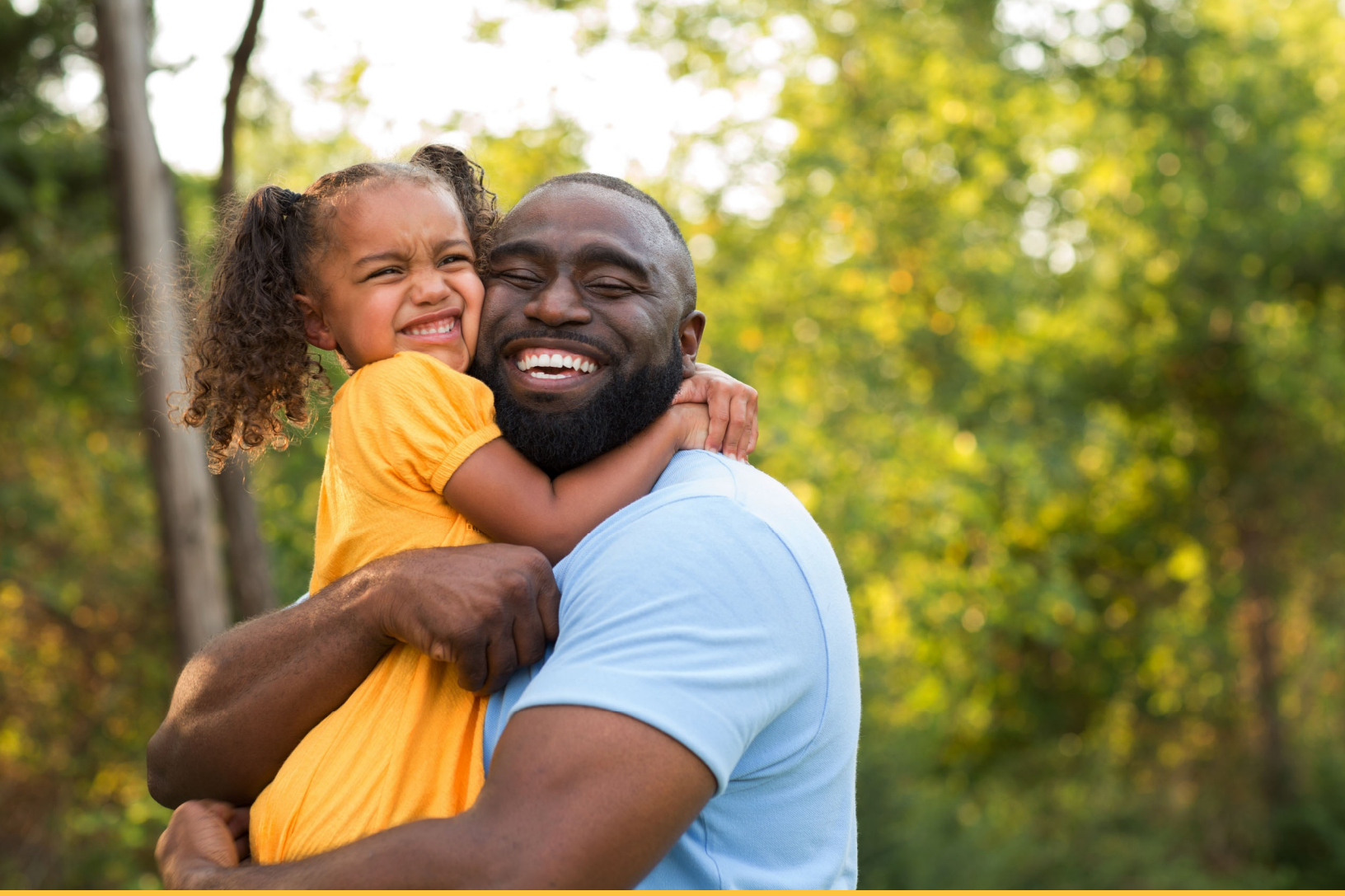

Charles R. Drew University
of Medicine and Science

A Private University with a Public Mission

2024

Benefit Summary

Welcome! Your well-being is important to us.

Charles R. Drew University of Medicine and Science ("CDU") continues to offer health and wellness benefits to help you stay healthy and provide financial protection against high healthcare costs. The program incorporates a variety of benefit plans from which employees can choose and the following pages provide a brief overview of the benefits available. The various plans made available are very comprehensive.

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Health Care Reform

You have heard about Healthcare Reform and the public health insurance marketplaces, including Covered California. Individuals who are not offered qualified healthcare coverage through their employer may be eligible for tax subsidies to help pay for health insurance premiums for plans purchased in the public marketplaces (based on the level of income and number of dependents). Due to the high standard of health coverage CDU offers, our employees will generally NOT be eligible for these subsidies.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 27-28 where Notice of Creditable Coverage begin for more details.

ELIGIBILITY and ENROLLMENT

ELIGIBLE EMPLOYEES

You may enroll in our benefits program if you are a Regular or Conditional employee working a minimum of 20 paid hours per week.

ELIGIBLE DEPENDENTS

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include your spouse or registered/unregistered domestic partner (same or opposite sex), and children up to the age of 26 for Medical, Dental, Vision, and Voluntary Life. If your child is mentally or physically disabled, coverage may continue beyond the age of 26. Children may include natural, adopted, stepchildren, or domestic partner's children.

WHEN COVERAGE BEGINS

Employees will be eligible for Medical, Dental, Vision, Life, Disability, EAP, FSA and Voluntary benefits on the first day of the month following date of hire with CDU and completion of the required paperwork. All elections are in effect for the entire plan year and can only be changed during Open Enrollment or if you experience a qualified status change.

NOTE: If you do not make health benefit elections within 30 days of your eligibility date, you will be deemed to have waived coverage until the next Open Enrollment period.

WHEN COVERAGE ENDS

In general, your coverage under CDU's Medical, Dental, and Vision plans ends the last day of the month in which you terminate employment. Your coverage under CDU's Life, Disability, EAP, and FSA plans ends on your last day of active employment. Covered employees and qualified dependents are permitted to continue certain coverages at their own expense after leaving CDU as provided by federal law (COBRA).

QUALIFIED STATUS CHANGES

You can make some limited changes during the year due to a Qualified Status Change. You must notify CDU within 30 days of a qualified status change. Some qualified status changes may include:

- Marriage or divorce
- Birth of a child
- Spouse's termination or commencement of employment
- A reduction or increase in hours of employment by the participant, spouse, or dependent, including a shift between part-time and full-time status, or going on or returning from an extended leave of absence

CHANGES IN BENEFIT ELECTIONS

Each year, during Open Enrollment, you will have the opportunity to change your elections for the following plan year.

In general, only during Open Enrollment will you have the opportunity to:

- ***Add or terminate coverage***
- ***Add or terminate dependents from coverage***

FSA ELECTIONS

Each year, you will need to re-enroll for your FSA elections. The FSA elections will NOT rollover.

QUESTIONS ABOUT YOUR BENEFITS?

The CDU Benefits Call Center and Benefits portal are available to assist you with any benefit questions you may have.

