

PROPOSED NEW HAMPSHIRE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	Matthew Thornton Hlth Plan (Anthem BCBS)
Product Name	HMO Blue New England
Plan Name	HMO BLUE NEW ENGLAND 25 50 WITH Rx 10 35 30 OOP 2500
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none">• Pediatric Oral (FEDVIP)• Pediatric Vision (FEDVIP)
Habilitative Services	Yes

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if Benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Visit to Treat an Injury or Illness	No							No
2	Specialist Visit	Covered	Specialist Visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Services	No					Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
5	Outpatient Surgery Physician/Surgical Services	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
6	Hospice Services	Covered	Hospice Services	No							No
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered	Non-Emergency care When Traveling Outside the U.S.								
8	Routine Dental Services (Adult)	Not Covered	Dental Services						No Benefits are available for preventive Dental Services. X-rays of the teeth are not covered. Orthodontia, TMJ appliances, splints or guards, braces, false teeth and biofeedback training are not covered. No Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered. no Benefits are available for treatment of cavities or care of the gums. No Benefits are available for restorativeDental Services, even if the underlying dental condition affects other health factors. No Benefits are available for noncovered dental procedures. covered		

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9	Infertility Treatment	Covered	Infertility Treatment	Yes	6	Other other	6 complete IVF-ET cycles before each live birth.		To be eligible for Benefits, neither partner can have undergone a previous voluntary or elective sterilization procedure. No Benefits are available for reversal of voluntary or elective sterilization or for diagnosis or treatment following the sterilization or sterilization reversal (successful or unsuccessful). No Benefits are available for any service related to achieving pregnancy through surrogacy or gestational carriers. Sex selection, genetic engineering, sperm penetration assay, microvolume straw technique and hamster penetration test (SPA) are not covered. No Benefits are available for egg harvesting or any other infertility procedure performed during an operation not related to an infertility diagnosis. Cryopreservation of donor eggs is not covered. Culture and fertilization of oocytes with coculture of embryos are not covered. Direct intraperitoneal insemination (DIPI) and peritoneal ovum and sperm transfer (POST) are not covered. No Benefits are available for ovulation kits and supplies such as thermometers and home pregnancy tests. No Benefits are available for cryopreservation of embryos or sperm or for donation, harvesting, banking or storage of sperm or eggs for future use unless the recipient is specifically identified and the expected time of use is appointed by your physician. Cost related to donor eggs for women with genetic oocyte defects or donor sperm for men with genetic sperm defects are not covered. Selective fetal reduction is covered only when the procedure is Medically Necessary.	Benefits are available for the following Covered Services: Infertility Diagnostic Services to determine the cause of medically documented infertility. Standard Infertility Treatments. Assisted Reproductive Technology (ART).	No
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care						No Benefits are available for services, supplies or charges for Custodial Care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered.		
11	Private-Duty Nursing	Not Covered	Private duty nursing services						Benefits are not provided for private duty nurses		
12	Routine Eye Exam (Adult)	Covered	Routine Eye Exam	Yes	1	Other other	1 every 2 years			Routine eye exam and refraction	No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Services in an Urgent Care Center or Facility	No							No
14	Home Health Care Services	Covered	Home Health Care Services	No					No Benefits are available for services, supplies or charges for Custodial Care.		No
15	Emergency Room Services	Covered	Emergency Room Services	No							No

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16	Emergency Transportation /Ambulance	Covered	Emergency Transportation /Ambulance	No							No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No					No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		Yes
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No					No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
19	Bariatric Surgery	Covered	Bariatric Surgery	No					Surgery to treat the condition of obesity itself or morbid obesity itself is not covered	Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.	No
20	Cosmetic Surgery	Not Covered	Cosmetic Surgery						No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services.		

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21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	Yes	100	Days per year			No Benefits are available for services, supplies or charges for Custodial Care. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.		No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No					Costs associated with surrogate parenting or gestational carriers are not covered.		No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Facility and Professional Services for Maternity Care	No				48	Costs associated with surrogate parenting or gestational carriers are not covered.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No

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24	Mental/ Behavioral Health Outpatient Services	Covered	Mental/ Behavioral Health Outpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits	No

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25	Mental/ Behavioral Health Inpatient Services	Covered	Mental/ Behavioral Health Inpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits	No

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26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits	No

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27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits	No
28	Generic Drugs	Covered	Generic Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
29	Preferred Brand Drugs	Covered	Preferred Brand Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No

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30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
31	Specialty Drugs	Covered	Specialty Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			Noncovered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes effecting the voice. No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for "Early Intervention Services". No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No

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33	Habilitation Services	Covered	Habilitation Services	Yes	20	Visits per year			Noncovered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes effecting the voice. no Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for "Early Intervention Services". No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, and speech therapy. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No
34	Chiropractic Care	Covered	Spinal manipulation and manual medical intervention services	No					Wellness care is not covered	Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment; and Medically Necessary diagnostic laboratory and x-ray tests.	No

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35	Durable Medical Equipment	Covered	Medical Equipment and Supplies	No					<p>No Benefits are available for: Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification; Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds; Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection; Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene; Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans; Heat lamps, heating pads, hydrocolliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems); Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device; Safety equipment, including, but not limited to: hats, belts, harnesses, glasses or restraints; Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system; Self-monitoring devices except as stated in 2. "Medical Supplies" (above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment; and Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.</p> <p>Convenience Services are not covered, including but not limited to personal comfort items and any equipment, supply or device this is primarily for the convenience of a Member, the Member's family or a Designated Provider. Food and food supplements are not covered except as specified. Nutrition and/or dietary supplements are not covered. Home test kits are not covered.</p>	Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices.	Yes

