COLORADO EHB BENCHMARK PLAN (2025-2027)

SUMMARY INFORMATION

Plan Type	N/A
Issuer Name	N/A
Product Name	N/A
Plan Name	N/A
Supplemented Categories (Supplementary Plan Type)	Pediatric Vision (FEP BlueVision) Pediatric Dental (Federal VIP)
Habilitative Services Included in Benchmark (Yes/No)	Yes
EHB-benchmark Plan Option (at 45 CFR §156.111(a))	45 CFR § 156.111(a)(3): Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.
Comments	Colorado changed its EHB-benchmark in 2021 to come into effect in plan year 2023. In fulfilling the scope of benefit requirements at § 156.111(b), Colorado used the Anthem Lumenos HSA-Compatible 5000D/100% plan offered in Colorado in plan year 2017 as the basis for determining the scope of benefits provided under a typical employer plan (with the pediatric vision EHB category supplemented by the FEP BlueVision plan offered in plan year 2017 and the pediatric dental EHB category supplemented by the Federal VIP plan from plan year 2017). Colorado selected the Government Employees Health Association, Inc. Benefit Plan as the basis to determine the most generous among a set of comparison plans. The state's completed application for EHB-benchmark changes is available for review at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#Colorado

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				pg. 9
Specialist Visit	Yes	Covered	No				pg. 9
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				pg. 9
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				pg. 9
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				pg. 9
Hospice Services	Yes	Covered	No			If you elect to receive hospice care, you will not receive additional benefits for the terminal illness	pgs. 12-13, Life expectancy < 6 months (check language)
Routine Dental Services (Adult)	No	Not Covered	No				

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Infertility Treatment	Yes	Covered	No			a. Services to reverse voluntary, surgically induced infertility. b. All services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services, and donor semen and donor eggs used for such services, such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.	pg. 9, The following services are covered, including X-ray and laboratory procedures: (a) Services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No				pg. 13, For hospital inpatient care, private duty nursing covered when a Plan Physician determines it is Medically Necessary.
Routine Eye Exam (Adult)	No	Covered	No			a. Eyeglass lenses and frames. b. Contact lenses. c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary. d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures). e. Orthoptic (eye training) therapy.	pgs. 31-32, Wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses are covered. Also covered are professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition. Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Urgent Care Centers or Facilities	Yes	Covered	No				pg. 11
Home Health Care Services	Yes	Covered	Yes	28	Hour(s) per Week	a. Custodial care. b. Homemaker Services. c. Care that the health plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.	pg. 8, Skilled nursing care, home health aide services and medical social Services are covered: a. only on a Part-Time Care or Intermittent Care basis; and b. only within our Service Area; and c. only if you are confined to your home; and d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Health Plan may approve additional time up to 35 hours per week but less than eight (8) hours per day on a case-by-case basis.
Emergency Room Services	Yes	Covered	No				pg. 10-11
Emergency Transportation/Ambulance	Yes	Covered	No			Transportation by other than a licensed ambulance.	pg. 12
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			(A)Dental services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State Law, (B) Cosmetic surgery related to bariatric surgery.	pgs. 13-14

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Inpatient Physician and Surgical Services	Yes	Covered	No				pgs. 13-14
Bariatric Surgery	Yes	Covered	No				pg.12, You must meet health plan's criteria to be eligible for coverage.
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	100	Day(s) per Year	Custodial Care.	pg. 14, The following services are covered: a. Room and board. b. Nursing care. c. Medical social services. d. Medical and biological supplies. e. Blood, blood products and their administration.
Prenatal and Postnatal Care	Yes	Covered	No				pg. 9
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				pg. 13
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a course, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary: d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	pgs. 20-21, Covered are: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling. Visits for the purpose of monitoring drug therapy are covered. Psychological testing as part of diagnostic evaluation is covered. Mental Health Wellness Exam (pg. 21)

