ARIZONA EHB BENCHMARK PLAN (PY 2025-2027)

SUMMARY INFORMATION

Plan Type	State Employee Plan
Issuer Name	N/A
Product Name	N/A
Plan Name	The State of Arizona EPO Employee Health Plan
Supplemented Categories (Supplementary Plan Type)	Pediatric dental (FEDVIP) Pediatric vision (FEDVIP) Habilitation services (Federal Definition)

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				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No			Services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house; Services and supplies for curative or life prolonging procedures; Services and supplies for which any other benefits are payable under the Plan; Services and supplies that are primarily to aid you or your dependent in daily living; Services and supplies for respite (custodial) care; and Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.	The Plan covers hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Provider as having a terminal illness with a prognosis of six (6) months or less to live.
Routine Dental Services (Adult)	No	Covered	No				
Infertility Treatment	No	Not Covered	No				Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Plan.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No				Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be medically appropriate by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered by the Plan.
Routine Eye Exam (Adult)	No	Covered	No			Exclusions include "routine refractions"; silent on routine vision exams.	
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	Yes	42	Visit(s) per Year	Home health services do not include services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house.	1. The physician must have determined a medical need for home health care and developed a plan of care that is reviewed at thirty day intervals by the physician. 2. The care described in the plan of care must be for intermittent skilled nursing, therapy, or speech services. 3. The patient must be homebound unless services are determined to be medically necessary by the Medical Management Organization. 4. The home health agency delivering care must be certified within the state the care is received. 5. The care that is being provided is not custodial care. A Home Health visit is considered to be up to four hours of services.
Emergency Room Services	Yes	Covered	No				

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Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	Yes	Covered	No			The following bariatric procedures are excluded: 1. Open vertical banded gastroplasty; 2. Laparoscopic vertical banded gastroplasty; 3. Open sleeve gastrectomy; 4. Open adjustable gastric banding.	1. The patient must have a body-mass index (BMI) ≥35. 2. Have at least one co-morbidity related to obesity. 3. Previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record: Active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components: a. Weight b. Current dietary program c. Physical activity (e.g., exercise program) 4. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by your Health Network to perform bariatric surgery. 5. The member must be 18 years or older, or have reached full expected skeletal growth.
Cosmetic Surgery	No	Not Covered	No				Cosmetic surgery or procedures excluded, other than to treat congenital defects and birth abnormalities.
Skilled Nursing Facility	Yes	Covered	Yes	90	Day(s) per Year		
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Newborn benefits do not apply to the newly born child of an Eligible Dependent daughter unless placement with the Employee is confirmed through a court order or legal guardianship.

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Mental/Behavioral Health Outpatient Services	Yes	Covered	No			1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Appropriate and otherwise covered under this Plan; 2. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; 3. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice; 4. Developmental disorders, including but not limited to: developmental reading disorders; developmental arithmetic disorders; developmental language disorders; or articulation disorders. 5. Counseling for activities of an educational nature; 6. Counseling for borderline intellectual functioning; 7. Counseling for occupational problems; 8. Counseling related to consciousness raising; 9. Vocational or religious counseling; 10. I.Q. testing; 11. Marriage counseling; 12. Custodial care, including but not limited to geriatric day care; 13. Psychological testing on children requested by or for a school system; 14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and 15. Biofeedback is not covered for reasons other than pain management.	

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Substance Abuse Disorder Outpatient Services	Yes	Covered	No			1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Appropriate and otherwise covered under this Plan; 2. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; 3. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice; 4. Developmental disorders, including but not limited to: developmental reading disorders; developmental arithmetic disorders; developmental language disorders; or articulation disorders. 5. Counseling for activities of an educational nature; 6. Counseling for borderline intellectual functioning; 7. Counseling for occupational problems; 8. Counseling related to consciousness raising; 9. Vocational or religious counseling; 10. I.Q. testing; 11. Marriage counseling; 12. Custodial care, including but not limited to geriatric day care; 13. Psychological testing on children requested by or for a school system; 14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and 15. Biofeedback is not covered for reasons other than pain management.	