The Benefits Call Center is available:

Monday – Thursday:
5 a.m. – 5 p.m. PST, and
Friday: 5 a.m. – 3 p.m. PST

(855) 230-0745,
extension 6412

customersupport@benxcel.com
www.benxcel.net

EMPLOYEE CONTRIBUTIONS

Your benefit contributions are automatically payroll deducted each pay period. Contributions for Medical, Dental, Vision, and Flexible Spending Accounts are deducted on a pre-tax basis. Deductions for certain other benefits are deducted on an after-tax basis in order for you to receive a tax-free benefit at time of claim.

The IRS requires that you pay taxes for domestic partner coverage if your domestic partner and the children of your domestic partner are not considered your IRS tax dependent. This impacts you in two ways. First, your payroll contribution for domestic partner coverage is an after-tax deduction. Second, CDU's cost of providing domestic partner coverage is added to your taxable income. Please contact Human Resources for a detailed description of the domestic partner requirements.

CARRIER	COVERAGE	CATEGORY	EMPLOYEE SEMI-MONTHLY COST	CDU SEMI-MONTHLY COST
Kaiser	Medical HMO	EE Only EE + Spouse EE + Child(ren) EE + Family	$57.48 $184.45 $140.19 $243.47	$309.80 $623.56 $520.91 $895.09
Aetna	Medical HMO	EE Only EE + Spouse EE + Child(ren) EE + Family	$57.88 $185.74 $141.17 $245.18	$312.64 $629.37 $525.73 $903.46
Aetna	Medical OAMC	EE Only EE + Spouse EE + Child(ren) EE + Family	$108.80 $314.50 $247.94 $430.62	$475.76 $971.51 $804.24 $1,381.59
DeltaCare USA	Dental HMO	EE Only EE + Spouse EE + Child(ren) EE + Family	$1.75 $4.42 $4.21 $6.53	$5.92 $8.78 $9.74 $14.96
Delta Dental of CA	Dental PPO	EE Only EE + Spouse EE + Child(ren) EE + Family	$5.54 $14.63 $16.68 $25.37	$17.97 $32.10 $32.71 $50.72
VSP	Vision	EE Only EE + Spouse EE + Child(ren) EE + Family	$2.57 $4.11 $3.30 $5.19	$1.19 $3.41 $3.84 $6.08
New York Life	Basic Life / AD&D Dependent Life Voluntary Life Voluntary AD&D	EE Only Dependents EE + Family EE + Family	CDU Paid Employee Paid Employee Paid Employee Paid	
Aetna	EAP	EE + Family	CDU Paid	
New York Life	STD / LTD	EE Only	CDU Paid	
Benefit Coordinators Corp (BCC)	Health Care FSA and Dependent Care FSA	Health Care up to $3,050/yr. Dep. Care up to $5,000/yr.	Employee Paid	
Voluntary Accident, Critical Illness, Hospital Indemnity	UNUM	EE + Family	Employee Paid	

MEDICAL

CDU has three medical plans to choose from. Please refer to our Medical Plan Comparison Chart on the next page for more details about these plans, or refer to your carrier benefit summaries.

AETNA HMO

The Aetna HMO plan is designed for you to visit in-network providers that are contracted with Aetna. You will need to choose a Primary Care Physician (PCP) and coordinate care with any Specialists through this PCP. Note that services received outside the Aetna HMO network are not covered except for emergency services.

AETNA OPEN ACCESS MANAGED CHOICE (OAMC)

The Aetna OAMC plan offers more flexibility in selecting providers. As a OAMC plan member, you may receive health care services from any licensed health care provider. However, if you choose an in-network provider (a provider who belongs to the Aetna Open Access network), claims will be submitted to Aetna for you and there is a significant cost savings compared to using a non-network provider. When using
non-network providers, members are responsible for any difference between the in-network contracted rate and the actual charges, as well as any deductible and coinsurance percentage.

KAISER PERMANENTE HMO

Under the Kaiser HMO plan, most services are covered in full or require a copay through Kaiser. You may select a Primary Care Physician from any of the Kaiser Permanente locations, but it is not required.

You can enroll in the Kaiser Permanente HMO if you live or work within the Kaiser service area. Under the plan, you must receive
non-emergency, routine and scheduled services (e.g., preventive care appointments, school physicals) from Kaiser physicians and facilities. Emergency care is covered at any hospital facility, including non-Kaiser facilities.

PRESCRIPTION DRUGS

If you are on a maintenance medication (e.g. high blood pressure, allergies, birth control, or other daily medications), you can save time and money by having your prescriptions dispensed through the mail order program.

Please note that the prescription drug formulary lists are periodically updated by the insurance carriers. Based on these updates, some drugs will change Rx tier, may require step therapy/pre-authorization or may require an alternative drug. These updates generally apply to all of the carrier's plans, not just to CDU's plan.

LOCATE A PROVIDER

To find participating providers, please use the Provider Search instructions on the BCC website.

MEDICAL PLANS COMPARISON

Each medical plan charges different copays and coinsurance for various services. The chart below provides a comparison of basic costs and services of the plans CDU offers. This chart is only a partial listing of plan features.

MEDICAL PLAN OPTIONS				
FEATURE OR SERVICE	**KAISER PERMANENTE HMO**	**AETNA HMO**	**AETNA OPEN ACCESS MANAGED CHOICE (OAMC)**	
			NETWORK	**NON-NETWORK**
Annual Deductible	None	None	$1,000 / Member $2,000 / Family	$2,000 / Member $4,000 / Family
Out-of-Pocket Maximum **Individual** **Family**	 $1,500 $3,000	 $2,000 $4,000	 $3,500 $7,000	 $7,000 $14,000
Office Visit	$30 per visit	$15 per visit (PCP) $30 per visit (Specialist)	$25 per visit (PCP) $50 per visit (Specialist)	40% after deductible
Preventive (physical exams, well-baby, etc)	No charge	No charge	No charge (deductible waived)	40% after deductible
Diagnostic X-Ray & Lab	No charge	No charge	20% after deductible	40% after deductible.
Urgent Care	$30 copay	$35 copay	$35 copay (deductible waived)	40% after deductible
Emergency Room (copay waived if admitted)	$100 copay	$150 copay	$150 copay + 20% (deductible waived)	$150 copay + 20% (deductible waived)
Chiropractic	Not covered	$15 per visit (20 visits/year)	$50 (20 visits/year) (deductible waived)	40% after deductible (20 visits/year)
Acupuncture	$30 per visit for certain services	$15 per visit (20 visits/year)	$25 (20 visits/year) (deductible waived)	40% after deductible (20 visits/year)
Hospital Coverage **Inpatient (to avoid add'l copays, preauthorization is recommended)** **Outpatient**	$500 per admit $100 per procedure	$250 per admit $100 per surgery	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Prescription Drug Retail Day Supply: **Preferred Generic** **Preferred Brand** **Non-Preferred** **Specialty**	Up to 30 days $15 copay $30 copay Not applicable 30% up to $150/ script	Up to 30 days $10 copay $30 copay $50 copay 30% up to $200/script	Up to 30 days $10 copay $30 copay $50 copay 20% up to $200/script	Not Covered
Prescription Drug Mail Order Day Supply: **Preferred Generic** **Preferred Brand** **Non-Preferred**	Up to 100 days $30 copay $60 copay Not applicable	Up to 90 days $20 copay $60 copay $100 copay	Up to 90 days $20 copay $60 copay $100 copay	Not Covered

AETNA PROGRAMS

- ***24/7 Nurse Line***
- ***Teledoc***
- ***Maternity Program***
- ***Simple Steps To a Healthier Life***
- ***Attain***
- ***Discount Programs***
- ***Fitness Discounts***
- ***Rx Mail Order.***

AETNA PROGRAMS AND SERVICES

24/7 NURSE LINE – INFORMED HEALTH ® | (800) 556-1555

The Informed Health ® program provides members with telephone and e-mail access to registered nurses to help them make informed healthcare decisions. Nurses are available 24 hours a day and 7 days a week.

