



Charles R. Drew University
of Medicine and Science



2026 Benefit Summary

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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 health care 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.



IMPORTANT: Charles R. Drew University of Medicine and Science (“CDU”) offers a fixed indemnity policy; this is NOT health insurance. If you are considering purchasing this policy, please read the notice on page 19 in its entirety.

Health Care Reform

You have heard about Health Care Reform and the public health insurance marketplaces, including Covered California. Individuals who are not offered qualified health care 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 28-32 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 or Domestic Partner'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

Questions About Your Benefits or Need Help Enrolling?

Contact the 4myBenefits Team!	Phone: (833) 487-4750 Hours: 5:00 AM to 2:00 PM PST
Common areas of support:	
– Assist with login issues – Assist with qualified life event enrollment changes – Help you choose the right plan for you and your family – Enroll in benefits over the phone	– Clarify coverage difference questions – Answers questions regarding which benefits or services are covered on your plan – Recommend benefit tools and resources to use

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 roll over.

How to elect your benefits?

1. The Login to UKG via Single Sign-On
2. Click on the "Myself" menu then "Benefits"
3. Click on "Manage My Benefits" to log in
4. Follow the prompts to select your benefits

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	\$64.94	\$346.85
		EE + Spouse	\$210.73	\$695.21
		EE + Child(ren)	\$160.16	\$581.06
		EE + Family	\$278.16	\$998.40
Blue Shield	Medical Full PPO	EE Only	\$129.09	\$558.17
		EE + Spouse	\$373.15	\$1,138.81
		EE + Child(ren)	\$294.19	\$942.87
		EE + Family	\$510.92	\$1,619.66
Blue Shield	Medical HMO	EE Only	\$73.95	\$388.80
		EE + Spouse	\$237.31	\$780.72
		EE + Child(ren)	\$180.37	\$652.52
		EE + Family	\$313.19	\$1,121.16
Blue Shield	Trio ACO HMO	EE Only	\$64.14	\$337.25
		EE + Spouse	\$205.85	\$677.20
		EE + Child(ren)	\$156.45	\$566.00
		EE + Family	\$271.70	\$972.63
DeltaCare USA	Dental HMO	EE Only	\$1.75	\$5.92
		EE + Spouse	\$4.42	\$8.78
		EE + Child(ren)	\$4.21	\$9.74
		EE + Family	\$6.53	\$14.96
Delta Dental of CA	Dental PPO	EE Only	\$5.54	\$17.97
		EE + Spouse	\$14.63	\$32.10
		EE + Child(ren)	\$16.68	\$32.71
		EE + Family	\$25.37	\$50.72
VSP	Vision	EE Only	\$2.57	\$1.19
		EE + Spouse	\$4.11	\$3.41
		EE + Child(ren)	\$3.30	\$3.84
		EE + Family	\$5.19	\$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	
ThrivePass	Health Care FSA and Dependent Care FSA	Health Care up to \$3,400/yr. Dep. Care up to \$7,500/yr.	Employee Paid	
UNUM	Voluntary Accident, Critical Illness, Hospital Indemnity	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.

BlueShield of California Access+ HMO

BlueShield of California Access+ HMO is a managed care plan that provides access to Blue Shield of California's largest HMO provider network. Members are required to select a Primary Care Physician (PCP) and coordinate all specialist care through their chosen PCP.

This plan is designed to offer comprehensive coverage through a broad network of contracted providers. However, services received outside the Access+ HMO network are not covered, except in cases of emergency medical care.

BlueShield of California Trio ACO HMO

BlueShield of California Trio ACO HMO is a managed care plan that functions similarly to the Access+ HMO, requiring members to designate a Primary Care Physician (PCP) and obtain referrals for specialist services through their PCP.

The key distinction lies in the Trio plan's narrower provider network, which includes a select group of physicians and hospitals. This plan operates under an Accountable Care Organization (ACO) model, designed to enhance care coordination and efficiency among contracted providers. As a result, members typically benefit from lower monthly premiums, with estimated savings of 10–15% compared to broader network HMO plans such as Access+.

Important: Coverage is limited to providers within the Trio network, with exceptions only for emergency services. Members are strongly encouraged to verify provider participation prior to enrollment.

