Benefits decision guide
Graduate Medical Education

You & your benefits
A partnership for good health

2016/ 2017
July 1, 2016 – June 30, 2017

Inside:
Medical..................... 1
Dental........................ 2
Vision ....................... 2
Life and AD&D............ 3
How to Enroll............. 4
FAQs ......................... 5
Terms ........................ 6
Contacts .................... 6
Legal Notices ............. 7
Notes ......................... 20
Enrollment Form ....... 21
Welcome to Tulane University School of Medicine. Providing great benefit choices to you and your family is just one of the many ways Tulane University School of Medicine supports the health and financial well-being of the people who make our school successful — you.

Your benefits
We’re committed to supporting your overall wellness with a comprehensive benefits program designed to meet your unique needs. Key features of your Tulane University School of Medicine benefits include:

- Choice among many popular benefit options.
- Effective and affordable health care coverage.
- Financial security through life and disability insurance.

This guide describes your health plan options and other important benefits. Use this information, along with other helpful resources available at http://tulane.edu/som/gme/resources-for-residents-and-fellows.cfm, to choose the coverage that’s right for you and your family. Then be sure to enroll and make the most of your benefits in 2016/2017.

Who’s eligible?
All regular full-time residents and their dependents are eligible for health benefits. Be sure to enroll by your enrollment deadline to make the most of your benefits in 2016/2017.

Eligible dependents of residents include:

- Your legal spouse.
- Your children who are younger than 26.
- Your children with disabilities who meet certain criteria.

Enrollment periods
- **New residents:** Enroll within 30 days from your date of hire. If you do not enroll or waive coverage within this time period, you will automatically be enrolled in the high option medical plan (LAX).
- **Open Enrollment:** Enroll before the enrollment deadline. If you do not make changes to your coverage within the enrollment time period, your current coverage will continue.

Making changes to your benefits
After your enrollment opportunity ends, you will not be able to make changes to your benefits until the next Open Enrollment, unless you experience a qualifying life event. These events include marriage, divorce, birth, adoption, or a change in your or your spouse’s employment status that affects your benefits eligibility.

Who pays?

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>Who Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>You &amp; Tulane University School of Medicine</td>
</tr>
<tr>
<td>Dental</td>
<td>You &amp; Tulane University School of Medicine</td>
</tr>
<tr>
<td>Vision</td>
<td>You &amp; Tulane University School of Medicine</td>
</tr>
<tr>
<td>Life and AD&amp;D</td>
<td>Tulane University School of Medicine</td>
</tr>
<tr>
<td>Long-term disability</td>
<td>Tulane University School of Medicine</td>
</tr>
</tbody>
</table>
Nothing is more important than your overall health and well-being. That’s why our benefits program offers plans to help keep you and your family healthy and also provide important protection in the event of illness or injury.

Medical

Tulane University School of Medicine offers two options of medical insurance, so you can select the option that’s best for you and your family.

You can choose from the following options:

• UnitedHealthcare PPO $250 Deductible Plan (LAX), a preferred provider organization.
• UnitedHealthcare PPO $500 Deductible Plan (LA1), a preferred provider organization.

Compare the medical plans

The chart below provides a comparison of key coverage features and costs for each medical plan available to you. Carefully consider your anticipated health care needs for the coming year when evaluating your options.

<table>
<thead>
<tr>
<th></th>
<th>$250 Deductible Plan (LAX)</th>
<th>$500 Deductible Plan (LA1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$250/$500</td>
<td>$250/$500</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum (includes deductible &amp; copay)</strong></td>
<td>$750/$1,500</td>
<td>$1,500/$3,000</td>
</tr>
<tr>
<td>Individual/family</td>
<td>$15 copay/Deductible + 20%</td>
<td>$20 copay/Deductible + 50%</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>$15 copay/Deductible + 20%</td>
<td>$40 copay/Deductible + 50%</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>Deductible + 10%</td>
<td>Deductible + 20%</td>
</tr>
<tr>
<td>X-rays, lab, etc.</td>
<td>Plan pays 100%</td>
<td>Deductible + 20%</td>
</tr>
<tr>
<td>Inpatient hospital (per stay)</td>
<td>Deductible + 10%</td>
<td>Deductible + 20%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
</tbody>
</table>

This is only a partial list of covered benefits. For a complete list of services, please refer to your Summary Plan Description.