TELEDOC ® | (855) 835-2362

Teladoc® is a convenient and affordable option for a variety of medical services, including General Medical, Dermatology and Behavioral Health. Access quality healthcare from the comfort of home, during your lunch break or while traveling. You can even get a prescription sent to your local pharmacy, when medically necessary.

BEGINNING RIGHT ® MATERNITY MANAGEMENT | (800) 272-3531

Pregnancy can be an exciting time filled with hopes and dreams for your baby! The most important thing you can do right now to make those dreams come true is to take good care of yourself. This program is designed to help you have a safe delivery and a healthy child. The line is staffed by registered nurses 24 hours a day, seven days a week. Enroll early and receive a reward when you sign up by the 16th week of pregnancy.

- A toll-free number you can call about pregnancy, labor, what to expect before and after delivery , newborn care, and more.
- Some women have health conditions that could affect their pregnancies,. If you do, you can work with a nurse case manager to help you lower those risks.
- Support to quit smoking and help to avoid you going into early labor.

WELLNESS AND DISCOUNT PROGRAMS

Simple Steps To a Healthier Life ® is a road to better health with programs and resources tailored to meet your needs. Aetna offers online coaching programs that are customized to your health and interests. Plus, you can earn a $50 gift card by taking that first step.

The Attain by Aetna® app combines your health history with your Apple Watch® activity to offer personalized goals,* achievable actions and big rewards — like an Apple Watch or gift cards. Explore more at https://www.attainbyaetna.com/.

To locate the discounts that are available to you, once you're an Aetna member, just log in to your member website at aetna.com. You can find a vision, hearing or natural therapy professional, sign up for a weight-loss program, buy health products, find a gym, and more.

KAISER PERMANENTE HEALTHY LIVING PROGRAMS

As a Kaiser Permanente member, you have access to discounts on health products and services through ChooseHealthy. As a comprehensive health website offering a directory of complementary health care providers, information about complementary health care services, and discounts on health and wellness products such as:

- Acupuncture
- Massage therapy services
- Fitness club memberships
- Chiropractic care
- Herbs, vitamins, and supplements
- Health and fitness books and videos

Visit www.kp.org/choosehealthy and click on "complementary care" or call American Specialty Health at **(877) 335-2746** to learn more about this program, sign up, or take an online tour.

MY HEALTH MANAGER | www.kp.org/register

My Health manager gives you access to powerful online tools designed to help you manage your health. You can email your doctor's office, order prescription refills, view most lab test results, request routine appointments, check past office visit information, look up future appointments, and more. Once you register, you will be able to get connected in a single visit, without having to wait for your password to be emailed to you.

HEALTHY LIFESTYLE PROGRAMS

Take advantage of these convenient perks — from personal health coaching to reduced rates on alternative medical therapies:

- Live healthier with helpful resources – With our wellness resources, you'll get tools, tips, and information to help you create positive changes in your life. Our complimentary resources can help you, lose weight, eat healthier, quit smoking, reduce stress, manage ongoing conditions like diabetes or depression. Visit http://www.kp.org/health-wellness for more information.
- Connect to a wellness coach – If you need more support, Kaiser offers coaching by phone at no cost. You'll work on-on on with your personal coach to make a plan to help you reach your health goals. Visit http://www.kp.org/wellnesscoach for more information.
- Join health classes – With all kinds of health classes and support groups offered at Kaiser facilities, there's something for everyone. Classes vary at each location, and some may require a fee. Visit http://www.kp.org/classes for more information.
- Take time for self-care – Manage stress, improve mood, sleep better, and more with the help of wellness apps, available at no cost to adult members. Visit http://www.kp.org/selfcareapps for more information.

Kaiser | www.kp.org

- ***Manage Your Health***
- ***Schedule Appointments***
- ***Refill Prescriptions***
- ***Email Your Doctor***
- ***View Test Results***
- ***Tools and Calculators***
- ***Health Classes***
- ***Healthy Lifestyle Programs***

Using the Kaiser Permanente website, you can access the latest healthy lifestyle and medical information right from your own home – anytime, day, or night. Whether you'd like to quit smoking, lose weight, control your cholesterol, start a fitness program, manage your diabetes, or reduce stress, the Kaiser Permanente website can help.

DENTAL

You and your eligible dependents have the option to enroll in one of two dental plans: the Deltacare Dental DHMO plan or the Delta Dental DPPO plan.

Under the DeltaCare Dental DHMO, there are no deductibles and most dental benefits are unlimited. Each family member must select a Primary Dentist/ Facility from the list of Delta Dental dentists when they enroll. All services and referrals to specialty care will be coordinated by the Primary Dentist/Facility.

The Delta Dental DPPO allows you the flexibility of seeing a network dentist and receiving benefits at a discounted rate, or seeing a non-network dentist and paying the difference between the fee schedule* charges and what your dentist bills. There is no need to select a dentist at enrollment under the Dental DPPO plan.

Using Your Dental Benefits Wisely

- ***To pay the least amount out-of-pocket, always use in-network dentists under the DPPO.***
- ***Use your preventive benefits and get cleanings for you and your family.***
- ***If your services are estimated to be $350 or more by your dentist, be sure to have your dentist get pre-determination of benefits to Delta Dental to ensure services are covered and to get an estimate of what the plan will pay.***

DENTAL PLAN OPTIONS			
FEATURE OR SERVICE	**DELTACARE DHMO**	**DELTA DENTAL DPPO**	
		NETWORK	**NON-NETWORK**
Deductible	**None**	**$50 / Individual $150 / Family**	
Deductible Waived on Preventive Services?	**N/A**	**Yes**	
Annual Calendar Year Benefit Maximum	**Unlimited**	**$1,500**	**$1,250**
Preventive Services	**copay schedule**	**No charge**	**80% covered**
Basic Services	**copay schedule**	**80% covered**	
Major Services	**copay schedule**	**50% covered**	
Orthodontia	**copay schedule**	**lifetime max of $1,500**	

Fee Schedule**: Claims incurred outside of the Delta Dental PPO dental network are subject to fee schedule levels. Fee schedule represents the maximum dollar amount Delta Dental will pay on certain services. ***The member is responsible for any amounts charged over the fee schedule.

VISION

You have the opportunity to participate in the VSP Vision Plan. The vision program allows you to utilize VSP's network of eye care providers or see an eye care professional outside the network.

NETWORK vs. NON-NETWORK COVERAGE

Dollar for dollar, you get the best value from your vision benefit when you visit a VSP in-network doctor. If you decide to see a non-network doctor, copays still apply and you'll typically receive a lesser benefit. When you use a non-network doctor, you are required to pay the provider in full at the time of your appointment and submit a claim form to VSP for reimbursement.

