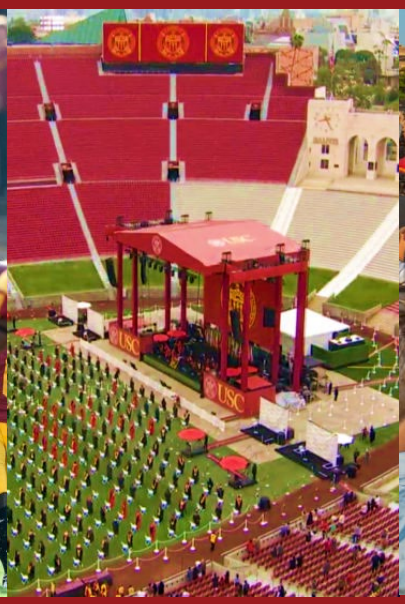


2025 | Keck Community Medical Group (KCMG)

Benefits Guide

Your Health, Our Priority

USC University of Southern California

CONTENTS

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail. Please contact HR for a full list of benefits and plan documents.

WELCOME!

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

You will receive a notification in your USC email to enroll in your benefits through Workday. (In some cases, you may receive this notification before your start date.) Gather all enrollment information (birthdates, Social Security numbers, etc.) and log into Workday from the Employee Gateway to complete enrollment.

Employee Gateway - https://employees.usc.edu/

Type the link into your web browser or scan the QR code using your smartphone device. You may wish to log into the Workday Help site to consult the user guides on benefits enrollment, and setting up direct deposit, to help you complete these processes.

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the HR Service Center at uschr@usc.edu or 213-821-8100.

GETTING STARTED

2025 BENEFITS

- Keck Community Medical Group (KCMG) / USC Care Medical Group
- Keck Community Medical Group (KCMG) Anthem Blue Cross Prudent Buyer Network / BlueCard Providers

No matter where you are in your career, Keck Community Medical Group (KCMG) supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

MEDICARE PART D NOTICE

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 the *Important Notices* section for more details.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

All full-time and part-time employees will be eligible for benefits. You must enroll within 30 days of your hire date. Most benefits take effect upon the first of the month following date of hire; but double deductions for premiums may be incurred depending on hire date.

*IMPORTANT: These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Eligible dependents

Medical, Dental, Vision: Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.

Other Coverages: Employees enrolled in Voluntary Life/AD&D coverage also have the option to enroll their Dependent Spouse/Domestic Partner and Dependent Children. It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. See page 11 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please refer to the policy certificate or HR for more information. Eligible dependents include:

- Your legal spouse or domestic partner who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- The employee's dependent children until the end of the month, in which, they turn age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Please visit the **Life Changes page** for a full list of eligible qualifying life events.

You must submit any changes within **31 days** after the event.

YOUR BENEFIT COSTS (per pay period)

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn.

Medical	
If you make $61,000 or less annually	**Biweekly cost**
Employee	$41.00
Employee + 1 adult or Employee + 1 child	$110.50
Employee + 2 children or Employee + adult + children	$164.00
If you make $61,000.01 to $120,000 annually	**Biweekly cost**
Employee	$59.00
Employee + 1 adult or Employee + 1 child	$149.50
Employee + 2 children or Employee + adult + children	$235.00
If you make $120,000.01 to $180,000 annually	**Biweekly cost**
Employee	$70.00
Employee + 1 adult or Employee + 1 child	$180.00
Employee + 2 children or Employee + adult + children	$280.00
If you make more than $180,000.01 annually and over	**Biweekly cost**
Employee	$73.00
Employee + 1 adult or Employee + 1 child	$186.50
Employee + 2 children or Employee + adult + children	$292.50

