Updates to your prescription benefits
Effective Jan. 1, 2020

Within the Prescription Drug List (PDL), prescription drugs are grouped by tier. The tier indicates the amount you pay when you fill a prescription. Please reference the chart to the right as you review the following updates to the PDL.

Prescription drugs with new benefit coverage
The following drugs were previously not covered under most benefit plans and are now eligible for coverage.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>Tier Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>Yupelri</td>
<td>3</td>
</tr>
<tr>
<td>Eye Inflammation</td>
<td>Lotemax SM</td>
<td>3</td>
</tr>
<tr>
<td>Infections</td>
<td>Nuzyra</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Xepi</td>
<td>3</td>
</tr>
<tr>
<td>Malaria</td>
<td>Arakoda</td>
<td>3</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>Inbrija</td>
<td>3</td>
</tr>
</tbody>
</table>

Prescription drugs moving to a lower tier
The following drugs are moving to a lower tier, making them a lower cost.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>Tier Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hereditary Polyneuropathy</td>
<td>Tegsedi</td>
<td>3 2</td>
</tr>
<tr>
<td>Infertility¹</td>
<td>Follistim AQ</td>
<td>3 2</td>
</tr>
<tr>
<td>Inflammatory Conditions</td>
<td>Olumiant, Rinvoq</td>
<td>3 2</td>
</tr>
<tr>
<td>Severe Allergic Reactions</td>
<td>Symjepi</td>
<td>3 2</td>
</tr>
</tbody>
</table>
### Prescription drugs moving to a higher tier

The following medications are moving to a higher tier. Medications may move from a lower tier to a higher tier when they are more costly and have available lower-cost options.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>Tier Placement</th>
<th>Lower-Cost Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Inflammation</td>
<td>FML</td>
<td>2 + 3</td>
<td>prednisolone (generic Pred Forte)</td>
</tr>
<tr>
<td></td>
<td>FML Forte</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pred Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>Cetrotide</td>
<td>2 + 3</td>
<td>ganirelix acetate (Merck/Organon)</td>
</tr>
<tr>
<td></td>
<td>Gonal-F</td>
<td></td>
<td>Follistim AQ</td>
</tr>
<tr>
<td></td>
<td>Gonal-F RFF</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prescription drugs excluded from benefit coverage