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Mental/Behavioral Health Inpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a course, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such services to be Medically Necessary: d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	pgs. 20-21, Covered are psychiatric hospitalization in a facility designated by Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Court-ordered treatment that exceeds the scope of this health benefit plan are not covered.	pgs. 19-20, Outpatient rehabilitative services for the treatment of alcohol and drug dependency are covered when referred by a Plan Physician.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Court-ordered treatment that exceeds the scope of this health benefit plan are not covered.	pgs. 19-20, Services are covered for the medical management of withdrawal symptoms. Medical services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.
Generic Drugs	Yes	Covered	No				pg. 22
Preferred Brand Drugs	Yes	Covered	No				pgs. 22-24
Non-Preferred Brand Drugs	Yes	Covered	No				pgs. 22-24
Specialty Drugs	Yes	Covered	No				pg. 23
Outpatient Rehabilitation Services	Yes	Covered	Yes	20	Visit(s) per Year		pgs. 27-28, Limit is per therapy.

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Habilitation Services	Yes	Covered	Yes	60	Visit(s) per Year		pg. 37, 20 visit limit per therapy.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year	a. Hypnotherapy. b. Behavior training. c. Sleep therapy. d. Weight loss programs. e. Services not related to the treatment of the musculoskeletal system. f. Vocational rehabilitation Services. g. Thermography. h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances. i. Transportation costs. This includes local ambulance charges. j. Prescription drugs, vitamins, minerals, food supplements or other similar products. k. Educational programs. l. Non-medical self-care or self-help training. m. All diagnostic testing related to these excluded Services. n. MRI and/or other types of diagnostic radiology. o. Physical or massage therapy that is not a part of the chiropractic treatment. p. Durable medical equipment (DME) and/or supplies for use in the home.	pg. 7, Coverage includes: a. Evaluation; b. Lab Services and X-rays required for chiropractic Services; and c. Treatment of musculoskeletal disorders.

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Durable Medical Equipment	Yes	Covered	No			Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs, Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan. i. Electronic monitors of bodily functions, except infant apnea monitors are covered. ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered. iii. Non-medical items such as sauna baths or elevators. iv. Exercise or hygiene equipment. v. Comfort, convenience, or luxury equipment or features. vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. vii. Replacement of lost equipment. viii. Repairs, adjustments or replacements necessitated by misuse. ix. More than one piece of DME serving essentially the same function, except for replacements. x. Spare equipment or alternate use equipment is not covered.	pgs. 25-26, When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Summary Chart" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge. You will be charged as a non-Member for items of DME, prosthetics and orthotics until your Deductible is met, if applicable.
Hearing Aids	Yes	Covered	No				pg. 36
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				pgs. 28-29

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Preventive Care/Screening/Immunization	Yes	Covered	No				pgs. 30-31
Routine Foot Care	No	Not Covered	No			Routine foot care Services that are not Medically Necessary.	
Acupuncture	Yes	Covered	Yes	6	Visit(s) per Benefit Period		pg. 6
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				pgs. 31-32
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per 2 Years	Exclusion: Replacement of lost or broken lenses or frames.	pgs. 35-36, 1 pair every 24 months includes the frames and lenses or contact lenses.
Dental Check-Up for Children	Yes	Covered	No				pgs. 34-35
Rehabilitative Speech Therapy	Yes	Covered	Yes	20	Visit(s) per Year	Speech Therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems. Long-term rehabilitation, not including treatment for autism spectrum disorders.	pgs. 27-28, Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature. Covered if, in the judgement of a Plan Physician, significant improvement is achievable within a two-month period.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	20	Visit(s) per Year	Long-term rehabilitation	pgs. 27-28, Covered if, in the judgement of a Plan Physician, significant improvement is achievable within a two month period. 60-day limit for inpatient rehab.

