

THE BENEFIT

Housing Benefits Plan (HBP) is the medical plan provided to you by your housing authority. It is directed by housing authority Executive Directors from across Southeast and Southwest NAHRO for the benefit of housing authorities.

Please share this with all of your HBP employees, retirees, and COBRA members. Also share with the ED, HR, and Finance.

Prescription Drug List updates effective May 1, 2021

UHC is updating their Prescription Drug List (PDL) effective 5/1/2021. Some drugs are being excluded as offering limited value over existing covered options. Please see the attached May 2021 pharmacy updates for changes that are coming to know if you will be affected. If impacted you may visit myuhc.com to find lower-cost medications with greater health care value. Impacted members should receive letters 30 days prior to the effective date. So that you will know what to expect, attached is a SAMPLE member letter for medications that moved to excluded. The letter will also show alternatives to the excluded medication.

April Webinar Training

Tues. April 20, 10 am EST (Tentative) *Boost Energy Naturally*
Find previous webinar recordings at <https://www.housingbp.com/links-2>

Simply Engaged

Please see the attached flyer about this program in which employees and their covered spouses may each earn up to \$200 in rewards annually for taking healthier actions.

If a member has a virtual visit to receive the virtual visit incentive, the visit must be with one of the network providers; Amwell, Doctor on Demand, or Teladoc. If a member does not use one of the three aforementioned providers, the member will not receive the incentive.

Although members will not be receiving 1099 Miscellaneous Income forms, UHC has informed HBP that the gift cards earned by members as healthy rewards are considered taxable for income tax purposes. Please contact your tax or legal advisor with any questions.

COVID-19 Testing, Treatment, and Vaccination during the National Public Health Emergency which is currently until April 20, 2021

Using in-network providers for testing and treatment will avoid out of network costs and saves you money.

Medically appropriate **COVID 19 testing and testing-related visits** will be covered according to your plan benefits when ordered by a physician or appropriately licensed health care professional for purposes of the diagnosis or treatment of an individual member. United Healthcare does not cover testing for employment, education, public health or surveillance unless required by law.

COVID19 in-patient and out-patient treatment will be covered according to your plan benefits.

The **vaccine** has no cost to members — no matter where they get it. However, as with a flu shot, if you get the vaccine during a regular office visit, the visit will be covered according to your plan benefits.

COVID-19 Resources

Click on the link for the **most current COVID-19 information** from UHC.

<https://www.uhc.com/health-and-wellness/health-topics/covid-19/faq>

Visit www.myuhc.com/covid for **up-to-date plan and benefit information.**

The HBP website at www.housingbp.com provides more information and helpful links.

Questions or comments? Email us at hbp@callhsa.com or call 1-800-288-7623, option 5



March 2021

Important Information for Texas Housing Authorities

As shared in last month's newsletter, Texas housing authorities because of Texas Senate Bill 51 must submit an employee's termination during the month the employee terminates to avoid additional payments. For example, if the termination is sent in the month after the employee terminates the housing authority must pay for that month also.

The Employee Enrollment/Change form is included with this newsletter. Please keep it handy for immediate submission of terminations. Complete the top two sections on page 1, Employer Section and Employee Information. The person completing the form may sign and date page 2. Email the completed form to ClientServices_Billing3@mercerc.com

Put Effective Date on Employee Enrollment/Change Forms

When completing this form, it is essential for the housing authority to enter the **Effective Date of Change** at the top of page 1, in the Employer Section. Mercer's Client Services will contact you if they have any questions. Email completed forms to ClientServices_Billing3@mercerc.com or fax them to 1-515-365-1310.

Know Before You Go

When scheduling a test or procedure inquire about the ancillary providers such as anesthesiologists and radiologists. If they are not in-network, find ones that are, even if you need to change to another in-network facility.



Updates to your prescription benefits

Effective upon renewal

Access PDL benefit summary

Dear Valued Customer:

We are pleased to announce our **Access Prescription Drug List (PDL)** pharmacy benefit updates. Our PDL Management Committee carefully reviews and evaluates prescription medications to place them in tiers corresponding to their overall health care value. By managing pharmacy benefits responsibly, we are able to provide integrated pharmacy benefit solutions for our customers and affordable medications for our members. If you have questions regarding the PDL and benefit plan updates listed below, please contact your broker or a UnitedHealthcare representative.

