# ARIZONA EHB BENCHMARK PLAN

## SUMMARY INFORMATION

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|---|---|
| **Plan Type** | Plan from largest state employee plan, Exclusive Provider Organization |
| **Issuer Name** | State of Arizona Self-Insured Plan, administered by United Healthcare |
| **Product Name** | State Employee EPO Plan |
| **Plan Name** | Arizona Benefit Options EPO Plan, administered by United Healthcare |
| **Supplemented Categories** (Supplementary Plan Type) | • Pediatric Oral (FEDVIP)<br>• Pediatric Vision (FEDVIP) |
| **Habilitative Services Included Benchmark** (Yes/No) | No |
| **Habilitative Services Defined by State** (Yes/No) | No |

## BENEFITS AND LIMITS

| Benefit Information | | | General Information | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| A<br>Benefit | B<br>EHB | C<br>Benefit Description (may be the same as the Benefit name) | D<br>Is the Benefit Covered? | E<br>Quantitative Limit on Service? | F<br>Limit Quantity | G<br>Limit Units | H<br>Minimum Stay | I<br>Exclusions | J<br>Explanations | K<br>Additional Limitations or Restrictions? |
| **Primary Care Visit to Treat an Injury or Illness** | Yes | Primary Care Visit to Treat an Injury or Illness | Covered | No | | | | | | No |
| **Specialist Visit** | Yes | Specialist Visit | Covered | No | | | | | | No |
| **Other Practitioner Office Visit (Nurse, Physician Assistant)** | Yes | Other Practitioner Office Visit (Nurse, Physician Assistant) | Covered | No | | | | Excludes non contracted practitioners/providers | | No |
| **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | Yes | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Covered | No | | | | | | No |
| **Outpatient Surgery Physician/Surgical Services** | Yes | Outpatient Surgery Physician/Surgical Services | Covered | No | | | | | | No |
| **Hospice Services** | Yes | Hospice Services | Covered | No | | | | Excludes everything except when diagnosed by a participating physician as having a terminal illness with a prognosis of six or fewer months to live. | | No |
| **Non-Emergency Care When Traveling Outside the U.S.** | | | Not Covered | | | | | | | |
| **Routine Dental Services (Adult)** | | | Not Covered | | | | | | | |
| **Infertility Treatment** | | | Not Covered | | | | | | | |
| **Long-Term/Custodial Nursing Home Care** | | | Not Covered | | | | | | | |
| **Private-Duty Nursing** | | | Not Covered | | | | | | | |
| **Routine Eye Exam (Adult)** | | Routine Eye Exam (Adult) | Covered | Yes | 1 | Visit per year | | Excludes refractive services | | No |
| **Urgent Care Centers or Facilities** | Yes | Urgent Care Centers or Facilities | Covered | No | | | | | | No |
| **Home Health Care Services** | Yes | Home Health Care Services | Covered | Yes | 42 | Visits per year | | | | No |
| **Emergency Room Services** | Yes | Emergency Room Services | Covered | No | | | | | | No |
| **Emergency Transportation/ Ambulance** | Yes | Emergency Transportation/Ambulance | Covered | No | | | | | | No |