How Long Has It Been Since Your Last Eye Exam?

Your eyes provide a clear view of your blood vessels. Optometrists and Ophthalmologists can be the first to detect symptoms of illnesses such as cardiovascular disease, diabetes, and thyroid disorders.

VISION PLAN HIGHLIGHTS		
FEATURE OR SERVICE	**NETWORK**	**NON-NETWORK**
Deductible for Materials	**$20**	
Exams	**$15**	**$45 Allowance**
Lenses*		
Single	**Paid in full**	**$30 Allowance**
Lined-Bifocal	**Paid in full**	**$50 Allowance**
Lined-Trifocal	**Paid in full**	**$65 Allowance**
Frames	**$120 Retail Allowance (plus 20% off amount over the allowance)**	**$70 Allowance**
Contacts (including fitting and evaluation)**	**$120 Retail Allowance**	**$105 Retail Allowance**
Frequency		
Exams	**12 Months**	
Lenses	**12 Months**	
Frames	**12 Months**	
Contacts (in lieu of lenses and frames)	**12 Months**	

**Members may be offered discounted fees for extra features added to lenses such as tinting, scratch coating, and progressive (blended bifocals) lenses when they utilize VSP providers.

**Members have the choice between lenses or contacts each 12-month interval. If you choose contact lenses, you will not be eligible for a frame for 12 months following the date contacts were obtained. Note, the contact lens evaluation fee and fitting costs are separate from the comprehensive vision care exam.

LASER VISION CARE

VSP has contracted with many of the nation's laser surgery facilities and doctors, offering members discounts off laser vision correction surgeries, available through contracted laser centers. Contact VSP to learn more.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT AND VOLUNTARY LIFE

Life insurance is an important part of a complete benefits package offered by CDU. CDU pays 100% of the cost of a Basic Life and Accidental Death & Dismemberment (AD&D) for all eligible employees through New York Life.

BASIC LIFE & AD&D INSURANCE

The basic life policy will pay a benefit of one times your annual salary to a maximum of $400,000, with a minimum benefit of $50,000. The benefit amount will reduce to 65% of the original amount when you reach age 65, and to 50% of the original amount at age 70. Spouse reductions are based on the spouse's age.

NOTE: To avoid imputed income on the premium for life insurance amounts over $50,000, you may opt to reduce your Basic Life/AD&D coverage to $50,000.

VOLUNTARY LIFE COVERAGE

CDU also offers voluntary life insurance. You may purchase additional Life insurance, for not only yourself, but also your dependents. The coverage amount will reduce to 65% at age 65 and 45% at age 70. You are eligible to purchase the following amounts:

VOLUNTARY LIFE PLAN OPTIONS	
COVERAGE TYPE	**COVERAGE AMOUNTS**
Employee	• **In increments of $10,000** • **The lesser of $500,000 or 5x salary** • **Guarantee Issue $100,000 (new employees only)**
Spouse/Domestic Partner	• **In increments of $5,000** • **Maximum 50% of Employee Face Amount, not to exceed $250,000** • **Guarantee Issue $50,000 (new employees only)**
Children	• **In increments of $2,000** • **Maximum of $10,000** • **Birth to 6 months limited to $1,000 coverage amount**

VOLUNTARY LIFE MEDICAL UNDERWRITING

The Guarantee Issue amounts apply only when you are first eligible for benefits under the CDU plan. If you (and/or your dependents) do not elect voluntary life insurance coverage when first eligible, the entire amount of life insurance elected will require medical underwriting.

Please note that certain changes during the year (e.g., salary updates) could result in an adjustment to your payroll deduction amounts.

Voluntary Life Insurance Features

Accelerated Benefit:

If you become terminally ill and are not expected to live beyond a certain period, you may request a % of your life insurance amount (to a certain maximum). Upon your death, the remaining benefit will be paid to the designated beneficiary(ies).

Portability and Conversion:

If you retire, reduce your hours, or terminate employment, you can generally take this coverage with you according to the terms outlined in the contract.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE COVERAGE

You: All active, Full-Time Employees of the Employer regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

Your Spouse*: Up to age 70, as long as you apply for and are approved for coverage yourself.

Your Child(ren): Is eligible as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

Voluntary AD&D Insurance Features

Portability and Conversion:

If you retire, reduce your hours, or terminate employment, you can generally take this coverage with you according to the terms outlined in the contract.

VOLUNTARY AD&D PLAN		
	BENEFIT AMOUNTS	**MAXIMUM**
Employee	**Units of $10,000**	**Lesser of 5 times salary or $500,000**
Spouse	**Units of $5,000**	**$250,000**
Children	**Units of $2,000**	**$10,000**

SHORT TERM DISABILITY

CDU has purchased Short Term Disability (STD) on your behalf. Our Short Term Disability program provides a source of weekly income should you become disabled and you are unable to work.

Benefits are paid for any non-occupational illness or injury that causes disability, including pregnancy and pre-existing conditions. The amount of your benefit equals 60% of your pay, up to a weekly maximum benefit of $1,750.

Why are Short Term Disability benefits important?

- ***Two-thirds of disabilities are non-work related and therefore, are not covered by worker's compensation.***
- ***Managing treatment early, especially for disabilities that could become long-term, can mean better outcomes.***

PLEASE NOTE!

Benefits are integrated with any amount you receive, or are entitled to receive, under such things as any state compulsory benefit act or law, or Social Security disability.

SHORT TERM DISABILITY BENEFITS	
FEATURE	**BENEFIT**
Income Replacement	**60% of your weekly covered earnings**
Weekly Maximum	**$1,750**
Benefit Waiting Period	**60 days for accident** **60 days for sickness**
Maximum Benefit Period	**26 weeks (includes Benefit Waiting Period)**

LONG TERM DISABILITY

Long Term Disability insurance is an essential part of a complete benefits package offered by CDU. This program covers disabling injuries or sicknesses that CDU pays 100% of the cost of Long Term Disability coverage for all eligible employees through New York Life. You must be continuously Disabled for 180 Days before benefits will be paid for a covered Disability.

The benefits under this plan are paid out at the following level:

LONG TERM DISABILITY BENEFITS	
FEATURE	**BENEFIT**
Income Replacement	**60% of your monthly covered earnings**
Monthly Maximum	**$12,500**
Elimination Period	**180 days**
Maximum Benefit Period	**Generally, Social Security Normal Retirement Age**
Pre-existing Condition Limitation	Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), during the 12 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after a continuous period of 12 months without any medical treatment, care of services in connection with the pre-existing conditions, and you have been insured under this plan for at least 24 months after your most recent effective date of insurance.

Did You Know?

Only 5% of baby boomers realize they have a one-in-three chance of becoming disabled during their working years.

And . . .

Without a paycheck, the typical employee's savings lasts less than 5 weeks.

PLEASE NOTE!

Benefits are integrated with any amount you receive, or are entitled to receive, under such things as any state compulsory benefit act or law, or Social Security disability.

