

ALASKA 2017 EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Small Group Market
Issuer Name	Premiera Blue Cross Blue Shield of Alaska
Product Name	Alaska Heritage Select Envoy
Plan Name	Heritage Select Envoy
Supplemented Categories (Supplementary Plan Type)	Pediatric dental (FEDVIP) Pediatric vision (FEDVIP)

BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Covered only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a physician.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	Yes	6	Month(s) per Lifetime	Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions, Over-the-counter drugs, solutions and nutritional supplements, Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care, Services provided to someone other than the ill or injured member, Services of family members or volunteers, Services, supplies or providers not in the written plan of care or not named as covered in this benefit, Custodial care, except for hospice care services, Non-medical services, such as spiritual, bereavement, legal or financial counseling, Normal living expenses, such as food, clothing, and household supplies; housekeeping services except for those of a home health aide as prescribed by the plan of care; and transportation services, Dietary assistance, such as "meals on Wheels," or nutritional guidance.	Inpatient hospice care up to a maximum of 10 days. Respite care, up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No				
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Not Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year	Services, supplies or providers not in the written plan of care or not named as covered benefit. Services provided to someone other than the ill or injured member. Custodial care, except for hospice care services. Non-medical services. Normal living expenses; and transportation services. Dietary assistance, such as "Meals on Wheels," or nutritional guidance.	130 visits per applies to home visits of a home health care provider or one or more: registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers; and a person with a master's degree in social work.
Emergency Room Services	Yes	Covered	No			Treatment of chemical dependency/substance abuse, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition.	

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Emergency Transportation/Ambulance	Yes	Covered	No			Air and Ground transportation: Services that aren't sudden and life-endangering. Transport by taxi, bus, private car or rental car, Meals and lodging.	Air and Ground transpiration benefit is limited to medical emergency. Ambulance services is separate benefit, covers both medical emergency transport and non-emergent transport.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless the medical condition makes inpatient care medically necessary. Any days of inpatient care that exceed the length of stay that is medically necessary to treat the condition.	
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Exceptions to no coverage for cosmetic surgery: Repair of a defect that's the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident. Repair of a dependent child's congenital anomaly. Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit. Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of obesity drugs), upon our review and approval.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year	Custodial care. Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency.	
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Dementia and sleep disorders. Biofeedback services for psychiatric conditions other than generalized anxiety disorder. Family and marital counseling, and family and marital psychotherapy, except when medically necessary to treat the diagnosed psychiatric condition or conditions of a member. Therapeutic or group homes, foster homes, nursing homes, boarding homes or schools, military academies, and child welfare facilities. Telephonic services, except for crisis/emergency evaluations, or when the member is temporarily confined to bed for medical reasons. Telehealth services that do not utilize real-time video or audio services. Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders. Treatment of sexual dysfunctions, such as impotence. All medical services provided in preparation for or after gender reassignment surgery, also including the surgery medical counseling and hormone therapy, regardless of age.	
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Treatment of non-dependent alcohol or drug use or abuse. Voluntary support groups, such as Alanon or Alcoholics Anonymous. Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential chemical dependency treatment. Residential detoxification.	
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Treatment of non-dependent alcohol or drug use or abuse. Voluntary support groups, such as Alanon or Alcoholics Anonymous. Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential chemical dependency treatment. Residential detoxification.	
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Recreational, vocational or educational therapy. Exercise or maintenance-level programs. Social or cultural therapy. Treatment that isn't actively engaged in by the ill, injured or impaired member. Gym or swim therapy. Custodial care. Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.	A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as 1 visit, unless provided by different health care providers.
Habilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.	Habilitative services is only covered in the context of autism spectrum disorders services, including ABA, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual.
Chiropractic Care	Yes	Covered	Yes	12	Visit(s) per Year		
Durable Medical Equipment	Yes	Covered	No			Supplies or equipment not primarily intended for medical use, Special or extra-cost convenience features, exercise equipment or weights, orthopedic appliances for use in sports, recreation or similar activities, penile prostheses, whirlpools, sauna baths, massage devices, structural modifications to home or vehicle.	
Hearing Aids	No	Not Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy, Allergy Testing, Covered inpatient diagnostic services furnished and billed by inpatient facility, covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services, services relating to testing, diagnosis, or treatment of infertility, mammography services.	
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				Routine foot care when the member is a diabetic.
Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year		Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Covered	No				
Dental Check-Up for Children	Yes	Covered	No				
Rehabilitative Speech Therapy	Yes	Covered	Yes	45	Visit(s) per Year		Visit limit for physical, speech, and occupational therapy services combined.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	45	Visit(s) per Year		Visit limit for physical, speech, and occupational therapy services combined.
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				
Transplant	Yes	Covered	Yes	75000	Dollar(s) per Lifetime	Organ, bone marrow and stem cell transplants, including any direct or indirect complications and after effects thereof, except as specifically stated under the Transplants benefit. Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit. Non-human or mechanical organs, unless they aren't "experimental or investigational services." Transplants or related services from a provider not approved by us. Services that will be paid by any government foundation or charitable grant. This includes services performed on potential or actual living donors or recipients and on cadavers. Planned blood storage for more than 12 months for possible future use.	Quantitative limit on Donor costs only. The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are: Heart, Heart/double lung, single lung, Double lung, Liver, Kidney, Pancreas, Pancreas with kidney, Bone marrow (autologous and allogenic), Stem cell (autologous and allogeneic).

