal, State, or Local program;</p> <p>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmentation or antipigmentation of the skin (e.g., Latisse, Propecia, and Vaniqa);</p> <p>Refills of any prescription older than one year;</p> <p>Unit dose packaging;</p> <p>Compound medications containing no legend (prescription) medication; and</p> <p>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature).</p>		No

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Specialty Drugs	Yes	Specialty Drugs	Covered	No				<p>Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g. syringes, needles, test strips, and lancets) that by Federal or State law do not require a prescription order and any medication that is equivalent to an OTC medication;</p> <p>Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity).</p> <p>Medications that are used to treat infertility;</p> <p>Weight management drugs except when medically necessary to treat morbid obesity and approved by the Plan(e.g. Xenical, diethylpropion, and phenteramine);</p> <p>Replacement of a prescription drug due to loss, damage, or theft;</p> <p>Outpatient Drugs dispensed in a Practitioner's office or non-retail pharmacy location;</p> <p>Experimental or Investigational drugs;</p> <p>Growth Hormone, except when medically indicated and approved by Sanford Health Plan;</p> <p>B-12 Injections, except for pernicious anemia;</p> <p>Immunological agents (allergy shot extracts);</p> <p>Acne Medications such as Renova and Retin-A Microgel for Members over age thirty (30);</p> <p>Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multivitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;</p> <p>Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;</p> <p>Smoking deterrent products such as Chantix;</p> <p>Drug Efficacy Study Implementation ("DESI") drugs;</p> <p>Drugs that may be received without charge under a Federal, State, or Local program;</p> <p>Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmentation or antipigmenting of the skin (e.g., Latisse, Propecia, and Vaniqa);</p> <p>Refills of any prescription older than one year;</p> <p>Unit dose packaging;</p> <p>Compound medications containing no legend (prescription) medication; and</p> <p>Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature).</p>		No

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Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	Yes	30	Treatments per year		Services provided in the Members' home for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time including therapy for chronic and/or recurring symptoms including but not limited to arthritis, back pain, and fibromyalgia; hot/cold pack therapy including polar ice therapy and water circulating devices; Speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal facility or clarity; voice training and voice therapy.		No
Habilitation Services	Yes	Habilitation Services	Covered	Yes	30	Treatments per year				No
Chiropractic Care	Yes	Chiropractic Care	Covered	Yes	20	Visits per year		Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack therapy including polar ice therapy and water circulating devices.		No

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Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No				<p>Home Traction Units.</p> <p>DME replacements due to physical growth.</p> <p>DME to aid in the correction of congenital anomalies over the age of five (5) years.</p> <p>Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances.</p> <p>Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.</p> <p>Revision of durable medical equipment, except when made necessary by normal wear or use.</p> <p>Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness, lost, or stolen.</p> <p>Duplicate or similar items</p> <p>Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates.</p> <p>Items which are primarily educational in nature or for vocation, comfort, convenience or recreation.</p> <p>Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication.</p> <p>Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools.</p> <p>Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.</p> <p>Home Modifications including, but not limited to, wiring, plumbing or changes for installation of equipment.</p> <p>Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier.</p> <p>Remote control devices as optional accessories.</p> <p>Any other equipment and supplies which the Plan determines is not eligible for coverage.</p>	Unit limits unique to type of DME defined per medical coverage policy	No
Hearing Aids			Not Covered							
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-Ray and Lab Work)	Covered	No						No
Imaging (CT/PET Scans, MRIs)	Yes	Imaging (CT/PET Scans, MRIs)	Covered	No						No

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Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/Imm unization	Covered	No				School physicals, sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses).		No
Routine Foot Care	Yes	Routine Foot Care	Covered	No				Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (except as stated above). Diagnosis and treatment of weak, strained, or flat feet.		No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	CHIP- Pediatric Vision- Routine Eye Exam for Children	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	CHIP- Pediatric Vision- Eye Glasses for Children	Covered	Yes	1	Pair of glasses every other year				No
Dental Check-Up for Children	Yes	CHIP-Pediatric Dental- Dental Check-up	Covered	Yes	2	Visits per year				No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	30	Treatments per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	30	Treatments per year				No
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
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						No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No						No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No						No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care - Adult			Not Covered							

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Abortion for Which Public Funding is Prohibited			Not Covered							
Transplant	Yes	Transplant	Covered	No				Transplant evaluations with no end organ complications; Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use; Artificial organs, any transplant or transplant services not listed above; Expenses incurred by a Participant as a donor, unless the recipient is also a Participant Costs related to locating organ donors; Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless if the donor is covered as a Participant under this Plan or not; Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies, drugs and aftercare for or related to artificial or non-human organ transplants; Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by Sanford Health Plan's medical director or its designee; Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Provider or non-center of excellence; Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria.	Transplant includes Transplant Services.	No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No
Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	Yes	8	Visits per year				No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No						No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
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
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No

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Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No

OTHER BENEFITS

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Family Planning	Yes	Family Planning	Covered	No						No
Family Planning Services	Yes	Family Planning Services	Covered	No				Genetic counseling or testing, elective abortion services, Implanon implantable contraceptive device, sterilization of Dependent children, reversal of voluntary sterilization.	Family Planning Services include consultations, and pre-pregnancy planning; Voluntary Sterilizations include tubal ligations and vasectomies; Mirena IUD device is covered every five (5) years	No
Allergy Care	Yes	Allergy Care	Covered	No				Provocative food testing and sublingual allergy desensitization.		No
Diagnostic Testing and Treatment of hearing illness or injury	Yes	Diagnostic Testing and Treatment of hearing illness or injury	Covered	No				Gradual hearing loss that occurs with aging and related adult hearing screening services, testing and supplies; Hearing aids; Tinnitus Maskers; All other hearing related supplies, purchases, examinations, testing or fittings.		No
Vision Services	Yes	Vision Services	Covered	No				Vision exams (routine); Refractive errors of the eye; Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere; Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; Replacement of lost, stolen, broken, or damaged lenses or glasses; Bifocal contact lenses; Special lens coating or lens treatments for prosthetic eyewear; Glasses and/or contacts after cataract surgery; Routine cleaning of Scleral Shells.		No

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Transplant Services	Yes	Transplant Services	Covered	No				Transplant evaluations with no end organ complications; Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use; Artificial organs, any transplant or transplant services not listed above; Expenses incurred by a Participant as a donor, unless the recipient is also a Participant Costs related to locating organ donors; Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless if the donor is covered as a Participant under this Plan or not; Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies, drugs and aftercare for or related to artificial or non-human organ transplants; Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by Sanford Health Plan's medical director or its designee; Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Provider or non-center of excellence; Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria.		No
Dental Benefits	Yes	Dental Benefits	Covered	No				Routine dental care and treatment; Natural teeth replacements including crowns, bridges, braces or implants; Osseointegrated implant surgery (dental implants); Extraction of wisdom teeth; Hospitalization for extraction of teeth; Dental x-rays or dental appliances; Shortening of the mandible or maxillae for cosmetic purposes; Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty; Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD).		No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	2
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	10
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	6
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	3
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	19
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	0
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	2
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	1
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	6
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	4
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	18
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	9
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	3
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	32
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	5
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	5
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	3
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	4
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	5
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	7
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	17
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	6
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	9

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	13
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	7
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	8
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	3
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	4
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	7