BlueShield of California Full PPO

Blue Shield of California Full PPO offers members maximum flexibility in choosing healthcare providers. As a Full PPO plan participant, you may receive care from any licensed provider, regardless of network affiliation. However, utilizing in-network providers—those contracted with BSCA's Full PPO network—offers significant cost savings and ensures that claims are submitted directly to BSCA. When receiving care from non-network providers, members are responsible for the difference between the provider's charges and BSCA's contracted rates, and any applicable out-of-network deductibles and coinsurance.

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 insurer or 4myBenefits 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.

Name of Plan	Kaiser 2026 HMO Medical Plan	BSCA PPO Plan		BSCA Access+ HMO Plan	BSCA Trio HMO Plan
Carrier	Kaiser Foundation Health Plan, Inc.	BlueShield of California		BlueShield of California	BlueShield of California
Medical Plan Provider Network	Kaiser Permanente – Southern California Network	Full PPO Network		Access+ HMO Network (In-Network Only)	Trio ACO HMO Network (In-Network Only)
Benefits Outline	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK (NON-CONTRACTED)	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Deductible (Individual/Family)	\$0 / \$0	\$500 / \$1,500	\$1,500 / \$4,500	\$0 / \$0	\$0 / \$0
Annual Out-of-Pocket Maximum (Individual/Family)	\$2,000 / \$4,000	\$3,000 / \$6,000	\$5,000 / \$10,000	\$1,500 / \$3,000	\$1,500 / \$3,000
Member Coinsurance (Amount You Pay)	Not applicable	20%	40%	Not applicable	Not applicable
Wellness / Preventive Care	No Charge	No Charge	Not Covered	No Charge	No Charge
Primary Care Office Visit	\$30 copay	\$20 copay per visit	40% after deductible	\$10 copay per visit	\$10 copay per visit
Specialist Office Visit	\$40 copay	\$25 copay per visit	40% after deductible	\$20 copay per visit	\$20 copay per visit
Walk-In / Urgent Care Visit	\$30 copay	\$20 copay per visit	40% after deductible	\$10 copay per visit	\$10 copay per visit
Emergency Room	\$200 copay	\$150 copay + 20%	\$150 copay + 20%	\$150 copay per visit	\$150 copay per visit
Outpatient Lab / X-Ray	\$10 copay per encounter	Lab Center: \$20 copay after deductible.	40% after deductible	No Charge	No Charge
		Outpatient Center: \$45 copay after deductible			
Complex Imaging (MRI, CAT, PET, et al.)	\$100 copay per procedure	20% after deductible	40% after deductible	No Charge	No Charge
Outpatient Surgical Facility	\$150 copay per procedure	20% after deductible	40% after deductible	\$200 copay per visit	\$200 copay per visit
Inpatient Hospital Facility	\$500 copay	20% after deductible	40% after deductible	\$250 copay per stay	\$250 copay per stay
Retail Pharmacy Prescriptions	\$15 copay / \$35 copay	\$10 copay / \$30 copay /	In-network Rx copays/ costs plus an additional 25% of the Rx purchase price	\$10 copay / \$30 copay /	\$10 copay / \$30 copay /
(30-Day Supply) Rx Tier 1 / 2 / 3 / 4	\$70 copay / 30% coinsurance up to \$250 copay	\$50 copay / 30% up to \$250 copay		\$50 copay / 20% up to \$250 copay	\$50 copay / 20% up to \$250 copay
Mail Order Prescriptions (90-Day Supply) Rx Tier 1 / 2 / 3 / 4	2x Retail Pharmacy Costs	2x Retail Pharmacy Costs	Not Covered	2x Retail Pharmacy Costs	2x Retail Pharmacy Costs

The above overview is for general comparison purposes only. Please refer to the plan summaries and documents for details.

Blue Shield California Programs and Services

24/7 Nurse Line – Informed Health[®] | (800) 304-0504

With NurseHelp 24/7, experienced nurses can help you figure out how you can care for yourself, evaluate treatment options, and help you decide whether to see a doctor.

