EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Diagnostic	PERIODIC ORAL EVALUATION	D0120	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	SCREENING OF A PATIENT	D0190	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	ASSESSMENT OF A PATIENT	D0191	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	EXTRAORAL FIRST FILM	D0250	21	N/A	Not covered	1 per 36 months
Adult Dental Services	Diagnostic	EXTRAORAL POSTERIOR RADIOGRAPH	D0251	21	N/A	Not covered	1 per 36 months
Adult Dental Services	Diagnostic	DENTAL BITEWING SINGLE IMAGE	D0270	21	N/A	Not covered	1 per year
Adult Dental Services	Diagnostic	DENTAL BITEWINGS TWO IMAGES	D0272	21	N/A	Not covered	1 per year
Adult Dental Services	Diagnostic	BITEWINGS FOUR IMAGES	D0274	21	N/A	Not covered	1 per year
Adult Dental Services	Preventive	DENTAL PROPHYLAXIS ADULT	D1110	21	N/A	Not covered	2 per year

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Preventive	TOPICAL FLUORIDE VARNISH	D1206	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	TOPICAL APP FLUORID EX VRNSH	D1208	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	ORAL HYGIENE INSTRUCTION	D1330	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	DENTAL SEALANT PER TOOTH	D1351	21	N/A	Not covered	1 per tooth per 3 years
Adult Dental Services	Preventive	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	D1354	21	N/A	Not covered	2 per tooth per 6 months
Adult Dental Services	Restorative	AMALGAM ONE SURFACE PERMANEN	D2140	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM TWO SURFACES PERMANE	D2150	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM THREE SURFACES PERMA	D2160	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM 4 OR > SURFACES PERM	D2161	21	N/A	Not covered	

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Restorative	RESIN ONE SURFACE-ANTERIOR	D2330	21	N/A	Not covered	Limitation should be once per [tooth + surface] per 3 years
Adult Dental Services	Restorative	RESIN TWO SURFACES-ANTERIOR	D2331	21	N/A	Not covered	
Adult Dental Services	Restorative	RESIN THREE SURFACES-ANTERIO	D2332	21	N/A	Not covered	
Adult Dental Services	Restorative	RESIN 4/> SURF OR W INCIS AN	D2335	21	N/A	Not covered	
Adult Dental Services	Restorative	ANT RESIN-BASED CMPST CROWN	D2390	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 1 SRFC RESINBASED CMPST	D2391	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 2 SRFC RESINBASED CMPST	D2392	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 3 SRFC RESINBASED CMPST	D2393	21	N/A	Not covered	
Adult Dental Services	Restorative	PROTECTIVE RESTORATION	D2940	21	N/A	Not covered	1 per tooth per day

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Periodontics	PERIODONTAL SCALING & ROOT	D4341	21	N/A	Not covered	4 units every 24 months
Adult Dental Services	Periodontics	PERIODONTAL SCALING 1-3TEETH	D4342	21	N/A	Not covered	4 units every 24 months
Adult Dental Services	Periodontics	SCALING IN PRESC OF MODERATE OR SEVERE INFLAMATION - FULL MOUNTH AFTER ORAL EVALUATION	D4346	21	N/A	Not covered	2 per year
Adult Dental Services	Periodontics	FULL MOUTH DEBRIDEMENT	D4355	21	N/A	Not covered	1 per year
Adult Dental Services	Oral and Maxillofacial Surgery	EXTRACTION CORONAL REMNANTS	D7111	21	N/A	Not covered	1 per tooth per lifetime
Adult Dental Services	Oral and Maxillofacial Surgery	TOOTH REIMPLANTATION	D7270	21	N/A	Not covered	1 per tooth per day
Adult Dental Services	Adjunctive General Services	TX DENTAL PAIN MINOR PROC	D9110	21	N/A	Not covered	None
Adult Dental Services	Adjunctive General Services	DENTAL CONSULTATION	D9310	21	N/A	Not covered	1 per year
Adult Dental Services	Adjunctive General Services	BEHAVIOR MANAGEMENT	D9920	21	N/A	Not covered	3 per year

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Category	Product Description	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Over the counter benefit	Cough,cold and allergy medications	0	999	Coverage of products must exceed allowable units as described in the pharmacy coverage policy for OTC benefits.	The managed care plan must provide over the counter benefits in the following categories up to $25 per member per month.
	Vitamins and supplements	0	999		
	Ophthalmic/Otic preparations	0	999		
	Pain relievers	0	999		
	Gastrointestinal products	0	999		
	First aid care	0	999		
	Hygiene products	0	999		
	Insect repellant (deet and non-deet)	0	999		
	Oral hygiene products	0	999		
	Skin care	0	999		

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adult)	Expanded Benefit Coverage (Units)
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY EVALUATION MODERATE COMPLEXITY	97166	21	N/A	Not Covered	1 per year
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY RE-EVALUATION	97168	21	N/A	Not Covered	1 per year
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY TREATMENT VISIT	97530	21	N/A	Not Covered	up to 7 therapy treatment units per week

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adult)	Expanded Benefit Coverage (Units)
Therapy	Physical Therapy	PHYSICAL THERAPY EVALUATION, MODERATE COMPLEXITY	97162	21	N/A	Not covered in an office setting, but may be covered within the $1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Physical Therapy	PHYSICAL THERAPY RE-EVALUATION	97164	21	N/A	Not covered in an office setting, but may be covered within the $1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Physical Therapy	PHYSICAL THERAPY TREATMENT VISIT	97110	21	N/A	Not covered in an office setting, but may be covered within the $1500 outpatient hospital services limit, if medically necessary.	up to 7 therapy treatment units per week

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Coverage (child bearing age)	Expanded Benefit Coverage (Units)
Expanded Prenatal/Perinatal Visits	N/A	HOSPITAL GRADE BREAST PUMP	E0604 (RO - rental only)	10	59	Max of three months (rental, PA is required)	Max of one per year (rental, PA is required)
Expanded Prenatal/Perinatal Visits	N/A	BREAST PUMP	E0603 (RO - rental only)	10	59	1 per every 5 years (PA required)	1 per 2 years (rental, no PA required)
Expanded Prenatal/Perinatal Visits	N/A	ANTEPARTUM MANAGEMENT	H1000	10	59	10 visits for low-risk pregnancies and 14 visits for high-risk pregnancies	14 visits for low-risk pregnancies and 18 visits for high-risk pregnancies
Expanded Prenatal/Perinatal Visits	N/A	POSTPARTUM CARE	59430	10	59	2 visits within 90 days following delivery	3 visits within 90 days following delivery

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Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Hearing Service	N/A	ASSESSMENT FOR HEARING AID	V5010	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID FITTING/CHECKING	V5011	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID MONAURAL IN EAR	V5050	21	N/A	1 per every 3 years	1 per year
Expanded Hearing Service	N/A	BEHIND EAR HEARING AID	V5060	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID DISPENSING FEE	V5090	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	IN EAR BINAURAL HEARING AID	V5130	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR BINAUR HEARING AI	V5140	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	DISPENSING FEE BINAURAL	V5160	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR CROS HEARING AID	V5180	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	CROS HEARING AID DISPENS FEE	V5200	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR BICROS HEARING AI	V5220	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	DISPENSING FEE BICROS	V5240	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING EVALUATION	92557	21	N/A	1 per every 3 years	1 per every 2 years

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Vision Services	Equipment	Contact lens, PMMA, spherical, per lens	V2500	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, PMMA, toric or prism ballast, per lens	V2501	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, gas permeable, toric, prism ballast, per lens	V2511	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, gas permeable, extended wear, per lens	V2513	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic, spherical, per lens	V2520	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic, toric, or prism ballast, per lens	V2521	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic , extended wear, per lens	V2523	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, other type	V2599	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Frames	V2020 V2025	21	N/A	1 per every 2 years	1 per year

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Vision Services	Equipment	Eye Exam	99173	21	N/A	Visual exam services when there is a reported vison problem, illness, disease, or injury but services cannot be performed exclusively to screen visual acuity.	1 per year

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Coverage (Adults)	Expanded Benefit Coverage (Units)
Therapy	Respiratory Therapy	INITIAL EVALUATION/RE-EVALUATION	S5180 (Modifier HA)	21	N/A	Not covered in an office setting, but may be covered within the $1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Respiratory Therapy	RESPIRATORY THERAPY VISIT	G0238	21	N/A	Not covered in an office setting, but may be covered within the $1500 outpatient hospital services limit, if medically necessary.	1 per day

Category	Sub-Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Therapy	Speech-Language Pathology Services	EVALUATION/RE-EVALUATION	92521-92524	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	EVALUATION OF ORAL & PHARYNGEAL SWALLOWING FUNCTION	92610	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	SPEECH THERAPY VISIT	92507	21	N/A	Not Covered	up to 7 therapy treatment units per week
Therapy	Speech-Language Pathology Services	AAC INITIAL EVALUATION	92597	21	N/A	1 per every five years	1 per year
Therapy	Speech-Language Pathology Services	AAC RE-EVALUATION	92597 (GN Modifier)	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	AAC FITTING, ADJUSTMENT, & TRAINING VISIT	92609	21	N/A	Not Covered	Up to four 30-minute AAC fitting, adjustment, and training sessions/ year

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Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99211	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99212	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99213	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99214	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99215	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99307	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99308	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99309	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99310	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	PREV VISIT EST AGE 18-39	99395	21	39	Once per recipient, per provider, per revolving year	Unlimited
Primary Care Visits for Adults	N/A	PREV VISIT EST AGE 40-64	99396	40	64	Once per recipient, per provider, per revolving year	Unlimited
Primary Care Visits for Adults	N/A	PER PM REEVAL EST PAT 65+ YR	99397	65	N/A	Once per recipient, per provider, per revolving year	Unlimited

Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (children)	Expanded Benefit Coverage (Units)
Newborn Circumcision	CIRCUMCISION NEONATE	54160	0	28 days	1/lifetime if medically necessary	1 per lifetime