We evaluate prescription drugs based on their total value, including how a drug works and how much it costs. When several drugs work in the same way, we may choose to exclude the higher-cost option. Effective Jan. 1, 2020, the drugs listed below may be excluded from coverage or you may need to get a prior authorization. Sign into your online account to check which drugs your plan covers and if there are any actions you need to take.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>Alternative Treatment Option(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Altreno</td>
<td>OTC Differin gel, tretinoin cream (generic Retin-A)</td>
</tr>
<tr>
<td></td>
<td>Minolira</td>
<td>minocycline immediate-release capsules (generic Minocin)</td>
</tr>
<tr>
<td></td>
<td>Seysara</td>
<td>doxycycline hyclate (generic Vibramycin), doxycycline monohydrate 50 mg and 100 mg (generic Monodox), minocycline immediate-release capsules (generic Minocin)</td>
</tr>
<tr>
<td>ADHD</td>
<td>Dexedrine (Brand Only)</td>
<td>dextroamphetamine extended-release (generic Dexedrine)</td>
</tr>
<tr>
<td>Allergies</td>
<td>dexchlorpheniramine maleate (generic Ryclora)</td>
<td>OTC chlorpheniramine (generic Chlor-Trimeton)</td>
</tr>
<tr>
<td></td>
<td>Ryclora</td>
<td>Retacrit</td>
</tr>
<tr>
<td>Anemia</td>
<td>Epogen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procrit</td>
<td></td>
</tr>
<tr>
<td>Angina</td>
<td>Ranexa (Brand Only)</td>
<td>ranolazine (generic Ranexa)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Albuterol HFA [Ventolin HFA authorized generic (Prasco)] Inhaler</td>
<td>Ventolin HFA</td>
</tr>
<tr>
<td></td>
<td>Pulmicort inhalation suspension (Brand Only)</td>
<td>budesonide inhalation suspension (generic Pulmicort)</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Lovenox (Brand Only)</td>
<td>enoxaparin (generic Lovenox)</td>
</tr>
<tr>
<td>Constipation</td>
<td>lactulose (generic Kristalose)</td>
<td>lactulose oral solution</td>
</tr>
<tr>
<td>COPD</td>
<td>Lonhala Magnair</td>
<td>Incruse Ellipta, Spiriva Handihaler/Resipmat, Yupelri</td>
</tr>
<tr>
<td></td>
<td>Tudorza Pressair</td>
<td>Incruse Ellipta, Spiriva Handihaler/Resipmat</td>
</tr>
<tr>
<td>Cough and Cold</td>
<td>Hydrocodone/Guaifenesin 2.5 mg/200 mg/5 mL Solution</td>
<td>guaifenesin/codeine solution (Cheratussin AC)</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Xalatan (Brand Only)</td>
<td>latanoprost (generic Xalatan)</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Norvasc (Brand Only)</td>
<td>amlodipine (generic Norvasc)</td>
</tr>
<tr>
<td>Therapeutic Use</td>
<td>Medication Name</td>
<td>Alternative Treatment Option(s)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Therapeutic Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hormone Replacement</strong></td>
<td>Minivelle (Brand Only)</td>
<td>estradiol patch (generic Minivelle), Vivelle-Dot</td>
</tr>
<tr>
<td></td>
<td>Prometrium (Brand Only)</td>
<td>progesterone (generic Prometrium)</td>
</tr>
<tr>
<td><strong>Infections</strong></td>
<td>Tolsura</td>
<td>itraconazole capsule (generic Sporanox)</td>
</tr>
<tr>
<td><strong>Inflammatory Conditions</strong></td>
<td>Ilumya</td>
<td>Cimzia, Cosentyx, Humira, Skyrizi, Stelara, Tremfya</td>
</tr>
<tr>
<td></td>
<td>Plaquenil (Brand Only)</td>
<td>hydroxychloroquine (generic Plaquenil)</td>
</tr>
<tr>
<td></td>
<td>Siliq</td>
<td>Cimzia, Cosentyx, Humira, Skyrizi, Stelara, Tremfya</td>
</tr>
<tr>
<td></td>
<td>Taltz</td>
<td></td>
</tr>
<tr>
<td><strong>Iron Overload</strong></td>
<td>Exjade (Brand Only)</td>
<td>desferasirox (generic Exjade)</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Abilify MyCite</td>
<td>aripiprazole (generic Abilify)</td>
</tr>
<tr>
<td><strong>Neuropathic Pain</strong></td>
<td>ZTLido</td>
<td>lidocaine patch (generic Lidoderm)</td>
</tr>
<tr>
<td><strong>Neutropenia</strong></td>
<td>Fulphila</td>
<td>Neulasta</td>
</tr>
<tr>
<td></td>
<td>Nivestym</td>
<td>Zarxio</td>
</tr>
<tr>
<td></td>
<td>Udenyca</td>
<td>Neulasta</td>
</tr>
<tr>
<td><strong>Parkinson's Disease</strong></td>
<td>Osmolex ER</td>
<td>amantadine immediate-release</td>
</tr>
<tr>
<td><strong>Pulmonary Hypertension</strong></td>
<td>Letairis (Brand Only)</td>
<td>ambrisentan (generic Letairis)</td>
</tr>
<tr>
<td><strong>Rosacea</strong></td>
<td>Oracea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Klonopin (Brand Only)</td>
<td>clonazepam (generic Klonopin)</td>
</tr>
<tr>
<td></td>
<td>Sympazan</td>
<td>clobazam (generic Onfi), clonazepam (generic Klonopin), lamotrigine (generic Lamictal), topiramate (generic Topamax)</td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td>Bryhali</td>
<td>fluocinonide 0.05% gel/solution (generic Lidex), desoximetasone 0.05% gel (generic Topicort)</td>
</tr>
<tr>
<td></td>
<td>Cordran 0.025% cream</td>
<td>hydrocortisone valerate 0.2% cream (generic Westcort cream), prednicarbate 0.1% cream (generic Dermatop cream), fluticasone propionate cream 0.05% (generic Cutivate cream)</td>
</tr>
<tr>
<td><strong>Skin Conditions</strong></td>
<td>diflorasone diacetate 0.05% ointment (generic Psorcon)</td>
<td>clobetasol 0.05% ointment (generic Temovate), halobetasol 0.05% ointment (generic Ultravate)</td>
</tr>
<tr>
<td></td>
<td>Halobetasol 0.05% (Lexette) foam</td>
<td>betamethasone 0.05% augmented gel (generic Diprolene), clobetasol propionate 0.05% gel/solution (generic Temovate)</td>
</tr>
<tr>
<td></td>
<td>Lexette</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ultravate 0.05% lotion</td>
<td></td>
</tr>
<tr>
<td><strong>Testosterone Replacement</strong></td>
<td>Xyosted</td>
<td>testosterone injection, Testim</td>
</tr>
<tr>
<td><strong>Thyroid Replacement</strong></td>
<td>Cytomel (Brand Only)</td>
<td>liothyronine (generic Cytomel)</td>
</tr>
</tbody>
</table>