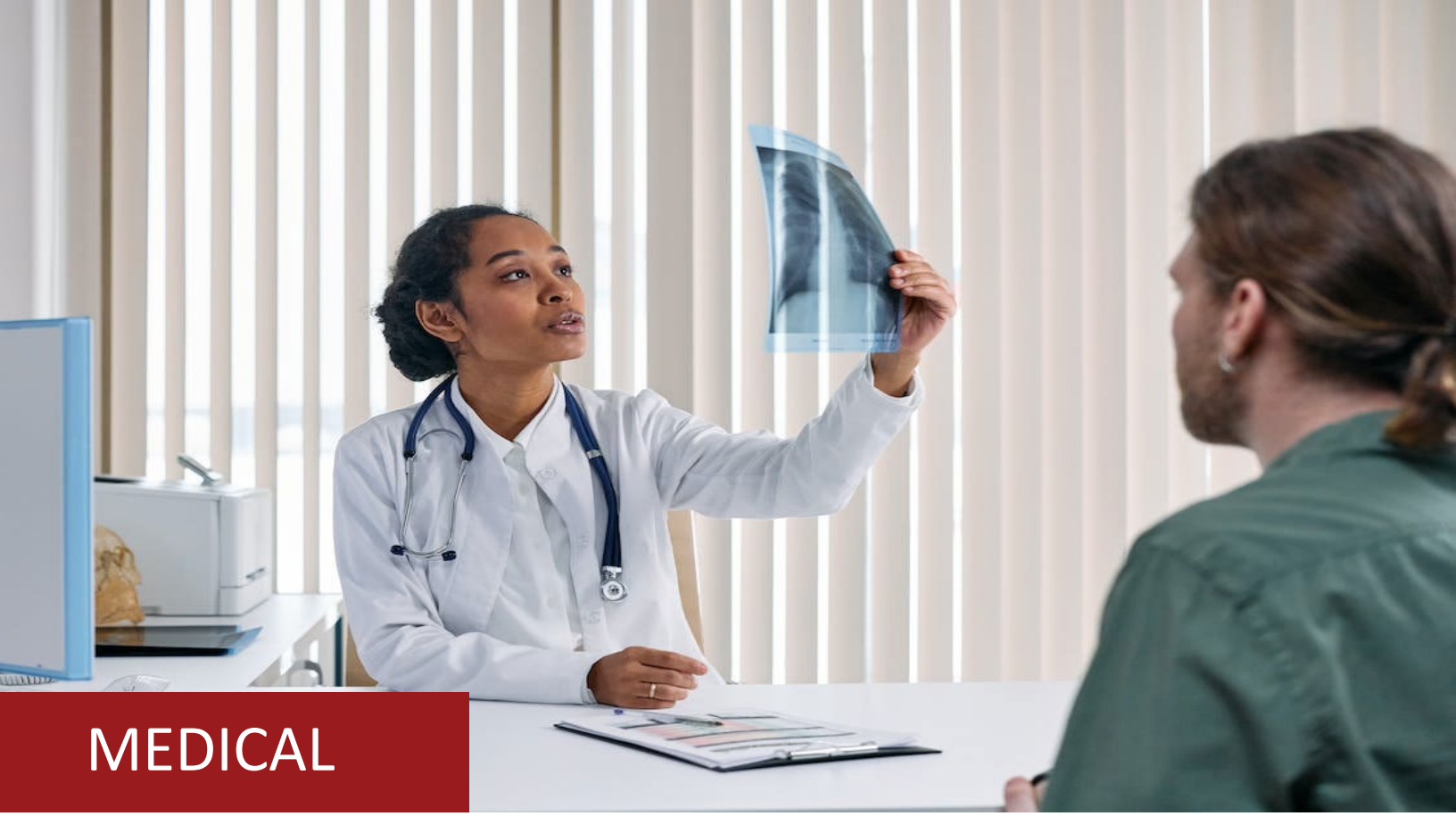
YOUR BENEFIT COSTS (per pay period)

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn.

Dental & Vision	Dental	Vision
Employee Only	$4.42	$1.50
Employee + 1 adult OR 1 child	$9.05	$3.00
Employee + Family	$13.54	$5.50

Life/AD&D	Basic	Term
Employee Only	**100% Company-Paid**	100% Voluntary up to $2,500,000
Spouse	**N/A**	100% Voluntary up to $250,000
Dependent Child(ren)	**N/A**	100% Voluntary up to $25,000

Disability	Short-Term & Long-Term
Employee Only	Employees located in California must elect CA disability Alternatively, employees in California may enroll in CA SDI at 1.1% of income to annual max.



MEDICAL

OUR PLANS

USC Care Medical Group

Keck Community Medical Group (KCMG) Anthem Blue Cross Prudent Buyer Network / BlueCard Providers

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Think about these factors when choosing your medical plan:

Do you like your doctors?

Check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more, consider a plan with out-of-network coverage.

What are your healthcare needs?

