

Clark County ESC
Insurance Benefit Premiums
New Rates Effective January 1, 2026
New rates begin with the December 5th payroll.

	Annual Cost			Monthly Cost			
	ESC Premium	ESC Cost	Employee Cost	ESC Premium	ESC Share 85%	FT Emp. Share 15%	PT Emp. Share 50%
United Health Care							
Single	\$ 12,608.64	\$ 10,717.34	\$ 1,891.30	\$ 1,050.72	\$ 893.11	\$ 157.61	\$ 525.36
Parent Child	\$ 24,386.76	\$ 20,728.75	\$ 3,658.01	\$ 2,032.23	\$ 1,727.40	\$ 304.83	\$ 1,016.12
Family	\$ 33,461.28	\$ 28,442.09	\$ 5,019.19	\$ 2,788.44	\$ 2,370.17	\$ 418.27	\$ 1,394.22
Delta Dental							
Dental					ESC Share 80 %	Share 20%	Share 50%
Single	\$ 410.16	\$ 328.13	\$ 82.03	\$ 34.18	\$ 27.34	\$ 6.84	\$ 17.09
Family	\$ 1,038.12	\$ 830.50	\$ 207.62	\$ 86.51	\$ 69.21	\$ 17.30	\$ 43.26
VSP							
Vision							
Single	\$ 94.68	\$ 75.74	\$ 18.94	\$ 7.89	\$ 6.31	\$ 1.58	\$ 3.95
Family	\$ 220.32	\$ 176.26	\$ 44.06	\$ 18.36	\$ 14.69	\$ 3.67	\$ 9.18

Health Care Benefit Summary	
<u>Annual Deductible</u>	
Single	\$2,500
EE + Children	\$5,000
Family	\$5,000
ESC Board Policy: SPOUSE ELIGIBILITY "If a spouse has health care coverage available to them through their employer, they are not eligible through the Clark County ESC health care plan."	

Board Policy:

FULL-TIME = 85/15 Medical 80/20 Vision/Dental
 Full-time Certified employees working at least 151 or more days and 30 hours or more per week.
 Full-time Classified employees working at least 151 or more days and 30 hours or more per week.
 *Preschool aides will be classified as full time for benefit structure

PART-TIME= 50/50
 Part-time Certified at least 14 hours per week to be eligible.
 Part-time Classified employees working at least 20 hours per week to be eligible.

***Client districts may request to opt out of providing P/T benefits
 ***PAYROLL DEDUCTIONS MUST BE USED TO RECEIVE BENEFITS.



Benefit Summary
ASO Choice Plus
Clark County ESC Medical Plan **HDHP**

UnitedHealthcare and EPC want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**® - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$2500 per year	\$5000 per year
Family Deductible	\$5000 per year	\$10000 per year
<ul style="list-style-type: none"> • Non Embedded Deductible 		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$2500 per year	\$5000 per year
Family Out-of-Pocket Maximum	\$5000 per year	\$10000 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • Non Embedded Out of Pocket Max 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	100% after Deductible has been met for most services	70% after Deductible has been met for most services
Lifetime Maximum Benefit		
The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan	Unlimited	Unlimited
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate plan - CVS. 		
Information of Pre-service Notification		
*Pre-service Notification is required for certain services.		
**Pre-service Notification is required for Equipment in excess of \$1,000 both in and out of network.		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 100% after Deductible has been met	* 100% after Deductible has been met after Network Deductible has been met
Dental Services – Accident Only		
	* 100% after Deductible has been met	* 100% after Deductible has been met after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: Benefits are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. Hearing Aids are limited to \$2500 per year.	100% after Deductible has been met	** 70% after Deductible has been met

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services – Outpatient		
	* 100% after Deductible has been met	* 100% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	100% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	100% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% after Deductible has been met	70% after Deductible has been met Pre-Service Notification is required Sleep Studies
Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine - Outpatient		
	100% after Deductible has been met	70% after Deductible has been met Pre-Service Notification is required
Mental Health and Substance Abuse Services – Inpatient and Intermediate		
	* 100% after Deductible has been met	* 70% after Deductible has been met
Mental Health and Substance Abuse Services – Outpatient		
	** 100% after Deductible has been met	* 70% after Deductible has been met
Ostomy Supplies		
	* 100% after Deductible has been met	70% after Deductible has been met
Physician Services – Surgical and Medical		
	100% after Deductible has been met after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	* 100% after Deductible has been met	70% after Deductible has been met
Specialist Physician Office Visit	* 100% after Deductible has been met	70% after Deductible has been met
In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Products		
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% no deductible applies	Non-Network Benefits are not available
Specialist Physician Office Visit	100% no deductible applies	
Lab, X-Ray or other preventive tests	100% no deductible applies	
Prosthetic Devices		
	100% after Deductible has been met	70% after Deductible has been met Pre-Service Notification is required for Prosthetic Device in excess of \$1000
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	
		<i>Pre-service Notification is required for certain services.</i>
Rehabilitation Services – Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows: Network and Non-Network benefits are limited to a combined total of 50 visits per calendar year for any combination of the following: Chiropractic treatment Physical therapy Occupational therapy Speech therapy Pulmonary rehabilitation Cardiac rehabilitation	* 100% after Deductible has been met Benefits for Habilitative Services are provided under and as part of Rehabilitation Services-Outpatient Therapy and Manipulative treatment and are subject to the limits as stated under Rehab Services	* 70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Post-Cochlear implant aural therapy Vision therapy		
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 300 days per year. Facility Services are limited to 120 days per incident.	100% after Deductible has been met	* 70% after Deductible has been met
Surgery – Outpatient		
	100% after Deductible has been met	70% after Deductible has been met
Therapeutic Services		
	100% after Deductible has been met	*70% after Deductible has been met
Transplantation Services		
	*100% after Deductible has been met	* Not Covered
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
Urgent Care Center Services		
	* 100% after Deductible has been met	70% after Deductible has been met
In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Products		
Vision Examinations		
Benefits are limited as follows: 1 exam every year	* 100% after Deductible has been met	Non-Network Benefits are not available

MEDICAL EXCLUSIONS
It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
Alternative Treatments
Acupressure; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in the SPD.
Dental
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
Devices, Appliances and Prosthetics
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.
Drugs
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.
Experimental or Investigational or Unproven Services
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.
Foot Care
Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports
Medical Supplies and Equipment
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, (except when used with Durable Medical Equipment as described under Durable Medical Equipment in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD
Mental Health / Substance Abuse
Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Abuse (MH/SA) Administrator; Services performed in connection with conditions not classified in the current edition of the <i>American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders</i> . Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia

and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Administrator. Services utilizing methadone, LA.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Administrator. Residential treatment services. Routine use of psychological testing without specific authorization; pastoral counseling. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with:

- Prevailing national standards of clinical practice for the treatment of such conditions.
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time.

The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

MEDICAL EXCLUSIONS Continued

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Nutritional Counseling in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemo-surgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Chiropractic treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, including oral appliances; surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Diagnosis or treatment of the jawbones, including Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Treatment of tobacco dependency. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Health services when a provider waives the Copay, Annual Deductible or Coinsurance.

amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia



Addendum to the Medical Benefit Summary for Self-Funded Groups

Choice Plus High Deductible Health Plans 1/1/2025

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Mental Health Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	80% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. <i>Prior Authorization is required for certain services.</i>
Neurobiological Disorders – Autism Spectrum Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	80% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. <i>Prior Authorization is required for certain services.</i>
Substance Use Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	80% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. <i>Prior Authorization is required for certain services.</i>
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	100% after Deductible has been met per visit.	Non-Network Benefits are not available.

This replaces the Mental Health exclusion section on the Benefit Summary:

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

This replaces the Neurobiological Disorders-Autism Spectrum Disorder exclusion section on the Benefit Summary:

Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

This replaces the Substance Use Disorders exclusion section on the Benefit Summary:

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.



Medical Benefit Summary Authorization Addendum for Self-Funded Groups Choice Plus

These Prior Authorization requirements shown here will change the Pre-Service Notification requirements indicated on your Benefit Summary.

Network Benefits

The following benefit requires [Pre-Service Notification][Prior Authorization] for Genetic Testing - BRCA.

- Ambulance Services – Non-Emergent Air
- Clinical Trials

The following benefits require [Pre-Service Notification][Prior Authorization] for certain services.

- Transplantation Services

The following benefits require [Pre-Service Notification][Prior Authorization] for Sleep Studies.

The following benefit requires [Pre-Service Notification][Prior Authorization] if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

The following benefits require [Pre-Service Notification][Prior Authorization] for Equipment in excess of \$1,000.

Non-Network Benefits

- Physician's Office Services
- Ambulance Services – Non-Emergent Air
- [Clinical Trials]
- Cochlear Implants]
- [Congenital Heart Disease (CHD) Surgeries]
- Home Health Care - Nutritional, Private Duty Nursing, Skilled Nursing
- Hospice Care- Inpatient Stay
- Hospital – Inpatient Stay
- [Infertility Services]
- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders-Inpatient [and Outpatient]
- Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine
- Mental Health and Substance Abuse Services – Outpatient and] Inpatient
- Reconstructive Procedures
- Skilled Nursing Facility/Inpatient Rehabilitation
- Substance Use Disorder Services-Inpatient [and Outpatient]]
- Surgery for the treatment for Gender Dysphoria]
- Surgery – Outpatient[Sleep Apnea] and Cardiac catheterization, diagnostic cardiac catheterization; cardiac electrophysiology implant, pacemaker insertion, implantable cardioverter defibrillators
- Therapeutic Treatments – Outpatient[Dialysis and IV infusion,] [and radiation oncology,] [and intensity modulated radiation therapy,] [and MR-guided focused ultrasound]]
- Transplantation Services

- Outpatient Diagnostic Services – For lab and radiology/X-ray

- Maternity Services

- [Diabetes Services]
- Durable Medical Equipment

- Prosthetic Devices

This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

SFEGYYYYY07PA

UPDATED: 8/15/2016



**Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 5630-1050, 1059
Clark County ESC**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Ohio

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference. Please refer to your Plan Certificate for more information on payment to Nonparticipating Dentists.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Benefits for bitewing X-rays are unlimited. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per three-year period for permanent bicuspid and molars for people age 13 and under. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids, and bicuspid once per tooth in any five-year period.
- Composite resin (white) restorations are payable on posterior teeth.

- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Occlusal guards are payable once in any three-year period.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, and dental case management. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment - \$750 per Member total per Benefit Year on all services except orthodontic services. \$750 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service - When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible - \$50 Deductible per Member total per Benefit Year limited to a maximum Deductible of \$100 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, sealants, brush biopsy, periodontal maintenance and orthodontic services.

Deductible Carry Forward - Any expenses incurred by an eligible person for covered services during the last three months of a benefit year and applied to the Deductible for that benefit year will also be applied to the Deductible for the following Benefit Year.

Waiting Period - Coverage for eligible employees who are actively at work is effective on the date specified by the employer. Dependent(s) effective date: Eligible dependent(s) will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty (30) days of meeting the Plan's eligibility requirements. The date the employee's coverage becomes effective. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty (30) days of the date acquired. Newborn children shall be covered from birth, regardless of confinement, provided the employee has applied for dependent coverage within thirty (30) days of birth. Coverage for a newly adopted child shall be effective on the date the child is placed for adoption, provided the employee has applied for dependent coverage within thirty (30) days of placement.

Eligible People - All regular employees as determined by the employer, shall be eligible to enroll for dental coverage under this plan. Clark County ESC (1050) and Clark County ESC COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), enrollees (1059).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits - If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits generally will cease on the last day of the month in which the employee is terminated or a dependent loses eligibility.

A Look at your VSP Vision Coverage




With VSP and CLARK CNTY ESC, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP® network doctor for you and your family.


Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

Provider choices you want.

 With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

 Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

PROVIDER NETWORK:

VSP Signature

EFFECTIVE DATE:

01/01/2024

Create an account today.

Contact us at:
800.877.7195 or vsp.com

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on vsp.com.

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Classification: Restricted

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Every calendar year 	\$10
ESSENTIAL MEDICAL EYE CARE	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details. Available as needed 	\$0 per screening \$20 per exam
PRESCRIPTION GLASSES		
FRAME*	<ul style="list-style-type: none"> \$170 featured frame brands allowance \$150 frame allowance 20% savings on the amount over your allowance \$150 Walmart®/Sam's Club®/Costco® frame allowance Every other calendar year 	Included in Prescription Glasses
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Every calendar year 	Included in Prescription Glasses
LENS ENHANCEMENTS	<ul style="list-style-type: none"> Standard progressive lenses Impact-resistant lenses Premium progressive lenses Custom progressive lenses Average savings of 40% on other lens enhancements Every calendar year 	\$0 \$0 \$80 - \$90 \$120 - \$160
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) Every calendar year 	Up to \$60
EXTRA SAVINGS	<ul style="list-style-type: none"> Routine Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor 	
YOUR COVERAGE GOES FURTHER IN-NETWORK		
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.		

Here's an overview of your CVS Caremark benefits.

Clark Co ECS HDHP 1/1/2025

If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help any time after your plan starts. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	Long-Term Medicines CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	\$0 after deductible for a generic medicine	\$0 after deductible for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	\$0 after deductible for a preferred brand-name medicine	\$0 after deductible for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	\$0 after deductible for a non-preferred brand-name medicine	\$0 after deductible for a non-preferred brand-name medicine
Refill Limit	None	None
Maximum Out-of-Pocket	\$2,500 per individual / \$5,000 per family (combined with medical)	
Annual Deductible	\$2,500 per individual / \$5,000 per family (combined with medical)	
Specialty Medicines	Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-2-2-1654 or visit www.caremark.com for verification of prior authorization.	

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654. If you access your pharmacy benefits information through the Caremark Web site, you can find Plan Members Rights and Responsibilities at www.caremark.com.

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
 - Auxiliary aids and services
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.