Below is a list of PDL updates effective upon your renewal.

| Medication Name | Current Benefit Coverage | New Benefit Coverage |
|------------------------------------------------------------------|--------------------------|-----------------------|
| abiraterone 500 mg (generic Zytiga) | EAL ¹ | Excluded ² |
| Absorica LD | EAL ¹ | Excluded ² |
| Actonel (Brand only) | 3/4 | Excluded ² |
| Afinitor 2.5 mg, 5 mg, 7.5 mg tablet (Brand only) | 3/4 | Excluded ² |
| Albuterol Sulfate HFA [Ventolin HFA authorized generic (Prasco)] | 3 | Excluded ² |
| Alvesco | 1 | Excluded ² |
| Amicar (Brand only) | 3/4 | Excluded ² |
| Arazlo | EAL ¹ | Excluded ² |
| Aromasin (Brand only) | 3/4 | Excluded ² |
| Asmanex HFA | 1 | Excluded ² |
| Asmanex Twisthaler | 1 | Excluded ² |
| Atacand (Brand only) | 3/4 | Excluded ² |
| Avapro (Brand only) | 3/4 | Excluded ² |
| Azeschew Prenatal/Postnatal | EAL ¹ | Excluded ² |

| Medication Name | Current Benefit Coverage | New Benefit Coverage |
|---------------------------------------------------------------|--------------------------|-----------------------|
| Berinert | 2 | 3/4 |
| Bethkis (Brand only) | 3/4 | Excluded ² |
| Bynfezia Pen | EAL ¹ | Excluded ² |
| Bystolic | 2 | 3/4 |
| Carafate (Brand only) | 3/4 | Excluded ² |
| Cequa | EAL ¹ | Excluded ² |
| Consensi | EAL ¹ | Excluded ² |
| Cozaar (Brand only) | 3/4 | Excluded ² |
| Cuprimine (Brand only) | 3/4 | Excluded ² |
| cyclobenzaprine 7.5 mg (generic Fexmid) | 1 | Excluded ² |
| Descovy | 3/4 | Excluded ² |
| diclofenac 1% gel (generic Voltaren) | 1 | Excluded ² |
| diclofenac sodium 1.5% topical solution (generic Pennsaid) | 1 | Excluded ² |
| Doral | 3 | Excluded ² |
| Duaklir | EAL ¹ | Excluded ² |
| Elidel (Brand only) | 3/4 | Excluded ² |
| Esperoct | EAL ¹ | Excluded ² |
| Estrace vaginal cream (Brand only) | 1 | Excluded ² |
| Fareston (Brand only) | 3/4 | Excluded ² |
| Fexmid 7.5 mg (cyclobenzaprine) | 3/4 | Excluded ² |
| Flector 1.3% patch | 3/4 | Excluded ² |
| Forteo | 3 | Excluded ² |
| Frova (Brand only) | 3/4 | Excluded ² |
| Glycate 1.5 mg tablet | 3/4 | Excluded ² |
| Glycopyrrolate 1.5 mg tablet (Authorized generic for Glycate) | 3/4 | Excluded ² |
| Halog 0.1% solution | EAL ¹ | Excluded ² |
| Halog cream (Brand only) | 3/4 | Excluded ² |
| Hemady | EAL ¹ | Excluded ² |
| Horizant | 3/4 | Excluded ² |
| icosapent ethyl 1 g capsule (generic Vascepa) | 1 | Excluded ² |
| Incruse Ellipta | 2 | Excluded ² |
| Inderal XL | 3 | Excluded ² |
| Innopran XL | 3 | Excluded ² |
| Invokamet | 2 | Excluded ² |
| Invokamet XR | 2 | Excluded ² |
| Invokana | 2 | Excluded ² |

