

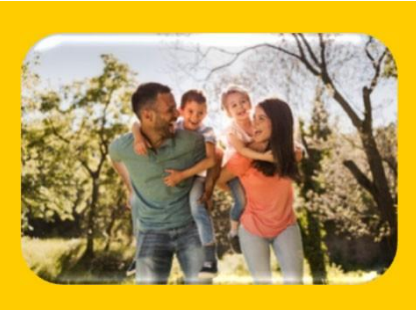


Charles R. Drew University of Medicine and Science

A Private University with a Public Mission



**A Guide to Your Employee Benefits
2025**



MEDICAL

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

AETNA HMO

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

AETNA OPEN ACCESS MANAGED CHOICE (OAMC)

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

KAISER PERMANENTE HMO

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

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

PRESCRIPTION DRUGS

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

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

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 16-17 where Notice of Creditable Coverage begin for more details.

LOCATE A PROVIDER

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

MEDICAL PLANS COMPARISON

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

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

AETNA PROGRAMS AND SERVICES

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

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

TELEDOC® | (855) 835-2362

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

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

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

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

WELLNESS AND DISCOUNT PROGRAMS

Aetna Health Your Way

Sign in at Aetna.com and select “Well-beingResources” or download the ActiveHealth® mobile app

Take your well-being assessment to start earning rewards

Review your personalized health report and recommended Health Actions

Connect your activity tracker or smart device to monitor your progress and/or get involved in individual and peer challenges

Earning rewards

Earn up to \$100 per year by completing well-being activities

Review your progress and redeem gift cards in the Reward Center

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



AETNA PROGRAMS

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



KAISER PERMANENTE HEALTHY LIVING PROGRAMS

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

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

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

MY HEALTH MANAGER | www.kp.org/register

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

HEALTHY LIFESTYLE PROGRAMS

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

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



Kaiser | www.kp.org

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

Using the Kaiser Permanente web site, 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.



EMPLOYEE ASSISTANCE PROGRAM

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

Daily life assistance:

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

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.

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

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

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.

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: \$3,300
- Dependent Care Reimbursement Account: \$5,000

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

CLAIMS SUBMISSION DEADLINE

You have a 2½ month grace period after the end of the plan year, to incur additional expenses. This means you may incur expenses through March 15, 2026.

For the 2025 plan year, you have until March 31, 2026, to submit claims to BCC for expenses incurred between January 1, 2025, and March 15, 2026.

After March 31, 2026, any unused money in either reimbursement account will be forfeited, as required by the IRS.

DEPENDENT CARE ELIGIBLE EXPENSES

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



ENROLL EVERY YEAR!

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

USE IT OR LOSE IT!

You must use all of the money in your FSA for eligible expenses incurred during the plan year or forfeit it. You can visit the

<http://www.fsastore.com> for unused funds.

FSA ELIGIBLE EXPENSES!

An in-depth outline of FSA eligible expenses can be found online at

<https://fsastore.com/FSA-Eligibility-List.aspx>.

If you have questions regarding a potentially qualifying expense, please contact BCC's Customer Service Center at (800) 685-6100.

HEALTH CARE REIMBURSEMENT ACCOUNT

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

Required Notices

PATIENT PROTECTIONS DISCLOSURE

The Charles R. Drew University of Medicine and Science Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna and Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aetna at (800) 445-5299 or www.aetna.com and Kaiser at (800) 464-4000 or www.kp.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna and Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna at (800) 445-5299 or www.aetna.com and Kaiser at (800) 464-4000 or www.kp.org.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

Aetna

Plan 1: AETN AHMO (Individual: 0% coinsurance and \$0 deductible; Family: 0% coinsurance and \$0 deductible)

Plan 2: AETNA OPEN ACCESS MANAGED CHOICE (OAMC) (Individual: 20% coinsurance and \$1,000 deductible; Family: 20% coinsurance and \$2,000 deductible)

Kaiser

Plan 1: KAISER PERMANENTE HMO (Individual: 0% coinsurance and \$0 deductible; Family: 0% coinsurance and \$0 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at (323) 563-5834 or CharlesBugarin@cdrewu.edu.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA – Medicaid</p> <p>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</p>	<p align="center">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p align="center">MAINE – Medicaid</p> <p>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</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>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</p>
<p align="center">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p align="center">WEST VIRGINIA – Medicaid and CHIP</p> <p>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)</p>
<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

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

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Charles A. Nagao-Bugarin - PHR - Human Resources Manager at (323) 563-5834 or CharlesBugarin@cdrewu.edu.

HIPAA SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Charles A. Nagao-Bugarin - PHR - Human Resources Manager at (323) 563-5834 or CharlesBugarin@cdrewu.edu.

Important Warning

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

NOTICE OF CREDITABLE COVERAGE

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 01, 2025
Name of Entity/Sender: Charles R. Drew University of Medicine and Science
Contact—Position/Office: Charles A. Nagao-Bugarin - PHR - Human Resources Manager
Office Address: 1731 E 120th St
Los Angeles, California 90059-3051
United States
Phone Number: (323) 563-5834

COBRA GENERAL NOTICE

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

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Charles R. Drew University of Medicine and Science
Charles A. Nagao-Bugarin - PHR - Human Resources Manager
1731 E 120th St
Los Angeles, California 90059-3051
United States
(323) 563-5834

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

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.^{1,2}

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 of these factors in determining whether to purchase a health plan through the Marketplace.

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.

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 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](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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 Charles A. Nagao-Bugarin.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 120th St		6. Employer phone number (323) 563-5834	
7. City Los Angeles		8. State California	9. ZIP code 90059-3051
10. Who can we contact about employee health coverage at this job? Charles A. Nagao-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? First day of the month following date of hire (mm/dd/yyyy) (Continue)

No

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

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? **\$57.48**

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

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

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (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

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

DISCLAIMER

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

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

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

Notes

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