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Well Baby Visits and Care	Yes	Covered	No				pg. 31
Laboratory Outpatient and Professional Services	Yes	Covered	No				pgs. 28-29
X-rays and Diagnostic Imaging	Yes	Covered	No				pgs. 28-29

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Basic Dental Care - Child	Yes	Covered	No				pgs. 34-35, Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
Orthodontia - Child	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
Major Dental Care - Child	Yes	Covered	No				pgs. 34-35, Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are: 1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or 2. When the pregnancy is the result of an act of rape or incest; or 3. Treatment of complications following an abortion.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Transplant	Yes	Covered	No			a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded. b. Non-human and artificial organs and their implantation are excluded. c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria. d. Travel and lodging expenses are excluded, except that in some situations, when the health plan or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the Transplant Administrative Offices.	pgs. 14-15, Transplants are covered on a LIMITED basis as follows: a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants. b. Bone marrow transplants (autologous stem cell or allogeneic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome. c. If all medical criteria developed by the health plan are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.
Accidental Dental	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
Dialysis	Yes	Covered	No				pgs.7-8, Dialysis services related to acute renal failure and end-stage renal disease are covered if the following criteria are met: 1. The Services are provided inside our Service Area; and 2. You meet all medical criteria developed by the health plan and by the facility providing the dialysis; and 3. The facility is certified by Medicare and contracts with the health plan; and 4. A Plan Physician provides a written referral for care at the facility.
Allergy Testing	Yes	Covered	No				pg. 29
Chemotherapy	Yes	Covered	No				pgs. 22-23, "Orally administered anti-cancer medication" covered even under basic drug option.
Radiation	Yes	Covered	No				pgs. 22-23, Radioactive materials used for therapeutic purposes.
Diabetes Education	Yes	Covered	No				pg. 30

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Prosthetic Devices	Yes	Covered	No			Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.	pg. 26, The following prosthetic devices are covered, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan: i. Internally implanted devices for functional purposes, such as pacemakers and hip joints. ii. Prosthetic devices for Members who have had a mastectomy. The Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prostheses is no longer functional. Custom-made prosthesis will be provided when necessary. iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members when prescribed by a Plan Physician and obtained from sources designated by Health Plan. iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.
Infusion Therapy	Yes	Covered	No				pgs. 22-23

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				pg. 10, TMJ is listed in exclusions but the following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.
Nutritional Counseling	Yes	Covered	No				pg. 30
Reconstructive surgery	Yes	Covered	No			Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. this includes cosmetic surgery related to bariatric surgery.	pgs. 13-14, Reconstructive surgery is covered when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma (port wine stains) on the face and neck of Members 18 years and younger. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.
Gender Affirming Care	Yes	Covered	No				pg. 38, Medically-necessary gender-affirming care coverage

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

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

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	0
Antimigraine Agents	Ergot Alkaloids	3
Antimigraine Agents	Prophylactic	3
Antimigraine Agents	Serotonin (5-HT) Receptor Agonist	3
Antimyasthenic Agents	Parasympathomimetics	1
Antimycobacterials	Antimycobacterials, Other	1
Antimycobacterials	Antituberculars	4
Antineoplastics	Alkylating Agents	4
Antineoplastics	Antiandrogens	4
Antineoplastics	Antiangiogenic Agents	2
Antineoplastics	Antiestrogens/Modifiers	3
Antineoplastics	Antimetabolites	4
Antineoplastics	Antineoplastics, Other	5
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	1
Antineoplastics	Molecular Target Inhibitors	8
Antineoplastics	Monoclonal Antibody/Antibody-Drug Conjugates	0
Antineoplastics	Retinoids	1
Antineoplastics	Treatment Adjuncts	4
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	9
Antiparkinson Agents	Anticholinergics	2
Antiparkinson Agents	Antiparkinson Agents, Other	2
Antiparkinson Agents	Dopamine Agonists	3
Antiparkinson Agents	Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors	1
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	1
Antipsychotics	1st Generation/Typical	9
Antipsychotics	2nd Generation/Atypical	5
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	1
Antivirals	Antiherpetic Agents	2