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| A Benefit | B EHB | C Benefit Description (may be the same as the Benefit name) | D Is the Benefit Covered? | E Quantitative Limit on Service? | F Limit Quantity | G Limit Units | H Minimum Stay | I Exclusions | J Explanations | K Additional Limitations or Restrictions? |
| **Inpatient Hospital Services (e.g., Hospital Stay)** | Yes | Inpatient Hospital Services (e.g., Hospital Stay) | Covered | No | | | | | | No |
| **Inpatient Physician and Surgical Services** | Yes | Inpatient Physician and Surgical Services | Covered | No | | | | | | No |
| **Bariatric Surgery** | Yes | Bariatric Surgery | Covered | No | | | | Excluded (open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding). | | No |
| **Cosmetic Surgery** | | | Not Covered | | | | | | | |
| **Skilled Nursing Facility** | Yes | Skilled Nursing Facility | Covered | Yes | 90 | Days per year | | | Long term acute care/sub-acute care. | No |
| **Prenatal and Postnatal Care** | Yes | Prenatal and Postnatal Care | Covered | No | | | | | | No |
| **Delivery and All Inpatient Services for Maternity Care** | Yes | Delivery and All Inpatient Services for Maternity Care | Covered | No | | | | | Deliveries in birthing centers. | No |
| **Mental/Behavioral Health Outpatient Services** | Yes | Mental/Behavioral Health Outpatient Services | Covered | No | | | | | | No |
| **Mental/Behavioral Health Inpatient Services** | Yes | Mental/Behavioral Health Inpatient Services | Covered | No | | | | | | No |
| **Substance Abuse Disorder Outpatient Services** | Yes | Substance Abuse Disorder Outpatient Services | Covered | No | | | | | | No |
| **Substance Abuse Disorder Inpatient Services** | Yes | Substance Abuse Disorder Inpatient Services | Covered | Yes | 90 | Days per year, 2 treatments per year | | | | Yes |
| **Generic Drugs** | Yes | Generic Drugs | Covered | No | | | | Excluded if under the age of 40 and does meeting the following no family history, not of African American race, previous borderline PSA level | | No |
| **Preferred Brand Drugs** | Yes | Preferred Brand Drugs | Covered | No | | | | | | No |
| **Non-Preferred Brand Drugs** | Yes | Non-Preferred Brand Drugs | Covered | No | | | | | | No |
| **Specialty Drugs** | Yes | Specialty Drugs | Covered | No | | | | | | No |
| **Outpatient Rehabilitation Services** | Yes | Outpatient Rehabilitation Services | Covered | Yes | 60 | Visits per year | | | | No |
| **Habilitation Services** | | | Not Covered | | | | | | | |
| **Chiropractic Care** | Yes | Chiropractic Care | Covered | Yes | 20 | Visits per year | | Excludes manipulation under anesthesia | | No |

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| **Durable Medical Equipment** | Yes | Durable Medical Equipment | Covered | No | | | | Excludes DME due to misuse, damage or replacement when lost | | No |
| **Hearing Aids** | Yes | Hearing Aids | Covered | Yes | 1 | Hearing aid per ear per year | | | | No |
| **Diagnostic Test (X-Ray and Lab Work)** | Yes | Diagnostic Test (X-Ray and Lab Work) | Covered | No | | | | | | No |
| **Imaging (CT/PET Scans, MRIs)** | Yes | Imaging (CT/PET Scans, MRIs) | Covered | No | | | | | | No |
| **Preventive Care/ Screening/ Immunization** | Yes | Preventive Care/Screening/ Immunization | Covered | Yes | 1 | Physical per year, one screening per year | | | | Yes |
| **Routine Foot Care** | Yes | Routine Foot Care | Covered | No | | | | Excludes services determined not to be medically necessary. | | No |
| **Acupuncture** | | | Not Covered | | | | | | | |
| **Weight Loss Programs** | | | Not Covered | | | | | | | |
| **Routine Eye Exam for Children** | Yes | Routine eye exam | Covered | Yes | 1 | Visit per year | | | | No |
| **Eye Glasses for Children** | Yes | Eye Glasses for Children | Covered | Yes | 1 | Pair of glasses (lenses and frames) per year | | | | No |
| **Dental Check-Up for Children** | Yes | Dental Exams | Covered | Yes | 1 | Visit every 6 months | | | Covered at 100% if the services were provided In Network and at 90% if they were Out of Network subject to the annual $10,000 maximum | No |
| **Rehabilitative Speech Therapy** | Yes | Rehabilitative Speech Therapy | Covered | No | | | | | | No |
| **Rehabilitative Occupational and Rehabilitative Physical Therapy** | Yes | Rehabilitative Occupational and Rehabilitative Physical Therapy | Covered | No | | | | | | No |
| **Well Baby Visits and Care** | Yes | Well Baby Visits and Care | Covered | No | | | | Excludes non contracted practitioners/providers | | No |
| **Laboratory Outpatient and Professional Services** | Yes | Laboratory Outpatient and Professional Services | Covered | No | | | | | | No |
| **X-rays and Diagnostic Imaging** | Yes | X-rays and Diagnostic Imaging | Covered | No | | | | | | No |
| **Basic Dental Care - Child** | | | Not Covered | | | | | Excludes everything except when diagnosed by a participating physician as having a terminal illness with a prognosis of six or fewer months to live. | | |
| **Orthodontia - Child** | | | Not Covered | | | | | | | |