| Medication Name | Current Benefit Coverage | New Benefit Coverage |
|-----------------------------------------------|--------------------------|-----------------------|
| Jadenu (Brand only) | 3/4 | Excluded ² |
| Jatenzo | EAL ¹ | Excluded ² |
| ketoprofen (generic Orudis) | 1 | Excluded ² |
| ketoprofen extended-release (generic Oruvail) | 1 | Excluded ² |
| Letairis (Brand only) | 3/4 | Excluded ² |
| Lotrel (Brand only) | 3/4 | Excluded ² |
| Mestinon 60 mg tablet (Brand only) | 3/4 | Excluded ² |
| Mycapssa | EAL ¹ | Excluded ² |
| Niacor | 1 | Excluded ² |
| Nityr | 2 | Excluded ² |
| Norco (Brand only) | 3/4 | Excluded ² |
| Nurtec ODT | EAL ¹ | Excluded ² |
| Nyvepria | EAL ¹ | Excluded ² |
| olopatadine 0.2% (generic Pataday) | 1 | Excluded ² |
| Ortikos | EAL ¹ | Excluded ² |
| Pataday (olopatadine 0.2%) (Brand only) | 3/4 | Excluded ² |
| Patanol (Brand only) | 3/4 | Excluded ² |
| Paxil CR (Brand only) | 3/4 | Excluded ² |
| Pazeo | 3/4 | Excluded ² |
| Pennsaid 2% solution | 3/4 | Excluded ² |
| Phexxi | EAL ¹ | Excluded ² |
| Prenara | EAL ¹ | Excluded ² |
| Prenatrix | EAL ¹ | Excluded ² |
| Prevacid Solutab (Brand only) | 3/4 | Excluded ² |
| Proair HFA (Brand only) | 2 | Excluded ² |
| Proair RespiClick | 2 | Excluded ² |
| Proventil HFA (Brand only) | 3 | Excluded ² |
| quazepam (generic Doral) | 1 | Excluded ² |
| QVAR RediHaler | 1 | Excluded ² |
| Relafen (Brand only) | EAL ¹ | Excluded ² |
| Relafen DS | EAL ¹ | Excluded ² |
| Revatio suspension (Brand only) | 3/4 | Excluded ² |
| Riomet (Brand only) | 3/4 | Excluded ² |
| Roxicodone (Brand only) | 3/4 | Excluded ² |

| Medication Name | Current Benefit Coverage | New Benefit Coverage |
|---------------------------------------|--------------------------|-----------------------|
| Seasonique (Brand only) | 3/4 | Excluded ² |
| Secuado | EAL ¹ | Excluded ² |
| Semglee | EAL ¹ | Excluded ² |
| Sensipar (Brand only) | 3/4 | Excluded ² |
| Sprix | 3 | 3/4 |
| Sustiva capsules (Brand only) | 3/4 | Excluded ² |
| Synthroid (Brand Only) | 2 | Excluded ² |
| Syprine (Brand only) | 1 | Excluded ² |
| Talicia | EAL ¹ | Excluded ² |
| Tarceva (Brand only) | 3/4 | Excluded ² |
| Tazorac 0.05% gel, cream | 2 | 3/4 |
| Tazorac 0.1% cream (Brand only) | 1 | 3/4 |
| Tazorac 0.1% gel | 2 | 3/4 |
| Tecfidera | 2 | Excluded ² |
| Temixys | EAL ¹ | Excluded ² |
| Temodar capsules (Brand only) | 3/4 | Excluded ² |
| Travatan Z (Brand only) | 3/4 | Excluded ² |
| True Metrix Blood Glucose Meters | 3 | Excluded ² |
| True Metrix Blood Glucose Test Strips | 3 | Excluded ² |
| Truetrack Blood Glucose Meters | 3 | Excluded ² |
| Truetrack Blood Glucose Test Strips | 3 | Excluded ² |
| Truvada 200 mg-300 mg (Brand only) | 3/4 | Excluded ² |
| Twirla | EAL ¹ | Excluded ² |
| Uroxatral (Brand only) | 3/4 | Excluded ² |
| Varubi | 2 | Excluded ² |
| Vascepa 0.5 g capsule | 2 | Excluded ² |
| Vascepa 1 g capsule | 2 | Excluded ² |
| Ventolin HFA | 2 | Excluded ² |
| Voltaren 1% gel | 1 | Excluded ² |
| Vumerity | EAL ¹ | Excluded ² |
| Xeloda (Brand only) | 1 | Excluded ² |

| Medication Name | Current Benefit Coverage | New Benefit Coverage |
|----------------------------|--------------------------|-----------------------|
| Zcort 7-day | EAL ¹ | Excluded ² |
| Zerviate 0.24% | EAL ¹ | Excluded ² |
| Ziextenzo | EAL ¹ | Excluded ² |
| Zohydro ER (Brand only) | 3/4 | Excluded ² |
| Zomig tablets (Brand only) | 3/4 | Excluded ² |
| Zonalon (Brand only) | 3/4 | Excluded ² |
| Zortress (Brand only) | 3/4 | Excluded ² |
| Zytiga 250 mg (Brand only) | 1 | Excluded ² |
| Zytiga 500 mg | 1 | Excluded ² |

¹ The Exclude at Launch Program (EAL) enables us to immediately exclude upon launch a high-cost medication from benefit coverage, eliminating unnecessary costs for you and allowing appropriate clinical programs to be implemented which minimizes any disruption for your employees. For clients that do not participate in the Exclude at Launch Program, these medications will be placed on the highest tier.