Compare how each plan covers the services you need most often, such as office visits, specialists, or prescriptions.

What's your budget?

What will you pay for coverage? Is there a deductible? What is your share of the cost for office visits and prescriptions? All of these factors together affect your total cost for healthcare.

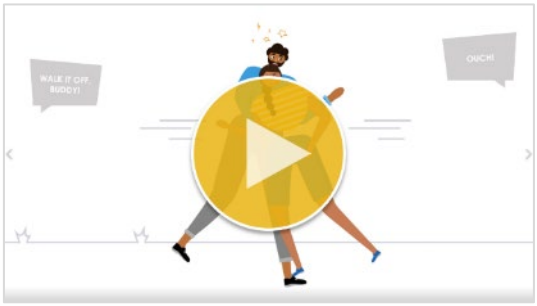
Medical

We provide you the option to purchase affordable medical coverage. For a complete list of in-network and out-of-network benefits, please refer to the full plan documents.

	Keck Medicine of USC Community / USC Care Medical Group	Keck Community Medical Group (KCMG) Anthem Blue Cross Prudent Buyer Network / BlueCard Providers
Annual Deductible	None	$500 individual / $750 employee and all covered dependents combined
Annual Out-of-Pocket Maximum	$5,000 individual / $10,000 employee and all covered dependents combined	$5,000 individual / $10,000 employee and all covered dependents combined
Office Visit	Plan pays 100% after $10 copay	Plan pays 100% after $25 copay (ded. waived)
Preventive Care	Plan pays 100%	Plan pays 100% (ded. waived)
Child immunizations Through age 18	Plan pays 100%	Plan pays 100% (ded. waived)
Maternity - physician office visit	Plan pays 100% after $10 copay	Plan pays 100% after $25 copay (ded. waived)
Maternity - physician delivery	Plan pays 100%	Plan pays 70%
Maternity - hospital charges	Plan pays 100%	Plan pays 70%
Urgent Care	Not Available	Plan pays 100% after $50 copay (ded. waived)
Emergency Room	Plan pays 100% after $100 copay	Plan pays 100% after $100 copay (ded. waived)
Hospitalization	Plan pays 100%	Plan pays 70%
Outpatient surgery center - physician	Plan pays 90%	Plan pays 70%
Outpatient Surgery	Plan pays 100%	Plan pays 70%
Skilled nursing facility Up to 120 days /calendar year	Plan pays 100%	Plan pays 70%
Home health care Up to 50 days /calendar year	Plan pays 70%	Home health care Up to 50 days /calendar year
Durable medical equipment	Plan pays 90%	Plan pays 70%
Hospice care	Plan pays 80%	Hospice care
Mental health/substance abuse Inpatient / Outpatient	Plan pays 100% / Plan pays 100% after $10 copay	Plan pays 70% / Plan pays 100% after $25 copay
Prescriptions Drugs	**USC Pharmacies**	**Navitus Pharmacies**
Out-of-Pocket Maximum	$1,600 individual / $3,200 employee and all covered dependents	$1,600 individual / $3,200 employee and all covered dependents
Generic	You pay 10% up to $5 max	You pay 20% up to $10 max
Brand Name	You pay 20%	You pay 30%
Non-Formulary	You pay 30%	You pay 50%

ENGAGE

Click to play videos



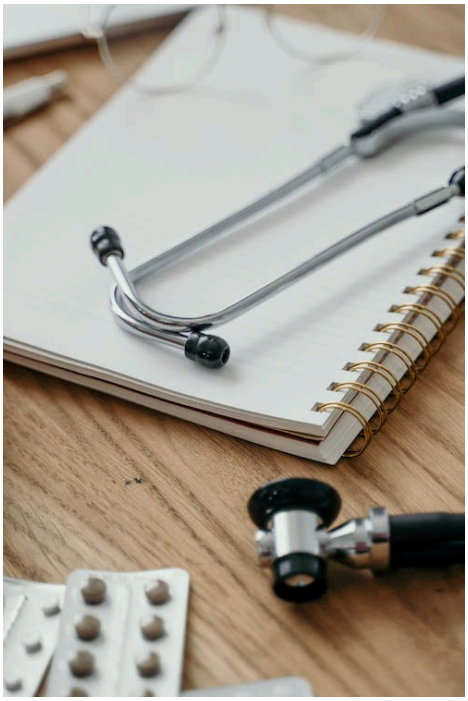
Urgent Care vs ER

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits

PREVENTIVE CARE



You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health.