Call NurseHelp 24/7SM toll-free at (877) 304-0504 (TTY: 711) and talk with a registered nurse anytime you have health related questions. This phone number is on your Blue Shield member ID card for easy reference. Or you can chat with a registered nurse online if you prefer. Use your Blue Shield login at [blueshieldca.com/nursehelp](https://www.blueshieldca.com/nursehelp) to access one-on-one support in a secure environment.

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 lunchbreak or while traveling. You can even get a prescription sent to your local pharmacy, when medically necessary. General medical visits can be scheduled ahead or requested on demand 24/7/365. Visit [blueshieldca.com/teladochealth](https://www.blueshieldca.com/teladochealth) to register or log in. You can request a consultation any time you need care.

Tip: Download the Blue Shield of California mobile app to access care from anywhere.

Maternity Management

Maven is here to support your pregnancy and family forming journey every step of the way. With Maven, you and your partner can get access to virtual support for pregnancy, postpartum, and returning to work after parental leave. You'll enjoy 24/7 access to Care Advocates, specialists, mental health support, and content tailored to your experience.

Key Benefits:

- » 24/7 Virtual Appoints for Pregnancy Support with Midwives, OB-GYNs, Doulas, Birth Planning Assistance Prenatal
- » Nutritionists, Miscarriage/Pregnancy loss support
- » On-Demand Postpartum Resources – Infant Care Education, Pediatricians, Lactation Consultants, Infant – Sleep Coaches

- » Navigate Returning to Work – Virtual Career Coaching & Emotional support

Sign up by visiting: <https://www.blueshieldca.com/en/home/be-well/conditions-and-care-programs/maternity-program>

WELLNESS

Explore all that Blue Shield of California has to offer with Wellvolution[®], the digital platform that guides you on your health journey. Wellvolution customizes your path to better health, matching you with clinically proven programs and apps that are right for you both in mind and body. Through Wellvolution, you have access to lifestyle-based tools and support designed to help you lose weight, treat diabetes, nurture mental health, and more. You'll get personalized plans, on-demand tools, and health coaches to assist you in reaching your goals. All at no extra cost to eligible Blue Shield members.

How it works:

1. **Create a Wellvolution account** – Visit [wellvolution.com](https://www.wellvolution.com) to get started. We'll confirm that you're qualified to receive the program at no extra cost.
2. **Get programs** – Pick one or more health goals you'd like to work on. We'll recommend the best program(s) for your needs. You can make your choice and get started.
3. **Become a healthier you** – With the assistance of your program, begin making healthier choices about diet, exercise, sleep, stress, and your overall health.

Fitness (Discounted Gym Memberships):

Tivity Health's Fitness Your Way lets you join as many gyms as you want, wherever you live, work and play. Learn more at bsca.fitnessyourway.tivityhealth.com

- » Seven gym packages, with three new options available, including studio and luxury locations, starting at \$19/month
- » Join as many gyms as you want and get access to 13,000+ fitness locations
- » Digital only package also available for just \$10 a month (all digital content included with gym packages)
- » On-demand videos available 24/7 and live virtual classes like cardio, bootcamps, barre, and yoga from m[®]



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:

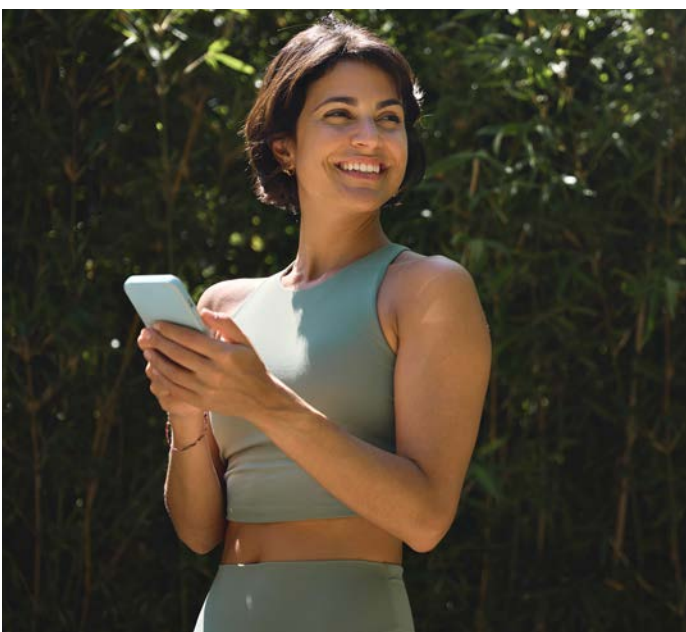
- » Acupuncture
- » Massage therapy services
- » Fitness club memberships
- » Chiropractic care
- » Herbs, vitamins, and supplements
- » Health and fitness books and videos

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 one-on-one 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.