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| **Major Dental Care - Child** | | | Not Covered | | | | | | | |
| **Basic Dental Care - Adult** | | | Not Covered | | | | | | | |
| **Orthodontia - Adult** | | | Not Covered | | | | | | | |
| **Major Dental Care – Adult** | | | Not Covered | | | | | | | |
| **Abortion for Which Public Funding is Prohibited** | | | Not Covered | | | | | Excludes refractive services | | |
| **Transplant** | Yes | Transplant | Covered | No | | | | Excludes coverage for member donor if recipient is not a member. Excludes travel and lodging over $10,000 for recipient. Excludes travel and lodging for donor. | | No |
| **Accidental Dental** | Yes | Accidental Dental | Covered | No | | | | Excludes services not started within 6 months of injury | Dental services after accidental injury to sound natural teeth | No |
| **Dialysis** | Yes | Dialysis | Covered | No | | | | | | No |
| **Allergy Testing** | Yes | Allergy Testing | Covered | No | | | | | | No |
| **Chemotherapy** | Yes | Chemotherapy | Covered | No | | | | | | No |
| **Radiation** | Yes | Radiation | Covered | No | | | | | | No |
| **Diabetes Education** | Yes | Diabetes Education | Covered | No | | | | Excluded (open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding). | | No |
| **Prosthetic Devices** | Yes | Prosthetic Devices | Covered | No | | | | Excludes biomechanical devices. Excludes replacement of external prosthetic appliances due to loss or theft. Excludes wigs hairpieces. | | No |
| **Infusion Therapy** | Yes | Infusion Therapy | Covered | No | | | | | | No |
| **Treatment for Temporomandibular Joint Disorders** | Yes | Treatment for Temporomandibular Joint Disorders | Covered | No | | | | | TMJ as a result of accident, trauma, a congenital defect, a developmental defect or a pathology. | No |
| **Nutritional Counseling** | Yes | Nutritional Counseling | Covered | No | | | | | | No |
| **Reconstructive Surgery** | Yes | Reconstructive Surgery | Covered | No | | | | | Medically necessary reconstructive surgery. | No |
| **Clinical Trials** | Yes | Clinical Trials | Covered | No | | | | | | No |
| **Diabetes Care Management** | Yes | Diabetes Care Management | Covered | No | | | | | | No |
| **Inherited Metabolic Disorder – PKU** | Yes | Inherited Metabolic Disorder – PKU | Covered | No | | | | | | No |
| **Off Label Prescription Drugs** | Yes | Off Label Prescription Drugs | Covered | No | | | | | | No |
| **Prescription Drugs Other** | Yes | Prescription Drugs Other | Covered | No | | | | | | No |

## OTHER BENEFITS

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| **Cosmetic Surgery** | Yes | Correction of congenital defect | Covered | No | | | | | | No |
| **Reconstructive Surgery** | Yes | Medically necessary reconstructive surgery | Covered | No | | | | | | No |
| **Preventive Care/Screening/Immunization** | Yes | Childhood immunizations | Covered | No | | | | | | No |
| **Well Baby Visits and Care** | Yes | Well baby/child up to 47 months | Covered | No | | | | | | No |
| **Specialist Visit** | Yes | Hearing Exam | Covered | Yes | 1 | Visit per year | | | | No |
| **Preventive Care/Screening/Immunization** | Yes | Family Planning Services | Covered | No | | | | | | No |
| **Preventive Care/Screening/Immunization** | Yes | Family planning fertility evaluation and diagnosis | Covered | No | | | | | | No |
| **Inpatient detoxification, including medical detoxification** | Yes | Inpatient detoxification, including medical detoxification | Covered | Yes | 2 | Treatments per year | | | | No |
| **Second opinion** | Yes | Second opinion | Covered | No | | | | | | No |
| **Outpatient detoxification, including medical detoxification** | Yes | Outpatient detoxification, including medical detoxification | Covered | No | | | | | | No |
| **ABA therapy for autism** | Yes | ABA therapy for autism | Covered | No | | | | Excludes Sensory Integration, LOVAAS Therapy and Music Therapy | | No |
| **Orthognathic treatment/surgery and certain dental /orthodontic services** | Yes | Orthognathic treatment/surgery and certain dental /orthodontic services | Covered | No | | | | | | No |
| **Rx and OTC smoking cessation aids** | Yes | Rx and OTC smoking cessation aids | Covered | No | | | | | | No |
| **Psychiatric assessment & stabilization in inpatient setting** | Yes | Psychiatric assessment & stabilization in inpatient setting | Covered | No | | | | | | No |
| **Psychiatric assessment & stabilization in ER** | Yes | Psychiatric assessment & stabilization in ER | Covered | No | | | | | | No |
| **Partial Hospitalization/Day treatment** | Yes | Partial Hospitalization/Day treatment | Covered | No | | | | | | No |

