FLORIDA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross and Blue Shield of Florida
Product Name	BlueOptions
Plan Name	BlueOptions 5462
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

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					Expenses for on line medical Services provided by a healthcare provider that is not a physician and expenses for Health Care Services rendered by telephone are excluded.		Yes
2	**Specialist Visit**	Covered	Specialist Visit	No							Yes
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant	No							Yes
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility fee (e.g. Ambulatory Surgery Center)	No							Yes
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No							Yes
6	**Hospice Services**	Covered	Health Care Services provided in connection with a Hospice treatment program	No							No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S	No							Yes
8	**Routine Dental Services (Adult)**	Not Covered	Routine Dental Services (Adult)						Dental Care or treatment of teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g. braces), intraoral Prosthetic Devices, palatal expansion devices, bruxism appliances, and dental x-rays.		

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
9	**Infertility Treatment**	Not Covered	Infertility Treatment including but not limited to, associated services, supplies, and medications for In Vitro Fertilization (IVF);Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI);embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; infertility treatment medication								
10	**Long-Term/Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care								
11	**Private-Duty Nursing**	Not Covered	Private Duty Nursing								
12	**Routine Eye Exam (Adult)**	Not Covered	Routine Eye Exam (Adult)								
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	20	Visits per year	Per benefit period		Homemaker or domestic maid services, sitter or companion services, Services rendered by an employee or operator of an adult congregate living facility, adult foster care, adult day care center, or a nursing home facility. Also excluded is Speech Therapy provided for a diagnosis of developmental delay. Custodial Care is excluded. Food, housing and home delivered meals and Services rendered in a Hospital, nursing home, or immediate care facilities are excluded.		Yes
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/Ambulance	No							Yes
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					Gowns, slippers, toiletries, telephone, TV, guest or gourmet meals, admission kits		Yes
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No							Yes
19	**Bariatric Surgery**	Not Covered	Bariatric Surgery								
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery								
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	60	Days per year	Days per benefit period		Confinement for custodial care; Room & Board; respiratory, pulmonary or inhalation therapy, blood products, dressings, casts, diagnostic services		Yes
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					Maternity Services rendered to a covered person who becomes pregnant as a Gestational Surrogate is not covered.		Yes

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
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	Yes	20	Visits per year	Visits per benefit period		Services for psychological testing associated with the evaluation and diagnosis of learning disabilities; marriage counseling; pre-marital counseling; court-ordered care or testing, or required as a condition of parole or probation; testing of aptitude, ability, intelligence or interest; evaluation for the purpose of maintaining employment inpatient confinement or inpatient mental health services received in a residential treatment facility		No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	Yes	30	Days per year	Days per benefit period		Services for psychological testing associated with the evaluation and diagnosis of learning disabilities; marriage counseling; pre-marital counseling; court-ordered care or testing, or required as a condition of parole or probation; testing of aptitude, ability, intelligence or interest; evaluation for the purpose of maintaining employment, services for cognitive remediation, inpatient confinement that are primarily intended for a change in environment, or inpatient (overnight) mental health services received in a residential treatment facility		Yes
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No							No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					Prolonged care or treatment or inpatient confinement primarily for change of environment		Yes