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.

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.

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.

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.

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.



Basic Life and Accidental Death & Dismemberment (AD&D) 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 & 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 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

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.

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.

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)

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.



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 or 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:

- » Every year, each family member who has Accident Insurance through UNUM can also receive a \$50 for getting a covered Be Well Benefit screening test.
- » 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 in 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

IMPORTANT: This is a fixed indemnity policy,

NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- » The payment you get isn't based on the size of your medical bill.
- » There might be a limit on how much this policy will pay each year.
- » This policy isn't a substitute for comprehensive health insurance.
- » Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- » Visit **HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- » To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- » For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- » If you have this policy through your job, or a family member's job, contact the employer.

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: \$3,400
- » Dependent Care Reimbursement Account: \$7,500

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

For plan year 2026, you have a 2½ month grace period after the end of the plan year, to incur additional expenses and submit them to **ThrivePass (2026 FSA plan vendor)**. This means, you may incur and submit eligible expenses through March 15, 2027.

After March 31, 2027, any remaining plan year 2026 funds in your reimbursement account will be forfeited, as required by the IRS.

Important Note (Applicable to Plan Year 2025 Elections Only): If you have unused funds in your **2025 FSA after December 31, 2025**, you can still use your 2025 FSA unused funds for eligible expenses incurred through March 15, 2026. However, you must submit claims to **BCC Benefit Solutions (2025 FSA plan vendor)** by that date.

Any remaining funds not claimed by March 31, 2026 will be forfeited, per IRS rules. **For questions regarding your 2025 FSA account balance contact BCC member services at 800-685-6100.**

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.

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.

FSA Eligible Expenses!

Please refer to IRS Publication 502, or contact ThrivePass to confirm if your FSA product or service is a qualified healthcare expense. For FSA eligible products, you can also make a purchase in the ThrivePass Marketplace. To do this, just go to your Thrive Account, click on "Spend Your Funds" under the "Your Marketplace" section, and you'll be able to browse all available items.

If you have questions regarding a potentially qualifying expense, please contact ThrivePass at (866) 855-2844.

Health Care Reimbursement Account

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

Work-related commuting expenses can really add up!

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.

FSA Transportation Benefit Information

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 complete a reimbursement request through the ThrivePass member portal website:

For more information or assistance, contact ThrivePass Pre-Tax Account Member Services Division at the below:

- » Contact Number: (866) 855-2844
- » Operating Hours: Monday – Thursday (7:30 am – 5:30 pm CT), Friday (7:30 am – 5:00 pm CT)
- » Email: tpa@thrivepass.com
- » Online support: <https://support.thrivepass.com/support/tickets/new>
- » Note: This team can assist with HCFSA, DCFSA or Commuter/Parking inquiries.

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

2026 MONTHLY CONTRIBUTION LIMITS:

\$340 for mass transit expenses

ThrivePass

Contact Number: (866) 855-2844

<https://support.thrivepass.com/support/home>





Retirement Plan - TIAA 403(b)

At Charles R. Drew University of Medicine and Science (CDU), we want to enhance our employees' ability to save for retirement. As a result, our 403(b) Supplemental Retirement Plan (SRP) administered by TIAA (Teachers Insurance and Annuity Association of America-College Retirement Equities Fund), has no minimum service eligibility requirements and includes an automatic enrollment feature. Under the plan's provisions, you will be automatically enrolled in the 403(b) plan within thirty (30) days of hire.