1 Coverage is determined by the consumer’s prescription drug benefit plan. Please consult plan documents regarding benefit coverage and cost-share. Infertility coverage is determined by the consumer’s prescription drug benefit plan. For those who qualify, all infertility medications are required to be either fully excluded or fully covered. Prior authorization (sometimes referred to as precertification) may be required for Oxford plans.
Updates to your prescription benefits

Effective Jan. 1, 2020

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective Jan. 1, 2020.

**N** Prior Authorization – Notification
Prior Authorization – Notification requires additional clinical information to verify members benefit coverage.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolyte Imbalance</td>
<td>Samsca Tablet</td>
</tr>
</tbody>
</table>

**MN** Medical Necessity
Medical Necessity is a type of Prior Authorization that evaluates the clinical appropriateness of a medication, such as condition being treated, type of medication, frequency of use, and duration of therapy. The following medications will now require Medical Necessity for coverage.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility</td>
<td>Cetrotide</td>
</tr>
</tbody>
</table>

**ST** Step Therapy
The below medications will be added to the Step Therapy program. You must try one or more other medications before the medication below may be covered.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>Step 1 Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility</td>
<td>Gonal-F</td>
<td>Follistim AQ</td>
</tr>
<tr>
<td></td>
<td>Gonal-F RFF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gonal-F RFF Rediject</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cetrotide</td>
<td>ganirelix acetate (Merck/Organon)</td>
</tr>
</tbody>
</table>
### Supply Limits

Supply Limits establish the maximum quantity of a drug that is covered per copay or in a specified time frame. The drugs below will now be part of the Supply Limits program.

<table>
<thead>
<tr>
<th>Therapeutic Use</th>
<th>Medication Name</th>
<th>New Supply Limit</th>
<th>Revised Supply Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Retacrit - 2,000 units/1 ml vials</td>
<td>12 mL (12 vials) per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retacrit - 3,000 units/1 ml vials</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retacrit - 4,000 units/1 ml vials</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retacrit - 10,000 units/1 ml vials</td>
<td>8 mL (8 vials) per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retacrit - 40,000 units/1 ml vials</td>
<td>4 mL (4 vials) per month</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Bosulif 400 mg tablets</td>
<td>31 tablets per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imbruvica 70 mg capsules</td>
<td>31 capsules per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imbruvica 140 mg capsules</td>
<td>31 capsules per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imbruvica 140 mg tablets; 280 mg tablets; 420 mg tablets; 560 mg tablets</td>
<td>31 tablets per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rubraca 250 mg tablets</td>
<td>124 tablets per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sprycel 80 mg tablets</td>
<td>31 tablets per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tasigna 50 mg capsules</td>
<td>124 capsules per month</td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Kalydeco 25 mg oral granules</td>
<td>62 packets per month</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Ozempic 2 mg/1.5 ml (0.5 mg injection) pen</td>
<td>1 pen per month</td>
<td></td>
</tr>
<tr>
<td>Electrolyte</td>
<td>Samsca 15 mg tablets</td>
<td>90 tablets per year</td>
<td></td>
</tr>
<tr>
<td>Imbalance</td>
<td>Samsca 30 mg tablets</td>
<td>60 tablets per year</td>
<td></td>
</tr>
<tr>
<td>Infertility¹</td>
<td>Cetroside 0.25 mg solution for injection</td>
<td>14 cartons per 21 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ganirelix acetate 250 mg prefilled syringe</td>
<td>14 syringes per 21 days</td>
<td></td>
</tr>
<tr>
<td>Inflammatory</td>
<td>Actemra ACTpen 162 mg/0.9 mL autoinjector</td>
<td>4 autoinjectors per month</td>
<td></td>
</tr>
<tr>
<td>Conditions</td>
<td>Symjepi 0.15 mg prefilled syringe</td>
<td>2 pens per copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symjepi 0.3 mg prefilled syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Conditions</td>
<td>Triderm (triamcinolone) 0.5% cream</td>
<td>15 grams per copay</td>
<td></td>
</tr>
</tbody>
</table>

¹Coverage is determined by the consumer’s prescription drug benefit plan. Please consult plan documents regarding benefit coverage and cost-share. Prior authorization (sometimes referred to as precertification) may be required for Oxford plans.

²Referred to as First Start in New Jersey.

### For additional information:

- Visit the member website listed on your health plan ID card to look up the price of drugs covered by your plan, find lower-cost options and more.
- Call the toll-free phone number on your ID card to speak with a Customer Service representative.
Nondiscrimination notice and access to communication services

UnitedHealthcare® and its subsidiaries do not discriminate on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of your experience. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us, including letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.
Multi-language interpreter services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

NÔI GIẢI ÁP: Nếu quý vị nói tiếng Việt (Việtnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakiawag an ang toll-free na numero ng telefona na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

فتنة: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sevis ki gratis pou ede w nan lang pa w. Tanpi rele nwmawo gratis ki sou kat idantifikasyon w.

ATTENTION: Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d’identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniamy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルに電話ください。

توجه: اگر زبان سفارسی (Farsi) می‌دانید، خدمات امداد زبانی به طور رایگان در اخبار شما می‌باشد. لطفاً شماره تلفن رایگان که روابط است، خدمات امداد زبانی به طور رایگان در اخبار شما می‌باشد.

ध्यान दें, यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं लिए, जिलुक्कुण उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kevpab txhais lus pub dawb rau kjoj. Thov hau rau tus xoivoog hj deub dawb uas teev muaj nyob rau ntawm kjoj daim yuaj cim qhia tus kheej.

ភាសាខ្មែរ: ឱ្មុះដៃយើងរបស់យើងជាជាដេសអភិវឌ៍ឍនិយនិយមសាស្រ្តិយ៍ ឱ្មុះដៃយើងរបស់យើងជាជាដេសអភិវឌ៍ឍនិយនិយមសាស្រ្តិយ៍ ឱ្មុះដៃយើងរបស់យើងជាជាដេសអភិវឌ៍ឍនិយនិយមសាស្រ្តិយ៍ ឱ្មុះដៃយើងរបស់យើងជាជាដេសអភិវឌ៍ឍនិយនិយមសាស្រ្តិយ៍ ឱ្មុះដៃយើងរបស់យើងជាជាដេសអភិវឌ៍ឍនិយនិយមសាស្រ្តិយ៍

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengghuahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telefona nga nakalista ayan iti identification card mo.

DÍL BAA’AKONINÍZHIN: Diné (Navajo) biazaad bee yanitli’go, saad bee a’ka’anida’ao’ii’gii, t’áá jíik’eh, bee ná’sho’tí’i. T’áá shooyí ninaaltsoos nits’íizi bee néehozhíi bine’deel’é t’áá jíik’ehgo bëësh bee hane’i biká’ííi bee hodíilinii.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefona khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.
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