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
28	**Generic Drugs**	Covered	Generic Drugs	No					Non-prescription medicines, vitamins, mineral supplements, over the counter drugs, drugs to treat sexual dysfunction	Covers up to 30 day supply (retail prescription); 90 day supply (mail order Prescription. Responsible Rx Programs such as Prior Authorization, Responsible Steps or Responsible Quantity may apply.	No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No					Blood or blood products to treat hemophilia unless for emergency stabilization, surgical procedure associated with an inpatient stay	Covers up to 30 day supply (retail prescription); 90 day supply (mail order Prescription. Responsible Rx Programs such as Prior Authorization, Responsible Steps or Responsible Quantity may apply.	No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No					Blood or blood products to treat hemophilia unless for emergency stabilization, surgical procedure associated with an inpatient stay	Covers up to 30 day supply (retail prescription); 90 day supply (mail order Prescription. Responsible Rx Programs such as Prior Authorization, Responsible Steps or Responsible Quantity may apply.	No
31	**Specialty Drugs**	Covered	Specialty Drugs	No							Yes
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	35	Visits per year	Visits per benefit period				Yes
33	**Habilitation Services**	Not Covered									
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	26	Visits per year	Manipulations per benefit period			Limit is combined with Outpatient Rehabilitation Services limit.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of DME solely because it is old or used are excluded.		No
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests (X-Rays and Laboratory Tests)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screening/ Immunization	Yes	1	Procedures per year	Preventive colonoscopy (age 50+) 1 every 10 years. High risk colonoscopy 1 every 2 years.		Adult preventive excluded services for routine vision and hearing exams and screenings.	In order for Preventive services to be covered, Services must be provided in accordance with prevailing medical standards consistent with the recommendations for Preventive Adult and Pediatric Health Care as indicated by the USPSTF.	No
40	**Routine Foot Care**	Covered	Routine Foot Care	No						Covered Services may include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.	No
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Enternal Formula	No					Food or food products not covered under enteral formula; coverage to treat inherited diseases of amino acid and organic acids shall include coverage for food products modified to be low protein up to 25th birthday.	Enternal formula $2,500 per benefit period.	No
2	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No						Medical self-administered drugs in the treatment of cancer, diabetes or conditions requiring immediate stabilization or administration of dialysis are covered.	No
3	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Chemotherapy	No						Chemo treatment for proven malignant disease.	No
4	**Other**	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center) and Physician/ Surgical Services	No						Breast reconstructive surgery. Surgery to re-establish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered.	No
5	**Other**	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center) and Physician/ Surgical Services	No						Breast cancer treatment including treatment for physical complications related to a Mastectomy (including lymphedemas), and outpatient post-surgical follow up in accordance with prevailing medical standards as determined by the attending physician are covered.	Yes
6	**Outpatient Surgery Physician/Surgical Services**	Covered	Surgical procedures performed by a physician	No						Covered services include Sterilization (tubal ligations and vasectomies)regardless of Medical Necessity.	Yes

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
7	**Outpatient Surgery Physician/Surgical Services**	Covered	Specific surgical procedures performed by a physician	No						Surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.	No
8	**Outpatient Surgery Physician/Surgical Services**	Covered	Specific surgical procedures performed by a physician	No						Oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth.	Yes
9	**Outpatient Surgery Physician/Surgical Services**	Covered	Specific surgical procedures performed by a physician	No						Surgical procedures involving bones or joints (e.g. TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.	Yes
10	**Outpatient Surgery Physician/Surgical Services**	Covered	Specific surgical procedures performed by a physician	No						Services of a Physician for the purpose if rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery.	No
11	**Home Health Care Services**	Covered	Home Health Care Services	Yes	40	Hours per week	Part time (less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e. a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide services.				Yes