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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	60	Visit(s) per Year	The following limitations apply to short-term rehabilitative therapy except as required for the treatment for Autism Spectrum Disorder: 1. Occupational therapy is provided only for purposes of training Members to perform the activities of daily living. 2. Speech therapy is not covered when: a. Used to improve speech skills that have not fully developed; b. Considered custodial or educational; c. Intended to maintain speech communication; or d. Not restorative in nature. 3. Phase 3 cardiac rehabilitation is not covered. If multiple services are provided on the same day by different Providers, a separate co-payment will apply to each Provider.	Short-term rehabilitative therapy includes services in an outpatient facility or physician's office that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy. Visit limit is for all therapy types combined.

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Habilitation Services	Yes	Covered	No				Supplementing with the federal definition of habilitative services: "Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year	1. Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law; 2. Charges for care not provided in an office setting; 3. Maintenance or preventive treatment consisting of routine, long term or Non-Medically Appropriate care provided to prevent reoccurrences or to maintain the patient's current status; and 4. Vitamin therapy.	HMOs may limit chiropractic visits to 20; PPOs must cover medically necessary chiropractic visits.
Durable Medical Equipment	Yes	Covered	No			1. Hygienic or self-help items or equipment; 2. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment; 3. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines; 4. Institutional equipment, such as air fluidized beds and diathermy machines; 5. Elastic stockings and wigs (except were indicated for coverage); 6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints; 7. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective; 8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and 9. Hearing aid batteries (except those for cochlear implants) and chargers.	
Hearing Aids	Yes	Covered	Yes	1	Item(s) per Benefit Period		Hearing aid devices limited to one per ear, per Plan Year when determined to be medically necessary by the Medical Management Organization.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	Yes	1	Exam(s) per Year		Well Woman and Well Man examinations are limited to 1 visit per year.
Routine Foot Care	No	Not Covered	No				
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Covered	No				

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Dental Check-Up for Children	Yes	Covered	No				
Rehabilitative Speech Therapy	Yes	Covered	Yes	60	Visit(s) per Year	Speech therapy is not covered when: a. Used to improve speech skills that have not fully developed; b. Considered custodial or educational; c. Intended to maintain speech communication; or d. Not restorative in nature.	Visit limit is for all therapy types combined (PT, OT, ST).
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	60	Visit(s) per Year	Occupational therapy is provided only for purposes of training Members to perform the activities of daily living.	Visit limit is for all therapy types combined (PT, OT, ST).
Well Baby Visits and Care	Yes	Covered	No				Well Child visits and immunizations are covered through 47 months as recommended by the American Academy of Pediatrics.
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	Not Covered	No				“Voluntary termination of pregnancy” is excluded.

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Transplant	Yes	Covered	No			These benefits are available when the Member is the recipient of an organ transplant. No coverage if Member is an organ donor for a recipient other than a Member enrolled under this plan. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.	Travel & lodging expenses are limited to $10,000 per transplant. Travel and lodging are not covered if the Member is a donor. Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform human to human organ or tissue transplants, such as: 1. Allogeneic bone marrow/stem cell; 2. Autologous bone marrow/stem cell; 3. Cornea; 4. Heart; 5. Heart/lung; 6. Kidney; 7. Kidney/pancreas; 8. Liver; 9. Lung; 10. Pancreas; 11. Small bowel/liver; or 12. Kidney/liver. Organ transplant coverage will apply only to non-experimental transplants for the specific diagnosis. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.
Accidental Dental	Yes	Covered	No				Benefits are payable for the services of a Physician, dentist, or dental surgeon, provided the services are rendered for treatment of an accidental injury to sound natural teeth where the continuous course of treatment is started within six (6) months of the accident.
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				