² This medication is excluded for the majority of benefit plans. For customers not participating in exclusions, this medication may be covered in the highest tier.

Access PDL clinical programs benefit summary

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective upon renewal.

N Prior Authorization – Notification

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

| Therapeutic Use | Medication Name |
|---------------------|-------------------------|
| Cancer | Zolinza |
| Diabetes | Adlyxin |
| Diabetes | Bydureon/Bydureon BCise |
| Diabetes | Byetta |
| Diabetes | Ozempic |
| Diabetes | Rybelsus |
| Diabetes | Trulicity |
| Diabetes | Victoza |
| High Cholesterol | Nexlizet |
| HIV | Fuzeon |
| Multiple Sclerosis | Bafiertam |
| Multiple Sclerosis | Gilenya |
| Parkinson's Disease | Apokyn |
| Rosacea | Mirvaso |
| Rosacea | Rhofade |
| Seizures | Xcopri |

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.

| Therapeutic Use | Medication Name |
|-----------------------|-----------------|
| Hereditary Angioedema | Berinert |
| Hereditary Angioedema | Firazyr |
| Hereditary Angioedema | Ruconest |
| Parkinson's Disease | Apokyn |
| Seizures | Fintepla |
| Skin Conditions | Halucort |

ST Step Therapy

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

| Therapeutic Use | Medication Name | Step 1 Medication |
|------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bladder Pain | Elmiron | amitriptyline |
| Dermatitis | Extina | Must try one of the following: (1) ciclopirox (generic ciclopirox gel, generic Loprox) (2) ketoconazole shampoo (generic Nizoral) |
| Diabetes | Invokamet ³ | Synjardy/Synjardy XR |
| Diabetes | Invokamet XR ³ | Synjardy/Synjardy XR |
| Diabetes | Invokana ³ | Must try both of the following: (1) metformin (generic Glucophage, Glucophage XR) (2) Jardiance |
| Hemophilia | Esperoct ³ | Must try three of the following: (1) Advate (2) Kogenate FS (3) Kovaltry (4) NovoEight (5) Nuwiq (6) Recombinate |
| Hereditary Angioedema | Berinert | Ruconest |
| HIV | Descovy | Truvada |
| Migraines | Nurtec ODT ³ | Must try Ubrelvy plus two of the following: almotriptan (Axert), eletriptan (Relpax), frovatriptan (Frova), naratriptan (Amerge), rizatriptan (Maxalt/Maxalt MLT), sumatriptan (Imitrex), zolmitriptan (Zomig) |
| Migraines | Ubrelvy | Must try two of the following: (1) almotriptan (Axert), (2) eletriptan (Relpax), (3) frovatriptan (Frova), (4) naratriptan (Amerge), (5) rizatriptan (Maxalt/Maxalt MLT), (6) sumatriptan (Imitrex), (7) zolmitriptan (Zomig) |
| Osteoporosis | Forteo ³ | Must try both: (1) Tymlos (2) Teriparatide |
| Pain | levorphanol tartrate | Must try three of the following: (1) hydromorphone (generic Dilaudid) (2) morphine immediate-release (3) oxycodone (generic Roxicodone) (4) oxymorphone (generic Opana) |
| Sedative Hypnotics | Dayvigo | Must try two of the following: (1) zolpidem (generic Ambien) (2) zaleplon (generic Sonata) (3) eszopiclone (generic Lunesta) |
| Skin Conditions - Infections | Veregen | Must try one of the following: (1) imiquimod (generic Aldara) (2) podofilox (generic Condylox) |

SL 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.