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
12	**Home Health Care Services**	Covered	Home Health Care Services	No						Additional services are limited to medical social services, nutritional guidance, respiratory or inhalation therapy, physical, speech or occupational therapy by a PT, OT or Speech Therapist, home health aide and services must be consistent with the plan of treatment ordered by the physician, and under the supervision of a Registered Nurse.	No
13	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					When death occurs outside the U.S., the medical evacuation and repatriation of remains is not covered.		No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
14	**Other**	Covered	Dental Surgery	No					Dental Implants	Dental services are limited to extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck. Anesthesia Services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to the member or covered dependent in a Hospital or Ambulatory Surgical Center if a) the Covered Dependent is under 8 yrs of age and it is determined by a dentist and the Covered Dependent's Physician that: i. dental treatment is necessary due to a dental condition that is significantly complex; or ii. The Covered Dependent has a developmental disability in which patient management in the dental office has proven uneffective or b) you have one or more medical conditions that would create significant or undue risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or Ambulatory Surgical Center.	No
15	**Other**	Covered	Dental Services Resulting From Accident	No					Dental Services provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such Services could have been rendered within 62 days	Coverage is limited to Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such services are for the treatment of damage to Sound Natural Teeth.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
16	**Other**	Covered	TMJ	Yes	2	Procedures per year	One splint in a six month period unless a more frequent replacement is determined to be medically necessary.				Yes
17	**Other**	Covered	Surgical procedures involving TMJ	No						Services are limited to surgical procedures involving bones or joints of the jaw (e.g. TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenial or developmental deformity, disease, or injury (e.g. Cleft palate).	No
18	**Other**	Covered	Diabetes Outpatient Self-Management	No					In order for services to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes educator or a board certified Physician specializing in endocrinology. Additionally, nutritional counseling must be provided by a licensed Dietitian.	Covered services include self-management training and educational services and nutritional counseling (including medically necessary equipment and supplies) to treat diabetes if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are medically necessary. Covered services may also include trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of diabetic foot disease.	No
19	**Other**	Covered	Cochlear Implants	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
20	**Emergency Transportation/Ambulance**	Covered	Emergency Transportation/Ambulance	No						Ground, air and water travel, combined per day maximum. Add'l limitations may exist for air and water transport; Covered when necessary to transport a newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child condition. Covered services for transportation between facilities when medically necessary. Services covered from one location to other when patient is bedridden, wheelchair bound and cannot otherwise be transported.5500 per day maximum.	No
21	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					All Inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Substance Dependency category), Pain Management, and respiratory ventilator management Services are excluded.	Inpatient Rehabilitation is covered; Partial Hospitalization is a Covered services include chemotherapy and radiation treatments for proven malignant disease, therapies and transplants.	No
22	**Cosmetic Surgery**	Covered	Reconstructive Surgey	No						Surgery to re-establish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered.	No
23	**Specialty Drugs**	Covered	Specialty Drugs	No						Testing and desensitization therapy (e.g., injections) and the cost of desensitization serum are covered; Contraceptive medication by injection is covered when administered by a Physician for the purposes of contraception, limited to medication and administration.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
24	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	No						Speech Therapy is covered for child cleft lip and cleft palate; Outpatient therapies include Cardiac, Occupational, Physical, Speech, Massage therapies in the Home Health Care, Hospital and Skilled Nursing Facility setting.	No
25	**Other**	Covered	Eye Surgery	No						Coverage includes soft lenses or sclera shells, for the treatment of aphakic patients, initial glasses or contact lenses following cataract surgery and physician services to treat an injury to or disease o the eyes	No
26	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No						Care for the mother includes the postpartum assessment.	No
27	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No						Partial Hospitalization is a covered service in lieu of inpatient hospitalization and is combined with the inpatient hospital benefit. Two days of partial hospitalization will count as one day toward the inpatient mental and nervous disorder benefit	No
28	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No						Covered services include intravenous solutions, transfusion supplies and equipment, chemotherapy treatment for proven malignant disease, Physical, Speech and Occupational Therapies.	No
29	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No						Surgical Assistant Services are covered when the assistant is necessary	No
30	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No						Covered Services include detoxification	No
31	**Specialist Visit**	Covered	Physician Administered Drugs	No						Medical self-administered drugs in the treatment of cancer, diabetes or conditions requiring immediate stabilization or administration of dialysis are covered.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
32	**Primary Care Visit to Treat an Injury or Illness**	Covered	Physician Administered Drugs	No						Medical self-administered drugs in the treatment of cancer, diabetes or conditions requiring immediate stabilization or administration of dialysis are covered.	No
33	**Other**	Not Covered	Weight Control Services							including any Service to lose, gain, or maintain weight regardless of the reason for the service or whether the service is part of a treatment plan for a Condition	
34	**Other**	Covered	Transplant Services (bone marrow transplant as defined in rule 59B-12.001 of the Florida Administrative code, corneal transplant, heart transplant, heart/lung combination transplant, liver transplant, kidney transplant, pancreas transplant, pancreas transplant performed simultaneously with a kidney transplant, whole single or whole bilateral lung transplant, donor costs and organ acquisition for transplants not covered whole or in part by any other insurance carrier, organization or person (excl bone marrow transplants)	No					Transplants considered to be experimental or investigational, involving non-human organ or tissue, donation or acquisition of organ or tissue for a recipient not covered, implant of an artificial organ, sold or donated organs, bone marrow transplants not specifically listed in rule 59B-12.001 of the Florida Administrative code, services in connection with identification of a donor from local, state or national listings except for bone marrow transplant, non-medical costs, device that replaces either the atrium or the ventricle.		No
35	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
36	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
37	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	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	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	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	20
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	3
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
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	7
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	32
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
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	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	8
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	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	6
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	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	11
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
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	8
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	7