CATEGORY	CLASS	SUBMISSION COUNT
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	2
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	6
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	13
Antivirals	Anti-HIV Agents, Other	2
Antivirals	Anti-HIV Agents, Protease Inhibitors (PI)	7
Antivirals	Anti-influenza Agents	3
Antivirals	Antiviral, Coronavirus Agents	0
Anxiolytics	Anxiolytics, Other	3
Anxiolytics	Benzodiazepines	7
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	4
Bipolar Agents	Bipolar Agents, Other	6
Bipolar Agents	Mood Stabilizers	4
Blood Glucose Regulators	Antidiabetic Agents	5
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	5
Blood Products and Modifiers	Anticoagulants	4
Blood Products and Modifiers	Blood Products and Modifiers, Other	3
Blood Products and Modifiers	Hemostasis Agents	2
Blood Products and Modifiers	Platelet Modifying Agents	5
Cardiovascular Agents	Alpha-adrenergic Agonists	3
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	1
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	2
Cardiovascular Agents	Antiarrhythmics	12
Cardiovascular Agents	Beta-adrenergic Blocking Agents	6
Cardiovascular Agents	Calcium Channel Blocking Agents, Dihydropyridines	3
Cardiovascular Agents	Calcium Channel Blocking Agents, Nondihydropyridines	2
Cardiovascular Agents	Cardiovascular Agents, Other	3
Cardiovascular Agents	Diuretics, Loop	3
Cardiovascular Agents	Diuretics, Potassium-sparing	2
Cardiovascular Agents	Diuretics, Thiazide	4
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2

CATEGORY	CLASS	SUBMISSION COUNT
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	4
Cardiovascular Agents	Dyslipidemics, Other	2
Cardiovascular Agents	Mineralocorticoid Receptor Antagonists	1
Cardiovascular Agents	Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)	0
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	2
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	2
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	3
Central Nervous System Agents	Central Nervous System, Other	6
Central Nervous System Agents	Fibromyalgia Agents	2
Central Nervous System Agents	Multiple Sclerosis Agents	3
Dental and Oral Agents	No USP Class	5
Dermatological Agents	Acne and Rosacea Agents	10
Dermatological Agents	Dermatitis and Pruritus Agents	13
Dermatological Agents	Dermatological Agents, Other	8
Dermatological Agents	Pediculicides/Scabicides	1
Dermatological Agents	Topical Anti-infectives	6
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral Replacement	2
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral/Metal Modifiers	2
Electrolytes/ Minerals/ Metals/ Vitamins	Phosphate Binders	2
Electrolytes/ Minerals/ Metals/ Vitamins	Potassium Binders	1
Electrolytes/ Minerals/ Metals/ Vitamins	Vitamins	1
Gastrointestinal Agents	Anti-Constipation Agents	2
Gastrointestinal Agents	Anti-Diarrheal Agents	1
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	2
Gastrointestinal Agents	Gastrointestinal Agents, Other	3
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	2
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	2
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	No USP Class	1
Genitourinary Agents	Antispasmodics, Urinary	1
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	4
Genitourinary Agents	Genitourinary Agents, Other	4

CATEGORY	CLASS	SUBMISSION COUNT
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	8
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)	No USP Class	2
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	0
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	7
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	8
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	No USP Class	2
Hormonal Agents, Suppressant (Adrenal or Pituitary)	No USP Class	5
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2
Immunological Agents	Angioedema Agents	1
Immunological Agents	Immunoglobulins	0
Immunological Agents	Immunological Agents, Other	5
Immunological Agents	Immunostimulants	1
Immunological Agents	Immunosuppressants	10
Inflammatory Bowel Disease Agents	Aminosalicylates	3
Inflammatory Bowel Disease Agents	Glucocorticoids	6
Metabolic Bone Disease Agents	No USP Class	6
Ophthalmic Agents	Ophthalmic Agents, Other	3
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	1
Ophthalmic Agents	Ophthalmic Anti-Infectives	9
Ophthalmic Agents	Ophthalmic Anti-inflammatories	6
Ophthalmic Agents	Ophthalmic Beta-Adrenergic Blocking Agents	3
Ophthalmic Agents	Ophthalmic Intraocular Pressure Lowering Agents, Other	6
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	1
Otic Agents	No USP Class	5
Respiratory Tract/ Pulmonary Agents	Antihistamines	5
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	6
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	1

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	3
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	7
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	1
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	5
Respiratory Tract/ Pulmonary Agents	Pulmonary Fibrosis Agents	0
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	3
Skeletal Muscle Relaxants	No USP Class	5
Sleep Disorder Agents	Sleep Promoting Agents	4
Sleep Disorder Agents	Wakefulness Promoting Agents	0