Worksite Benefits - UNUM

Voluntary Accident Insurance

CDU provides voluntary Accident coverage through UNUM. Accident coverage provides a cash benefit in one lump sum if you or a covered family member is injured because of an accident. Use accident coverage to help pay for out-of-pocket medical costs, such as ambulance fees, physical therapy, X-rays or daily expenses like rent, food, transportation. This plan covers accidents that occur both at and outside of the workplace.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- No medical questions or exam needed to enroll.
- You can take your coverage with you even if you leave your employer.
- No limitations for pre-existing conditions.
- Covers accidents that occur on and off the job.
- You can keep your coverage if you change jobs or retire, if you port the coverage you'll be billed directly.

Voluntary Critical Illness

CDU provides voluntary Critical Illness coverage through UNUM. Critical illness coverage provides benefits for heart attack, stroke, invasive cancer, major organ transplant, and neurological conditions such as advanced Alzheimer's and advanced Parkinson's. The coverage pays for the first diagnosis of certain illnesses after your coverage becomes effective. It may also cover a new cancer diagnosis even with a previous cancer diagnosis.

Key features:

- You will receive a tax-free cash payment to help you focus on your health.
- Coverage is available for yourself, your spouse, and your dependent children.
- Coverage is portable. You may take the coverage with you if you leave the company or retire, you'll be billed directly
- Every year, each family member who has Critical Illness coverage can also receive $75 for getting a covered Be Well Benefit screening test

Voluntary Hospital Indemnity

CDU provides voluntary Hospital Indemnity coverage through UNUM. Hospital Indemnity provides a lump-sum, tax-free cash benefit to help pay for costs that can come with a hospital stay. Use your hospital indemnity coverage to help pay for out-of-pocket medical costs or daily expenses like rent, food or transportation.

Key features:

- Covers hospitalization for normal pregnancy from day one with no waiting period.
- No limitations for pre-existing conditions.
- No medical questions or exam needed to enroll.
- Coverage is available for yourself, your spouse and dependent children.
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.
- Every year, each family member who has Hospital coverage can also receive $50 for getting a covered Be Well screening test

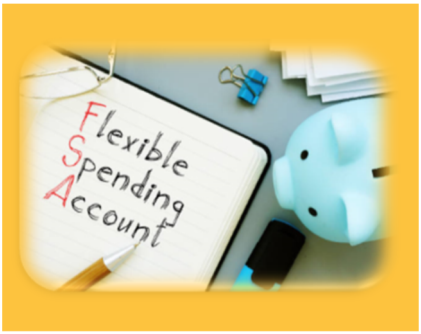
PLEASE NOTE!

If enrolled on the Hospital Indemnity plan and/or the Critical Illness plan you are eligible for the Be Well Benefit.

Be Well Benefit

Be Well screening test includes:

- ***Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams***
- ***Screenings for cancer, including pap smear, colonoscopy***
- ***Cardiovascular function screenings***
- ***Screenings for cholesterol and diabetes***
- ***Imaging studies, including chest X-ray, mammography***
- ***Immunizations including HPV, MMR, tetanus, influenza***



FLEXIBLE SPENDING ACCOUNTS

The reimbursement accounts offer you a great way to save money. These accounts allow you to set aside pre-tax money from each paycheck to pay for eligible out-of-pocket health care or dependent care expenses that you and your dependents incur throughout the plan year. Budget carefully! Unused funds are forfeited at the end of the plan year.

Since the deduction comes out of your paycheck before taxes are computed, your taxable income is reduced. This means you pay less income tax!

IT'S EASY

You determine how much money to set aside in your account(s) for the plan year. The amount is then subtracted in equal amounts from each paycheck BEFORE taxes are deducted. The per-pay-period amount is then deposited into your personal reimbursement account(s).

Claims are paid once a week. When you have a health care expense not covered by our medical, dental, or vision plans, you pay the bill using your FSA debit card. You can also submit a claim for reimbursement manually by filling out a claim form and submitting it to our plan administrator, BCC. Claim forms are available via the BCC benefits portal.

MAXIMUM CONTRIBUTIONS

The maximum amount you can contribute to an FSA during the plan year is:

- Health Care Reimbursement Account: $3,050
- Dependent Care Reimbursement Account: $5,000

Please note: If your spouse participates in a separate Dependent Care Reimbursement Account, the total combined amount between both accounts cannot exceed $5,000.

CLAIMS SUBMISSION DEADLINE

You have a 2½ month grace period after the end of the plan year, to incur additional expenses. This means you may incur expenses through March 15, 2025.

For the 2024 plan year, you have until March 31, 2025, to submit claims to BCC for expenses incurred between January 1, 2024, and March 15, 2024.

After March 31, 2025, any unused money in either reimbursement account will be forfeited, as required by the IRS.

DEPENDENT CARE ELIGIBLE EXPENSES

- Child care services provided inside or outside your home, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child)
- The child must be up to 13 years of age and must be your dependent under federal tax rules.

ENROLL EVERY YEAR!

You must re-enroll in the FSA plan every year at Open Enrollment to continue your FSA benefits – elections will NOT roll over year-to-year.

USE IT OR LOSE IT!

You must use all of the money in your FSA for eligible expenses incurred during the plan year or forfeit it. You can visit the http://www.fsastore.com for unused funds.

FSA ELIGIBLE EXPENSES!

An in-depth outline of FSA eligible expenses can be found online at https://fsastore.com/FSA-Eligibility-List.aspx.
If you have questions regarding a potentially qualifying expense, please contact BCC's Customer Service Center at (800) 685-6100.

HEALTH CARE REIMBURSEMENT ACCOUNT

Over-the-counter medicines are eligible for reimbursement without a prescription, along with Feminine menstrual care products.

MY FLEXIBLE SPENDING ACCOUNTS

TRANSPORTATION BENEFIT INFORMATION

Work-related commuting expenses can really add up! Fortunately, you can be reimbursed for a number of those expenses under your company-sponsored Commuter Benefit program. Below is a list of eligible transportation expenses and the steps to take to apply for reimbursement if you do not use your existing FSA benefits debit card.

TRANSPORTATION EXPENSES

- Transit Pass
- Transit Token
- Transit Fare-Care
- Transit Voucher
- Van-Pooling
- Commuter Highway Vehicle Expense*
- Similar items may also be eligible for reimbursement pending approval from your employer

**A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults, not including the driver, used for travel between the employee residence and place of employment.*

HOW CAN I GET REIMBURSED?

You can use your existing FSA debit card at the point of service to pay for eligible expenses OR submit a paper reimbursement form with substantiation to BCC by following these instructions:

1. Get receipt for your commuter expense.
2. Complete the Commuter Expense Reimbursement Request Form and attach a copy of the receipt.
   - *If you cannot obtain a receipt, you must complete and sign the Employee Certification section AND the Authorization section of the Reimbursement Form.*
3. Send the completed form and receipt:
   - **BY MAIL**: BCC, Attn: Claims
Two Robinson Plaza, Ste. 200
Pittsburgh, PA 15205
   - **BY FAX**: 412-276-7185
   - **BY E-MAIL**: fsa-claims@benxcel.com
   - **MY SMARTCARE**: online portal or mobile app

For more information, contact BCC's Customer Service Center at 800-685-6100.