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36	Hearing Aids	Covered	Hearing Aids	Yes	1	Other other	1 per ear each time prescription changes		No Benefits are available for hearing aids for Members who are 19 years old or older.	Benefits are available for one hearing aid per ear each time a hearing aid prescription changes for Members who are 18 years old or younger.	No
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Tests	No					No Benefits are available for diagnostic x-rays in connection with research or study		No
38	Imaging (CT/PET Scans, MRIs)	Covered	Advanced Diagnostic Imaging Services	No							No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/ Screenings and Immunizations	No						Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012	No
40	Routine Foot Care	Not Covered	Routine Foot Care						No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered.		
41	Acupuncture	Not Covered	Acupuncture						No Benefits are available for alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST) and iridology-study of the iris.		
42	Weight Loss Programs	Not Covered	Weight Loss Programs								
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			Covered at 100% if the services were provided In Network and at 90% if they were Out of Network subject to the annual \$10,000 maximum	No
46	Other										

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 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	Radiation Therapy	No							No
2	Other	Covered	Chemotherapy	No							No
3	Other	Covered	Infusion Therapy	No							No
4	Other	Covered	Renal Dialysis/ Hemodialysis	No							No
5	Other	Covered	Allergy Treatment	No							No
6	Other	Covered	Injectable Drugs and Other Drugs Provided/ Administered During an Office Visit	No							No
7	Other	Covered	Autism Services	No						PT/OT/ST is covered as part of therapy not subject to any visit limits with Autism diag	Yes
8	Other	Covered	Applied Behavior Analysis (ABA)	Yes	27000	Other other	Dollar limit per year			Ages 0-12: \$36k/yr; Ages 13-21: \$27k/yr; PT/OT/ST services w/ autism diagnosis not subject dollar or visit limits	No
9	Other	Covered	Applied Behavior Analysis (ABA)	Yes	36000	Other other	Dollar limit per year			Ages 0-12: \$36k/yr; Ages 13-21: \$27k/yr; PT/OT/ST services w/ autism diagnosis not subject dollar or visit limits	No
10	Other	Covered	Early Intervention Services	Yes	3600	Other other	\$3600 calendar year limit. Limit does not apply to occupational, physical or speech therapy services.			Early intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by Network Behavioral Health Providers, such as Clinical Social Workers. These physical, speech and occupational therapy visits do not count toward the annual PT/OT/ST limits.	No

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11	Other	Covered	Vision Correction After Surgery or Accident	No						Eyewear (frames and/or lenses or contact lenses) is covered if the lens of the eye has been surgically removed or is congenitally absent	No
12	Other	Covered	Medical supplies, equipment, and education for diabetes care for all diabetics	No						Diabetes Management Programs. Covered Services include: individual counseling visits, group education programs and fees required to enroll in an approved group education program, and external insulin pump education is covered for Members whose external insulin pump has been approved by Anthem.	No
13	Other	Covered	Dental Services for Accidental Injury and Other Related Medical Services	No					Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Initial emergency treatment within 24 hours of an accidental injury to sound natural teeth. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Benefits are available for hospital facility charges (Inpatient or Outpatient), surgical day care facility charges and general anesthesia furnished by a licensed anesthesiologist or anesthesiologist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility.	No
14	Other	Covered	Organ and Tissue Transplant Services including heart, heart valve, heart/lung, lung, cornea, kidney, liver, pancreas, pancreas/kidney, bone marrow.	No						When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.	No

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15	Durable Medical Equipment	Covered	Covered Wigs	Yes	350	Other other	\$350 per calendar year			Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury. For Members who have hair loss as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia	No
16	Durable Medical Equipment	Covered	External breast prosthesis	Yes	2	Other other	2 prosthesis per breast per CY			Coverage for external breast prostheses is limited to 2 prostheses per breast, per Calendar Year. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis. Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post mastectomy bras is limited to 3 bras per Member, per Calendar Year	No
17	Durable Medical Equipment	Covered	Enteral formula and modified low protein food products	Yes	1800	Other other	\$1800 per member per CY			Benefits are available for enteral formulas required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. For modified low protein food products, benefits are limited to a total of \$1,800 per Member, per Calendar Year.	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
18	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Rehabilitation Facility	Yes	60	Days per year					No
19	Other	Covered	Human Organ and Tissue Transplants	No						Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.	No
20	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
21	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
22	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	13
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	22
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	9
ANTIBACTERIALS	MACROLIDES	6
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	BARBITURIC ACID DERIVATIVE	1
ANTICONVULSANTS	BENZODIAZEPINE DERIVATIVE	4
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	7
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	ANTIFUNGALS	24
ANTIGOUT AGENTS	ANTIGOUT AGENTS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7

Category	Class	Submission Count
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS	52
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	4
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
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	ANTISPASTICITY AGENTS	5
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	8
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	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	4
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21

Category	Class	Submission Count
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	9
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	9
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	6
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
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	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	2
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	5
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	DENTAL AND ORAL AGENTS	7
DERMATOLOGICAL AGENTS	DERMATOLOGICAL AGENTS	27
ENZYME REPLACEMENT/MODIFIERS	ENZYME REPLACEMENT/MODIFIERS	17
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	2
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9

Category	Class	Submission Count
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	4
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	24
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	22
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	2
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	13
IMMUNOLOGICAL AGENTS	VACCINES	15
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	8
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	METABOLIC BONE DISEASE AGENTS	13
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	8
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OPHTHALMIC ANTI-INFLAMMATORIES	OPHTHALMIC ANTI-INFLAMMATORIES	1
OTIC AGENTS	OTIC AGENTS	4
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	7
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2

Category	Class	Submission Count
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	9
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	6
SKELETAL MUSCLE RELAXANTS	SKELETAL MUSCLE RELAXANTS	8
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	10
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	5