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Accidental Dental	Yes	Covered	No			Services must be completed within 12 months unless an extension is granted.	
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				Benefit limited to initial purchase of prosthetic; does not cover replacement unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.
Infusion Therapy	Yes	Covered	No			Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions. Over-the-counter drugs, solutions and nutritional supplements. Drugs and solutions received while you're an inpatient in a hospital or other medical facility.	
Treatment for Temporomandibular Joint Disorders	No	Not Covered	No				
Nutritional Counseling	Yes	Covered	No			"Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits."	
Reconstructive Surgery	Yes	Covered	No				Breast reconstruction allowed.

PREScription DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	21
Analgesics	Opioid Analgesics, Long-acting	12
Analgesics	Opioid Analgesics, Short-acting	16
Anesthetics	Local Anesthetics	3
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	2
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence Treatments	1
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	0
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	3
Antibacterials	Aminoglycosides	6
Antibacterials	Antibacterials, Other	16
Antibacterials	Beta-lactam, Cephalosporins	9
Antibacterials	Beta-lactam, Other	1
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Macrolides	5
Antibacterials	Quinolones	7
Antibacterials	Sulfonamides	5
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	4
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	5
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	8
Antidepressants	Monoamine Oxidase Inhibitors	4
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	13
Antidepressants	Tricyclics	9
Antiemetics	Antiemetics, Other	9
Antiemetics	Emetogenic Therapy Adjuncts	7
Antifungals	No USP Class	23
Antigout Agents	No USP Class	6
Anti-inflammatory Agents	Glucocorticoids	27
Anti-inflammatory Agents	Nonsteroidal Anti-inflammatory Drugs	20
Antimigraine Agents	Ergot Alkaloids	2

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Prophylactic	3
Antimigraine Agents	Serotonin (5-HT) 1b/1d Receptor Agonists	6
Antimyasthenic Agents	Parasympathomimetics	2
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	10
Antineoplastics	Alkylating Agents	3
Antineoplastics	Antiandrogens	3
Antineoplastics	Antiangiogenic Agents	3
Antineoplastics	Antiestrogens/Modifiers	3
Antineoplastics	Antimetabolites	5
Antineoplastics	Antineoplastics, Other	5
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	5
Antineoplastics	Molecular Target Inhibitors	15
Antineoplastics	Monoclonal Antibodies	1
Antineoplastics	Retinoids	3
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	11
Antiparasitics	Pediculicides/Scabicides	6
Antiparkinson Agents	Anticholinergics	2
Antiparkinson Agents	Antiparkinson Agents, Other	3
Antiparkinson Agents	Dopamine Agonists	4
Antiparkinson Agents	Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors	2
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	9
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	4
Antivirals	Anti-cytomegalovirus (CMV) Agents	2
Antivirals	Anti-hepatitis B (HBV) Agents	7
Antivirals	Anti-hepatitis C (HCV) Agents	7
Antivirals	Antiherpetic Agents	5
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	4
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	5
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	13
Antivirals	Anti-HIV Agents, Other	3
Antivirals	Anti-HIV Agents, Protease Inhibitors	9
Antivirals	Anti-influenza Agents	4

CATEGORY	CLASS	SUBMISSION COUNT
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	0
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	7
Bipolar Agents	Mood Stabilizers	5
Blood Glucose Regulators	Antidiabetic Agents	28
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	10
Blood Products/Modifiers/ Volume Expanders	Anticoagulants	7
Blood Products/Modifiers/ Volume Expanders	Blood Formation Modifiers	7
Blood Products/Modifiers/ Volume Expanders	Coagulants	0
Blood Products/Modifiers/ Volume Expanders	Platelet Modifying Agents	8
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	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	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	8
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	4
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	4
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	4
Central Nervous System Agents	Central Nervous System, Other	8
Central Nervous System Agents	Fibromyalgia Agents	3
Central Nervous System Agents	Multiple Sclerosis Agents	8
Dental and Oral Agents	No USP Class	7
Dermatological Agents	No USP Class	87
Enzyme Replacement/ Modifiers	No USP Class	8
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	4

CATEGORY	CLASS	SUBMISSION COUNT
Gastrointestinal Agents	Gastrointestinal Agents, Other	10
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	4
Gastrointestinal Agents	Irritable Bowel Syndrome Agents	3
Gastrointestinal Agents	Laxatives	3
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	6
Genitourinary Agents	Antispasmodics, Urinary	6
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	8
Genitourinary Agents	Genitourinary Agents, Other	5
Genitourinary Agents	Phosphate Binders	4
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	31
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	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	17
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progesterone Agonists/Antagonists	0
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	16
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	3
Hormonal Agents, Stimulant/Replacement/ Modifying (Pituitary)	No USP Class	5
Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)	No USP Class	4
Hormonal Agents, Suppressant (Adrenal)	No USP Class	2
Hormonal Agents, Suppressant (Parathyroid)	No USP Class	3
Hormonal Agents, Suppressant (Pituitary)	No USP Class	7
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	3
Immunological Agents	Angioedema (HAE) Agents	1
Immunological Agents	Immune Suppressants	17
Immunological Agents	Immunizing Agents, Passive	0
Immunological Agents	Immunomodulators	18
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	13
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostanoid Analogs	3
Ophthalmic Agents	Ophthalmic Agents, Other	18
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	9
Ophthalmic Agents	Ophthalmic Antiglaucoma Agents	18
Ophthalmic Agents	Ophthalmic Anti-inflammatories	10
Otic Agents	No USP Class	8

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Antihistamines	9
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	7
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	2
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	3
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	11
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	5
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	8
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	2
Skeletal Muscle Relaxants	No USP Class	6
Sleep Disorder Agents	GABA Receptor Modulators	3
Sleep Disorder Agents	Sleep Disorders, Other	7
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Modifiers	7
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Replacement	4
Therapeutic Nutrients/ Minerals/ Electrolytes	Vitamins	0