COMMUTER BENEFITS ACCOUNT

- ALLOWS YOU TO SET ASIDE PRE-TAX DOLLARS FOR QUALIFIED MASS TRANSIT EXPENSES ASSOCIATED WITH YOUR DAILY COMMUTE TO WORK
- ELIGIBLE EXPENSES INCLUDE BUS/FERRY/SUBWAY TICKETS AND PASSES, AND VANPOOL FEES
- BENEFITS OF ENROLLING:
  - MONEY CONTRIBUTED IS TAX FREE AND REMAINS TAX FREE WHEN SPENT ON ELIGIBLE MASS TRANSIT EXPENSES
  - ON AVERAGE, PARTICIPANTS ENJOY A 30% TAX SAVINGS ON THEIR ANNUAL CONTRIBUTION
  - YOU CAN ADJUST YOUR CONTRIBUTION AT ANY TIME

2024 MONTHLY CONTRIBUTION LIMITS:

- $300 for mass transit expenses

mySMARTCARE

EMPLOYEE ASSISTANCE PROGRAM

Our Employee Assistance Program (EAP) through Aetna will help you with a wide spectrum of resources including Community Referrals, Legal Services, Online Tools, and Counseling.

Daily life assistance:

- Child Care
- School and financial aid research
- Elder Care
- Household Services
- Attorney Services (Family law, Divorce, Wills and document prep)
- Special Needs
- Pet Care
- Financial Counseling (Retirement, credit/debt issues, college planning)

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week

Occasionally, personal problems may arise or situations may develop that interfere with your ability to perform your job effectively. When this occurs, it is important to have an understanding person accessible who can offer professional assistance. Aetna is available to help you, or an eligible dependent address life stressors that may include:

- Family or Marital Conflict
- Anxiety
- Depression
- Grief, loss, or responses to traumatic events
- Work life balance
- Stress Management
- Substance misuse
- Self-esteem and personal development
- Identity theft recovery services

Benefits also include up to six confidential sessions per issue per year – at no charge. If further help past the initial sessions is necessary, the EAP can assist you in coordinating additional treatment through your medical plan.

EMPLOYEE ASSISTANCE PROGRAM	
FREE Face-to-face Counseling Sessions	**Up to 6 face-to-face sessions per family member per problem each year**
24-Hour Hotline	**1 (800) 342-8111 / TTY:711**
Website	**Resourcesforliving.com** **User Name: CDREWU Password: EAP**

THIS REPRESENTS ONLY A SUMMARY OF BENEFITS.

DETAILS AND PLAN DESCRIPTIONS ARE AVAILABLE IN THE HUMAN RESOURCES DEPARTMENT.

OTHER BENEFITS

TALKSPACE

Talkspace is an online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist – from anywhere, at any time. With Talkspace, you can send unlimited text, video and audio messages to your dedicated therapist via web browser or the Talkspace mobile app. You can also schedule real-time 30 minute live sessions. No commutes, appointments or scheduling hassles.

- **1-800-342-8111 / TTY 711**
- **resourcesforliving.com**
- **Username: CDREWU**
- **Password: EAP**

RETIREMENT PLANS

The University offers a Group Retirement Plan (GRP) and a Supplemental Retirement Plan (SRP). The Group Retirement Plan is a defined contribution plan fully funded by the University at the rate of 7% of the benefits eligible employee's earnings. Eligible employee must be classified as benefits eligible, at least 18 years old; completed one year of continuous services with the University and worked at least 1,000 hours.

The Supplemental Retirement Plan (SRA) is solely funded by the employee through a set pre-tax payroll deduction of 3%, via automatic enrollment, into a default investment fund. New hires have the option to opt-out or change their contribution and investment options. Based on IRS guidelines, the maximum contribution for the year 2024 is $23,000. Catch-up contribution for age 50 or older is $7,500.

VACATION

The University provides vacation time to all eligible employees. The vacation year shall coincide with the employee's anniversary date. Vacation benefits will begin to accrue on day one of hire. The vacation accrual schedule and accrued maximum for a full-time employee is as follows:

- 0 months to 5 years: 10 hours per month up to maximum 180 hours
- 5 years and 1 month to 14 years: 13.33 hours per month up to maximum 240 hours
- 14 years and 1 month and above: 16.66 hours per month up to maximum 300 hours

SICK TIME

Beginning the first day of employment, sick leave accrues at a rate of 8 hours per month to a maximum of 480 hours (60 days). Sick leave can be used as it is accrued, and can be used for the illness of the employee or to care for a sick family member (child, spouse, or parent). It may also be used for medical or dental appointments, including routine checkups or treatment. Sick leave will be integrated with state disability insurance, and CDU provided Short & Long Term Disability as appropriate.

COMMUNITY SERVICE LEAVE

Community Service Leave (CSL) is provided each calendar year to all benefits-eligible employees working twenty (20) hours or more a week. CDU allows employees to take up to sixteen (16) hours of leave time each calendar year with approval of your supervisor to participate in specific approved community volunteer activities or programs.

LEAVE DONATION PROGRAM

The Leave Donation Program provides salary and benefits continuation for eligible employees who have exhausted all paid leave due to their own serious illness or injury, or due to the need to care for an immediate family member who has experienced a catastrophic illness or injury.

OTHER BENEFITS

LEAVES OF ABSENCE

The University complies with the State and Federal laws for provision of leaves of absence. These include Pregnancy Disability Leave (PDL), Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Paid Family Leave, Parent Time Off for School Activities, and Military Leave. For specific information regarding eligibility for leaves of absence, please contact the Human Resources Department. Sick leave will be integrated with state disability insurance, and CDU provided Short & Long Term Disability as appropriate.

EDUCATION

Educational leave may be used to pursue course work at an academic institution for up to 4 hours per week. Educational leave is unpaid. Approval of educational leave is at the discretion of the supervisor.

EMPLOYEE TUTION BENEFIT

The University provides the opportunity for qualified employees who have completed two years of continuous service and their dependents to participate in Employee Tuition Benefit (ETB) program. ETB is applicable to admission and enrollment in selected academic programs at the degree, certificate, or track levels.

THIS REPRESENTS ONLY A SUMMARY OF BENEFITS.

DETAILS AND PLAN DESCRIPTIONS ARE AVAILABLE IN THE HUMAN RESOURCES DEPARTMENT.

JURY DUTY

The University encourages employees to fulfill their civic responsibilities by serving jury duty when required. All employees will receive their usual compensation for up to 10 days while excused from his/her work in order to satisfy jury duty obligations.

BEREAVEMENT

Bereavement leave is granted to all regular and conditional employees to make arrangements for and/or attend the funeral or memorial service of an immediate family member of the employee's family. Paid bereavement leave is for five (5) days, and must be used within 3-months of the date of death.

LIBRARY

A free library card is available to any regular full-time employee. An employee may use the services of the campus library during campus hours.

WORKING ADVANTAGE

A 10 million member employee shopping network allows subscribers to save up to 60% on purchases such as: Movie Passes, Broadway Shows, Theme Parks, Ski Tickets, Sports Events, Hotels and Travel, Health and Fitness, Museums and City Passes, Merchant Gift Certificates, Online Shopping….and much more!

PARKING

Parking is free and available on the 118th street side of the Cobb Building. A Parking Permit will be issued by the Campus Safety Office.

Electric Car Charging Stations

Students, Faculty, Staff and Visitors have the convenience of charging their electric vehicles in the parking lot on 118th Street, for $2.00 per hour. Currently, we have a total of 18 charging stations.