Unless you take action to decline this automatic enrollment, CDU assumes that you have authorized the University to withhold for each pay period on a pre-tax basis an amount equal to 3% of pay. This withholding percentage will remain in effect until such a date that you make an election to increase, decrease, or cease your contributions to the plan. As a participant, you may make such a change in contributions at any time in UKG, to be effective beginning on the payroll date after your UKG election notice's receipt by human resources. All withheld pay deferrals will be invested in the "TIAA-CREF Lifecycle Fund" until otherwise changed by you.

The University Offers a Group Retirement Plan (GRP) and a Supplemental Retirement Plan (SRP)

Group Retirement Plan (GRP)

The Group Retirement Plan (GRA) is a defined contribution plan fully funded by the University at the rate of 7% of the benefits eligible employee's earnings. Eligible employees must be at least 18 years of age, completed one year of continuous service with the University, and worked at least 1,000 hours.

Supplemental Retirement Plan (SRP)

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 2026 is \$24,500. Catch-up contribution for age 50 or older is \$8,000, totaling \$32,500, and for those employees aged 60 to 63, a new higher catch-up amount of \$11,500, totaling \$36,000.

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
- » Special needs
- » Pet care
- » Attorney services (family law, divorce, wills and document prep)
- » Financial counseling (retirement, credit/debt issues, college planning)

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

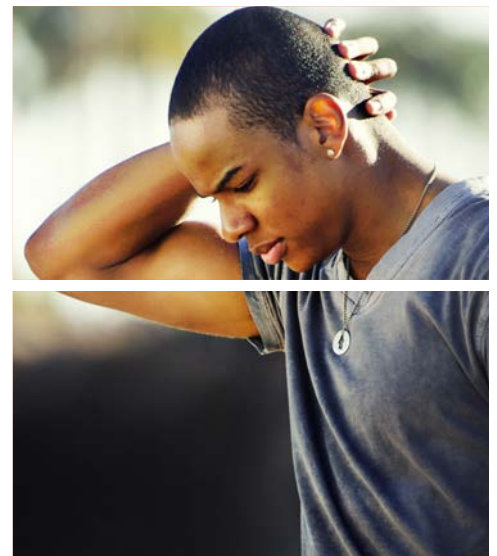
Benefits also include up to six confidential sessions per issue per year – at no charge. If further help past the initial sessions is necessary, the EAP can assist you in coordinating additional treatment through your medical plan.

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

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





Other Benefits

This represents only a summary of benefits. Details and plan descriptions are available in the human resources department.

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.

- » (800) 342-8111 / TTY 711
- » resourcesforliving.com
- » Username: CDREWU
- » Password: EAP

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.

Personal Time Off Days

Personal Time Off Days (PTOD) 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 PTOD each calendar year to use as you choose. Time off must be taken in whole hours.

All PTOD must be requested via UKG and must be approved by the employee's manager to ensure proper coverage in your respected department. Personal Time Off Days (PTOD) should not conflict with the work schedules and other work-related responsibilities that may create a need for overtime or cause conflicts with other employees' schedules. Approval for PTOD is contingent upon business needs.

Personal Time Off Days are not accrued, cannot be banked, nor paid out at time of separation. Personal Time Off Days are use or lose it.

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.

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 Tuition 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.

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.

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.

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.

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. Currently, we have a total of 18 charging stations.

Voluntary Remote Work

The University does allow for voluntary remote work, depending on position with the approval of your department lead or manager.

Financial Wellness and Advice



Your CAPTRUST at Work Benefit

As part of your employee benefit package, Charles R. Drew University of Medicine and Science has given you access to a financial wellness solution called CAPTRUST at Work. To learn more about this benefit please click on the link below:

<https://www.captrustatwork.com/your-captrust-at-work-benefit/>

CAPTRUST advice team members are available to consult with you as a part of your benefit package.

Our goal is to make sure you feel confident about meeting your financial goals.

You can join live webinars, receive monthly newsletters or have phone consultations with advisors by calling (800) 967-9948.