Monthly medical plan premiums

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>PPO Plan A (LAX)</th>
<th>PPO Plan B (LA1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident only</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Resident + spouse</td>
<td>$355.66</td>
<td>$224.28</td>
</tr>
<tr>
<td>Resident + children</td>
<td>$266.00</td>
<td>$109.65</td>
</tr>
<tr>
<td>Family</td>
<td>$599.96</td>
<td>$384.64</td>
</tr>
</tbody>
</table>
Dental

When it comes to staying healthy, your teeth and gums play an important role. That’s why we offer dental insurance that helps pay for the cost of routine checkups — and just about any other type of dental work you might need. You have a choice of two dental plans, which offer different levels of coverage to match your specific needs.

<table>
<thead>
<tr>
<th></th>
<th>Low Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$50/$150</td>
<td>$50/$150</td>
</tr>
<tr>
<td>(individual/family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit-year</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Major services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Benefits shown are for in-network providers and are based on negotiated fees. Out-of-network coverage is based on reasonable and customary (R&C) charges.

Vision

With the Tulane University School of Medicine vision coverage, the focus is on you. Your vision plan covers periodic eye exams, eyeglasses, contact lenses, and more for you and your covered dependents.

<table>
<thead>
<tr>
<th></th>
<th>Vision Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits through a preferred provider</td>
</tr>
<tr>
<td>Exam (every 12 months)</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Prescription glasses</td>
<td>$25 copay</td>
</tr>
<tr>
<td>• Lenses (every 12 months)</td>
<td>Covered</td>
</tr>
<tr>
<td>• Frames (every 24 months)</td>
<td>$130 allowance + 20% off amount over allowance</td>
</tr>
<tr>
<td>Contact lenses (every 12 months, in lieu of frames)</td>
<td>$130 allowance</td>
</tr>
</tbody>
</table>

Monthly dental and vision plan premiums

<table>
<thead>
<tr>
<th></th>
<th>Dental</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Option</td>
<td>High Option</td>
</tr>
<tr>
<td>Resident only</td>
<td>$15.04</td>
<td>$22.40</td>
</tr>
<tr>
<td>Resident + spouse</td>
<td>$31.55</td>
<td>$47.01</td>
</tr>
<tr>
<td>Resident + children</td>
<td>$34.55</td>
<td>$51.49</td>
</tr>
<tr>
<td>Family</td>
<td>$51.08</td>
<td>$76.10</td>
</tr>
</tbody>
</table>
Life and AD&D insurance

Tulane University School of Medicine provides you with basic life and AD&D insurance so that you can protect those you love from the unexpected. It can be used to pay off debts — such as credit cards and a mortgage — or for other expenses. You can also purchase additional protection at your own expense.

**Company-paid**
- Resident basic life and AD&D insurance of $25,000.

**Resident-paid**
- Resident supplemental life: increments of $10,000 with a minimum of $20,000 up to a maximum of $500,000.
- Spouse dependent life: increments of $5,000 with a minimum of $5,000 up to a maximum of $250,000, not to exceed 50% of resident’s amount.
- Child dependent life: $100 for children 14 days to under 6 months; options of $1,000, $5,000, or $10,000 for children 6 months to 26 years.

**AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.**

What is AD&D insurance?

Should you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D insurance provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Disability insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Disability insurance replaces a portion of your income to help you continue paying your bills and meeting your financial obligations.

**Summary of disability benefits**

<table>
<thead>
<tr>
<th></th>
<th>Long-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who pays</td>
<td>Employer-paid</td>
</tr>
<tr>
<td>Benefit provided</td>
<td>Up to 60% of base monthly salary</td>
</tr>
<tr>
<td>Maximum benefit payable</td>
<td>$4,500</td>
</tr>
<tr>
<td>Maximum benefit duration</td>
<td>Until you’re no longer considered disabled or you reach normal retirement age, whichever comes first</td>
</tr>
<tr>
<td>Waiting period</td>
<td>90 days</td>
</tr>
</tbody>
</table>

Have you named a beneficiary?

The beneficiary will receive the benefit paid by a life insurance policy in the event of the policyholder’s death. It’s important to designate a beneficiary and keep that information up-to-date. To add or change a beneficiary, contact Helen Weisler at 504-988-1746 or hweisler@tulane.edu.
After you’ve carefully considered your benefit options and anticipated needs, it’s time to make your benefit selections. Follow the instructions below to enroll yourself and any eligible dependents you want to cover.

How to enroll
All enrollments are paper enrollments.

What happens if you don’t enroll?
As a new resident – Enrollment for health benefits must be made within 30 days from your hire date. If you are a full-time resident and you do not enroll or waive coverage within this time period, you will automatically be enrolled in the high option medical plan (LAX). You won’t be able to change your benefits coverage again during the year unless you experience a qualifying life event (e.g., marriage, birth).

During Open Enrollment – If you want to make changes to your benefits, you must take action before the enrollment deadline. If you don’t take any action, you will keep your current coverage.

Enrolling a spouse?
If you are enrolling a spouse in benefits coverage, you may need to provide proof of your relationship, such as a marriage certificate.

Enrollment checklist
Open Enrollment is June 1 – June 30. During your enrollment period, make sure to:

- Learn about your benefit options described in this brochure.
- Review your current coverage and consider how well it has been meeting your needs.
- Think about your anticipated health care needs for 2016/17.
- Make changes to your benefits, if needed.
- Update your beneficiary and dependent information. Have SSNs and birthdates available.
- Get the coverage you need.
FAQs
Here are answers to some common questions you may have about your benefits program.

Q: What is an annual Open Enrollment period?
A: It’s the time of year that you may add, drop, or change your level of coverage for certain before-tax benefit options. For 2016/2017, the Open Enrollment period for residents is June 1 – June 30.

Q: What happens if I miss the deadline to enroll in the company’s benefit programs?
A: If you don’t make your benefit elections within 30 days after your date of hire, you won’t be able to enroll until the next Open Enrollment period unless you have a qualifying life event.

Q: When will I receive my health care ID cards?
A: Once you submit your enrollment information, your medical card(s) should arrive within three to four weeks.

Q: How can I receive additional or replacement ID cards?
A: Call the benefit providers directly.

Q: When can I continue coverage under COBRA?
A: You and/or your dependents are eligible to continue group health care under COBRA if coverage is lost because:
• You leave the company for any reason other than “gross misconduct.”
• Your work hours are reduced.
• You die.
• You become entitled to and enroll in Medicare prior to electing COBRA.
• You divorce.
• Your dependent loses dependent status.

Q: What if I get married or divorced, or have a new child in my family, during the plan year?
A: You must notify the GME office within 30 days of any qualifying life event. Otherwise, you will have to wait until the next Open Enrollment period to change your benefit options or coverage levels. You may also be required to show official documentation as proof of the change such as a marriage license, birth certificate, or court papers.

Q: What is an explanation of benefits (EOB)?
A: It’s a statement provided to a plan participant explaining how and why a claim was or wasn’t paid. Always review your EOB statements for accuracy. If you have a question about an EOB — or see an error — contact the provider directly.
Please become familiar with the following terms to better understand your benefit programs, then contact the appropriate provider listed below to learn more about a specific benefit plan. We also invite you to speak with your GME Office when you have questions.

**Coinsurance** – The portion of covered expenses that you must pay for care, after first meeting a deductible amount, if any.

**Copayment** – A flat fee that you pay for health care services at the time they’re received, regardless of the actual amount charged by your doctor or another provider. This generally applies to office visits and prescription drugs.

**Deductible** – The amount you need to pay each year before your plan starts paying benefits.

**Network** – A group of doctors and hospitals who offer discounts on services based on their relationship with UnitedHealthcare.

**Out-of-pocket maximum** – The most you will pay in a given year for all covered expenses. After you reach this amount, your benefit plan will pay all covered expenses for the rest of the year.

**Reasonable & customary (R&C) charge** — The usual amount charged by most doctors for a particular service. The R&C charge may be different in two different geographic areas or if the service was provided under different circumstances (for example, in an emergency versus a nonemergency). R&C charges may apply only if you use out-of-network providers. You’re responsible for paying any amount that exceeds the R&C limit.

<table>
<thead>
<tr>
<th>Questions about</th>
<th>Contact</th>
<th>Phone number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>UnitedHealthcare</td>
<td>1-866-633-2446</td>
<td>myuhc.com</td>
</tr>
<tr>
<td>Dental</td>
<td>Guardian</td>
<td>1-800-627-4200</td>
<td>guardiananytime.com</td>
</tr>
<tr>
<td>Vision</td>
<td>Guardian</td>
<td>1-800-627-4200</td>
<td>guardiananytime.com</td>
</tr>
<tr>
<td>Life and AD&amp;D</td>
<td>The Hartford</td>
<td>1-800-523-2233</td>
<td>thehartfordatwork.com</td>
</tr>
<tr>
<td>Disability</td>
<td>The Hartford</td>
<td>1-800-523-2233</td>
<td>thehartfordatwork.com</td>
</tr>
<tr>
<td>Tulane University School of Medicine</td>
<td>Helen Weisler, Program Manager</td>
<td>504-988-1746</td>
<td><a href="mailto:hweisler@tulane.edu">hweisler@tulane.edu</a></td>
</tr>
</tbody>
</table>

This document highlights some of the provisions of Tulane University School of Medicine’s benefits program. Complete details may be found in the official plan documents. While every effort has been made to ensure accuracy of this benefits guide, the plan documents and contracts will prevail in case of discrepancy between this brochure and the plan documents and contracts. In addition, Tulane University School of Medicine reserves the right to amend or terminate any benefit plans at any time.
Tulane University School of Medicine believes both health plans offered, Choice Plus Plan LAX (M) (high option) and Choice Plus Plan LA1 (M) (low option), are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Helen Weisler, at hweisler@tulane.edu or 504-988-1746. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2017 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Tulane University School of Medicine and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the Tulane University School of Medicine prescription drug plans listed below, you’ll be interested to know that coverage is, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as “creditable coverage.”
late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Choice Plus Plan LAX (M)
- Choice Plus Plan LA1 (M)

If you decide to enroll in a Medicare prescription drug plan and you are an active resident or family member of an active resident, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Tulane University School of Medicine coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Tulane University School of Medicine plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Tulane University School of Medicine and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Tulane University School of Medicine coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here’s how to get more information about Medicare prescription drug plans:

- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Helen Weisler  
504-988-1746  
hweisler@tulane.edu
Tulane University School of Medicine
HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Tulane University School of Medicine health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Dental and Vision. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It’s important to note that these rules apply to the Plan, not Tulane University School of Medicine as an employer — that’s the way the HIPAA rules work. Different policies may apply to other Tulane University School of Medicine programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. How the Plan may share your health information with Tulane University School of Medicine.
**How the Plan may share your health information with Tulane University School of Medicine**

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Tulane University School of Medicine for plan administration purposes. Tulane University School of Medicine may need your health information to administer benefits under the Plan. Tulane University School of Medicine agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The GME Office are the only Tulane University School of Medicine employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and Tulane University School of Medicine, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose “summary health information” to Tulane University School of Medicine, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Tulane University School of Medicine information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Tulane University School of Medicine cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Tulane University School of Medicine from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

**Other allowable uses or disclosures of your health information**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ compensation</td>
<td>Disclosures to workers’ compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws</td>
</tr>
<tr>
<td>Necessary to prevent serious threat to health or safety</td>
<td>Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody</td>
</tr>
<tr>
<td>Public health activities</td>
<td>Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects</td>
</tr>
<tr>
<td>Victims of abuse, neglect, or domestic violence</td>
<td>Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you’ll be notified of the Plan’s disclosure if informing you won’t put you at further risk)</td>
</tr>
<tr>
<td>Judicial and administrative proceedings</td>
<td>Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)</td>
</tr>
<tr>
<td>Purpose</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Law enforcement purposes</td>
<td>Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan’s premises.</td>
</tr>
<tr>
<td>Decedents</td>
<td>Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.</td>
</tr>
<tr>
<td>Organ, eye, or tissue donation</td>
<td>Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.</td>
</tr>
<tr>
<td>Research purposes</td>
<td>Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.</td>
</tr>
<tr>
<td>Health oversight activities</td>
<td>Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.</td>
</tr>
<tr>
<td>Specialized government functions</td>
<td>Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.</td>
</tr>
<tr>
<td>HHS investigations</td>
<td>Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan’s compliance with the HIPAA privacy rule.</td>
</tr>
</tbody>
</table>

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can’t revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

**Your individual rights**

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

**Right to request restrictions on certain uses and disclosures of your health information and the Plan’s right to refuse**

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you’re notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information
regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

**Right to receive confidential communications of your health information**

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

**Right to inspect and copy your health information**

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan’s cost.

**Right to amend your health information that is inaccurate or incomplete**

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:
• Make the amendment as requested
• Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
• Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

• For treatment, payment, or health care operations
• To you about your own health information
• Incidental to other permitted or required disclosures
• Where authorization was provided
• To family members or friends involved in your care (where disclosure is permitted without authorization)
• For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
• As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on July 1, 2016. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice by e-mail and/or one will be sent to your home address on file.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, contact Helen Weisler at 504-988-1746.

Contact
For more information on the Plan’s privacy policies or your rights under HIPAA, contact Helen Weisler at 504-988-1746
Women’s Health and Cancer Rights Act (WHCRA) Notice

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.

If you would like more information on WHCRA benefits, call the UnitedHealthcare customer service department at 1-866-633-2479.

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, 2016. Contact your State for more information on eligibility –
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Phone</th>
<th>State</th>
<th>Medicaid Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td><a href="http://myalhipp.com/">Website</a></td>
<td><a href="1-855-692-5447">Phone</a></td>
<td>GEORGIA</td>
<td><a href="http://dch.georgia.gov/medicaid">Website</a></td>
<td><a href="404-656-4507">Phone</a></td>
</tr>
<tr>
<td>ALASKA</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">Website</a></td>
<td>[Phone](Outside of Anchorage: 1-888-318-8890, Anchorage: 907-269-6529)</td>
<td>INDIANA</td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
<td><a href="http://www.hip.in.gov">Website</a></td>
</tr>
<tr>
<td>COLORADO</td>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
<td><a href="1-888-346-9562">Phone</a></td>
<td>IOWA</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">Website</a></td>
<td><a href="1-888-346-9562">Phone</a></td>
</tr>
<tr>
<td>FLORIDA</td>
<td><a href="http://flmedicaidtplrecovery.com/hipp/">Website</a></td>
<td><a href="1-877-357-3268">Phone</a></td>
<td>KANSAS</td>
<td><a href="http://www.kdheks.gov/hcf/">Website</a></td>
<td><a href="1-785-296-3512">Phone</a></td>
</tr>
<tr>
<td>KENTUCKY</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">Website</a></td>
<td><a href="1-800-635-2570">Phone</a></td>
<td>NEW HAMPSHIRE</td>
<td><a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">Website</a></td>
<td><a href="603-271-5218">Phone</a></td>
</tr>
<tr>
<td>LOUISIANA</td>
<td><a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">Website</a></td>
<td><a href="1-888-695-2447">Phone</a></td>
<td>NEW JERSEY</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">Website</a></td>
<td><a href="1-800-701-0710">Phone</a></td>
</tr>
<tr>
<td>MAINE</td>
<td><a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">Website</a></td>
<td><a href="1-800-442-6003">Phone</a></td>
<td>TTY: Maine relay 711</td>
<td>Medicaid Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">Website</a></td>
<td><a href="1-800-541-2831">Phone</a></td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
<td><a href="1-800-462-1120">Phone</a></td>
<td>NORTH CAROLINA</td>
<td><a href="http://www.ncdhhs.gov/dma">Website</a></td>
<td><a href="919-855-4100">Phone</a></td>
</tr>
<tr>
<td>MINNESOTA</td>
<td><a href="http://mn.gov/dhs/ma/">Website</a></td>
<td><a href="1-800-657-3739">Phone</a></td>
<td>NORTH DAKOTA</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">Website</a></td>
<td></td>
</tr>
<tr>
<td>MISSOURI</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
<td><a href="573-751-2005">Phone</a></td>
<td>OKLAHOMA</td>
<td>Medicaid Website: <a href="http://www.insureoklahoma.org">Website</a></td>
<td><a href="1-888-365-3742">Phone</a></td>
</tr>
<tr>
<td>MONTANA</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">Website</a></td>
<td><a href="1-800-694-3084">Phone</a></td>
<td>OREGON</td>
<td><a href="http://www.oregonhealthykids.gov">Website</a></td>
<td><a href="1-888-365-3742">Phone</a></td>
</tr>
<tr>
<td>NEBRASKA</td>
<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">Website</a></td>
<td><a href="1-855-632-7633">Phone</a></td>
<td>PENNSYLVANIA</td>
<td><a href="http://www.dhs.pa.gov/hipp">Website</a></td>
<td><a href="1-800-692-7462">Phone</a></td>
</tr>
<tr>
<td>NEVADA</td>
<td><a href="http://dwss.nv.gov/">Website</a></td>
<td><a href="1-800-992-0900">Phone</a></td>
<td>RHODE ISLAND</td>
<td><a href="http://www.eohhs.ri.gov/">Website</a></td>
<td><a href="401-462-5300">Phone</a></td>
</tr>
</tbody>
</table>
SOUTH CAROLINA – Medicaid  
Website: http://www.scdhhs.gov  
Phone: 1-888-549-0820

VIRGINIA – Medicaid and CHIP  
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm  
Medicaid Phone: 1-800-432-5924  
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm  
CHIP Phone: 1-855-242-8282

SOUTH DAKOTA - Medicaid  
Website: http://dss.sd.gov  
Phone: 1-888-828-0059

WASHINGTON – Medicaid  
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx  
Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid  
Website: http://gethipptexas.com/  
Phone: 1-800-440-0493

WEST VIRGINIA – Medicaid  
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx  
Phone: 1-877-598-5820, HMS Third Party Liability

UTAH – Medicaid and CHIP  
Website: Medicaid: http://health.utah.gov/medicaid  
CHIP: http://health.utah.gov/chip  
Phone: 1-877-543-7669

WISCONSIN – Medicaid and CHIP  
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf  
Phone: 1-800-362-3002

VERMONT – Medicaid  
Website: http://www.greenmountaincare.org/  
Phone: 1-800-250-8427

WYOMING – Medicaid  
Website: https://wyequalitycare.acs-inc.com/  
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You’re getting this notice because you recently gained coverage under Tulane University School of Medicine’s 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 UnitedHealthcare.

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 may be required to pay for COBRA continuation coverage.

If you’re a resident, 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 a resident, 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-resident dies;
- The parent-resident’s hours of employment are reduced;
- The parent-resident’s employment ends for any reason other than his or her gross misconduct;
- The parent-resident 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.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Tulane University School of Medicine, and that bankruptcy results in the loss of coverage of any retired resident covered under the Plan, the retired resident will become a qualified beneficiary. The retired resident’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the resident;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The resident’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the resident and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify UnitedHealthcare within 60 days after (1) the date of the event or (2) the date on which coverage would be lost, whichever is later. You must provide this notice to: UnitedHealthcare COBRA. Tulane University School of Medicine has the responsibility of notifying UnitedHealthcare COBRA of the resident’s death, termination of employment, reduction in hours or Medicare entitlement.

How is COBRA continuation coverage provided?
Once UnitedHealthcare 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 residents 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 UnitedHealthcare 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. The resident, spouse or dependent has 30 days to notify UnitedHealthcare COBRA from the date of a final determination that he or she is no longer disabled.

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 resident or former resident 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, Medicaid, 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.

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 UnitedHealthcare 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 UnitedHealthcare.

Plan contact information
UnitedHealthcare COBRA (414) 443-4247

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

Q: What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.
Q: Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

¹An 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.

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

Q: How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.
Part B: Information About Health Coverage Offered by Your Employer

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

<table>
<thead>
<tr>
<th>3. EMPLOYER NAME</th>
<th>4. EMPLOYER IDENTIFICATION NUMBER (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tulane University School of Medicine</td>
<td>72-0423889</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. EMPLOYER ADDRESS</th>
<th>6. EMPLOYER PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1430 Tulane Ave., Box 8025</td>
<td>(504) 988-1746</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. CITY</th>
<th>8. STATE</th>
<th>9. ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Orleans</td>
<td>LA</td>
<td>70112</td>
</tr>
</tbody>
</table>

10. WHO CAN WE CONTACT AT THIS JOB?

Tulane University School of Medicine’s Graduate Medical Education Office

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

- As your employer, we offer a health plan to:
  ☑ All employees.

- With respect to dependents:
  ☑ We do offer coverage. Eligible dependents are:
    A lawful spouse and dependent children less than 26 years old. Under certain circumstances, children 26 or older may be eligible.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
Tulane University School of Medicine
Resident Enrollment Form

Please fill out both sides of this enrollment form legibly.

Name ________________________________________ □ Male □ Female Date of Birth __________________
Address ___________________________________________ Date of Hire __________________
City, State, ZIP __________________________________________ Marital Status____________________
Social Security Number ___________________________________ Phone _______________________

Medical/Rx Plan – Low Option (UnitedHealthcare) Choice Plus Plan LA1

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Declination of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Only</td>
<td>$0</td>
<td>I am declining this medical coverage.</td>
</tr>
<tr>
<td>Resident + Spouse</td>
<td>$224.28</td>
<td></td>
</tr>
<tr>
<td>Resident + Child(ren)</td>
<td>$109.65</td>
<td></td>
</tr>
<tr>
<td>Full Family</td>
<td>$384.64</td>
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</tr>
</tbody>
</table>

Medical/Rx Plan – High Option (UnitedHealthcare) Choice Plus Plan LAX

<table>
<thead>
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<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Declination of Coverage</th>
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</thead>
<tbody>
<tr>
<td>Resident Only</td>
<td>$0</td>
<td>I am declining this medical coverage.</td>
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<tr>
<td>Resident + Spouse</td>
<td>$355.66</td>
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</tr>
<tr>
<td>Resident + Child(ren)</td>
<td>$266.00</td>
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</tr>
<tr>
<td>Full Family</td>
<td>$599.96</td>
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Dental Plan – Low Option (Guardian) G-513680

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Declination of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Only</td>
<td>$15.04</td>
<td>I am declining this dental coverage.</td>
</tr>
<tr>
<td>Resident + Spouse</td>
<td>$31.55</td>
<td></td>
</tr>
<tr>
<td>Resident + Child(ren)</td>
<td>$34.55</td>
<td></td>
</tr>
<tr>
<td>Full Family</td>
<td>$51.08</td>
<td></td>
</tr>
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Dental Plan – High Option (Guardian) G-513680

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Declination of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Only</td>
<td>$22.40</td>
<td>I am declining this dental coverage.</td>
</tr>
<tr>
<td>Resident + Spouse</td>
<td>$47.01</td>
<td></td>
</tr>
<tr>
<td>Resident + Child(ren)</td>
<td>$51.49</td>
<td></td>
</tr>
<tr>
<td>Full Family</td>
<td>$76.10</td>
<td></td>
</tr>
</tbody>
</table>

Vision Plan (Guardian) G-513680

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Declination of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Only</td>
<td>$4.77</td>
<td>I am declining this vision coverage.</td>
</tr>
<tr>
<td>Resident + Spouse</td>
<td>$8.78</td>
<td></td>
</tr>
<tr>
<td>Resident + Child(ren)</td>
<td>$9.20</td>
<td></td>
</tr>
<tr>
<td>Full Family</td>
<td>$14.41</td>
<td></td>
</tr>
</tbody>
</table>

Basic Life/AD&D and Long Term Disability

These programs are provided at no cost to you.
## Supplemental Life/AD&D

If coverage was initially declined at the time you were newly eligible, if you requested an amount over the G.I. maximum, or you are electing to increase your current coverage, an Evidence of Insurability form will need to be completed and coverage approved before it will become effective. If you have life insurance coverage with Hartford Life and Accident Insurance Company, I understand and agree that the life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with Hartford Life and Accident Insurance Company, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

### Resident Coverage Requested (limited to $500,000)

- **Spouse Coverage Requested** (limited to $250,000 or 50% of resident coverage)
  - Amount requested $____________________
- **Child(ren) Coverage Requested**
  - Amount requested $________________________________________
- **I decline this coverage**

---

### Your Dependents

List all of the dependents you will cover. Dependents over the age of 19 will require proof of full-time student status for medical, dental and vision.

<table>
<thead>
<tr>
<th>Legally Married Spouse/Dependent's Name(s)</th>
<th>Sex M/F</th>
<th>Relationship</th>
<th>Birthdate (mm/dd/yy)</th>
<th>Social Security Number</th>
<th>Coverage Desired</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dental</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

### Your Beneficiaries

List all of your beneficiary designations for basic life, AD&D and supplemental life benefits.

<table>
<thead>
<tr>
<th>Legally Married Spouse/Dependent's Name(s)</th>
<th>Relationship</th>
<th>Social Security Number</th>
<th>Primary/Contingent</th>
<th>%</th>
<th>Basic Life/AD&amp;D</th>
<th>Supplemental Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>No</td>
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<td>Yes</td>
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<td>No</td>
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<td>Yes</td>
<td>Yes</td>
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<td></td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

---

### Rates Table

<table>
<thead>
<tr>
<th>Age</th>
<th>Resident OR Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25</td>
<td>$0.08</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.091</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.091</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.114</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.137</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.228</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.65</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.901</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.505</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.85</td>
</tr>
<tr>
<td>75 or over</td>
<td>$14.79</td>
</tr>
</tbody>
</table>

---

Guarantee Issue when enrolling during your initial eligibility period: • You $150,000 • Your Spouse $50,000 • Your Children $10,000  For any election over the Guaranteed Issue amount of $50,000 for your spouse, an Evidence of Insurability form will need to be submitted for approval.
Authorization

Please read and sign the following statement for your coverage to take effect: Please enroll me in the benefit(s) I have elected and make the necessary payroll deductions from my pay. I have read and understand the enrollment form and its explanatory material. I understand that this election of benefits is binding on me and cannot be marked or modified until the next enrollment period unless I have a family status change as defined by the flexible benefits plan. I agree that if I do not elect medical coverage for myself or my dependents, I will not hold my employer liable for any material expense incurred by the dependents or me. WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison. I declare that I am actively at work on the date of this enrollment form and that the information furnished to the best of my knowledge and belief is true, correct and complete.

An employee’s decision to elect Medical, Dental or Vision or not elect Medical, Dental or Vision must be retained until the next plan’s Open Enrollment period. If the employee elects not to enroll in the vision coverage, they are not eligible to enroll until the plan’s next Open Enrollment period.

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person’s insurability. Guardian or its designee has the right to reject your request.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

Name (please print)

________________________________________

Signature

________________________________________

Social Security Number

________________________________________

Date
Make note of any questions you may have after reviewing this guide. You may also want to use this space to write down your benefit selections so you have them handy when enrolling in your selected benefits.