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| **Psychiatric Services** | Yes | Psychiatric Services | Covered | No | | | | | | No |
| **Psych and neuropsych testing** | Yes | Psych and neuropsych testing | Covered | No | | | | | | No |
| **ECT** | Yes | ECT | Covered | No | | | | | | No |
| **Behavioral health treatment** | Yes | Behavioral health treatment | Covered | No | | | | | | No |
| **Behavioral health counseling/therapy services** | Yes | Behavioral health counseling/therapy services | Covered | No | | | | | | No |
| **Pharmacotherapy (medication management)** | Yes | Pharmacotherapy (medication management) | Covered | No | | | | | | No |
| **Diabetic Supplies** | Yes | Diabetic Supplies | Covered | No | | | | | | No |
| **Prostate Screening** | Yes | Prostate Screening | Covered | No | | | | Excluded if under the age of 40 and does meeting the following no family history, not of African American race, previous borderline PSA level | | No |
| **Mammography Screening** | Yes | Mammography Screening | Covered | No | | | | Excluded if under the age of 35 unless there is a family medical history | | No |
| **Allergy Testing /Antigen Administration** | Yes | Allergy Testing /Antigen Administration | Covered | No | | | | | | No |
| **Nutritional Evaluation** | Yes | Nutritional Evaluation | Covered | No | | | | Excludes intra oral wiring, dietary formulae, hypnosis, cosmetics, health and beauty aids | | No |
| **Autism Spectrum Disorder** | Yes | Autism Spectrum Disorder | Covered | No | | | | | | No |
| **Medical Foods** | Yes | Medical Foods | Covered | No | | | | Excludes standard infant formula, food thickeners, baby food, regular grocery products, nutrition for diagnosis of anorexia, and mood disorders | | No |
| **Breast Reconstructive Surgery** | Yes | Breast Reconstructive Surgery | Covered | No | | | | | | No |
| **Cancer Clinical Trials** | Yes | Cancer Clinical Trials | Covered | No | | | | Excludes any treatment if required criteria is not met | | No |
| **Foot Orthotics** | Yes | Foot Orthotics | Covered | No | | | | | | No |
| **Insulin Pump** | Yes | Insulin Pump | Covered | No | | | | | | No |
| **Radiation Therapy** | Yes | Radiation Therapy | Covered | No | | | | | | No |
| **Ostomy Supplies** | Yes | Ostomy Supplies | Covered | No | | | | | | No |
| **Internal Prosthetic/Medical Appliances** | Yes | Internal Prosthetic/Medical Appliances | Covered | No | | | | | | No |

## Prescription Drug EHB-Benchmark Plan Benefits by Category and Class

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANALGESICS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 20 |
| ANALGESICS | OPIOID ANALGESICS, LONG-ACTING | 10 |
| ANALGESICS | OPIOID ANALGESICS, SHORT-ACTING | 11 |
| ANESTHETICS | LOCAL ANESTHETICS | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | ALCOHOL DETERRENTS/ANTI-CRAVING | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | OPIOID ANTAGONISTS | 3 |
| ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS | SMOKING CESSATION AGENTS | 3 |
| ANTI-INFLAMMATORY AGENTS | GLUCOCORTICOIDS | 1 |
| ANTI-INFLAMMATORY AGENTS | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS | 20 |
| ANTIBACTERIALS | AMINOGLYCOSIDES | 9 |
| ANTIBACTERIALS | ANTIBACTERIALS, OTHER | 20 |
| ANTIBACTERIALS | BETA-LACTAM, CEPHALOSPORINS | 18 |
| ANTIBACTERIALS | BETA-LACTAM, OTHER | 5 |
| ANTIBACTERIALS | BETA-LACTAM, PENICILLINS | 11 |
| ANTIBACTERIALS | MACROLIDES | 5 |
| ANTIBACTERIALS | QUINOLONES | 8 |
| ANTIBACTERIALS | SULFONAMIDES | 4 |
| ANTIBACTERIALS | TETRACYCLINES | 4 |
| ANTICONVULSANTS | ANTICONVULSANTS, OTHER | 2 |
| ANTICONVULSANTS | CALCIUM CHANNEL MODIFYING AGENTS | 4 |
| 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 | SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS | 9 |
| ANTIDEPRESSANTS | TRICYCLICS | 9 |
| ANTIEMETICS | ANTIEMETICS, OTHER | 10 |
| ANTIEMETICS | EMETOGENIC THERAPY ADJUNCTS | 8 |
| ANTIFUNGALS | NO USP CLASS | 26 |
| ANTIGOUT AGENTS | NO USP CLASS | 5 |
| ANTIMIGRAINE AGENTS | ERGOT ALKALOIDS | 2 |
| ANTIMIGRAINE AGENTS | PROPHYLACTIC | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANTIMIGRAINE AGENTS | SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS | 7 |
| ANTIMYASTHENIC AGENTS | PARASYMPATHOMIMETICS | 3 |
| ANTIMYCOBACTERIALS | ANTIMYCOBACTERIALS, OTHER | 2 |
| ANTIMYCOBACTERIALS | ANTITUBERCULARS | 10 |
| ANTINEOPLASTICS | ALKYLATING AGENTS | 8 |
| ANTINEOPLASTICS | ANTIANGIOGENIC AGENTS | 2 |
| ANTINEOPLASTICS | ANTIESTROGENS/MODIFIERS | 3 |
| ANTINEOPLASTICS | ANTIMETABOLITES | 3 |
| ANTINEOPLASTICS | ANTINEOPLASTICS, OTHER | 6 |
| ANTINEOPLASTICS | AROMATASE INHIBITORS, 3RD GENERATION | 3 |
| ANTINEOPLASTICS | ENZYME INHIBITORS | 3 |
| ANTINEOPLASTICS | MOLECULAR TARGET INHIBITORS | 12 |
| ANTINEOPLASTICS | MONOCLONAL ANTIBODIES | 3 |
| ANTINEOPLASTICS | RETINOIDS | 3 |
| ANTIPARASITICS | ANTHELMINTICS | 3 |
| ANTIPARASITICS | ANTIPROTOZOALS | 12 |
| ANTIPARASITICS | PEDICULICIDES/SCABICIDES | 6 |
| ANTIPARKINSON AGENTS | ANTICHOLINERGICS | 3 |
| 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 | 5 |
| ANTIVIRALS | ANTI-CYTOMEGALOVIRUS (CMV) AGENTS | 4 |
| ANTIVIRALS | ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS | 5 |
| ANTIVIRALS | ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS | 11 |
| ANTIVIRALS | ANTI-HIV AGENTS, OTHER | 3 |
| ANTIVIRALS | ANTI-HIV AGENTS, PROTEASE INHIBITORS | 9 |
| ANTIVIRALS | ANTI-INFLUENZA AGENTS | 4 |
| ANTIVIRALS | ANTIHEPATITIS AGENTS | 12 |
| ANTIVIRALS | ANTIHERPETIC AGENTS | 6 |
| ANXIOLYTICS | ANXIOLYTICS, OTHER | 4 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| ANXIOLYTICS | SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS) | 5 |
| BIPOLAR AGENTS | BIPOLAR AGENTS, OTHER | 6 |
| BIPOLAR AGENTS | MOOD STABILIZERS | 5 |
| BLOOD GLUCOSE REGULATORS | ANTIDIABETIC AGENTS | 21 |
| BLOOD GLUCOSE REGULATORS | GLYCEMIC AGENTS | 2 |
| BLOOD GLUCOSE REGULATORS | INSULINS | 10 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | ANTICOAGULANTS | 7 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | BLOOD FORMATION MODIFIERS | 8 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | COAGULANTS | 1 |
| BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS | PLATELET MODIFYING AGENTS | 8 |
| CARDIOVASCULAR AGENTS | ALPHA-ADRENERGIC AGONISTS | 5 |
| 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 | 4 |
| 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 | 6 |
| 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 | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | CENTRAL NERVOUS SYSTEM AGENTS, OTHER | 4 |
| CENTRAL NERVOUS SYSTEM AGENTS | FIBROMYALGIA AGENTS | 3 |
| CENTRAL NERVOUS SYSTEM AGENTS | MULTIPLE SCLEROSIS AGENTS | 7 |
| DENTAL AND ORAL AGENTS | NO USP CLASS | 7 |
| DERMATOLOGICAL AGENTS | NO USP CLASS | 34 |
| ENZYME REPLACEMENT/MODIFIERS | NO USP CLASS | 17 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| GASTROINTESTINAL AGENTS | ANTISPASMODICS, GASTROINTESTINAL | 6 |
| GASTROINTESTINAL AGENTS | GASTROINTESTINAL AGENTS, OTHER | 6 |
| GASTROINTESTINAL AGENTS | HISTAMINE2 (H2) RECEPTOR ANTAGONISTS | 4 |
| GASTROINTESTINAL AGENTS | IRRITABLE BOWEL SYNDROME AGENTS | 2 |
| GASTROINTESTINAL AGENTS | LAXATIVES | 3 |
| GASTROINTESTINAL AGENTS | PROTECTANTS | 2 |
| GASTROINTESTINAL AGENTS | PROTON PUMP INHIBITORS | 6 |
| GENITOURINARY AGENTS | ANTISPASMODICS, URINARY | 7 |
| GENITOURINARY AGENTS | BENIGN PROSTATIC HYPERTROPHY AGENTS | 9 |
| GENITOURINARY AGENTS | GENITOURINARY AGENTS, OTHER | 3 |
| GENITOURINARY AGENTS | PHOSPHATE BINDERS | 3 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL) | GLUCOCORTICOIDS/MINERALOCORTICOIDS | 23 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY) | NO USP CLASS | 4 |
| 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 | 4 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | ESTROGENS | 6 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | PROGESTINS | 5 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) | SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS | 1 |
| HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) | NO USP CLASS | 3 |
| HORMONAL AGENTS, SUPPRESSANT (ADRENAL) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) | NO USP CLASS | 1 |
| HORMONAL AGENTS, SUPPRESSANT (PITUITARY) | NO USP CLASS | 9 |
| HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) | ANTIANDROGENS | 5 |
| HORMONAL AGENTS, SUPPRESSANT (THYROID) | ANTITHYROID AGENTS | 2 |
| IMMUNOLOGICAL AGENTS | IMMUNE SUPPRESSANTS | 23 |
| IMMUNOLOGICAL AGENTS | IMMUNIZING AGENTS, PASSIVE | 4 |
| IMMUNOLOGICAL AGENTS | IMMUNOMODULATORS | 10 |
| INFLAMMATORY BOWEL DISEASE AGENTS | AMINOSALICYLATES | 3 |