| Therapeutic Use | Medication Name | New Supply Limit | Revised Supply Limit |
|--------------------------------------------------|--------------------------------------------|-------------------------|-----------------------|
| ADHD | Dexedrine 5 mg | 310 capsules per month | |
| ADHD | Dexedrine 10 mg | 124 capsules per month | |
| ADHD | Dexedrine 15 mg | 124 capsules per month | |
| Asthma | Nucala 100 mg/ml autoinjector/syringe | .04 ml per month | |
| Asthma/COPD | Dulera 50 mcg/5 mcg | 0.44 mcg | |
| Endocrine | Jynarque 15 mg Therapy Pack | 56 tablets per month | |
| Endocrine | Jynarque 30/15 mg Therapy Pack | 56 tablets per month | |
| Endocrine | tolvaptan 30 mg (generic Samsca) tablets | 56 tablets per month | |
| Hereditary Angioedema | Berinert 500 units injectable kit | 10 boxes per month | |
| Hereditary Angioedema | Firazyr 30 mg syringe | 6 syringes per month | |
| Hereditary Angioedema | Ruconest 2100 unit vials | 8 vials per month | |
| HIV | Temixys 300-300 mg tablet | 31 tablets per month | |
| Infections | gentamicin sulfate 0.1% cream and ointment | 30 mg per copay | |
| Infections | gentamicin sulfate 0.3% solution | 15 mL per copay | |
| Infections | Nyamyx 100000 unit/gm powder | 12 gm per copay | |
| Infections | nystatin 100000 unit/gm cream and ointment | 90 mg per copay | |
| Infections | Nystop 100000 unit/gm powder | 120 mg per copay | |
| Inflammatory Conditions | Dupixent 200 mg/1.4 mL pre-filled syringe | | 2 syringes per month |
| Inflammatory Conditions | Dupixent 300 mg/2 mL pre-filled syringe | | 2 syringes per month |
| Inflammatory Conditions | Enbrel 25 mg/0.5 mL | 4.65 ml per month | |
| Inflammatory Conditions/ Rheumatoid Arthritis | Olumiant 1 mg tablets | 31 tablets per month | |
| Migraines | Aimovig 140 mg | 1 syringe per month | |
| Migraines | Nurtec 75 mg ODT | | 8 tablets per 24 days |
| Migraines | Reyvow 100 mg tablet | | 8 tablets per 24 days |
| Migraines | Ubrelvy 50 mg tablet | | 8 tablets per 24 days |
| Migraines | Ubrelvy 100 mg tablet | | 8 tablets per 24 days |
| Multiple Sclerosis | Gilenya 0.25 mg capsules | 31 capsules per month | |
| Parkinson's Disease | Apokyn 10 mg/mL | 30 cartridges per month | |
| Pulmonary Hypertension | Tracleer 32 mg tablets | 124 tablets per month | |

³ Typically excluded from coverage. For benefits that do not exclude, step therapy may be required.

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 their 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。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, 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 hội 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. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

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

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo 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)**, udostępniłiśmy 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お電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xovtooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

Díí BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqoqdí ninaaltsoos nit'izíí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í bik'á'ígíí bee hodíílnih.

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

Learn more



Call the toll-free phone number on your health plan ID card to speak with a Customer Service representative.



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.

**United
Healthcare**

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P.O. Box 510941
Livonia, MI 48151-6941

<MEMBER_FIRST_NAME> <MEMBER_LAST_NAME>
<MEMBER_ADDRESS1>
<MEMBER_ADDRESS2>
<MEMBER_CITY>, <MEMBER_STATE> <MEMBER_ZIP>

Month DD, YYYY

Dear <MEMBER_FIRST_NAME>,

We want to let you know about a change to your prescription drug coverage.

Starting <CHANGE_CODE_EFFECTIVE_DATE>, the drug(s) below will no longer be covered by your plan.

Our records show that you recently filled a prescription for the drug(s) listed below.

When there are similar drugs available to treat the same condition, higher-cost options are not always covered. Here are some other, lower-cost drug(s) that may work for you:

| Drug(s) not covered by the plan | Other covered drug(s) |
|---------------------------------|-----------------------|
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |
| <TARGET_MED> | <MED_ALTERNATIVE> |

What do I need to do?

Please talk to your doctor as soon as possible. If a lower-cost drug will work for you, your doctor will need to write a prescription for the new drug(s).

Questions?
We're here to help.

Call <TFN>.