Retirement Blueprint®

- » CAPTRUST Retirement Blueprint® technology allows our financial advisors to give you personal retirement planning advice.
- » The financial advisor will help you identify your goals and your risk tolerance.
- » The financial advisor will take you through various “what if” scenarios to optimize different retirement strategies.
- » You will have the opportunity to implement advice on the spot with assistance from your financial advisor.
- » You will have access to your blueprint immediately after your consultation.
- » A reminder will be sent to you on an annual basis to update your blueprint.

captrustadvice.com

There are a number of resources available to you on the participant website:

- » Schedule your appointment with a financial advisor.
- » Access helpful articles on a range of topics.
- » Check your progress with financial calculators.
- » Watch informative three-minute videos from CAPTRUST subject matter experts.
- » Register for easy-to-understand topical financial webinars.
- » View recordings of prior webinars.

Financial Wellness

CAPTRUST services and technologies help you address difficult financial challenges—from managing student loan debt to securing retirement. CAPTRUST’s financial wellness and advice services meet you where you are in your career, with the help you need to answer the most pressing questions about your various financial goals.

Carrier/Vendor Contacts

Benefit	Provider	Group ID	Phone/Website
Medical HMO and PPO	Blue Shield of California	W3002153	PPO: (888) 256-1915 Access+: (888) 256-1915 Trio: (855) 829-3566 https://www.blueshieldca.com/en/home
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	ThrivePass	774	866-855-2844 app.thrivepass.com (Note: You will receive an activation code in the mail to register)
Employee Assistance Program	Aetna	N/A	(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	CAPTRUST Retirement Group	Charles R. Drew University	(888) 201-5488 www.pensionmark.com
Benefits Call Center	4myBenefits	N/A	(833) 487-4750 https://www.4mybenefits.com/

Questions?

This guide summarizes the benefits that are available to you as an employee of CDU. For specific questions, please contact 4myBenefits or the benefits providers at the phone numbers listed on this page.

Required Notices

Charles R. Drew University of Medicine and Science

Important Legal Notices



**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 page 9 for more details.**

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 this plan.

NEWBORNS ACT DISCLOSURE – FEDERAL

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Blue Shield and Kaiser 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, Blue Shield 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 Blue Shield at (800) 393-6130 or www.blueshieldca.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 Blue Shield 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 Blue Shield at (800) 393-6130 or www.blueshieldca.com and Kaiser at (800)464-4000 or www.kp.org.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful,

the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Charles Bugarin – Human Resources Manager
1731 E 120th St. Los Angeles, CA 90059
(323) 563-5834
charlesbugarin@cdrewu.edu

Your Information. Your Rights. Our Responsibilities.

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.***

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date: 01/01/2026
- Name of Entity/Sender: Charles R. Drew University of Medicine and Science
- Contact: Charles Bugarin – Human Resources Manager
- Address: 1731 E 120th St. Los Angeles, CA 90059
- Phone: (323) 563-5834

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

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 Blue Shield and Kaiser for the plan year 2026 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, the following options may apply:

- You may stay in the Blue Shield or Kaiser plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Blue Shield or Kaiser creditable coverage.
- You may stay in the Blue Shield or Kaiser plans and also enroll in a Medicare prescription drug plan. The Blue Shield or Kaiser will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage of Blue Shield or Kaiser and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Blue Shield or Kaiser plan you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or 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: 01/01/2026
Name/Entity of Sender: Charles R. Drew University of Medicine and Science
Contact Position/Office: Charles Burgarin – Human Resources Manager
Address: 1731 E 120th St. Los Angeles, CA 90059
Phone Number: (323) 563-5834

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, 2025. 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@MyAKHIP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIP (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.flmedicaidtprecovery.com/flmedicaidtprecovery.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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) 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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov 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=en_US 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/health-care-coverage/ Phone: 1-800-657-3672	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: HHSHIPProgram@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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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 Rlte 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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, 2025, 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)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Charles R. Drew University of Medicine and Science
Contact--Position/Office:	Charles Bugarin – Human Resources Manager
Address:	1731 E. 120 th St. Los Angeles CA, 90059
Phone Number:	(323) 563-5834

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.

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. 120 th St.		6. Employer phone number (323) 563-5834	
7. City Los Angeles		8. State CA	9. ZIP code 90059
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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

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

15. For the lowest-cost plan that meets the minimum value standard* 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? \$

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.* (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

Notes



Charles R. Drew University
of Medicine and Science