| CATEGORY | CLASS | SUBMISSION COUNT |
|---|---|---|
| INFLAMMATORY BOWEL DISEASE AGENTS | GLUCOCORTICOIDS | 5 |
| INFLAMMATORY BOWEL DISEASE AGENTS | SULFONAMIDES | 1 |
| METABOLIC BONE DISEASE AGENTS | NO USP CLASS | 15 |
| OPHTHALMIC AGENTS | OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS | 3 |
| OPHTHALMIC AGENTS | OPHTHALMIC AGENTS, OTHER | 4 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-ALLERGY AGENTS | 9 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTI-INFLAMMATORIES | 11 |
| OPHTHALMIC AGENTS | OPHTHALMIC ANTIGLAUCOMA AGENTS | 14 |
| OTIC AGENTS | NO USP CLASS | 6 |
| RESPIRATORY TRACT AGENTS | ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS | 6 |
| RESPIRATORY TRACT AGENTS | ANTIHISTAMINES | 11 |
| RESPIRATORY TRACT AGENTS | ANTILEUKOTRIENES | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, ANTICHOLINERGIC | 2 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES) | 3 |
| RESPIRATORY TRACT AGENTS | BRONCHODILATORS, SYMPATHOMIMETIC | 10 |
| RESPIRATORY TRACT AGENTS | MAST CELL STABILIZERS | 1 |
| RESPIRATORY TRACT AGENTS | PULMONARY ANTIHYPERTENSIVES | 6 |
| RESPIRATORY TRACT AGENTS | RESPIRATORY TRACT AGENTS, OTHER | 5 |
| SKELETAL MUSCLE RELAXANTS | NO USP CLASS | 6 |
| SLEEP DISORDER AGENTS | GABA RECEPTOR MODULATORS | 3 |
| SLEEP DISORDER AGENTS | SLEEP DISORDERS, OTHER | 5 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL MODIFIERS | 7 |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | ELECTROLYTE/MINERAL REPLACEMENT | 10 |