Telecommuting Benefits

The University provides a monthly $50.00 allowance to eligible employees who are required to work remotely. Eligibility varies, and Manager and HR approval required.

QUESTIONS?

This guide summarizes the benefits that are available to you as an employee of CDU. For specific questions, please contact the Benefits Call Center (BCC) or the benefits providers at the phone numbers listed on this page.

CARRIER/VENDOR CONTACTS

BENEFIT	PROVIDER	GROUP ID	PHONE/WEBSITE
Medical HMO and OAMC	Aetna	# 120219 - HMO and OAMC	(800) 445-5299 (HMO) (877) 204-9186 (OAMC) www.aetna.com
Medical HMO	Kaiser	# 227461	(800) 464-4000 www.kp.org
Dental DHMO	DeltaCare USA	# 75418	(800) 422-4234 www.deltadentalins.com
Dental DPPO	Delta Dental of CA	# 02642	(800) 765-6003 www.deltadentalins.com
Vision	VSP	# 00112813	(800) 877-7195 www.vsp.com
Basic Life and AD&D Insurance	New York Life	# FLX969287 - Life # OK970729 - AD&D	(888) 842-4462 www.newyorklife.com/group-benefit-solutions/forms
Voluntary Life Insurance	New York Life	# FLX969287	(888) 842-4462 www.newyorklife.com/group-benefit-solutions/forms
Voluntary AD&D Insurance	New York Life	# OK970729	(888) 842-4462 www.newyorklife.com/group-benefit-solutions/forms
Disability Insurance	New York Life	# LK752614 - STD # LK966172 - LTD	(888) 842-4462 https://www.newyorklife.com/group-benefit-solutions/employees/group-insurance/disability/how-to-file-claim
Accident, Hospital Indemnity, and Critical Illness	UNUM	# 919673 - Accident # 919674 - Critical Illness # 919675 - Hospital	(800) 635-5597 unum.com/claims
Flexible Spending Accounts	BCC	CDU	(855) 230-0745, extension 6412 https://benxcel.net
Employee Assistance Program	Aetna	N/A	1-800-342-8111 / TTY 711 www.resourcesforliving.com Username: CDREWU PW: EAP
Discount Program	Working Advantage	# 80566247	(800) 565-3712 www.workingadvantage.com
Discount Program	Employee Savings Tickets	Charles R. Drew University	(310) 316-3384 www.est.us.com Access code: CDUFUN
Retirement Account	TIAA-CREF	# 151047	(800) 842-2252 www.tiaa.org
Retirement Services & Education	Pensionmark Retirement Group	Charles R. Drew University	(888) 201-5488 www.pensionmark.com
Benefits Call Center	BCC	CDU	(855) 230-0745, extension 6412 https://benxcel.net

REQUIRED NOTICES

Patient Protections Disclosure

The Charles R. Drew University of Medicine and Science Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna and Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aetna at 800.445.5299 or www.aetna.com and Kaiser at 800.464.4000 or www.kp.org.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Aetna and Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna at 800.445.5299 or www.aetna.com and Kaiser at 800.464.4000 or www.kp.org.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Aetna

Plan 1: AETN AHMO (Individual: 0% coinsurance and $2,000 deductible; Family: 0% coinsurance and $4,000 deductible)

Plan 2: AETNA OPEN ACCESS MANAGED CHOICE (OAMC) (Individual: 20% coinsurance and $3,500 deductible; Family: 20% coinsurance and $7,000 deductible)

Kaiser

Plan 1: KAISER PERMANENTE HMO (Individual: 0% coinsurance and $1,500 deductible; Family: 0% coinsurance and $3,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 323.563.5834 or CharlesBugarin@cdrewu.edu.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Charles R. Drew University of Medicine and Science is committed to the privacy of your health information. The administrators of the Charles R. Drew University of Medicine and Science Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Charles Bugarin - Human Resources Manager at 323.563.5834 or CharlesBugarin@cdrewu.edu.

HIPAA Special Enrollment Rights

Charles R. Drew University of Medicine and Science Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Charles R. Drew University of Medicine and Science Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Charles Bugarin - Human Resources Manager at 323.563.5834 or CharlesBugarin@cdrewu.edu.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Charles R. Drew University of Medicine and Science
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Charles R. Drew University of Medicine and Science and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Charles R. Drew University of Medicine and Science has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Charles R. Drew University of Medicine and Science coverage will not be affected. You can keep this coverage if you elect Part D, but the group health plan will not coordinate with Part D cover age If you do decide to join a Medicare drug plan and drop your current Charles R. Drew University of Medicine and Science coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Charles R. Drew University of Medicine and Science and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Charles R. Drew University of Medicine and Science changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2024**
Name of Entity/Sender:	**Charles R. Drew University of Medicine and Science**
Contact—Position/Office:	**Charles Bugarin - Human Resources Manager**
Office Address:	**1731 E 120th St** **Los Angeles, California 90059-3051** **United States**
Phone Number:	**323.563.5834**

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Charles Bugarin.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Charles R. Drew University of Medicine and Science
Charles Bugarin - Human Resources Manager
1731 E 120th St
Los Angeles, California 90059-3051
United States
323.563.5834

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Charles Bugarin.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Charles R. Drew University of Medicine and Science		4. Employer Identification Number (EIN) 95-6151774
5. Employer address 1731 E 120th St		6. Employer phone number 323.563.5834
7. City Los Angeles	8. State California	9. ZIP code 90059-3051
10. Who can we contact about employee health coverage at this job? Charles Bugarin		
11. Phone number (if different from above)	12. Email address CharlesBugarin@cdrewu.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are: Those who work a minimum of 20 hours per week.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: Your spouse or registered/unregistered domestic partner (same or opposite sex), and children up to the age of 26.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? First day of the month following date of hire.
(mm/dd/yyyy) (Continue)

☐ **No**

14. Does the employer offer a health plan that meets the minimum value standard[3]?

☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard[3] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? **$57.48**
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.[3] (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

[3] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

California HIPP Notice

State of California
Health and Human Services Agency
Department of Health Care Services

Health Insurance Premium Payment (HIPP) Program
DISCLOSURE STATEMENT
(Required)

Please read entire disclosure statement before signing.

The California Department of Health Care Services (DHCS) will pay, when it is cost-effective to do so, medical insurance premiums for full scope Medi-Cal beneficiaries who have a high cost medical condition. As an applicant or enrollee, you must submit the policy booklet or Evidence of Coverage from your individual or group health insurance carrier, a Statement of Diagnosis Medical Report signed and dated within six (6) months of the date of application and other requested documentation. The following applies to all applicants and enrollees of the HIPP Program, effective July 1, 2014.