If you fill a prescription for the drug(s) after [<CHANGE_CODE_EFFECTIVE_DATE>](#), you will pay the full cost of the prescription(s). The amount you pay will not count toward any deductible or out-of-pocket maximum you may have.

In some situations, coverage may be extended if you need extra time to review your options with your doctor.

Questions? We're here to help.

If you have any questions, please:

- Call [<TFN>](#).
- Visit [myuhc.com](#) for more information about your pharmacy benefits. Please note, the changes described in this letter will not appear on the website until [<CHANGE_CODE_EFFECTIVE_DATE>](#).

Thanks for letting us serve you.

Sincerely,

The UnitedHealthcare Team

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Healthcare®**

If you are no longer a member of this health plan after the effective date of these changes, please disregard this letter. Always refer to your benefit plan materials to determine your coverage for medications and copayments. Some medications listed on the Prescription Drug List may not be covered under your specific benefit. When there are differences, the benefit plan documents will rule.

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Earn up to \$200* for completing health and wellness activities

With SimplyEngaged, you can get rewarded for taking healthier actions.



Here's how SimplyEngaged works

Through Rally®, you can access the SimplyEngaged® health and wellness activities available to you. For each Health Action you complete, you'll earn Rally Coins,** which you can redeem for rewards. Plus, you can earn financial incentives. Rally's digital experience gives you one place to track your activities and rewards.

To get started, go to myuhc.com® > Health Resources > Rally

| Health Actions | Reward |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <p>Complete the Health Survey and watch the video</p> <p>The Health Survey takes about 15 minutes and upon completion, you'll receive personalized suggestions to help you set health goals. Pair this with a short Health Actions video to see your opportunities to earn rewards.</p> | <p>\$25+ Rally Coins</p> |
| <p>Complete a Virtual Visit</p> <p>Virtual Visits may be a convenient option when you need care. You can talk to a doctor—24/7—by phone or video for conditions like the flu, allergies, rashes, migraines and many more.</p> | <p>\$25+ Rally Coins</p> |

*Earnings are per person and include covered spouse or domestic partner.

**Rally Coins can be earned under Rally Health. A reward can only be earned once per incentive year per health action, with the exception of the Fitness Action, up to the maximum incentive amount. Rally Coins may be used to enter sweepstakes for additional rewards.

continued

Complete a coaching program

The results of your Health Survey will provide recommendations for coaching programs that may help improve your health and wellness. These programs are available at no additional cost as part of your health plan benefits. Complete one of the following programs to earn more rewards:

Wellness Coaching provides access to expert coaches and digital tools to help you reach your health goals. It's all about getting and staying healthy—your way—anytime. Choose from a variety of programs designed to help your sleep better, eat smarter and get fit.

Real Appeal® may help you start living a healthier life with online weight loss tools designed to help you achieve lifelong results, one small step at a time. Real Appeal provides the support to help you lose weight through online coaching, a Success Kit delivered to your door and a community of members to keep you motivated.

Quit For Life® has helped 4 million enrollees quit smoking or using tobacco.¹ It provides the tools, 1-on-1 support and a personalized plan to help you quit your way.

\$100+
Rally Coins

Complete a biometric screening

A biometric health screening may help you and your doctor make more informed decisions about your health.

Get screened for:

- Total cholesterol
- Blood pressure
- Blood sugar (glucose)
- Body mass index (BMI)

You have 4 options to participate in the biometric health screening:

- 1 Employer on-site event, if available.
- 2 Doctor's office or convenience care clinic. (Provider Results form must be completed.)
- 3 Quest Diagnostics® Patient Service Center.
- 4 At-Home Test Kits.*

\$75+
Rally Coins

Complete a Gym Check-in

Check in to a participating fitness center at least 12 days per month on the Rally Health app. Select from a network of leading fitness centers, where you'll find boxing, climbing, cycling, yoga, Pilates, traditional gyms and more.

\$20/mo. +
Rally Coins



myuhc.com > Health Resources > Rally

**United
Healthcare**

* At-Home Test Kits are not currently available in the state of New York.

¹ Quit For Life Employer Book of Business Survey results, cumulative from 2006 to 2018.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Real Appeal is a voluntary weight loss program that is offered to eligible participants as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

UnitedHealthcare understands the importance of protecting your privacy. We care about the relationship we have with you. Our business practices are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security requirements.

The Quit For Life Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

Quest Diagnostics is a registered trademark of Quest Diagnostics.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

SimplyEngaged® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving rewards under this program. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-215-0230 and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.



Enrollment and Change Form

Please print or type clearly in blue or black ink.

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|
| EMPLOYER SECTION Please complete for employee | | |
| Agency Name _____ | Agency State _____ | Billing Acct # _____ <small>(from the bills of current members)</small> |
| CHECK ONE: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Voluntary Cancellation <input type="checkbox"/> Non-Voluntary Cancellation <input type="checkbox"/> Other _____ | | |
| Date of Hire _____ | Effective Date of Change _____ | |
| Type of Change _____ | Reason for Change _____ | |

| | | | |
|---------------------------------|----------------------------------|---------------------|------------------------------|
| EMPLOYEE INFORMATION | | | |
| Name (Last) (First) (MI) _____ | | | Social Security Number _____ |
| Address _____ | | City _____ | State _____ ZIP _____ |
| Gender | Status | Date of Birth _____ | Occupation _____ |
| <input type="checkbox"/> Male | <input type="checkbox"/> Single | | |
| <input type="checkbox"/> Female | <input type="checkbox"/> Married | | |

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| MEDICAL PLAN (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> EE/+ Child(ren) <input type="checkbox"/> Coverage Waived <input type="checkbox"/> Not applicable (Benefit not offered by authority) | Circle or Write Plan Name - (Value PPO, Value PPO w/Premier RX, Premier PPO, Premier Plus PPO, Out of Area) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------|
| LIFE AD&D INSURANCE | | |
| <input type="checkbox"/> Life Insurance/AD&D Coverage - \$10,000 <input type="checkbox"/> Life Insurance/AD&D Coverage - \$50,000 <input type="checkbox"/> Life Insurance/AD&D Coverage - <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> Other: Per \$1,000 = _____ <input type="checkbox"/> Not applicable (Benefit not offered by authority) | | |
| <input type="checkbox"/> Optional Dependent Life: \$2,000 for Spouse and \$1,000 per child <input type="checkbox"/> Not applicable (Benefit not offered by authority) | | |
| Beneficiary/Beneficiaries (Last, First, MI) | Percentage of Benefit | Relationship |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DENTAL PLAN (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> EE/+ Child(ren) <input type="checkbox"/> Coverage Waived | <input type="checkbox"/> Not applicable (<i>Benefit not offered by authority</i>) Benefit through United Healthcare www.welcometouhc.com/openaccess 888-679-8925 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VISION PLAN (check one) - VSP <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Coverage Waived | <input type="checkbox"/> Not applicable (<i>Benefit not offered by authority</i>) Benefit through Vision Service Plan www.vsp.com 800-877-7195 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VISION PLAN (check one) - UHC <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Coverage Waived | <input type="checkbox"/> Not applicable (<i>Benefit not offered by authority</i>) Benefit through United Healthcare www.myuhcvision.com 800-638-3120 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| LONG TERM DISABILITY <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Coverage Waived <input type="checkbox"/> Not applicable (<i>Benefit not offered by authority</i>) | Monthly Salary \$ _____ Occupation _____ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------|-------------------|--------------|---------|--------|--------|
| DEPENDENT INFORMATION Please list all eligible family members to be enrolled in medical, dental and/or vision coverage. Add separate sheet if necessary. | | | | | | | |
| Dependent Full Name | Sex | Date of Birth | Social Security # | Relationship | Medical | Dental | Vision |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

AUTHORIZATION

- ** I accept the coverage provided by **Housing Benefits Plan** and authorize deductions from earnings of the required contributions, if any, towards the cost of my coverage. This authorization applies only if employee contributions are required.
- ** Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.
- ** I understand and acknowledge that **Housing Benefits Plan** is a tax qualified voluntary employees' beneficiary association sponsored by SERC-NAHRO & SWRC-NAHRO and not by my employer. I further acknowledge and agree that **Housing Benefits Plan** is subject to the provisions of the Internal Revenue Code and ERISA.
- ** I hereby certify that the foregoing information is true and correct to the best of my knowledge and accept the provisions above.
- ** I have read and understand the eligibility rules and represent and warrant the people I have enrolled are eligible.

Employee Signature _____ Date _____

For individuals making changes to their coverage, or being added to or terminated from the Housing Authority's plan, please scan/email this completed form to ClientServices_Billing3@mercer.com or fax it to 1-515-365-1310.