The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Typical Screening for Adults:

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

KNOW WHERE TO GO

Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Examples
Office visit ($) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
Urgent care ($$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever, respiratory infections
Emergency room (24/7—$$$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

Getting the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often, things such as anesthesia are not covered even though the primary physician is in-network.

DENTAL

OUR PLANS

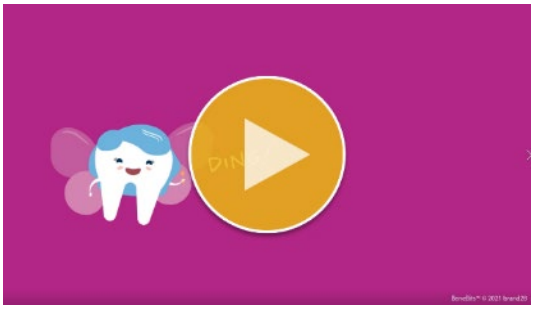
Delta Dental PPO

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



DENTAL

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

	In-Network	Out-of-Network
Annual Deductible	$50 individual / $150 family	$50 individual / $150 family
Annual Plan Maximum	$1500 per person per calendar year (maximum payments to an out-of-network provider: $1000)	
Diagnostic & Preventive	100% (ded. waived)	80%*
Basic Services	80%	80%*
Major Services	50%	50%*
Orthodontia (children only)	50%	50%*
Ortho Lifetime Max	$1000 per person	$1000 per person

*Percent of the lesser of the fee charged, or the fee that satisfies most Delta Dental dentists.

Delta Dental | deltadentalins.com | (800) 765-6003

VISION

OUR PLANS

VSP Vision

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Click to play video

VISION

Your vision checkup is fully covered after your exam copay. After any materials copay, the plan covers frames, lenses, and contacts as described below. Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

	In-Network
Copay	**Exam:** 100% after a $25 copay
Frames	$25 copay (combined with exam) $170 Featured Frame Brands allowance $150 frame allowance, plus 20% savings on the amount over your allowance
Lenses	**Single Vision:** 100% after a $25 copay **Bifocal:** 100% after a $25 copay **Trifocal:** 100% after a $25 copay
Contacts (Elective)	100% (up to $110)
Frequency	**Exam:** Once every 12 months **Frames:** Once every 24 months **Lenses**: Once every 24 months **Contacts (Elective):** Once every 24 months in lieu of lenses/frames glasses

VSP | vsp.com | (800) 877-7195

LIFE & DISABILITY

Life Insurance

Is your family protected?

Life and AD&D insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage premiums are paid in full by USC.

Company-Paid Basic Life / AD&D

Employee: $50,000

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

Your Beneficiary = Who Gets Paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

LONG-TERM DISABILITY INSURANCE (LTD)

Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. USC pays the cost of this coverage. Coverage is provided by MetLife.

MetLife LTD Plan

Monthly Benefit Amount	Plan pays 60% of your covered monthly earnings
Maximum Monthly Benefit[1]	$15,000
Benefits Begin After	52 weeks of disability
Maximum Payment Period[1]	SSNRA

[1]Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Voluntary Life and AD&D
- Voluntary Short-Term Disability
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance
- Voluntary Pet Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

VOLUNTARY LIFE AND AD&D INSURANCE

How to Apply?

You may apply for life insurance coverage quickly and securely online using Workday. Click the Workday icon on the Employee Gateway at employees.usc.edu.

Note: If you do not wish to make a change to your coverage, you do not need to do anything

*All applications are subject to review and approval by Metropolitan Life Insurance Company. Based on the plan design and the amount of coverage requested, a Statement of Health may need to be submitted to complete your application.

AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for losses to a hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.

If you enroll when first offered, you receive up to the guaranteed issue amount without having to answer medical questions.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Plans section for details.

Employee-Paid Voluntary Life/AD&D	
For You	$10,000 to $2,500,000 in $10,000 increments
For Your Spouse / Domestic Partner	$5,000 to $250,000 in $5,000 increments, the lesser of 100% of your coverage amount or $250,000
For Your Dependent Children*	$5,000 to $25,000 in $5,000 increments, the lesser of 100% of your coverage amount or $25,000
Benefit Cost	Employee-paid

Definition of “Eligible Dependents”

- Spouse – eligibility may terminate at Spouse age 70.
- Child – dependent children ages from birth to 26 years old, are eligible for coverage. In TX, regardless of student status, child(ren) are covered until age 25.

Important – Please Read!

- New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active at Work/eligible status.
- Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefits may be reduced for employees over age 65 per ADEA.

Voluntary Short-Term Disability Insurance (STD)

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Short-term disability insurance provides up to 52 weeks of coverage, after a seven-day unpaid waiting period. California faculty and staff are automatically enrolled in the California State Disability Insurance.

If preferred, benefits-eligible faculty and staff may choose to instead enroll in USC's Basic Short Term Disability insurance that provides the same amount of coverage as well as additional benefits:

• Participants of the USC Basic Short Term Disability plan generally receive a greater benefit than they would under California State Disability Insurance.

• Only participants of the USC Basic Short Term Disability plan may choose to enhance their coverage by also electing the USC Supplemental Short Term Disability plan.

Supplemental Disability

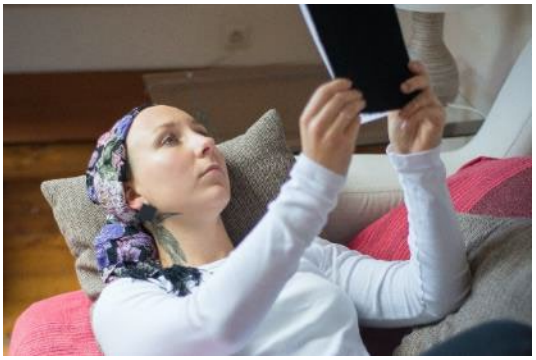
Supplemental Disability insurance provides a larger percentage of base wages for up to 52 weeks. Eligibility to enroll begins after 12 months of active benefits-eligible employment and is only available when already enrolled in USC Basic Short Term Disability insurance. .

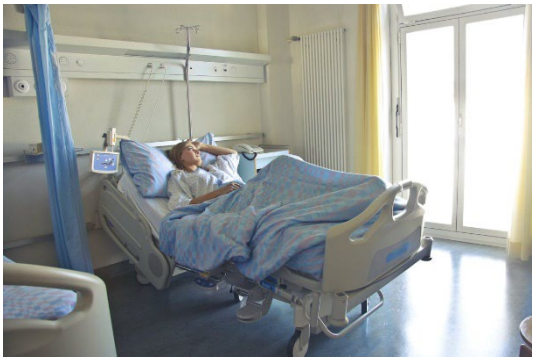
	CA State Disability	USC Basic (Employer Paid)	USC Supplemental
Benefit Amount	60-70% of wages earned 5-18 months prior to the start of disability leave	70% of base weekly pay	100% of weekly pay for up to 10 weeks (one week per year of service) then 80% of weekly pay
Maximum Benefit – weekly	$1,620	$2,062	N/A
Duration	52 Weeks	52 Weeks	52 Weeks
Waiting Period	7 Days	7 Days	7 Days

Submitting A Claim

If a staff member has a disabling injury or illness, they need to notify their manager and HR Partner, and then call Broadspire, USC's third-party administrator, at 800-495-2315. You will need additional information ready for your call. This information can be found at employees.usc.edu/benefits-perks/disability-and-workers-compensation/disability.

VOLUNTARY HEALTH-RELATED PLANS





THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident insurance from MetLife helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. This plan includes a wellness benefit that pays you $60 for completing one of a number of preventive health care activities (completing USC's health assessment is one of them).

Visit the accident coverage page.

Critical Illness Insurance

Critical illness insurance from MetLife can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. This plan includes a wellness benefit that pays you $50 for completing one of a number of preventive health care activities, but if you have critical illness insurance only, and complete a mammogram, the plan pays you $200.

Visit the critical illness coverage page.

Hospital Indemnity Insurance

Hospital indemnity insurance from MetLife can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide. Because MetLife makes the payment to you, not your healthcare provider, you can use the money any way you see fit. This plan includes a wellness benefit that pays you $50 for completing one of a number of preventive health care activities (completing USC's health assessment is one of them).

Visit the hospital indemnity coverage page.

VOLUNTARY HEALTH-RELATED PLANS

Hospital Indemnity Insurance Cont.

Identity Theft Protection - Keep your identity secure with proactive monitoring and alerts if threats to your personal info—like your bank accounts, credit, Social Security Number, IDs and more—are detected.

Financial Fraud Protection - Get alerted to new inquiries to your credit, suspicious transactions on your bank accounts, and changes to your car or home title.

Digital Security - Shop, bank, and work online more privately with safety tools including VPN/Wi-Fi security, antivirus, and password manager.

Privacy - Aura requests removal of your personal info from data broker lists to help reduce spam like robocalls, robotexts, and more.

Visit the Identity Theft & Fraud coverage page.

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Pet Insurance offered by MetLife can give you the confidence that you can care for your pet when an unexpected accident or illness occurs.
Coverage is purchased directly through MetLife at the Pet Insurance coverage page link.

Visit the Pet Insurance coverage page.

Legal Insurance

Low-cost access to legal coverage is available from MetLife Legal Plans. Fully covered legal services are free when you enroll and pay the small monthly premium. You must enroll in the plan within 30 days of your employment at USC or wait until the next open enrollment. The plan provides unlimited, confidential telephone advice and office consultation, giving you the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded matters, even if the matter is not fully covered under the plan.

During the consultation, the attorney will explain your rights, point out your options and, if needed, recommend a course of action. The attorney will identify any further coverage available under the plan and will undertake representation if you wish. If representation is covered by the plan, you will not be charged for the network attorney's services. If representation is recommended, but is not covered by the plan, the network attorney will provide a written fee statement in advance. Some of the services provided include purchase, sale or refinancing of a primary residence, wills and estate planning, deed preparation and immigration assistance, debt matters and identity theft defense and civil litigation defense.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

- Healthcare Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (DC FSA)
- 401(k) Retirement Savings Plan

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

Health Equity
healthequity.com
(800) 442-7247

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Do you pay for dependent care?
Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the FSA plan works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to **$3,300** , the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully! FSA Money "Use It or Lose It" Rule:

If you don't spend all the money in your account, you forfeit the leftover balance at the end of the year. You cannot stockpile money in your FSA. You should only contribute the amount of money you expect to pay out of pocket that year. If you do not use it, you lose it.

Health FSA

Health FSAs allow you to pay for qualified health care expenses with pre-tax dollars.

What can a Health FSA be used for?
- Medical plan deductibles
- Most insurance copays
- Prescription drugs
- Some OTC medications – with a prescription
- Vision exams, eyeglasses and contact lenses
- Laser eye surgery
- And More!

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Click to play video

Every Opportunity to Save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Health Equity.

Here's how the FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children younger than 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household, per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

You cannot transfer funds between the Healthcare FSA and Dependent Care FSA

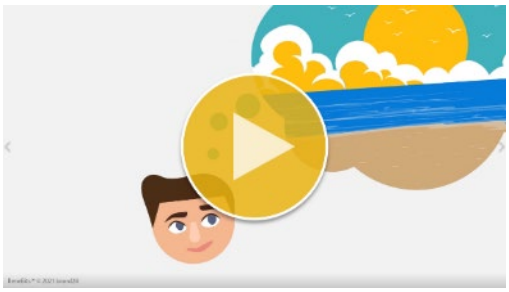
The Health Care FSA option allows continuation through COBRA if you have contributed more than you have withdrawn at the time of termination.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Health Equity | healthequity.com | (800) 442-7247

SAVE NOW, ENJOY LATER

Click to play video



WHAT ARE YOUR PLANS?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k)-retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

With the company match and compound interest, that "small amount" can grow over time. You'll be a retirement saver before you know it.

401(k) Retirement Savings Plan—up to $23,000 per year

Our 401(k) Retirement Savings Plan helps you save for retirement. The plan offers tax savings NOW through pre-tax contributions.

USC will match 100% of your before-tax or Roth contributions up to a maximum of 4% of your eligible earnings on a paycheck-by-paycheck basis. Your contributions begin with the pay period following enrollment. Review the USC Hospital Summary Plan Description (SPD) for more information.

Visit the employees.usc.edu/benefits-perks/retirement-benefits/uschospital-401k to manage your account, investments and contributions.

Fidelity offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.

Important differences of a Roth 401(k)

- You pay taxes when you contribute, at your current tax rate.
- Account interest and dividends are not taxed if you meet certain criteria.
- Like a traditional 401(k), you can withdraw money without penalties when you reach age 59½, but you must have held the account for at least 5 years.
- You are not forced to take distributions at age 70½. You can keep the money in your Roth account as long as you want.

WELLBEING & BALANCE

“The key to keeping your balance is knowing when you've lost it. ”

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it’s not always easy.

We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.
- Take time to spend with family and friends, take care of personal business, or just for yourself.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

To access services, visit **usc.lifeworks.com/life/employee-assistance** and log in with:

- **Username - USC**
- **Password - workwell**

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Lifeworks can help you handle a wide variety of personal issue such as emotional health and substance use disorder; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- Unlimited web access to helpful articles, resources, and self-assessment tools.

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

TIME AWAY FROM WORK

Paid time off policies

PURPOSE: To state Keck Community Medical Group (KCMG)'s procedure and definitions in regards of Paid Time Off and absences from work.

POLICY: It is the policy of Keck Community Medical Group (KCMG) to provide Paid Time Off (PTO) for absence from work. This includes time off for a variety of reasons such as relaxation, recreation, leisure, illness, civic duty and other emergency time off. All scheduled PTO leave must be requested in advance and approved by the employee's immediate supervisor. Every effort will be made to grant requests with first consideration given to patient care and the operating efficiency of the department. Union employees please reference Collective Bargaining Agreement for Time Off plans.

DEFINITION

1. Paid Time Off (PTO)

Eligibility: All employees who are regularly scheduled to work 24 or more hours per week are eligible. Eligible new hires will begin accruing on the 61st day of employment. PTO is accrued at the rate of .0962 per each straight time hour worked and stops at 324 hours. The amount of Paid Time Off an employee is entitled to is based on length of service and annually represents the combination of:

LENGTH OF USC SERVICE

PTO Categories	<5 Years	>5 Years
Vacation / Personal	10 Days	15 Days
Holiday	9 Days	9 Days
Sick	6 Days	6 Days
Total	25 Days or 200 Hours (accrual .0962)	30 Days or 240 Hours (accrual .1154)

2. Sick Leave Reserve (SLR)

- The SLR program, together with the State Disability Insurance (SDI) benefit, provides income for longer term illness beyond the six (6) days included in the annual PTO accrual. All benefit eligible employees are eligible for SLR benefits after their first ninety (90) days of employment.
- Sick Leave Reserve time is accrued by full-time staff at the rate of 2.15 hours per pay period or 7 days per year. For part-time employees, this amount is pro-rated depending upon the amount of time worked in a pay period.
- To qualify for payment from SLR, an employee must be hospitalized overnight, or must qualify for State Disability Insurance or Workers' Compensation benefits. Qualification for State Disability occurs when an employee is ill or disabled for longer-than 7 days. Qualification for Workers' Compensation occurs when you are hospitalized or disabled longer than three calendar days as a result of a work-related illness or injury.
- If an employee becomes eligible for payment from Sick Leave Reserve, of the first 7 days of absence 50% will be charged to the employee's PTO balance and 50% to SLR for a total not to exceed the employee's budgeted work hours. Payment for the remaining absence from work will come from the SLR, integrated with SDI, presuming there is an adequate reserve balance.
- Sick Leave Reserve hours may accumulate to a maximum of eighty (80) hours.

Because the purpose of this program is only to assist in the event of long-term illness, no payment is made upon termination for accumulated Sick Leave Reserve.

Complete information can be found here.

2025 HOLIDAYS & OTHER PERKS

Keck Community Medical Group (KCMG) Perks

Keck Community Medical Group (KCMG) employees are also entitled to free onsite annual certification renewals, free onsite parking, and employee discounts in cafeterias, gift shop, pharmacy, and entertainment activities.

Employees are eligible to receive discounts ranging from the USC Ticket Office, transportation and travel, software, cell phone discounts and more. Please visit our Discounts and Perks page via the USC Employee Gateway for more detailed information.

2025 paid holidays

Keck Community Medical Group (KCMG) provides 9 paid holidays per year for all full-time, benefit eligible employees.

New Year's Day	**January 1**
MLK Day	**January 15**
Presidents' Day	**February 19**
Memorial Day	**May 27**
Independence Day	**July 4**
Labor Day	**September 2**
Thanksgiving	**November 28**
Day After Thanksgiving	**November 29**
Christmas Day	**December 25**

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

PLAN CONTACTS

PLAN TYPE	CARRIER	CONTACT INFO	WEBSITE
Medical	HealthComp	(800) 442-7247	healthcomp.com
Prescription Coverage	Navitus	(855) 673-6504	navitus.com
Dental	Delta Dental	(800) 765-6003	deltadentalins.com
Vision	VSP	(800) 877-7195	vsp.com
Flexible Spending Account(s)	Health Equity	(800) 442-7247	healthequity.com
USC Basic, Supplemental, Long-Term Disability	USC Disability	uschr@usc.edu or (213) 821-8100	uschr@usc.edu or (213) 821-8100
California State Disability	California State Disability Insurance (SDI) Program	Disability Insurance: (800) 480-3287 Paid Family Leave: (800) 238-4373	edd.ca.gov/disability/
Life/AD&D Long-Term Disability	MetLife	HR Service Center at uschr@usc.edu or (213) 821-8100	metlife.com/USC/life-insurance/
Accident, Critical Illness, Hospital Indemnity, Legal, and Identity Theft & Fraud Protection	MetLife	(800) 438-6388	metlife.com/info/USC/
Employee Assistance Program	LifeWorks	cwfl@usc.edu (213) 821-0800	usc.lifeworks.com/life/employee-assistance
Retirement	Various Vendors	HR Service Center at uschr@usc.edu or (213) 821-8100	HR Service Center at uschr@usc.edu or (213) 821-8100

Disability and Paid Family Leave calls centers available 8 a.m. to 5 p.m. (Pacific time), Monday through Friday, except on state holidays. Accident, Critical Illness, and Hospital Indemnity Customer service is available Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

GLOSSARY

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on the Employee Gateway.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on the Employee Gateway. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Keck Community Medical Group (KCMG)
- Anthem Blue Cross Prudent Buyer

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available Employee Gateway.

- Keck Medicine of USC Community / USC Care Medical Group / USC Care Medical Group
- Delta Dental PPO

DETERMINING ELIGIBILITY

EMPLOYEE ELIGIBILITY: LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Keck Community Medical Group (KCMG) uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of 30 days from your hire date.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and Keck Community Medical Group (KCMG) is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP). Your IMP will begin on January 1, 2024. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage INITIAL STABILITY START. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period during which Keck Community Medical Group (KCMG) counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Keck Community Medical Group (KCMG) uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: STARTS: DATE DURATION: STANDARD MEASURE DURATION

Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: STARTS: STANDARD STABILITY START DURATION: STANDARD MEASURE DURATION

Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

DETERMINING ELIGIBILITY

EMPLOYEE ELIGIBILITY: MONTHLY MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Keck Community Medical Group (KCMG) uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

Medicare Part D Notice

Important Notice from Keck Community Medical Group (KCMG) 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 Keck Community Medical Group (KCMG) 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. Keck Community Medical Group (KCMG) has determined that the prescription drug coverage offered by the Anthem Blue Cross Prudent Buyer 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 Keck Community Medical Group (KCMG) coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Anthem Blue Cross Prudent Buyer is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Keck Community Medical Group (KCMG) prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Keck Community Medical Group (KCMG) 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 Keck Community Medical Group (KCMG) 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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 1, 2025
Name of Entity/Sender:	Keck Community Medical Group (KCMG)
Contact-Position/Office:	Human Resources
Address :	1812 Verdugo Blvd Glendale, CA 92108
Phone Number:	(818) 790-7100

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances in Verdugo Hills Hospita's medical plans apply. If you would like more information on WHCRA benefits, call your plan administrator.

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Keck Community Medical Group (KCMG) health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Keck Community Medical Group (KCMG) health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Keck Community Medical Group (KCMG) health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

Important Notice from Keck Community Medical Group (KCMG) About Your Prescription Drug Coverage and MedicareWe maintain the HIPAA Notice of Privacy Practices for Keck Community Medical Group (KCMG) describing how health information about you may be used and disclosed.

Michelle's Law

The Anthem Blue Cross Prudent Buyer plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Keck Community Medical Group (KCMG) LLC's Human Resources Department in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.

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)**.

f 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, 2024**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program 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+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – 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
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
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
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
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
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
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, 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

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USC University of Southern California