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Prosthetic Devices	Yes	Covered	No			1. Any biomechanical devices. Biomechanical devices are any external prosthetics operated through or in conjunction with nerve conduction or other electrical impulses; 2. Replacement of external prosthetic appliances due to loss or theft; and 3. Wigs or hairpieces (except where indicated in column "I").	The Plan covers the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury, congenital defect, or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns. External prosthetic appliances shall include artificial arms and legs, wigs, hair pieces and terminal devices such as a hand or hook. Wigs and hair pieces are limited to one per Plan Year and $150 maximum. Members must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns with a submitted claim for coverage. All other diagnosis are excluded. Replacement of artificial arms and legs and terminal devices are covered only if necessitated by normal anatomical growth or as a result of wear and tear.
Infusion Therapy	Yes	Covered	No				Infusion/IV Therapy in an Outpatient setting including, but not limited to: Infliximab (Remicade), Alefacept (Amevive), and Etanercept (Enbrel).
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				Benefits are payable for covered services and supplies which are necessary to treat TMJ disorder which is a result of: 1. An accident; 2. Trauma; 3. A congenital defect; 4. A developmental defect; or 5. A pathology.
Nutritional Counseling	Yes	Covered	No				Covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to: 1. Morbid obesity 2. Diabetes 3. Cardiovascular disease 4. Hypertension 5. Kidney disease 6. Eating disorders 7. Gastrointestinal disorders 8. Food allergies 9. Hyperlipidemia

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Reconstructive Surgery	Yes	Covered	No				Following a mastectomy, the following services and supplies are covered: 1. Surgical services for reconstruction of the breast on which the mastectomy was performed; 2. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; 3. Post-operative breast prostheses; and 4. Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs. During all stages of mastectomy, treatments of physical complications, including lymphedema, are covered. Cosmetic Surgery is covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for Eligible Dependent children.

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	19
Analgesics	Opioid Analgesics, Long acting	10
Analgesics	Opioid Analgesics, Short-acting	21
Anesthetics	Local Anesthetics	1
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	3
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence	4
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	1
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	1
Antibacterials	Aminoglycosides	3
Antibacterials	Antibacterials, Other	15
Antibacterials	Beta-lactam, Cephalosporins	8
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Carbapenems	0
Antibacterials	Macrolides	4
Antibacterials	Quinolones	4
Antibacterials	Sulfonamides	2
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	6
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Modulating Agents	9
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	3
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	14
Antidepressants	Tricyclics	11
Antiemetics	Antiemetics, Other	9
Antiemetics	Emetogenic Therapy Adjuncts	6
Antifungals	No USP Class	12
Antigout Agents	No USP Class	6

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	0
Antimigraine Agents	Ergot Alkaloids	3
Antimigraine Agents	Prophylactic	4
Antimigraine Agents	Serotonin (5-HT) Receptor Agonist	6
Antimyasthenic Agents	Parasympathomimetics	1
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	9
Antineoplastics	Alkylating Agents	5
Antineoplastics	Antiandrogens	5
Antineoplastics	Antiangiogenic Agents	3
Antineoplastics	Antiestrogens/Modifiers	4
Antineoplastics	Antimetabolites	4
Antineoplastics	Antineoplastics, Other	6
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	2
Antineoplastics	Molecular Target Inhibitors	20
Antineoplastics	Monoclonal Antibody/Antibody-Drug Conjugates	0
Antineoplastics	Retinoids	2
Antineoplastics	Treatment Adjuncts	4
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	13
Antiparkinson Agents	Anticholinergics	2
Antiparkinson Agents	Antiparkinson Agents, Other	4
Antiparkinson Agents	Dopamine Agonists	5
Antiparkinson Agents	Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors	3
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	10
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	3
Antivirals	Anti-cytomegalovirus (CMV) Agents	1
Antivirals	Anti-hepatitis B (HBV) Agents	4
Antivirals	Anti-hepatitis C (HCV) Agents	2
Antivirals	Antiherpetic Agents	3

CATEGORY	CLASS	SUBMISSION COUNT
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	4
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	6
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	14
Antivirals	Anti-HIV Agents, Other	4
Antivirals	Anti-HIV Agents, Protease Inhibitors (PI)	7
Antivirals	Anti-influenza Agents	4
Antivirals	Antiviral, Coronavirus Agents	0
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	8
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	8
Bipolar Agents	Mood Stabilizers	4
Blood Glucose Regulators	Antidiabetic Agents	23
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	10
Blood Products and Modifiers	Anticoagulants	7
Blood Products and Modifiers	Blood Products and Modifiers, Other	7
Blood Products and Modifiers	Hemostasis Agents	2
Blood Products and Modifiers	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	14
Cardiovascular Agents	Beta-adrenergic Blocking Agents	12
Cardiovascular Agents	Calcium Channel Blocking Agents, Dihydropyridines	7
Cardiovascular Agents	Calcium Channel Blocking Agents, Nondihydropyridines	2
Cardiovascular Agents	Cardiovascular Agents, Other	7
Cardiovascular Agents	Diuretics, Loop	4
Cardiovascular Agents	Diuretics, Potassium-sparing	2
Cardiovascular Agents	Diuretics, Thiazide	5
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2

CATEGORY	CLASS	SUBMISSION COUNT
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	7
Cardiovascular Agents	Dyslipidemics, Other	7
Cardiovascular Agents	Mineralocorticoid Receptor Antagonists	2
Cardiovascular Agents	Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)	3
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	5
Central Nervous System Agents	Central Nervous System, Other	13
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	Acne and Rosacea Agents	12
Dermatological Agents	Dermatitis and Pruritus Agents	22
Dermatological Agents	Dermatological Agents, Other	16
Dermatological Agents	Pediculicides/Scabicides	5
Dermatological Agents	Topical Anti-infectives	19
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral Replacement	4
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral/Metal Modifiers	5
Electrolytes/ Minerals/ Metals/ Vitamins	Phosphate Binders	4
Electrolytes/ Minerals/ Metals/ Vitamins	Potassium Binders	1
Electrolytes/ Minerals/ Metals/ Vitamins	Vitamins	1
Gastrointestinal Agents	Anti-Constipation Agents	6
Gastrointestinal Agents	Anti-Diarrheal Agents	4
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	3
Gastrointestinal Agents	Gastrointestinal Agents, Other	11
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	3
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	6
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	No USP Class	6
Genitourinary Agents	Antispasmodics, Urinary	8
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	8
Genitourinary Agents	Genitourinary Agents, Other	10

CATEGORY	CLASS	SUBMISSION COUNT
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	8
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	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	16
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	17
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	6
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	No USP Class	2
Hormonal Agents, Suppressant (Adrenal or Pituitary)	No USP Class	8
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2
Immunological Agents	Angioedema Agents	2
Immunological Agents	Immunoglobulins	1
Immunological Agents	Immunological Agents, Other	10
Immunological Agents	Immunostimulants	2
Immunological Agents	Immunosuppressants	13
Inflammatory Bowel Disease Agents	Aminosalicylates	4
Inflammatory Bowel Disease Agents	Glucocorticoids	6
Metabolic Bone Disease Agents	No USP Class	13
Ophthalmic Agents	Ophthalmic Agents, Other	4
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	6
Ophthalmic Agents	Ophthalmic Anti-Infectives	15
Ophthalmic Agents	Ophthalmic Anti-inflammatories	10
Ophthalmic Agents	Ophthalmic Beta-Adrenergic Blocking Agents	4
Ophthalmic Agents	Ophthalmic Intraocular Pressure Lowering Agents, Other	8
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	4
Otic Agents	No USP Class	9
Respiratory Tract/ Pulmonary Agents	Antihistamines	11
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	9
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	3

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	6
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	14
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	2
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	8
Respiratory Tract/ Pulmonary Agents	Pulmonary Fibrosis Agents	0
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	7
Skeletal Muscle Relaxants	No USP Class	9
Sleep Disorder Agents	Sleep Promoting Agents	11
Sleep Disorder Agents	Wakefulness Promoting Agents	2