1. Purchasing or paying for health insurance coverage is not cost-effective when a court has ordered a non-custodial parent to provide medical insurance, a Medi-Cal beneficiary is also enrolled in Medicare, an individual or employee has been fully reimbursed for his/her payment of health care premiums, and a beneficiary is also enrolled in a Medi-Cal managed care plan.
2. HIPP does not pay for premiums paid prior to the month the application was received by HIPP or for past due premiums. If premiums are past due, the applicant must bring the premiums current before approval can be determined.
3. HIPP pays medical insurance premiums, coinsurance, deductibles, and other cost-sharing obligations.
4. The California Code of Regulations, Title 22, Section 50763(a) (1) states, "An applicant or beneficiary shall: apply for, and/or retain any available health care coverage when no cost is involved." This means that if you drop your private health coverage without DHCS approval after the state begins paying your premiums, you could lose your Medi-Cal benefits.
5. As a condition of HIPP eligibility, any reimbursement received for medical coverage premiums must be forwarded to DHCS.
6. It is the responsibility of the HIPP enrollee to notify the HIPP Program within ten (10) days of any changes in health insurance coverage, insurance premium amount, personal contact information, marital status, or any changes that may otherwise affect the HIPP Program eligibility.
7. Each case is redetermined at least annually to determine if the case remains cost-effective for the state to pay the medical insurance premiums. Failure to submit required documents for redetermination may result in disenrollment from the HIPP program.
8. A HIPP enrollee may be terminated from the program if their Medi-Cal eligibility is terminated, their private health coverage is terminated, the enrollee is Medicare eligible, they fail to provide requested information, or if it is no longer cost-effective for DHCS to pay the medical insurance premiums. Only one letter of termination will be mailed to the address of record.
9. In accordance with All County Welfare Directors Letter No. 95-82, there are no appeal rights for the HIPP Program.
10. Funding for the HIPP Program is contingent upon a state budget. In the event a state budget is not enacted timely, HIPP payments may be delayed. If HIPP payments are delayed, HIPP enrollees, in order to avoid the potential loss of their health insurance, may be personally responsible for making the insurance premium payments. DHCS will reimburse those payments once a state budget has been enacted.

CERTIFICATION: I certify that I have thoroughly read the provisions listed above, and I understand and agree to them.

Name of Applicant (print):	*Signature of Applicant/Guardian:*	*Date:*
Name of Policyholder (print):	*Signature of Policyholder:*	*Date:*

PLEASE RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

DHCS 9121 (Rev. 06/19)

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Contributors:
Charles R. Drew University of Medicine and Science Human Resources Dept.
Gallagher Benefit Services

Restricted Rights

The information contained in this document is proprietary and confidential to Charles R. Drew University of Medicine and Science ("CDU").

No part of this document may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying and recording, for any purpose without the express written permission of CDU.

This document is subject to change without notice. CDU does not warrant that the material contained in this document is error-free. If you find any problems with this document, please report them to CDU Human Resources in writing.

CDU reserves the right to terminate, suspend, withdraw, or modify the benefits described in this document, in whole or in part, at any time for any reason. No statement in this or any other document, and no oral representation, should be construed as a waiver of this right.

This is not a legal document. Please refer to the Summary Plan Descriptions for detailed information. This document is not intended to cover every option in detail. Complete details are in the legal documents, contracts, and administrative policies that govern benefit operation and administration.

If there should ever be any differences between the summaries in this guide and the legal documents, contracts, and policies, the legal documents, contracts, and policies will be the final authority.

Neither the Plan, the Summary Plan Descriptions, nor your coverage under the Plan, give you any right to continue your employment with CDU, nor will they interfere in any way with your right or CDU's right to terminate your employment at any time for any reason, which right is hereby expressly reserved.

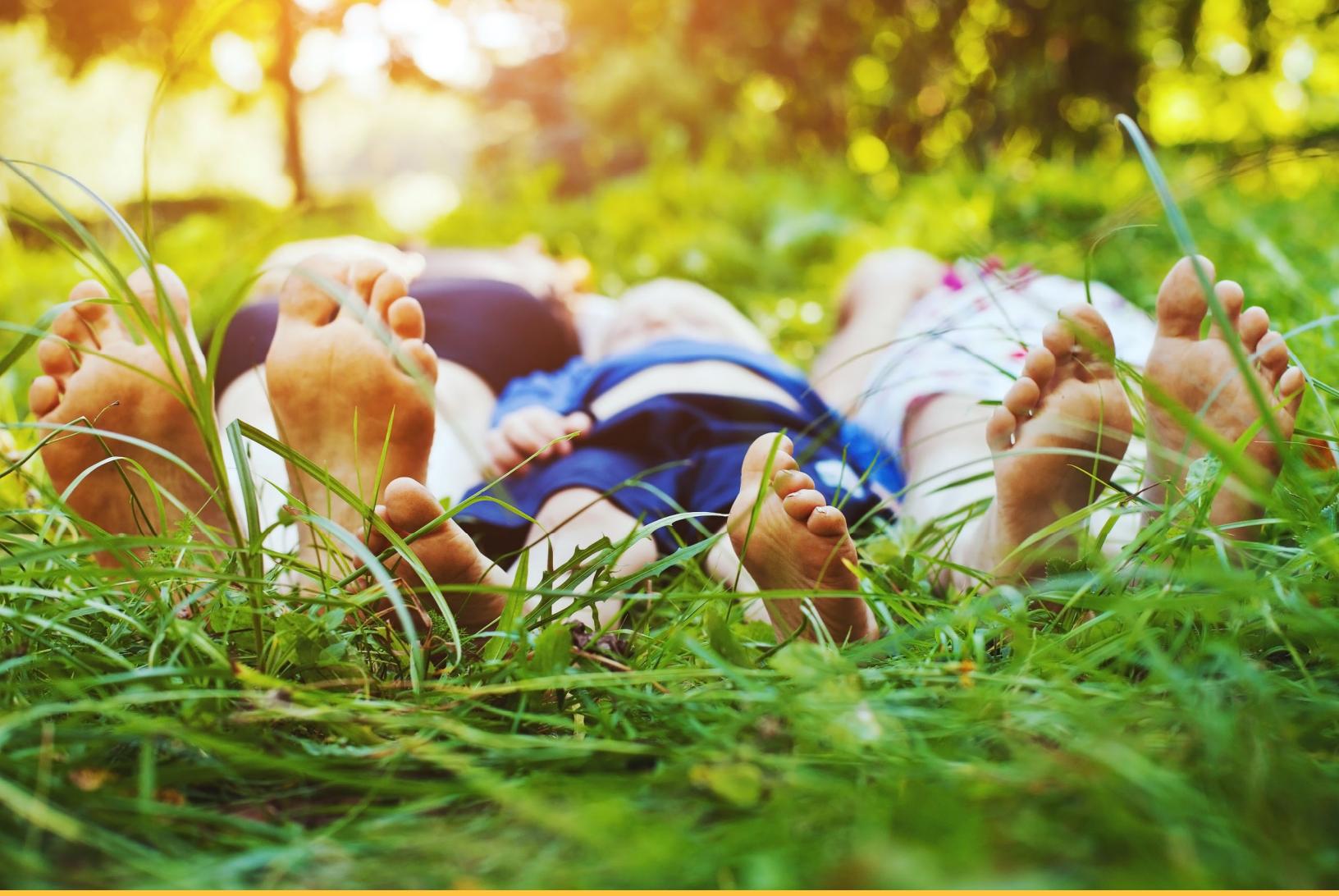
Charles R. Drew University
of Medicine and Science
A Private University with a Public Mission

VISION STATEMENT

Excellent health and wellness for all in a world without health disparities.

MISSION STATEMENT

Charles R. Drew University of Medicine and Science is a private non-profit student centered University that is committed to cultivating diverse health professional leaders who are dedicated to social justice and health equity for underserved populations through outstanding education, research, clinical service, and community engagement.



This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting