Benefits Overview

Affordable Care Act Medical Insurance Plan Eligibility

The Affordable Care Act (ACA) requires employers to offer minimum essential coverage to employees who work 30 hours of service or more per week as determined under applicable ACA regulations. You and your eligible dependents may be eligible to participate in one of Rice’s employer-sponsored medical insurance plans. If you are eligible to participate in one of Rice’s medical insurance plans under the ACA, you will not be able to participate in Rice’s other employer-sponsored benefit plans such as dental, life insurance, holidays and benefit time until you move into a Rice benefits eligible position as defined by University Policy 403.

If you become benefits eligible as defined by University Policy 403, you will have 31 days from the effective date of the change in eligibility to enroll in Rice’s other employer-sponsored benefit plans.

Faculty and Staff Benefits Eligibility

Benefits eligible faculty and staff members may participate in health and welfare benefit plans (medical and dental insurance, life insurance, etc.) as well as retirement plans. Those who are not considered benefits eligible still may participate in some benefit plans, such as the supplemental retirement annuity plan (SRA). Each benefit program may have its own eligibility requirements.

Staff

An employee who works in a position that requires 20 or more hours of work per week and is scheduled to work at least 1,000 hours each year is eligible to participate in benefit plans. If an individual employed in a nonbenefits-eligible position later meets the eligibility criteria, he or she becomes eligible for enrollment in insurance programs and paid time-off benefits on the earlier of the date the criteria are met or the time it becomes known that the position requirements will meet or exceed benefits eligibility requirements. Temporary assignments may be extended only for a reasonable, short period of time based on the nature of the assignment.

All staff members who become benefits eligible will remain eligible for benefits until they no longer meet the criteria of working 1,000 hours for one year from their original hire date. Once they work the year without meeting the benefits eligibility requirements, the staff member will lose their benefits-eligible status. If you have a reduction in hours and fall below the previous benefits-eligible requirement, please meet with a member of the benefits team to discuss your benefits and any changes you may need to make.

Faculty

All tenured and tenure-track faculty members are eligible for benefits. Annually appointed teaching faculty must teach at least three courses per academic year and be on an annual appointment for two semesters to be eligible for benefits.

Services performed by any employee to satisfy course or degree requirements at Rice and services compensated through financial aid programs do not qualify for benefits eligibility.

In any event, the Retirement Plan Document (available on the HR website) governs eligibility for participation in the retirement plan. See Page 31 for more information about retirement benefits.
Eligible Dependents

Benefits eligible faculty and staff can choose to cover eligible dependents with medical, dental, optional life, long-term care, and optional accidental death and dismemberment insurance.

Eligible dependents include:
• Spouse, unless you’re legally separated (including legally recognized same-sex spouse)
• Domestic partner (for whom you have completed the Certification of Domestic Partner form)
• Dependent children up to age 26 for the medical plan and age 25 for all other plans, including your:
  • Natural children
  • Legally adopted children
  • Stepchildren
  • Children for whom you are the legal guardian
  • Foster children
  • Children placed with you for adoption
  • Children of your domestic partner who depend on you for support and live with you in a
    regular parent/child relationship
  • Unmarried dependent grandchildren (must provide court-ordered documentation of
    dependent status)

Dependent children may continue under the medical plan for which they are eligible until they reach age 26, regardless of their status as a student. All other insurance plans only cover your unmarried dependent children until age 25. As your children approach these age limits, please call the benefits team to discuss your situation.

Dependent children, age 26 or older, who are mentally or physically impaired and incapable of taking care of themselves also are eligible for coverage in the medical plan as long as disability started prior to the date he or she reaches the maximum age for dependent children. You must provide proof of disability to human resources and Aetna prior to the date the dependent reaches the maximum age under the plan. Coverage for a disabled dependent can continue for as long as the dependent is incapable of self-support, remains unmarried and is dependent on you for support. Aetna will have the right to require proof of the continuation of the handicap.

Coverage for your dependents continues for as long as they are eligible, provided your own coverage continues. When a dependent child loses eligibility because he or she reaches the age limit, he or she becomes eligible for 36 months of COBRA continuation for medical and/or dental benefits. See Continuation of Benefits (COBRA) on Page 15 for more information.

You must notify HR immediately when a dependent is no longer eligible so that the appropriate paperwork can be completed and your benefit deductions adjusted, if appropriate.

Are there any implications for enrolling a domestic partner or domestic partner’s child(ren)?

Enrolling a domestic partner is a completely voluntary and private decision. However, you are required to register your partner for them to be considered eligible for benefits. The university keeps such information in strict confidence within the human resources department. Human resources even has notaries available within the department to help complete the domestic partner application process. (See the HR website at http://people.rice.edu for the Domestic Partner Registration Packet.)

Because of system limitations, please make domestic partner changes during the annual benefits open enrollment period directly with a member of the Benefits Team and not through Esther.

Since domestic partners and their children may not be considered dependents for the purposes of the employee’s tax return, payments for premiums on behalf of the partner and nondependent children must be paid in post-tax dollars. That part of the premium may not be paid in pretax dollars. (See Page 4 for more information about pretax and post-tax deductions.) Further, the employee should be aware that contributions made by the university on behalf of the domestic partner and nondependent children may result in imputed income to the employee. Rice will, consistent with tax regulations, permit the use of pretax deductions to the fullest extent possible.

What is imputed income?

Currently, the Internal Revenue Service (IRS) says that if an employee receives employer-paid benefits for anyone who is not the employee’s tax dependent, the value of the coverage is “imputed income” and is taxable. The additional coverage for your domestic partner and/or your partner’s child becomes a taxable benefit — unlike medical coverage for other enrolled family members. Imputed income is separate from —
and in addition to — your monthly plan cost. The amount of your imputed income depends on the plans in which you are enrolled and the level of your coverage.

Imputed income is taxable — that is, it increases your taxable gross income for federal and state income taxes as well as for FICA (Social Security and Medicare) taxes withheld from your paycheck. Your imputed income is reported on your annual Form W-2, which you file with the IRS each year.

**Enrollment Deadlines**

Rice University has strict enrollment deadlines. The following chart details the enrollment deadlines:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Frame to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>New hire</td>
<td>No more than 31 days from your hire date</td>
</tr>
<tr>
<td>Change in status</td>
<td>No more than 31 days from date of qualifying event</td>
</tr>
<tr>
<td>Medicaid or CHIP enrollment</td>
<td>No more than 60 days from date of enrollment or disenrollment</td>
</tr>
<tr>
<td>Open enrollment</td>
<td>April 4–22, 2016</td>
</tr>
</tbody>
</table>

For new hires and most qualifying changes in status, coverage is effective on the first day of the month coincident with or following the enrollment date. You have 31 days from your date of hire to complete enrollment paperwork with the benefits office. Please note that every benefits-eligible new hire at Rice is automatically enrolled in the ACO medical plan at the employee-only level with coverage being effective the first of the following month upon expiration of 31 days from your date of hire. If you wish to select a different plan than the ACO, add dependents or decline coverage, you will need to do this prior to your 31-day expiration. If a qualifying event is the birth or adoption of a child, coverage can be made effective as of the date of the event; however, the paperwork must be completed in HR within the 31-day window. Changes in coverage made during open enrollment are effective on July 1.

**Pretax Versus Post-tax Deductions**

What is the benefit of having the cost of your portion of the insurance deducted from your paycheck before taxes (pretax)? By choosing this, you reduce your taxable income, therefore reducing the taxes you owe. However, you cannot drop coverage until the next open enrollment period or until you have a qualifying change in status.

What are the benefits of having your deductions after taxes (post-tax)? You can drop your insurance coverage, should you choose. However, if you do drop coverage in one of the insurance plans, you will not be eligible to enter the plan again until the next open enrollment period or until you have a qualifying event.

Whether you choose pretax or post-tax deductions, you sign a benefit election form (or authorize Rice through the open enrollment process) authorizing the university to withdraw your cost of the coverage from your paycheck.

Paying for long-term disability (LTD) coverage on a post-tax basis has another consequence. Should you go on a qualified LTD leave of absence from Rice and had elected to have the university pay the cost of this benefit, the benefits payable to you will be taxable. If you choose to pay the cost of LTD coverage after taxes, then your benefit will be payable to you tax-free.

**Change in Status**

Pretax salary reduction amounts for Rice’s insurance programs cannot be changed outside of an open enrollment period except in the case of a qualifying change in status. Certain changes in family status or changes in an individual’s, spouse’s or domestic partner’s employment meet the definition of a qualifying event. Even with a qualifying event, the desired change must be consistent with the event and the change paperwork must be completed with human resources within 31 days of the event. For example, if the birth of a child is the qualifying event, a consistent change would be to add your child to your medical coverage. Remember that you only have 31 days from the date of the event to make the change in your benefits coverage.
The following are examples of qualifying changes in status:

- marriage or divorce
- death of a spouse, partner or dependent child
- birth or adoption of a child
- spouse’s termination of employment or new job
- change of employment status from full time to part time or vice versa
- taking an unpaid leave of absence
- returning to work after a leave of absence
- open enrollment of spouse’s plans
- loss of other coverage, including COBRA

Also, the law allows a change of plans upon a qualifying change in status (for example, change from HMO to POS upon birth of a child or upon retirement).

**Retiring From Rice University**

When you consider your retirement, please contact the human resources department to discuss your options. We also recommend you meet with a representative from TIAA and/or Fidelity Investments to discuss your investment choices and distribution options. See Page 31 for more information about retirement benefits.

Rice defines a retiree as an employee with at least 10 years of continuous benefits-eligible employment at the university and where age plus years of service equals at least 65. More on the definition of a university retiree, plus the advantages of retiring from Rice, can be found in University Policy 422 (see http://bit.ly/policy422). You need not be considered a Rice retiree to be eligible to receive benefits from the Rice retirement plan.

Rice currently allows qualifying employees to continue their current medical and dental benefits after leaving Rice as retirees. You must complete the appropriate form in HR to enroll in retirement benefits. You have 31 days from your retirement date to complete these forms. You cannot elect new coverage as a retiree but may change your current plan elections at the time of retirement or during the annual retiree open enrollment in May (i.e., from one medical or dental plan to another). The retiree is required to pay 100 percent of the cost of the coverage for the benefit (not just the employee portion), and if the retiree and dependents are 65 or older they must enroll in Medicare Part A and B upon retirement. If you decide not to elect Rice retiree benefits, you are not allowed to enter the plans at a later date. For more information regarding the cost of coverage, see the separate benefits rate sheet located at http://benefits.rice.edu. Retirees also have the option to convert to an individual life insurance, accidental death and dismemberment and/or long-term care insurance policy. Contact human resources for more information regarding retiree benefits.

For more information on planning for your retirement, please visit http://people.rice.edu.
Benefits-eligible faculty and staff members may elect to enroll in one of four medical plan options, each of which are administered by Aetna:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>What you pay (monthly)</th>
<th>What Rice pays (monthly)</th>
<th>Total (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aetna Memorial Hermann ACO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$79</td>
<td>$448</td>
<td>$527</td>
</tr>
<tr>
<td>Employee plus spouse/partner</td>
<td>$299</td>
<td>$833</td>
<td>$1132</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$261</td>
<td>$735</td>
<td>$996</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$509</td>
<td>$1,124</td>
<td>$1,633</td>
</tr>
<tr>
<td><strong>Aetna Select HMO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$95</td>
<td>$512</td>
<td>$607</td>
</tr>
<tr>
<td>Employee plus spouse/partner</td>
<td>$355</td>
<td>$951</td>
<td>$1,306</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$309</td>
<td>$838</td>
<td>$1,147</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$604</td>
<td>$1,279</td>
<td>$1,883</td>
</tr>
<tr>
<td><strong>Aetna Consumer-Driven Health Plan (CDHP)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$120</td>
<td>$831</td>
<td>$951</td>
</tr>
<tr>
<td>Employee plus spouse/partner</td>
<td>$365</td>
<td>$1,507</td>
<td>$1,872</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$353</td>
<td>$1,459</td>
<td>$1,812</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$626</td>
<td>$2,129</td>
<td>$2,755</td>
</tr>
<tr>
<td><strong>Aetna POS II</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$162</td>
<td>$643</td>
<td>$805</td>
</tr>
<tr>
<td>Employee plus spouse/partner</td>
<td>$574</td>
<td>$1,180</td>
<td>$1,754</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$505</td>
<td>$1,040</td>
<td>$1,545</td>
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<tr>
<td>Employee plus family</td>
<td>$974</td>
<td>$1,555</td>
<td>$2,529</td>
</tr>
</tbody>
</table>

The rates above are based on 12 months of pay. Should you receive pay over nine months, your monthly deductions will be higher to accommodate the fewer deductions, but your coverage will be intact in the summer months (or through June 30 if leaving Rice).

**What is an ACO?**

An accountable care organization, or ACO, is a specific network of doctors and hospitals that shares responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. At the heart of each patient’s care is a primary care physician, or PCP. ACO providers get paid more if they keep their patients well. The Aetna Memorial Hermann ACO is limited to the Memorial Hermann network of doctors and facilities, and care outside of Houston is for emergency only. You will select a Memorial Hermann PCP, and that PCP will guide your care.

**What is an HMO?**

A health maintenance organization, or HMO, is a health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific plan providers and require the election of a PCP, or primary care physician. This physician serves as a “gatekeeper” to all medical services, meaning that you need to consult with your Aetna PCP prior to receiving services from most Aetna specialist physicians or other providers.

**What is a Consumer-Driven Health Plan (CDHP)?**

A consumer-driven health plan, or CDHP, is a group of hospitals and physicians under contract with an insurance company or plan administrator. Health care providers in the network serve plan members for negotiated fees after you meet the plan deductible. Members of the CDHP accept responsibility for paying the up-front deductible for medical services and prescriptions before coinsurance/copayments begin and filing claims within six months of the date of service, or the claims may not be paid. The CDHP (a qualified HDHP) also allows you to elect a health savings account, or HSA, that is similar to a flexible medical savings account, but does not have the “use it or lose it” provisions and allows for more pretax contributions. See the Flexible Spending Accounts section on Page 29 or http://benefits.rice.edu for more information on the HSA.
**What is the POS?**
The point-of-service (POS) plan is similar to the HMO, as you pay only a nominal amount for network care. Unlike HMO coverage, however, you always retain the right to seek care outside the network at a lower level of coverage, and you can see an in-network specialist without having to see your primary care physician first (no referrals required). If you do not designate a primary care physician with HR or Aetna, your visit to any PCP will be subject to the specialist copayment.

**What is the “out-of-network” part of the POS and CDHP plans?**
When you see a provider that is not part of the POS or CDHP network, you are generally charged a greater portion of the cost of your care and are subject to separate, higher deductibles. You will also be subject to “reasonable and customary” limits. You may be responsible for any amount the provider charges above the limit (as determined by Aetna). This cost is in addition to the percentage of coinsurance you may owe in the plan.

**How do I contact Aetna to find out more about the provider networks?**
All of Rice’s medical plans are administered by Aetna. Aetna’s Member Services phone numbers are located on your ID card or can be found online at http://benefits.rice.edu.

Aetna’s Web address is www.aetna.com. You can search for doctors by using its online DocFind tool at www.aetna.com/docfind/. Members of the Aetna POS II and CDHP can use non-network physicians, but they will pay a greater portion of the cost of care.

You also can log on to Aetna Navigator (www.aetna.com) to:
- Locate a doctor or dentist.
- Designate a primary care physician (if in the ACO, HMO or POS).
- Check claim status and review your claims history.
- Request ID cards and print temporary medical and dental ID cards.
- Contact Aetna Concierge at 1-800-905-7670.

When using Aetna’s website or talking with your doctor’s office, please use the following Aetna plan names:
- Aetna Memorial Hermann ACO = Aetna Whole Health Plans, Aetna Whole Health – Memorial Hermann Accountable Care Network
- Aetna HMO = Aetna Standard Plans, Aetna Select
- Aetna CDHP = Aetna Open Access Plans, Aetna Choice POS II (Open Access)
- Aetna POS II = Aetna Open Access Plans, Aetna Choice POS II (Open Access)

For all of the medical plans, should you travel outside the United States, your network coverage is limited to non-network, if available, and/or emergency care only.

**Does Rice offer vision benefits?**
Yes, your vision benefits are part of your medical or dental plan. The medical plan covers one routine eye exam every 12 months with participating providers at 100 percent and discounts on eyeglasses, contact lenses and LASIK procedures. If you do not purchase the medical plan, the dental plan provides an eye exam at a copay as well as discounts. You will need to show your Aetna medical or dental ID card at the time of service to the network provider for the savings. For the specifics on the discount program, visit the benefits website at http://benefits.rice.edu.

**What if I am enrolled in the ACO or HMO plan and my dependents do not have access to an Aetna network where they live?**
The ACO network is limited to the Houston area, whereas the HMO is a national network of providers. Employees who have dependents who live away from home and are in the ACO or without an Aetna HMO network in the area may have the option to enroll the dependent in the out-of-area dependent PPO plan. This would apply to employee’s dependents who live outside the ACO or HMO service areas. Examples of eligible out-of-area dependent enrollment include a dependent away at school, a dependent living with a custodial parent or a dependent spouse who has a “commuting” arrangement. The out-of-area dependent plan is provided at no additional cost — employees still pay the same premium for the ACO or HMO plan. Dependents are not allowed to arbitrarily switch back and forth from the out-of-area dependent PPO plan to the ACO or HMO plan. For example, if a dependent returns home from school for the summer or holiday, they cannot switch to the ACO and then switch back to the out-of-area plan when they depart. Enrollment in this plan must be completed with a member of the benefits team.
Do I have to participate in a Rice medical plan?
No. Participation in a medical plan is voluntary, and Rice does not require proof of other coverage before you decline coverage in Rice medical plans. Rice will automatically enroll new faculty and staff into the ACO plan at employment unless otherwise designated by the employee within the initial 31-day enrollment period. However, it is your responsibility to modify this enrollment or add dependents before your 31-day limit. Be sure to contact the benefits team at 713-348-2363 or benefits@rice.edu for enrollment assistance.

Pharmacy Benefit Program for All Medical Plans

Your prescription drug benefits are administered by EnvisionRxOptions (Envision). Headquartered in Twinsburg, Ohio, Envision has been providing pharmacy benefit management services nationally since 2001. Additional information about Envision and your prescription benefits can be found by registering at http://envisionrx.com and on the back of your Aetna ID card. The following information is an overview of Rice University prescription drug benefits being administered by Envision.

Your prescription drug benefits feature a formulary drug list. A formulary is a list of medications organized into groups or tiers.

Formulary Tier Definitions

<table>
<thead>
<tr>
<th>Tier One (1)</th>
<th>Tier Two (2)</th>
<th>Tier Three (3)</th>
<th>Tier Four (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most generics</td>
<td>Preferred brand-name medications with no generics available</td>
<td>Nonpreferred brand-name medications with generics available</td>
<td>Specialty medications</td>
</tr>
</tbody>
</table>

For a full formulary listing, please visit http://envisionrx.com/resources/druglist.aspx.

Copays and coinsurance — the portion of the drug cost that you are responsible to pay — are listed in the table below for the Aetna Memorial Hermann ACO, HMO, POS II and CDHP plans:

<table>
<thead>
<tr>
<th></th>
<th>30-Day Retail</th>
<th>90-Day Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1</td>
<td>Tier 2</td>
</tr>
<tr>
<td>generic</td>
<td>Tier 1</td>
<td>Tier 2</td>
</tr>
<tr>
<td>brand</td>
<td>nonformulary</td>
<td>specialty</td>
</tr>
<tr>
<td>$10 copay</td>
<td>$40 copay</td>
<td>$60 copay</td>
</tr>
</tbody>
</table>

Tier 4 specialty drug information may be found under Costco Specialty Services on the next page.

CDHP plan covers prescription drugs at the copay levels after meeting the plan deductible.

Dispense as Written
Dispense as written requires that if a generic equivalent drug is available for your prescription and you request the brand, you will pay the difference between the generic and brand drug face value as well as the brand copay.

Maintenance Medications
You may fill up to two 30-day maintenance medications at a retail pharmacy. Thereafter, you must fill maintenance medications for 90 days at a retail pharmacy or use the mail order program through Orchard Pharmaceutical.

Retail Services
The Envision network includes more than 62,000 retail locations representing all major chains (such as Costco, CVS, Rite Aid, Sam’s Club, Stop and Shop, Target, Walgreens and Walmart) as well as many independent pharmacies throughout the United States. Simply present your Aetna ID and your prescription to a participating pharmacy (the Envision information is on the back of your ID card).

At the time of service, you must pay the required copay, deductible or coinsurance. To access the Pharmacy Locator, please visit http://envisionrx.com. You may also call the EnvisionRx Options help desk at 1-800-361-4542 for additional assistance.
**Mail Order Services**

Mail order services are provided through Orchard Pharmaceutical Services in North Canton, Ohio.

Mail order is an excellent way to receive prescriptions you will be taking for a long time with no worries about availability of supply at the local pharmacy. In addition, mail order saves you money, as you receive a 90-day supply for the price of a 75-day supply.

When you need a new prescription, you must register your information with Orchard Pharmaceutical Services. You may use any of the following three easy registration options:

- **Online (recommended method):** Visit http://orchardrx.com and select “Register now.” Your account will activate within 24 hours. By registering online, members also can track the progress of their orders.
- **Phone:** Call Orchard Pharmaceutical Services’ customer service at 1-866-909-5170 to speak with a representative.
- **Mail:** Complete the Registration and Prescription Order Form. Once registered, your physician can fax your prescription(s) to Orchard at 1-866-909-5171. Only faxes sent from a physician’s office will be valid.

**Costco Specialty Services**

Costco Specialty Services is the exclusive provider for your specialty medications as part of your prescription drug plan. What this means for you is that you and those covered under your benefit will receive the personalized care and expertise of Costco Specialty Services’ dedicated pharmacists, which is essential to successful therapy. This is because Costco Specialty Services goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

Because specialty medications can be more difficult to manage, Costco Specialty Services offers the following patient support services at no additional charge:

- Personalized support to help you achieve the best results from your prescribed therapy.
- Convenient delivery to your home or prescriber's office.
- Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects, and provide confidential support — all with one toll-free phone call.
- Assistance with your specialty medication refills.

As a convenience, you can choose to receive your first specialty prescription through the mail or pick it up at any retail Walgreens location. After that first fill, you will be required to use Costco Specialty Services for all of your specialty medication needs.

If you have any questions, or to begin to take advantage of these complimentary patient support services, please call Costco Specialty Services toll free at 1-866-443-0060.

**Identification Cards**

Your Aetna ID card will have all of the Envision information printed on the back of it. Please show your Aetna ID card to the network pharmacy to receive your covered benefits. Should you misplace your ID card and need your covered prescriptions immediately, please take this information to the pharmacy and present it to the pharmacist:

- **BIN:** 009893
- **PCN:** ROIRX

You also will need the information on the front of your Aetna ID card, which can be printed from www.aetna.com after you register and log in. You may also have the pharmacy call the EnvisionRx Options help desk at 1-800-361-4542 for assistance. Please contact Aetna Concierge Customer Service at 1-800-905-7670 for a new ID card.
Employee Assistance Program (EAP)

The Rice University Employee Assistance Program (EAP) is provided by UTEAP. This plan is available to all Rice employees whether they participate in a Rice medical plan or not.

Through the EAP, you, your family members, dependents or anyone significant in your life can access free, convenient and confidential services. The EAP offers a variety of services, including counseling sessions with a licensed mental health professional, legal and financial resources, and WorkLife referrals.

Through the EAP, a counselor will work with you to identify and provide assessment for any personal and/or work-related problems you may be experiencing. The counselor will assist you in resolving the problem within the available EAP visits or make recommendations for the most appropriate treatment in response to your unique needs.

EAP works with a large network of licensed providers, so they can arrange a counseling appointment that is convenient to where you live or work. Our network includes licensed mental health counselors, psychologists, clinical social workers, marriage and family therapists, and chemical dependency professionals. EAP can help with:

- Stress and anxiety
- Depression
- Alcohol/drug problems
- Parenting and family concerns
- Couple and relationship issues
- Grief or bereavement
- Anger management
- Change and life transitions
- Work conflicts
- Communication skills
- Everyday issues
- Education
- Financial
- Legal
- Work/life resources
- Health and wellness

Get in touch with UTEAP today at www.mylifevalues.com (company name/user ID: owls; password: owls) or call 713-500-3327 or 800-346-3549.

The following pages are a summary of the four Rice medical plan options. This is intended only to provide a summary of coverage and does not guarantee payment. Complete details are provided in written summaries for the plans available on the HR website. Standardized Summary of Benefits Coverage, or SBCs, are available at http://people.rice.edu/SBC.aspx.
## Summary of Medical Plan Options

### General Plan Provisions

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Aetna Memorial Hermann ACO</th>
<th>Aetna Select HMO Network</th>
<th>CDHP Non-Network•</th>
<th>Aetna POS II Network</th>
<th>Aetna POS II Non-Network•</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td>$2,600</td>
<td>$7,800</td>
<td>$250</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
<td>$7,800</td>
<td>$23,400</td>
<td>$500</td>
</tr>
<tr>
<td>Lifetime Benefit Max</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$5,000</td>
<td>$9,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$12,500</td>
<td>$27,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

### Preventive Services

- **Routine Physical Exam** (limits may apply)
  - Covered 100%
- **Routine Child and Well Baby Care; Immunizations**
  - Covered 100%
- **Routine GYN Care** (one per 365 days)
  - Covered 100%
- **Mammogram (annual females 35 and older)**
  - Covered 100%
- **Routine Colorectal Cancer (for adults 50 and older)**
  - Covered 100%
- **Routine Eye Exam** (freq./age limits may apply)
  - Covered 100%
- **Pediatric Dental**
  - Not covered
- **Hearing Exam** (routine screening)
  - Covered 100%
- **Hearing Aids**
  - Not covered

### Physician Services

- **Primary Care**
  - $25 copay
- **Office Visit**
  - $35 copay
- **X-ray & Laboratory at Facility**
  - $35 copay
- **Laboratory at Doctor's Office**
  - Included
- **Outpatient Physical/ Speech/Occupational Therapy**
  - $35 copay
- **Outpatient Dialysis/ Chemotherapy**
  - $35 copay
- **Allergy Testing/ Treatment**
  - $35 copay

### Emergency Services

- **Emergency Room**
  - $200 copay
- **Urgent Care**
  - $50 copay
- **Ambulance**
  - No copay

---

*Applies to usual and customary charges*
### Summary of Medical Plan Options, continued

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Aetna Memorial Hermann ACO</th>
<th>Aetna Select HMO Network</th>
<th>CDHP Non-Network</th>
<th>Aetna POS II Network</th>
<th>Aetna POS II Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hosp. Visit (semiprivate room)</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Fac. (in lieu of hosp. limits may apply)</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Maternity OB visit (initial visit)</td>
<td>$35 copay</td>
<td>$40 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$45 copay after deductible</td>
</tr>
<tr>
<td>Hospital (includes newborn services)</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$100 copay</td>
<td>$175 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$200 copay after deductible</td>
</tr>
<tr>
<td>Home Health (Outpat.) (limits may apply)</td>
<td>No copay</td>
<td>No copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>No copay after deductible</td>
</tr>
<tr>
<td>Hospice (Inpatient/Outpatient)</td>
<td>No copay</td>
<td>$300 copay/No copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay/No copay after deductible</td>
</tr>
</tbody>
</table>

### Mental Health & Substance Abuse

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Aetna Memorial Hermann ACO</th>
<th>Aetna Select HMO Network</th>
<th>CDHP Non-Network</th>
<th>Aetna POS II Network</th>
<th>Aetna POS II Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Inpat.</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Mental Health Outpat.</td>
<td>$35 copay</td>
<td>$40 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$45 copay after deductible</td>
</tr>
<tr>
<td>Substance Abuse Detox. Inpatient</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Substance Abuse Detox. Outpatient</td>
<td>$35 copay</td>
<td>$40 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$45 copay after deductible</td>
</tr>
<tr>
<td>Rehab Inpatient</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$400 copay after deductible</td>
</tr>
<tr>
<td>Rehab Outpatient</td>
<td>$35 copay</td>
<td>$40 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$45 copay after deductible</td>
</tr>
</tbody>
</table>

### Other Services

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Aetna Memorial Hermann ACO</th>
<th>Aetna Select HMO Network</th>
<th>CDHP Non-Network</th>
<th>Aetna POS II Network</th>
<th>Aetna POS II Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care (20 visits ann. max)</td>
<td>$35 copay</td>
<td>$40 copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>$45 copay after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No copay</td>
<td>No copay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>No copay after deductible</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Aetna Memorial Hermann ACO</th>
<th>Aetna Select HMO Network</th>
<th>CDHP Non-Network</th>
<th>Aetna POS II Network</th>
<th>Aetna POS II Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail-Form. Generic (30-day sup.)</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay after deduct.</td>
<td>Not covered</td>
<td>$10 copay after deduct.</td>
</tr>
<tr>
<td>Retail-Form. Brand (30-day sup.)</td>
<td>$40 copay</td>
<td>$40 copay</td>
<td>$40 copay after deduct.</td>
<td>Not covered</td>
<td>$40 copay after deduct.</td>
</tr>
<tr>
<td>Retail-Non-Form. Brand &amp; Gen. (30-day supply)</td>
<td>$60 copay</td>
<td>$60 copay</td>
<td>$60 copay after deduct.</td>
<td>Not covered</td>
<td>$60 copay after deduct.</td>
</tr>
<tr>
<td>Mail Ord.-Form. Brand (90-day supply)</td>
<td>$100 copay</td>
<td>$100 copay</td>
<td>$100 copay after deduct.</td>
<td>Not covered</td>
<td>$100 copay after deduct.</td>
</tr>
<tr>
<td>Mail Order-Non-Form. Brand &amp; Gen. (90-day supply)</td>
<td>$150 copay</td>
<td>$150 copay</td>
<td>$150 copay after deduct.</td>
<td>Not covered</td>
<td>$150 copay after deduct.</td>
</tr>
</tbody>
</table>

---

**Applies to usual and customary charges**
Dental Coverage

Rice University offers two insured dental plan options:

- **Aetna Dental PPO**
  - Employee only: $48.75
  - Employee plus one: $97.19
  - Employee plus two or more: $142.24

- **Aetna DMO**
  - Employee only: $13.68
  - Employee plus one: $24.91
  - Employee plus two or more: $34.88

Employees earning less than $40,000 per year (annualized) may be eligible for a 50 percent dental subsidy.

**What is the dental PPO plan?**
Under the dental PPO plan, participants may use any dentist of their choosing. Members submit bills for reimbursement, and the plan pays a percentage of the services, which are subject to reasonable and customary limits. If you use a network dentist, you are not subject to any usual and customary charges in excess of Aetna’s reimbursement rates.

**What are the indemnity dental plan coverage amounts?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible per person per plan year</td>
<td></td>
</tr>
<tr>
<td>Individual deductible amount (Basic/Major)</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Waived for basic dental services</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual maximum per person per plan year</td>
<td>$1,500</td>
</tr>
<tr>
<td>Orthodontia lifetime maximum</td>
<td>$1,500</td>
</tr>
<tr>
<td>Insured percentage of allowable charges</td>
<td></td>
</tr>
<tr>
<td>Preventive dental services</td>
<td>100%</td>
</tr>
<tr>
<td>Basic dental services (fillings, root canals and oral surgery)</td>
<td>80%</td>
</tr>
<tr>
<td>Major dental services (crowns, dentures and inlays)</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics (child to age 19)</td>
<td>50%</td>
</tr>
</tbody>
</table>

**How do I locate a dentist in the Aetna PPO network?**
Visit www.aetna.com/docfind and use the “Dental PPO/PDN with PPO II network.”

**What is the DMO?**
The DMO plan requires participants to select a dentist from those on the DMO panel. The plan covers most frequently performed procedures either in full or with a required copayment that is specified on a printed schedule. A copy of the schedule may be obtained via the benefits website. There are no claim forms to be filed, and the cost for procedures is known in advance.

**What are some examples of the costs in the DMO?**

<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Procedure</th>
<th>Patient Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1110</td>
<td>Office visit (during regular hours)</td>
<td>$5</td>
</tr>
<tr>
<td>2140</td>
<td>Amalgam (silver), one surface, primary</td>
<td>$16</td>
</tr>
<tr>
<td>2740</td>
<td>Crown/porcelain/ceramic substrate</td>
<td>$315</td>
</tr>
<tr>
<td>3330</td>
<td>Root canals, molar</td>
<td>$303</td>
</tr>
<tr>
<td>5110</td>
<td>Complete denture maxillary (upper or lower)</td>
<td>$300</td>
</tr>
<tr>
<td></td>
<td>Orthodontic treatment, children or adult (comprehensive)</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

More complete details on covered procedures are available on the human resources website.
What else do I need to know about the DMO?
Should you need a specialty dentist (i.e., endodontist, oral surgeon, periodontist, prosthodontist, pediatric dentist), you must be referred by your participating general dentist. Services that are performed that are not on the dental benefits copayment list are not covered procedures. If you have any questions concerning coverage or fees, obtain a written treatment plan and call Aetna Member Services at 877-238-6200.

Aetna also has a website with a directory of current DMO dental providers at www.aetna.com/docfind/. When using Aetna’s website, please select “Dental Maintenance Organization (DMO)” as the plan under the “DMO/Managed Dental” category. Remember, consult the dentist at the time of service to determine the procedure he or she intends to follow, whether it is covered and under what cost schedule. This will help avoid any misunderstanding at the time of payment.

How do I change my primary dentist?
You can change your primary dentist by logging on to Aetna Navigator or by calling 877-238-6200. If you make the change prior to the 15th of the month, the change will be effective on the 1st of the following month. For example, if you change your dentist on March 12, you can see your new dentist after April 1. If you change your dentist after the 15th, it will be effective on the next month (i.e., if you make the change on March 18, you can see the new dentist after May 1). You can continue to see your existing primary dentist until the change is effective.

How do I contact my dental insurance provider?
The member services telephone number is 1-877-238-6200.

Why don’t I get a dental ID card?
Aetna does not print dental ID cards. To print a dental ID card, visit www.aetna.com and log in to Aetna Navigator. You also can have the dentist contact Aetna to verify your coverage. Dental ID cards are not required to receive dental care.

Wellness
Rice’s mission is to foster a healthy and supportive environment and provide access to convenient and high quality programs and services, aimed to enable faculty, staff, and their families to pursue physical, social and emotional well-being to inspire people to participate.

Throughout the year, various wellness offerings are available for benefits eligible faculty and staff. Offerings may include education seminars, biometric screenings, health risk assessment, skin cancer screenings, challenges, access to an online portal and more. To learn more about wellness at Rice, visit www.people.rice.edu/wellness.aspx.
Continuation of Benefits (COBRA)

Should you leave Rice for reasons other than “gross misconduct” and not qualify as a retiree, or if your spouse or dependent has a qualifying event, you have the option to continue medical and dental benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a limited period of time.

If you are entitled to COBRA benefits, Rice will give you a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all rights to benefits. Once COBRA coverage is chosen, you are required to pay for 102 percent of the cost of coverage.

Rice University treats domestic partners as spouses for purposes of COBRA coverage under the Rice medical and dental plans. Please contact human resources should you, your spouse or domestic partner, or your dependent become eligible for COBRA coverage or if your dependent should no longer qualify for coverage.

The following chart details the length of time you or your dependent will be entitled to COBRA benefits:

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Beneficiary</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination or reduced hours</td>
<td>Employee</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>Dependent Child</td>
<td>18 months</td>
</tr>
<tr>
<td>Divorce or legal separation</td>
<td>Spouse</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Dependent Child</td>
<td>36 months</td>
</tr>
<tr>
<td>Death of covered employee</td>
<td>Spouse</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Dependent Child</td>
<td>36 months</td>
</tr>
<tr>
<td>Loss of “dependent child” status</td>
<td>Dependent Child</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) under a Rice medical or dental plan because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
Genetic Information Nondiscrimination Act (GINA)

GINA — Genetic Information Nondiscrimination Act of 2008 — expands the genetic information protections included under HIPAA. HIPAA prevents the Rice medical plans from imposing a pre-existing condition exclusion provision based solely on genetic information and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information). GINA provides that group health plans cannot base premiums for a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) GINA also generally prohibits group health plans from requesting or requiring you to undergo a genetic test. However, your health care provider is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although GINA limits the scope of the request to only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that you undergo a genetic test. GINA also prohibits group health plans from collecting genetic information (including family medical history) prior to or in connection with enrollment. Thus, under GINA, group health plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment. An exception is included for incidental collection, provided the information is not used prior to or in connection with enrollment. However, this exception is not available if it is reasonable for group health plans to anticipate that health information will be received in response to a collection unless the collection explicitly states that genetic information should not be provided.

Medicaid and Children’s Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Phone/Website</th>
<th>CHIP Phone/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1-800-362-1504, <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>1-866-444-EBSA (3272)</td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>Phone (Outside of Anchorage): 1-888-318-8890, Phone (Anchorage): 907-269-6529</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>1-888-474-8275, <a href="http://www.arkidsfirst.com">www.arkidsfirst.com</a></td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>1-800-866-3515, <a href="http://www.colorado.gov">www.colorado.gov</a></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>1-800-869-1150, (Click on Programs, then Medicaid)</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>1-800-869-1150, <a href="http://www.dhs.state.ia.us/hipp">www.dhs.state.ia.us/hipp</a></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>1-800-657-3739, (Click on Health Care, then Medical Assistance)</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>1-800-462-1120, <a href="http://www.dhs.state.mn.us">www.dhs.state.mn.us</a></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>1-888-255-3092, <a href="http://www.dhhs.state.ne.gov">www.dhhs.state.ne.gov</a></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1-800-852-3545 x 5254</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>1-800-997-2583, <a href="http://www.njfamilycare.org">www.njfamilycare.org</a></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>1-888-997-2583, (Click on Insure New Mexico)</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>1-800-755-2604, <a href="http://www.nd.gov/dhs/services/medicalserv/medicalassistance">www.nd.gov/dhs/services/medicalserv/medicalassistance</a></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1-888-365-3742, <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1-888-549-0820, <a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a></td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1-800-440-0493, <a href="http://www.gethipptexas.com">www.gethipptexas.com</a></td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>1-888-359-9517, <a href="http://www.scdhhs.gov">www.scdhhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>1-888-873-2647, <a href="http://www.famis.org">www.famis.org</a></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>1-800-562-6136, <a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1-888-365-3742, <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a></td>
<td></td>
</tr>
</tbody>
</table>

To see if any more states have added a premium assistance program since Feb. 16, 2010, or for more information on special enrollment rights, you can 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, Ext. 61565
Protection From Loss of Medical Coverage

The Health Insurance Portability and Accountability Act, which is a federal law, protects you from loss of medical coverage if you change jobs. Your new employer’s plan cannot deny or postpone coverage for “pre-existing conditions” before notifying you, in writing, of: (1) the existence and terms of any pre-existing condition exclusion under the plan and (2) your right to demonstrate creditable coverage (and any applicable waiting periods).

A certificate of group health coverage will be provided when you or a dependent loses coverage under a Rice medical plan. You may need this certificate for your new group or individual plan to provide evidence of your prior coverage.

Women’s Health and Cancer Rights Act of 1998

Because the Rice medical plans provide medical and surgical benefits in connection with a mastectomy, the university’s medical plans also will provide benefits for certain reconstructive surgery. In particular, the plans will provide, to a participant or beneficiary who is receiving (or presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation between the attending physician and the patient.

To the extent permitted by applicable law, this coverage also may be subject to benefit maximums and copayment provisions that may apply under the plans. You should review the provisions of your plan regarding any such restrictions that may apply.

If you have any questions regarding this coverage, please contact human resources.

Newborns’ and Mothers’ Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery and less than 96 hours following a cesarean section. However, federal law does not generally 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, the Rice medical plans 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). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Qualified Medical Child Support Order

If you are enrolled in a Rice medical plan and you are required under a “qualified medical child support order” (as that term is defined under ERISA) to provide coverage for a minor dependent child, you may enroll such minor dependent child included in the order at any time following the date on which the order was signed by a competent court or administrative agency. Rice University will determine whether an order is a qualified medical child support order and whether such child is eligible for coverage under the qualified medical child support order.
Continuing Health Coverage During a Military Leave (USERRA Rights)

In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you are called into military service (active duty or inactive duty training), you may continue coverage under the Rice medical and dental plans during a USERRA leave as long as you continue to make the required contributions. Generally, you may continue your coverage through the 18-month period beginning on the date on which your USERRA leave begins or through the period ending on the day after the date on which you fail to return to a position of employment with Rice University, as determined in accordance with USERRA, whichever ends earlier. If your USERRA leave is 31 days or longer, you may be required to pay up to 102 percent of the required contributions. If the USERRA leave is for less than 31 days, your required contributions will remain the same as similarly situated active employees. Note that coverage provided under USERRA will run concurrently with any right-to-continue coverage under COBRA.

To be eligible for USERRA benefits, you are generally required to give advance notice of your military leave to human resources. For more information about continuing coverage under USERRA, contact human resources.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: April 14, 2003.

The William Marsh Rice University Health and Welfare Benefits Plan (the “Plan”) is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan’s uses and disclosures of Protected Health Information (PHI).
- Your privacy rights with respect to your PHI.
- The Plan’s duties with respect to your PHI.
- Your right to file a complaint with the Plan and to the secretary of the U.S. Department of Health and Human Services.
- The person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations

When carrying out treatment, payment and health care operations, the Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object. The Plan also will disclose PHI to the Plan sponsor, Rice University, for purposes related to treatment, payment and health care operations. The university, as Plan sponsor, has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating specialist the name of another of your treating physicians so that the specialist may ask your treating physician for X-rays and test results.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management; case management; conducting or arranging for medical review; legal services; and auditing functions, including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your consent
If you decline to provide consent for the use of your PHI for treatment, payment and health care operations, you will not be enrolled in the Plan.

Uses and disclosures that require your written authorization
Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release
Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:
- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization or opportunity to object is not required
Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct postmarketing surveillance. If authorized by law, PHI also may be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made, unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is, or is suspected to be, a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual’s agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan’s best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may, subject to conditions, use or disclose PHI for research (using summary level information) aimed at studying the Plan’s patterns, costs or effectiveness.

10. When consistent with applicable law and standards of ethical conduct, if the Plan believes in good faith the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

Except as otherwise noted in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures
You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, abiding by such a request is at the Plan’s discretion, as the Plan is not required by law to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following officer: Rice University’s Director of Benefits, 713-348-2363, mailing address: Rice University, Benefits–MS 92, P.O. Box 1892, Houston, TX 77251-1892.

Right to Inspect and Copy PHI
You have a right to inspect and obtain a copy of your PHI contained in a “designated record set” for as long as the Plan maintains the PHI.

“Protected Health Information” includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

“Designated record set” includes the medical records and billing records for individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.
You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Rice University’s Director of Benefits, 713-348-2363, mailing address: Rice University, Benefits–MS 92, P.O. Box 1892, Houston, TX 77251-1892. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the secretary of the U.S. Department of Health and Human Services.

**Right to Amend PHI**

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: Rice University’s Director of Benefits, 713-348-2363, mailing address: Rice University, Benefits–MS 92, P.O. Box 1892, Houston, TX 77251-1892.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set and provide a reason to support a requested amendment. While the law requires the Plan to provide these procedures for you, you should understand that the Plan itself rarely will be the source of any PHI and may therefore often refer your requests under this provision to the provider who created the PHI.

**The Right to Receive an Accounting of PHI Disclosures**

At your request, the Plan also will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**The Right to Receive a Paper Copy of This Notice Upon Request**

To obtain a paper copy of this notice, contact the following officer: Rice University’s Director of Benefits, 713-348-2363, mailing address: Rice University, Benefits–MS 92, P.O. Box 1892, Houston, TX 77251-1892.

**A Note About Personal Representatives**

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative in order to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.
Section 3. The Plan’s Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003, and the Plan is required to comply with the terms of this notice as of that date. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed, electronically or in paper form, within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan, or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:
- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures to the secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan’s compliance with legal regulations.

This notice does not apply to all information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: Associate Vice President for Human Resources, 713-348-2363, mailing address: Rice University, Office of Human Resources–MS 92, P.O. Box 1892, Houston, TX 77251-1892.

You may file a complaint with the secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C., 20201.

The Plan may not, and will not, retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: Rice University’s Director of Benefits, 713-348-2363, mailing address: Rice University, Benefits–MS 92, P.O. Box 1892, Houston, TX 77251-1892.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.
Basic Life Insurance

Rice University pays for basic life insurance of 100 percent of salary, up to $50,000, for all benefits-eligible faculty and staff. Coverage is effective on the date of hire or on the date of benefits eligibility. If you are absent from work on the date your coverage would normally begin due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment. The coverage amount automatically increases with any salary increase. Basic life insurance is subject to the benefit reduction schedule noted in the Optional Life Insurance section below.

How do I designate a beneficiary?
Faculty and staff designate a beneficiary at enrollment in the plan. The employee is then responsible for notifying human resources if he or she wishes to change the beneficiary. Beneficiary forms can be found on the HR website at http://people.rice.edu.

Can I continue my coverage if I leave the university?
A conversion and portability option is available upon termination of employment, including retirement. The employee should contact the benefits team within 31 days from when coverage ends in order to initiate this process.

For more detailed information, you can request a copy of the Summaries and Certificates of Coverage published by Unum from human resources.

Optional Life Insurance

New benefits-eligible faculty and staff members may choose to enroll in additional group term life insurance in the following amounts:

- 100 percent of annual base salary
- 200 percent of annual base salary
- 300 percent of annual base salary
- 400 percent of annual base salary
- 500 percent of annual base salary

If you are an existing employee enrolled in voluntary life, you can increase coverage one benefit level without evidence of insurability during the annual open enrollment period.

Employee and Spouse Optional Life Insurance Rates (per $1,000 of coverage):

<table>
<thead>
<tr>
<th>Age (benefit reduction)</th>
<th>Rates (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$0.040</td>
</tr>
<tr>
<td>30 to 34</td>
<td>$0.056</td>
</tr>
<tr>
<td>35 to 39</td>
<td>$0.064</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$0.080</td>
</tr>
<tr>
<td>45 to 49</td>
<td>$0.120</td>
</tr>
<tr>
<td>50 to 54</td>
<td>$0.185</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$0.337</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$0.522</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$0.972</td>
</tr>
<tr>
<td>70 to 74 (45%)</td>
<td>$1.582</td>
</tr>
<tr>
<td>75 to 79 (35%)</td>
<td>$1.991</td>
</tr>
<tr>
<td>80 to 84 (15%)</td>
<td>$1.991</td>
</tr>
<tr>
<td>85 and older (10%)</td>
<td>$1.991</td>
</tr>
</tbody>
</table>

The maximum amount of coverage available under this plan is $1,000,000. Beneficiaries are the same as those selected for the basic life insurance unless otherwise designated.
Beginning on and after your 70th birthday, your life insurance benefit decreases. Your benefit is payable as a percentage of the amount otherwise payable as follows:

- From age 70 to 74 — 45%
- From age 75 to 79 — 35%
- From age 80 to 84 — 15%
- From age 85 on — 10%

If you and your eligible dependents enroll within 31 days of hire, you may select up to 500% of your salary, $50,000 for your spouse and $10,000 for your child(ren) without evidence of insurability. Each year during the annual enrollment period, participants may increase one benefit level without evidence of insurability. New elections or any amount greater than one benefit level is contingent on approval of evidence of insurability. Once the insurance company has approved insurability, the increase in coverage becomes effective on the later of the beginning of the new plan year or the date of approval.

**What is “evidence of insurability”?”**

The evidence of insurability (EOI) questionnaire seeks medical information about you or your dependents and must be completed. When you choose certain amounts of optional life insurance for yourself, you must provide EOI. And if you elect certain amounts of dependent life insurance for your spouse, domestic partner or child(ren), you must provide evidence of your spouse’s, domestic partner’s or child(ren)’s good health.

**Optional Spouse/Domestic Partner Life Insurance**

The spousal/partner plan offers life insurance from $5,000 to $100,000 in $5,000 increments. If you elect less than $50,000 for your spouse/partner, you may increase that amount by $5,000 each year (to a maximum of $50,000) without evidence of insurability. Any increase of more than $5,000 annually or any amount of coverage over $50,000 is subject to approval of evidence of insurability. Rates for the spouse/partner will be based on the employee’s age. If both spouses or partners are Rice employees, only ONE may elect dependent coverage. You will be required to provide EOI for any new spouse/partner life insurance election during open enrollment.

**Optional Child Life Insurance**

The child(ren) optional life insurance offers coverage at $5,000 or $10,000 at a cost of $0.50 per $5,000. The rate is the same regardless of the number of children covered under the coverage amount, but you must enroll each “new” child. Unmarried children are eligible for coverage to age 25, regardless of student status. To be covered, a child must be dependent on you for support, as defined by the IRS.

**What does “guaranteed issue” mean?**

The term “guaranteed issue” means that you are covered at that level of insurance without any medical questions to answer or examinations to take. Terminally ill dependents cannot be covered under any guaranteed issue amounts.

**How is the cost for optional life insurance determined?**

The cost for the optional employee and optional spouse life insurance is based on the employee’s age, the amount of coverage and your salary. See the previous benefits rate table for more information.

The cost of this insurance is paid in post-tax dollars.

**Can I drop my life insurance coverage at any time?**

Insurance may be canceled effective the first of any month, but the employee is not eligible for reapplication until the next annual enrollment or if you have a qualifying event and would have to show evidence of insurability when reapplying. Approval of the new coverage is not guaranteed.

**Can I cover my domestic partner or domestic partner’s children?**

Yes, you can cover your registered domestic partner and/or domestic partner’s child(ren) under the optional life insurance.

**What if my dependent is totally disabled on the date coverage would normally begin?**

If your eligible dependent is totally disabled, your dependent’s coverage will begin on the date your eligible dependent is no longer totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.
**What benefits are available to me should I become terminally ill?**

The accelerated life benefit allows employees who have a qualifying terminal illness or condition to receive a portion of their life insurance benefits while they are living. This benefit can help terminally ill individuals access funds so they can afford appropriate care without exhausting their assets or estate.

**Optional Accidental Death and Dismemberment Insurance**

Benefits-eligible faculty and staff members may choose to enroll in accidental death and dismemberment (AD&D) insurance.

Individuals may elect coverage for themselves only or for themselves and their eligible dependents under the family plan. For this plan, the term “eligible dependents” covers a spouse (under age 70) and children, including step, foster and legally adopted children (under age 25, regardless of student status). AD&D coverage does not require any evidence of insurability.

**What is AD&D insurance?**

AD&D insurance protects you and your family in case of a death or dismemberment due to a covered accident.

**What is the difference between life insurance and AD&D insurance?**

Both life insurance and AD&D coverage protect your family’s financial security in the event of premature death. However, there are some basic differences between these plans:

- Both pay a benefit if you die; however, AD&D only pays if the cause of death was accidental.
- AD&D costs less because the incidence of an accidental death is much lower than that of death from natural causes.
- AD&D also pays benefits when an accident results in the loss of a limb or paralysis (certain exclusions apply).

The financial plan for most families should include life insurance. AD&D should not be considered a substitute; however, it can provide valuable additional protection, especially at younger ages when responsibilities are greatest and liquid assets are not.

**What are the employee coverage amounts?**

Employee coverage amounts are available from $10,000 to $500,000 (in multiples of $10,000).

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>What you pay monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$0.20 per $10,000 (available in multiples of $10,000)</td>
</tr>
<tr>
<td>Employee and family</td>
<td>$0.40 per $10,000 (available in multiples of $10,000)</td>
</tr>
</tbody>
</table>

**What are the benefits under the family plan?**

Under family plan coverage, the amount of dependent coverage is a percentage of the employee’s coverage and depends on the composition of the family at the time of any claim:

<table>
<thead>
<tr>
<th>Family Members Covered</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee and Spouse (no children)</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Employee</td>
<td>60% of employee coverage up to a max of $250,000</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td>Employee, Spouse and Children</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Employee</td>
<td>50% of employee coverage up to a max of $250,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>10% of employee coverage up to a max of $25,000</td>
</tr>
<tr>
<td>Each child</td>
<td></td>
</tr>
<tr>
<td>Employee and Children (no spouse)</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Employee</td>
<td>15% of employee coverage up to a max of $25,000</td>
</tr>
<tr>
<td>Each child</td>
<td></td>
</tr>
</tbody>
</table>
Is there a reduction in AD&D benefits as I get older?
If you are age 70 or older at the time you sustain injuries in a covered accident, your benefit reduces to 45 percent of the elected benefit amount; at age 75, to 35 percent; at age 80, to 15 percent; and at age 85, to 10 percent. Coverage for your spouse or domestic partner ends once he or she reaches age 70.

For more information, you can request a copy of the Summaries and Certificates of Coverage published by Unum from human resources.

Business Travel Accident Insurance

Rice University carries an accident insurance policy covering faculty and staff during the course of travel on university business or in the performance of their responsibilities. For more information on this policy, see http://tinyurl.com/rice-travel-insurance.

Additional information regarding your benefits while traveling either on Rice business or for leisure can be found online at http://tinyurl.com/rice-travel-policies.

Short-Term Disability

Benefits-eligible faculty and staff members who are unable to work for medical reasons that are not work related may have 80 percent of their current base salary continued for a specified period under the terms of Rice University’s short-term disability (STD) program. Benefits also continue while on STD, except for benefit time accumulations and holiday pay.

When do STD benefits begin?
The period of salary and benefits continuation for staff begins after an absence of five consecutive work days. If the staff member has accumulated benefit time, it will be applied to cover the first five days of absence in each incident. Otherwise, the employee will not be paid for those days absent. Faculty have coverage effective the first date of absence.

How long do STD benefits last?
The maximum amount of leave time covered by short-term disability for each illness or diagnosed injury (including additional absences for the same diagnosis) depends on the specific illness or incident and length of service according to the table below:

<table>
<thead>
<tr>
<th>Length of Employment</th>
<th>Faculty</th>
<th>Professional Staff</th>
<th>Technical/Support Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1 year</td>
<td>1/2 academic year salary</td>
<td>0 days</td>
<td>0 hours</td>
</tr>
<tr>
<td>1 year–3 years</td>
<td>Same as above</td>
<td>65 days</td>
<td>520 hours</td>
</tr>
<tr>
<td>3+ years</td>
<td>Same as above</td>
<td>130 days</td>
<td>1,040 hours</td>
</tr>
</tbody>
</table>

See the short-term disability policy on the University Policies website (http://tinyurl.com/rice-short-term) for more details about this benefit.

Who administers the STD benefit?
Rice partners with Unum to administer our STD benefits. Should you be approved for STD benefits, your pay will continue through your normal Rice paycheck process.

You can submit your claim to Unum by either calling their toll-free number — 888-857-0157 from 7 a.m.–7 p.m. Central time — or visiting them online at http://unum.com/claims.

Rice’s group number is 129790.

Unum’s claims professionals will evaluate and certify your length of disability. Your claim may be referred to a nurse consultant to gather more information, and they may also contact your supervisor to learn about your occupational requirements.
Long-Term Disability

Benefits-eligible faculty and staff members are enrolled in long-term disability (LTD) insurance that provides coverage of 60 percent of one’s base salary (less any disability payment collectible from Workers’ Compensation, Social Security or other legally mandated programs) in the event of total disability to a maximum of $25,000 per month. Coverage is effective with the date of employment or transfer into a position that satisfies the requirement for benefits eligibility.

When do LTD benefits begin?
LTD benefits begin on the 181st day of continuous disability or after half of an academic year for faculty, and benefits are payable at the end of each subsequent month during the term of continuous total disability.

How long do LTD payments last?
Benefit payments will continue until the earliest of:
1. the date you are no longer totally disabled,
2. the date you die, or
3. the date you reach one of the following age and/or time limits:

<table>
<thead>
<tr>
<th>Age When Maximum Disability Starts</th>
<th>Duration of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60</td>
<td>To age 65 (but not less than five years)</td>
</tr>
<tr>
<td>60, but less than 65</td>
<td>60 months</td>
</tr>
<tr>
<td>65, but less than 70</td>
<td>To age 70 (but not less than 12 months)</td>
</tr>
<tr>
<td>70 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Does the university pay for the cost of the LTD coverage?
The university can pay the full cost of the LTD coverage. However, if the university pays the plan premiums, your benefits (should you become disabled) are taxable at the time of payment. This can significantly reduce the benefit amount you receive.

You may arrange to pay the premium for the LTD insurance by post-tax payroll deduction, where you pay the cost of the plan. If you choose to pay, your benefits (should you become disabled) will not be taxable. The cost of the coverage is .33 percent of your monthly base salary. If you are interested in paying for LTD insurance on a post-tax basis, human resources can help you determine the cost of your coverage.

For more detailed information, you can request a copy of the Summaries and Certificates of Coverage published by Unum from human resources or visit http://benefits.rice.edu.
Long-Term Care Insurance

All faculty and staff are eligible to apply for long-term care (LTC) insurance at any time during their employment. LTC premiums are deducted on a post-tax basis. Guaranteed issue amounts are only available during the employee’s initial 31-day hire enrollment period.

What is long-term care?
Long-term care is the type of care received either at home or in a facility when someone needs assistance with activities of daily living (bathing, dressing, toileting, transferring, continence or eating). These expenses are not covered by your medical plan.

Why would I need LTC insurance?
LTC insurance can help you meet the financial obligations of a long-term care situation. At any age, you may find yourself in a position where you need help and could benefit from long-term care coverage.

Whom can I cover with LTC insurance?
You can cover yourself, your spouse, parents, stepparents or grandparents under the LTC policy. Depending on the coverage you desire, a completed medical questionnaire may be required. You are able to continue your long-term care coverage after your group coverage terminates, but you must notify a member of the benefits team. You have 31 days from when coverage terminates to complete the appropriate paperwork.

How do I find out more about LTC coverage?
To learn more about LTC and if it is right for your needs, contact human resources or visit the website at http://www.unuminfo.com/wmru.

Flexible Spending Accounts

Flexible spending accounts allow participants to set aside pretax dollars for qualifying medical and/or dependent care expenses. Claims for reimbursement must be submitted no later than Nov. 30 following the end of the plan year (June 30). Money remaining in either account must be incurred prior to the end of the plan year or it will be forfeited. For this reason, accounts should be funded wisely. Careful planning is essential because the amount allocated cannot be changed during a plan year unless you have a qualifying event. Flexible spending accounts at Rice are administered by WageWorks (www.wageworks.com).

What is a medical spending account?
Employees may set aside money on a pretax basis to pay for qualified, uninsured medical expenses. By setting the money aside on a pretax basis, you are reducing your take-home pay and therefore reducing the taxes you pay. The funds cannot be used to pay insurance premiums. The maximum contribution is $2,550 per plan year. This account can be used to pay for medical and dental plan deductibles and copayments, uninsured medical expenses, and other eligible expenses, such as contact lenses and eyeglasses for you or any member of your immediate family (family member must be an IRS dependent). Faculty and staff enrolled in the HDHP medical plan are not eligible to enroll in the medical spending account.

Are reimbursements based on when I had the service or when I paid for the service?
Reimbursement for medical expenses is based on when you had the service (incurred the expense) — not when you paid the bill. Be sure to use your qualifying services between July 1 and Sept. 15 of the covered period.

You must submit your expenses no later than Nov. 30, and your services must have been received by Sept. 15 to qualify for reimbursement (regardless of when the services were paid).

What medical expenses qualify under the medical spending account?
In general, any medical expense (but excluding insurance premiums) qualify for reimbursement if it would be considered deductible by the IRS. All eligible expenses are listed on WageWorks’ website (http://bit.ly/wageworks-eligible-expenses).

Why must I keep my receipts when I use my WageWorks Visa?
You may be required to show that your charges were for eligible expenses, and the IRS may request them upon audit. Visit www.wageworks.com/card for more information.
**What is a health savings account?**
A health savings account (HSA) is a pretax medical savings account available to taxpayers in the United States who are enrolled in a consumer-driven health plan (CDHP, a qualified high-deductible health plan). You can use the funds to pay for eligible health care expenses for you, your spouse and your tax dependents. Or you can save the funds for the future. Under current Internal Revenue Service rules, the 2016 annual contribution limits are $3,350 for individuals and $6,750 for families (or $4,350/$7,750 if age 55+). The HSA plan is administered by Payflex (www.payflex.com). Carefully review your HSA election with your spouse/partner to avoid going over the annual contribution limits. There are tax penalties for excess HSA contributions. Rice will not withdraw excess funds from your HSA account if you go over your calendar-year maximum.

**What is the advantage of an HSA over a traditional medical spending account?**
Unlike a traditional medical spending account, funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, and you can take the account with you should you leave Rice. The HSA also has an option to invest the accumulation over $1,000 in selected mutual funds. The funds can accumulate tax free, grow tax free and be used for eligible expenses tax free. It’s a great way to save money for health care costs down the road, even in retirement.

**What is a dependent care spending account?**
Under current Internal Revenue Service rules, a married employee with a working spouse or a single parent may allocate up to $5,000 in pretax dollars to a dependent care account. This amount is limited to $2,500 in the case of a separate return filed by a married individual. Expenses payable through the account are those incurred in order to permit the individual (and, if married, the spouse) to work, rather than caring for the dependent full time.

**What dependents qualify under the dependent care spending account?**
Dependents who qualify include children under age 13 and any other dependent (such as a disabled spouse or elderly parent) who is physically or mentally incapable of self-support and who is claimed as a dependent on the employee's federal tax return. Reimbursable expenses include care provided inside or outside the dependent's home, day care centers that meet state licensing requirements, and preschool tuition. Each dollar allocated to a dependent care account reduces by $1 the amount that is allowable as a tax deduction under the tax credit method for these expenses.

**What if the costs of my child's care change within a plan year?**
If your dependent’s cost of care changes during the plan year, you may change your dependent care election starting the first of the following month. Contact human resources within 31 days of the change to modify your dependent care spending account contribution.

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**Commuter Benefits**

Do you commute? Chances are you can save big on taxes. Go green and save some green!

Train. Bus. Vanpool. Parking your car at the station or at a non-Rice facility. However you ride, the Commuter Benefits Program lets you pay for your eligible commuting costs through automatic, pretax payroll deductions. It works wherever you do: for any transit system, anywhere, plus any non-Rice parking provider or vanpool operator nationwide.

The more you spend, the more you save on your taxes. All it takes is a quick online order to get your pass delivered to your home every month and set up direct, automatic monthly parking payments.

Visit www.wageworks.com and log in if you are an existing WageWorks flexible spending account user or register as a first-time user, or call 877-WageWorks (877-924-3967) Monday–Friday, 8 a.m.–8 p.m. EST.

**Enroll in minutes.** There’s no annual open enrollment period, so you can sign up or make changes whenever you choose. Just go online, choose your transit pass, parking provider or both; and the rest is automatic. And because you can also cancel at any time before the monthly cutoff, unlike some other pretax programs, you don’t need to worry about spending your account by the end of the year.
Retirement Plan

Rice University sponsors the William Marsh Rice University Defined Contribution Retirement Plan (the "Retirement Plan"), a plan qualified under Section 401(a) of the Internal Revenue Code, for the benefit of eligible faculty and staff members 21 years of age and older. Contributions are made to accounts held by Teachers Insurance and Annuity Association (TIAA) or Fidelity Investments. Contributions are made for eligible employees from their date of hire. Employees are vested in the Retirement Plan after the completion of one year of continuous benefits-eligible service.

What does the term “vested” mean?
Once you are vested, you are entitled to your retirement benefits when you qualify to start distributions from the Retirement Plan (subject to plan rules). If you do not become vested in the Retirement Plan before you leave Rice, you forfeit 100 percent of your retirement benefits.

Can I direct how the money in the retirement account is invested?
Each person has the power and personal responsibility to initially set and change the distribution of his or her allocation to TIAA (investments with an annually set, fixed rate of return, stocks, bonds or money markets) and/or Fidelity Investments (stocks, bonds or money markets). Your account is automatically created for you at TIAA or Fidelity Investments, depending on the default at your date of hire, and it is your responsibility to set the investment allocation and plan beneficiaries.

How much does the university contribute for me?
The university contributes to each individual account an amount determined according to the following schedule, regardless of whether or not you make contributions to the supplemental retirement annuity.

<table>
<thead>
<tr>
<th>Plan Contributions as a Percentage of Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary Within Social Security Wage Base</td>
</tr>
<tr>
<td>An additional 5% for compensation over wage base</td>
</tr>
</tbody>
</table>

The Social Security Wage Base for calendar year 2016 is $118,500. The maximum salary considered for the Retirement Plan is set by the federal government. For 2016, the maximum salary is $265,000.

What if I terminate my employment at Rice?
Retirement income is available from vested accumulations in various options upon termination of employment and per the plan rules. Payment from the plan can only start once you are considered eligible, based on the plan definitions. Payments are taxed as income and may be subject to IRS penalty if withdrawn prior to age 59 1/2. You need not be considered a Rice retiree to be eligible for benefits from the Rice retirement plan.

If you leave Rice prior to qualifying as a retiree, you can withdraw your retirement plan investment. If you request this withdrawal to be paid directly to you, IRS penalties and taxes may apply. You can roll over this money into another qualifying plan or IRA without IRS penalties or taxes. Withdrawing the money is an option but not a requirement — you can always leave the money in the Rice retirement plan until you qualify to start distributions.

There are other options for withdrawing a portion of your Rice retirement money once you terminate employment at Rice. Contact TIAA at 800-842-2776 or Fidelity Investments at 800-343-0860 for more information on your withdrawal options.
How can I get more information about the Retirement Plan?
The above description of the Retirement Plan is intended only to be a brief overview and is not intended to be the summary plan description. For more detailed information, you can request a copy of the Retirement Plan’s Summary Plan Description from human resources or review it on the HR website. In addition, Rice University sponsors workshops throughout the year, with topics chosen to assist individuals in the management of their retirement accumulations. They are provided to assist faculty and staff in a better understanding of their retirement accounts and in preparing for retirement.

Supplemental Retirement Annuity (SRA)
To permit employees to supplement their retirement savings, Rice University offers an opportunity to contribute to a 403(b) supplemental retirement annuity (SRA). The salary reductions are made in pretax dollars, and the earnings accumulate on a tax-deferred basis.

Automatic Enrollment
For newly hired benefits eligible faculty and staff, Rice will automatically enroll you in the SRA with TIAA at a 4 percent contribution rate. You may opt out of or change this election at any time, effective the first of the month following submission of the form to HR. Forms can be found on the HR website at http://people.rice.edu.

How much can I contribute to the SRA?
For calendar year 2016, you may contribute up to $18,000. Employees 50 years or older also may contribute an additional $6,000. Also, there is a “catch-up” provision for an employee with 15 or more years of service with the university that may permit an increased contribution of an additional $3,000 for up to five years. Faculty and staff using the catch-up provision should realize that a separate prior contribution limit might reduce the maximum they may contribute under this provision before they reach the full catch-up amount. Any contribution over the SRA limits made by an employee who is 50 years old or older counts first toward the catch-up contribution limits. Individual participants remain responsible for monitoring contribution limits.

Please review your contribution strategy each year. You are required to complete a new salary reduction agreement each time you wish to change or terminate your contribution to the plan.

What if I contribute more than the limits?
Contributions in excess of the maximums listed above may subject the individual to penalties with the IRS and/or may necessitate payment of additional taxes or filing an amended return.

What are the advantages of investing in an SRA?
The first advantage is that you are saving for your future — your retirement. Most people will not be able to live on Social Security or Rice Retirement Plan benefits alone. The Rice Retirement Plan helps, but the more you invest at an earlier age, the more savings you will have when you retire.

Secondly, by placing pretax dollars into an SRA account, you reduce your take-home pay, which reduces the taxes you owe. For example, if you put $50 per month into the SRA on a pretax basis, your reduction in take-home pay is only $42 (if you are in the 15 percent tax bracket). The extra $8 is due to the reduction in taxes you pay.

Finally, a single filer or married person filing separately whose adjusted gross income is less than $30,500 in 2016 will qualify for a tax credit on up to $2,000 in 403(b) retirement plan contributions. The credit also is available to joint filers with an adjusted gross income under $61,000 in 2016. Another reason to save for your future!

Where can I invest my SRA?
You may direct SRA contributions to accounts with Fidelity Investments or TIAA. Both administrators have a variety of investment options with varying degrees of risk. Once you have money in your account, you can alter your investments based on your needs. Please contact the appropriate administrator for more information.

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Phone Number</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelity Investments</td>
<td>800-343-0860</td>
<td><a href="http://www.fidelity.com">www.fidelity.com</a></td>
</tr>
<tr>
<td>TIAA</td>
<td>800-842-2776</td>
<td><a href="http://www.tiaa.org">www.tiaa.org</a></td>
</tr>
</tbody>
</table>
How do I enroll or change my payroll deduction amount?
You can change your contribution amount to the SRA on a monthly basis. The amounts you elect will be in effect on the first of the following month. You must complete a salary reduction agreement to initiate your enrollment or each time you wish to change your contributions, and this form can be found online at http://people.rice.edu.

Do I have to be benefits-eligible to participate?
Supplemental retirement accounts are open to all employees and paid students, regardless of benefits eligibility. Rice University encourages the use of the SRA and has set no minimum contribution amount to participate.

Financial Counseling
Rice University offers access to financial counseling to assist faculty and staff in the management of their retirement accounts with the hope that use of this and other assistance available will help them more successfully prepare for a rewarding retirement.

Financial Engines
Rice University offers access to Financial Engines, an online advisory service intended to assist faculty and staff in the management and investment of their retirement accounts. More information is available on the HR website, or you may go directly to Financial Engines at http://corp.financialengines.com.

Benefits-eligible employees are offered access at no cost. Each employee establishes an individual account and chooses a password. The service is confidential — no personal information entered there is available to anyone else. Enter information about yourself, your spouse or partner, and your various accounts, including the Rice retirement account, SRAs, IRAs and even taxable accounts such as brokerage accounts. The service will allow you to examine the effects of changing the amount of retirement income desired, changing the age of intended retirement, changing the savings rate and changing the risk of investments to see what impact each of those may have on the probability of achieving retirement goals. If desired, Financial Engines will provide advice on adjusting investment choices within the options available in the retirement plan and supplemental retirement annuity.

Financial Planning Services
Access to financial planning courses is offered by the university free of charge to all benefits-eligible faculty and staff. The course normally consists of three evening classes dealing with planning and money management and a follow-up personal session with the financial adviser to go over your individual financial plan. Spouses or partners are encouraged to participate, or you can bring a friend for no additional fee.

Participants are expected to complete the information-gathering form and risk assessment survey for the adviser to permit him to construct the financial plan. There is an initial registration fee of $69, which is reimbursable upon completion of the course. For those who complete the workshop, Rice may be required to show that the individuals have received $69 in taxable income.

Information is available at the HR benefits website for review. This benefit is offered through arrangement with Cetera Advisors.

HelloWallet
Rice University offers benefits-eligible faculty and staff HelloWallet, an online personal financial service that helps you manage your expenses and find more money to save.

With this free membership to HelloWallet, you can find surprising, simple and practical ways to make smarter decisions about your finances. HelloWallet will help you:

- Manage your expenses — track all of your household’s expenses in one place, automatically.
- Find more money to save — identify simple ways to reduce unnecessary fees, find discounts and budget for the unexpected.
- Receive personalized guidance on how to grow your savings over time.

When using HelloWallet, your personal information is kept private and secure. HelloWallet uses bank-level information security protection, and you cannot transfer money via HelloWallet. HelloWallet’s recommen-
The service is designed to help you make smarter financial decisions and find more money to save. In fact, after a few months of use, the average HelloWallet member boosted their savings by approximately $300 per month by reducing debt and finding more money in their budgets to meet financial goals. In these tough economic times, that’s a benefit we can all appreciate.

To sign up, please go to www.HelloWallet.com/RiceU or the HelloWallet smartphone app (search “HelloWallet” in your mobile store and use the promo code “riceuhello”).
Claims and Appeals Procedures

If you or any enrolled dependent (or his or her authorized representative) believe that you are being denied any rights or benefits under the William Marsh Rice University Health and Welfare Benefits Plan, Rice University has established claims and appeals procedures to ensure that disputes are settled fairly. Rice University has the full discretion and authority to determine all claims under the Plan unless such discretion and authority is delegated to a claims or insurer administrator. Any action or determination made by Rice University, a claims administrator or an insurer administrator during the claims and appeals process is final, conclusive and binding on you and your family members.

Medical, Dental and Medical Flexible Spending Account Programs

Claims Procedures

For information on filing claims for benefits under the medical and dental programs, visit the HR website or contact human resources. For information on filing claims and deadlines for filing claims for the Medical Flexible Spending Account Program, see the Flexible Spending Accounts section in this booklet.

The insurer decides all claims filed under the Rice dental and LTD programs. Rice University decides all claims filed under the Medical Flexible Spending Account Program. For claims filed under the medical program, Aetna is the appropriately named fiduciary of the plan for all appeals, level one and two. Aetna is collectively referred to as the claims administrator and will provide written or electronic notice of its binding decision within the following timeframes.

• Postservice claims. A postservice claim is a claim for payment of benefits after care has been received. For example, a claim that is submitted after you go to the doctor’s office is a postservice claim, as is a claim for reimbursement from your medical flexible spending account.

You will receive notice of a postservice claim denial within 30 days following receipt of your claim. This 30-day period may be extended up to an additional 15 days if an extension is necessary to process your claim due to matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the reasons for the delay and when you may expect a decision.

If additional information is needed to process your postservice claim, you will be notified of the information needed and you will have 45 days to provide the information. If you provide the requested information within the 45 days, you will be notified of a decision within 15 days after the requested information is received. If you do not provide the requested information within the 45-day period, your postservice claim will be denied.

• Preservice claims. A preservice claim is a claim for preauthorization or precertification before receiving care. For example, the Rice medical plans require that you obtain preauthorization before receiving non-urgent hospitalization or elective surgery or precertification for mental health care.

Your preservice claim must include the patient’s name, the specific medical condition or symptom, and a request for approval for a specific treatment, service or product. Aetna will provide notice of a preservice claim approval or denial within 15 days following receipt of the claim. This 15-day period may be extended up to an additional 15 days if an extension is necessary to process your claim due to matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the reasons for the delay and when the claims administrator expects to make a decision.

If your preservice claim is filed improperly, you will be notified within five days after receipt of your claim of the proper procedures to be followed in filing a preservice claim. Notice of an improperly filed preservice claim may be provided orally or, if you request, in writing.
If additional information is needed to process your preservice claim, you will be notified of the information needed and you will have 45 days to provide the information. If you provide the requested information within the 45 days, Aetna will notify you of its decision within 15 days after the requested information is received. If you do not provide the requested information within the 45-day period, your preservice claim will be denied.

• **Urgent care claims.** An urgent care claim is a claim that requires notification or preauthorization before receiving care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the requested care or treatment. The determination of whether a claim involves urgent care will be made by Aetna, which will apply the judgment of a “prudent layperson” who possesses an average knowledge of health and medicine. However, the claim will automatically be treated as an urgent care claim if a physician who knows your medical condition determines that the claim involves urgent care.

Your urgent care claim must include the patient’s name, the specific medical condition or symptom, and a request for approval for a specific treatment, service or product. Aetna will provide notice of an urgent care claim approval or denial as soon as possible, taking into account the medical circumstances, but no later than 72 hours following receipt of the claim. To expedite the processing of an urgent care claim, Aetna’s notice may be oral, but a written or electronic confirmation will follow within three days.

If your urgent care claim is filed improperly, you will be notified within 24 hours after receipt of your claim of the proper procedures to be followed in filing an urgent care claim. Notice of an improperly filed urgent care claim may be provided orally or, if you request, in writing.

If additional information is needed to process your urgent care claim, you will be notified within 24 hours following receipt of your claim, and you will have not less than 48 hours to provide the information. Aetna will then have 48 hours from the earlier of: the claim administrator’s receipt of the requested information or the end of the additional 48-hour period. If you do not provide the requested information within 48 hours of when it is requested, your urgent care claim will be denied.

• **Concurrent care claims.** Concurrent care claims are claims to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments. For example, if a hospital admission was initially authorized for three days and your doctor requests that it be extended to five days, that would be a concurrent care claim. Concurrent care claims also include claims where previously approved treatments are reduced or terminated under the terms of a health program.

If you request an extension of ongoing treatment in an urgent care situation, Aetna will provide notice of a concurrent claim approval or denial as soon as possible, taking into account the medical circumstances, but no later than 24 hours following receipt of the claim, provided that your claim is made at least 24 hours before the end of approved treatment. If your request for extended treatment is not made within 24 hours before the end of the previously approved treatment period, Aetna will follow the urgent care time frames for approval or denial.

If you request an extension of ongoing treatment in a nonurgent care situation, your request will be considered a new claim and will be approved or denied within the postservice or preservice time frames, whichever applies.

If an ongoing course of treatment will be reduced or terminated, Aetna will notify you sufficiently in advance to give you an opportunity to appeal before the reduction or termination takes effect.

**Appeal Procedures**

If your claim for health benefits is denied, in whole or in part, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief.

Aetna reviews all appeals filed under the Rice medical and dental programs. Rice University reviews all appeals under the Medical Flexible Spending Account Program (collectively referred to as the “appeals administrator” for purposes of these appeals procedures). All appeals must be filed with the appropriate appeals administrator within 180 days of the receipt of the written or electronic notice of denial.
Your appeal must be made in writing and may include written comments, documents, records and other information relating to your claim, even if you didn’t include that information with your original claim. In the case of notice of denial of an urgent care claim, you may submit an appeal orally or in writing, and all necessary information may be transmitted by telephone, facsimile or other available similarly expeditious method. You may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records and other information relevant to your claim.

In reviewing an appeal, the appeals administrator will take all the information into account, even if it was not submitted or considered in the initial claim determination, and shall provide a review that does not afford deference to the initial determination. If your appeal involves a medical judgment, including whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the previous notice of denial, and who is not that person’s subordinate. As part of the appeal process, you consent to this referral and the sharing of pertinent medical claim information. If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of the individual.

After receiving your appeal, the appeals administrator will provide written or electronic notice of its decision within the following time frames:

- **Postservice appeals.** The appeals administrator will provide notice of its appeal decision within 60 days following receipt of your appeal.
- **Preservice appeals.** The appeals administrator will provide notice of its appeal decision within 30 days following receipt of your appeal.
- **Urgent care appeals.** The appeals administrator will provide notice of its appeal decision as soon as possible, taking into account the medical circumstances, but no later than 72 hours following receipt of the appeal. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including the notice of the appeal decision, will be provided to you or your representative by telephone, fax or other similarly expeditious method.

### Notice of Denial and Notice of Denial on Appeal

If your claim or appeal is denied in whole or in part, you or your authorized representative will receive written or electronic notification that will include:

- The specific reason or reasons for the adverse determination,
- References to the specific plan provisions on which the determination was based,
- A statement regarding your rights to obtain, upon request and free of charge, a copy of any internal rules, guidelines, protocol or other similar criterion on which the determination was based, and
- A statement regarding your rights to obtain, upon request and free of charge, an explanation of any scientific or clinical judgment if the determination was based on a medical necessity or experimental treatment (or similar exclusion or limit).

In the case of a Notice of Denial, the notice also will include:

- A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary,
- A description of the appeals procedures (or the expedited appeals procedures in the case of an urgent care claim) and applicable time limits, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a notice of denial on appeal.

In the case of a Notice of Denial on Appeal, the notice also will include:

- A statement regarding your right to obtain, upon request and free of charge, reasonable access to, and copies of, all records, documents and other information relevant to your claim,
- A statement that you may have other voluntary alternative dispute resolution options, such as mediation, and to contact your local office of the Department of Labor or your state insurance regulatory agency, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA.
Short-Term and Long-Term Disability Programs and Nondeath Claims Under Accidental Death and Dismemberment and Business Travel Accident Programs

For information on filing claims for benefits under the Short-Term Disability (STD), Long-Term Disability (LTD), Accidental Death and Dismemberment (AD&D) and Business Travel Accident Programs, you can request a copy of the Summaries and Certificates of Coverage published by the insurers from human resources.

Claims Procedures

Rice University has designated the insurer administrators to decide all claims filed under the STD, LTD, AD&D and Business Travel Programs (collectively referred to as the “claims administrator” for purposes of these claims procedures).

The claims administrator will provide written or electronic notice of a disability claim denial within 45 days following receipt of the claim. This 45-day period may be extended up to an additional 30 days if an extension is necessary to process your claim due to matters beyond the control of the claims administrator. This first 30-day extension period may be extended for up to an additional 30 days beyond the original extension (for a total of 105 days) if the additional extension is necessary to process your claim due to matters beyond the control of the claims administrator. If an extension is necessary, you will be notified of the reasons for the delay, the standards on which entitlement to a benefit is based, and when the insurer administrator expects to make a decision prior to the expiration of the initial 45-day period or first 30-day extension period, whichever the case may be.

If additional information is needed to process your disability claim, you will be notified of the information needed and you will have 45 days to provide the information. If you provide the requested information within the 45 days, the insurer administrator will notify you of its decision within 30 days after the requested information is received. If you do not provide the requested information within the 45-day period, your disability claim will be denied.

Appeals Procedures

If your claim for benefits is denied, in whole or in part, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief.

Rice University has designated the insurer administrators to review all appeals filed under the LTD, AD&D and Business Travel Programs, and Rice University reviews all appeals filed under the Short-Term Disability Program (collectively referred to as the “appeals administrator” for purposes of these appeals procedures). An appeal must be filed with the appropriate appeals administrator within 180 days of the receipt of the written or electronic notice of denial.

Your appeal must be made in writing and may include written comments, documents, records and other information relating to your claim, even if you didn’t include that information with your original claim. You may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records and other information relevant to your claim. The insurer administrator will assign a qualified individual who was not involved in the initial claim determination (and is not that person’s subordinate) to review and decide your appeal.

The insurer administrator must take all the information into account, even if it was not submitted or considered in the initial claim determination, and shall provide a review that does not afford deference to the initial determination. If the initial claim determination was based in whole or in part on a medical judgment, the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the previous notice of denial, and who is not that person’s subordinate. As part of the appeal process, you consent to this referral and the sharing of pertinent medical claim information. If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of the individual.

The insurer administrator will provide written or electronic notice of its appeal decision within the 45-day period following receipt of your appeal. This 45-day period may be extended up to an additional 45 days if an extension is necessary to process your claim due to matters beyond the control of the insurer admin-
istrator. If an extension is necessary, you will be notified before the end of the initial 45-day period of the reasons for the delay and when the insurer administrator expects to make a decision.

Notice of Denial and Notice of Denial on Appeal

If your claim or appeal is denied in whole or in part, you or your authorized representative will receive written or electronic notification that will include:

- The specific reason or reasons for the adverse determination,
- References to the specific contract provisions on which the determination was based,
- A copy of any internal rules, guidelines, protocol or other similar criterion on which the determination was based, and
- An explanation of any scientific or clinical judgment if the determination is based on a medical necessity or experimental treatment (or similar exclusion or limit).

In the case of a Notice of Denial, the notice also will include:

- A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary,
- A description of the appeals procedures and applicable time limits, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a Notice of Denial on Appeal in the case of a claim filed under the STD, LTD, AD&D and Business Travel Programs.

In the case of a Notice of Denial on Appeal, the notice also will include:

- A statement regarding your right to obtain, upon request and free of charge, reasonable access to, and copies of, all records, documents and other information relevant to your claim,
- A statement that you may have other voluntary alternative dispute resolution options, such as mediation, and to contact your local office of the Department of Labor or your state insurance regulatory agency, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA in the case of an appeal filed under the STD, LTD, AD&D and Business Travel Programs.

Life Insurance Program, Dependent Care Flexible Spending Account Program, and Death Claims Under Accidental Death and Dismemberment and Business Travel Accident Programs

For information on filing claims for benefits under the Life Insurance, Accidental Death and Dismemberment (AD&D) and Business Travel Programs, you can request a copy of the Summaries and Certificates of Coverage published by the insurers from human resources. For information on filing claims and deadlines for filing claims for the Dependent Care Flexible Spending Account Program, see the Flexible Spending Accounts section in this booklet.

Claims Procedures

Rice University has designated the insurer administrators to decide all claims filed under the Life Insurance, AD&D and Business Travel Programs, and Rice University decides all claims filed under the Dependent Care Flexible Spending Account Program (collectively referred to as the “claims administrator” for purposes of these claims procedures).

After receiving your claim, the claims administrator will provide written or electronic notice of a claim denial within 90 days following receipt of the claim. This 90-day period may be extended up to an additional 90 days if an extension is necessary to process your claim due to matters beyond the control of the Plan Administrator. If an extension is necessary, you will be notified of the reasons for the delay and when a decision may be expected prior to the expiration of the initial 90-day period.
Appeals Procedures

If your claim for benefits is denied, in whole or in part, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief.

Rice University has designated the insurer administrators to review all appeals filed under the Life Insurance, AD&D and Business Travel Programs, and Rice University reviews all appeals filed under the Dependent Care Flexible Spending Account Program (collectively referred to as the “appeals administrator” for purposes of these appeals procedures). All appeals must be filed with the appropriate appeals administrator within 60 days of the receipt of the written or electronic notice of denial.

Your appeal must be made in writing and may include written comments, documents, records and other information relating to your claim even if you didn’t include that information with your original claim. You may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records and other information relevant to your claim.

The appeals administrator must take all the information into account even if it was not submitted or considered in the initial claim determination and shall provide a review that does not afford deference to the initial determination.

The appeals administrator will provide written or electronic notice of its appeal decision within 60 days following receipt of your appeal. This 60-day period may be extended up to an additional 60 days if an extension is necessary to process your claim due to matters beyond the control of the appeals administrator. If an extension is necessary, you will be notified before the end of the initial 60-day period of the reasons for the delay and when the appeals administrator expects to make a decision.

Notice of Denial and Notice of Denial on Appeal

If your claim or appeal is denied in whole or in part, you or your authorized representative will receive written or electronic notification that will include:

• The specific reason or reasons for the adverse determination, and
• References to the specific contract or plan provisions on which the determination was based.

In the case of a Notice of Denial, the notice also will include:

• A description of any additional material or information necessary for you to perfect (complete) a claim and an explanation of why such material or information is necessary,
• A description of the program’s appeals procedures and applicable time limits, and
• A statement of your right to bring a civil action under Section 502(a) of ERISA following a Notice of Denial on Appeal in the case of a claim filed under the Life Insurance, AD&D and Business Travel Programs.

In the case of a Notice of Denial on Appeal, the notice also will include:

• A statement regarding your right to obtain, upon request and free of charge, reasonable access to, and copies of, all records, documents and other information relevant to your claim, and
• A statement of your right to bring a civil action under Section 502(a) of ERISA in the case of an appeal filed under the Life Insurance, AD&D and Business Travel Programs.

Review Procedures for Eligibility Determination

If you have not filed a claim for benefits and have not been issued a notice of denial under any of the claims procedures described above and you believe that you are being denied enrollment in the Plan or in any benefit program, you or your authorized representative must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief. An appeal must be filed within 60 days of the receipt of the written or electronic notice of denial of enrollment. Rice University will provide written or electronic notice of its appeal decision within 60 days following receipt of your appeal. This 60-day period may be extended up to an additional 60 days if an extension is necessary to process your claim due to matters beyond the control of Rice University. If an extension is necessary, you will be notified before the end of the initial 60-day period of the reasons for the delay and when Rice University expects to make a decision.
Plan Information

Many of the benefits described in this booklet are provided under the William Marsh Rice University Health and Welfare Benefits Plan (the “Plan”). This section contains important information about that Plan.

Plan References

**Plan Sponsor:** William Marsh Rice University
Benefits–MS 92
P.O. Box 1892
Houston, TX 77251-1892
713-348-2363
Employer Identification Number: 74-1109620

**Plan Name and Plan Number:**
William Marsh Rice University Health and Welfare Benefits Plan
Plan Number: 511
When requesting additional information about the Plan from the Department of Labor, refer to the plan number.

**Plan Administrator:**
William Marsh Rice University
Benefits–MS 92
P.O. Box 1892
Houston, TX 77251-1892
713-348-2363

**Human Resources Department (benefits team):**
Gloria O’Bryan, Benefits Specialist
713-348-4080, gloobry@rice.edu
Verónica Villaseñor, Benefits Specialist
713-348-3557, vdv@rice.edu
Marian Saldívar, Benefits Specialist
713-348-6074, marians@rice.edu
Susan Prochazka, Director of Benefits
713-348-4663, susan.l.prochazka@rice.edu

**Agent for Service of Legal Process:**
William Marsh Rice University
General Counsel–MS 94
P.O. Box 1892
Houston, TX 77251-1892
713-348-5237

**Plan Year:** July 1 to June 30

Plan Administrator

William Marsh Rice University is the Plan Administrator for the William Marsh Rice University Health and Welfare Benefits Plan (the “Plan”). As the plan administrator, Rice University has all the powers and discretionary authority necessary to supervise the administration of the Plan, to control its operations, and to adopt such rules and procedures, including allocating responsibility of the day-to-day administration of the Plan to others, as it deems desirable for the administration of the Plan, provided that any exercise of its powers and authority shall be consistent with the provisions of the Plan and, to the extent required, ERISA. Such powers and authority include, but are not limited to, the discretionary and final authority to construe and interpret the provisions of the Plan and its benefit programs, as well as any uncertain terms, to decide all questions of eligibility and participation under the Plan and its benefit programs; to determine the manner, time and amount of payment of any benefits under the Plan and its benefit programs; and to determine any disputes arising under and all questions concerning administration of the Plan and its benefit programs, unless delegated to a claims administrator or insurer administrator. Any action taken or determination made by the plan administrator, claims administrator or insurer administrator will be final, conclusive and binding for purposes of the Plan.
### Benefit Programs, Funding and Types of Administration

The William Marsh Rice University Health and Welfare Benefits Plan and its Benefit Programs (the “Plan”) are unfunded, and contributions to the Plan are not placed in trust but are considered a part of Rice University’s general assets. Both Rice University and employees make contributions to the Plan. Each plan year, Rice University determines the amount employees are required to contribute toward their benefits. Rice University then contributes the difference between the amount contributed by employees and the amount required to provide the benefits under the Plan. The Benefit Programs offered under the Plan are set forth below:

<table>
<thead>
<tr>
<th>William Marsh Rice University Benefit Program</th>
<th>Type of Benefit</th>
<th>Type of Administration</th>
<th>Contract or Insurer Administrator</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by contract administrator</td>
<td>Aetna Life Insurance Company (“Aetna”)</td>
<td>Combination unfunded/stop loss insured; Rice and employee contributions</td>
</tr>
<tr>
<td>Prescription Drug Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by contract administrator</td>
<td>Envision Rx Options (“Envision”)</td>
<td>Unfunded; Rice and employee contributions</td>
</tr>
<tr>
<td>Dental Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by insurer administrator</td>
<td>Aetna</td>
<td>Fully insured; Rice and employees pay all premiums</td>
</tr>
<tr>
<td>Medical Flexible Spending Account Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by contract administrator</td>
<td>WageWorks</td>
<td>Unfunded; employees make all contributions</td>
</tr>
<tr>
<td>Health Savings Account Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by contract administrator</td>
<td>PayFlex</td>
<td>Unfunded; employees make all contributions</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account Program</td>
<td>Fringe Benefit</td>
<td>Claims paid by contract administrator</td>
<td>WageWorks</td>
<td>Unfunded; employees make all contributions</td>
</tr>
<tr>
<td>Life Insurance Program</td>
<td>Welfare Benefit • Life</td>
<td>Claims paid by insurer administrator</td>
<td>Unum</td>
<td>Fully insured; Rice University pays premiums for basic coverage; employees pay premiums for optional coverage</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Program</td>
<td>Welfare Benefit • Life/Health</td>
<td>Claims paid by insurer administrator</td>
<td>Unum</td>
<td>Fully insured; employees pay all premiums</td>
</tr>
<tr>
<td>Business Travel Accident Program</td>
<td>Welfare Benefit • Life</td>
<td>Claims paid by insurer administrator</td>
<td>Hartford Life Insurance</td>
<td>Fully insured; Rice University pays all premiums</td>
</tr>
<tr>
<td>Short-Term Disability Program</td>
<td>Welfare Benefit • Disability</td>
<td>Claims paid by Rice University</td>
<td>Unum</td>
<td>Unfunded; Rice University makes all contributions</td>
</tr>
<tr>
<td>Long-Term Disability Program</td>
<td>Welfare Benefit • Disability</td>
<td>Claims paid by insurer administrator</td>
<td>Unum</td>
<td>Fully insured; employee chooses whether Rice University or employee pays premiums</td>
</tr>
<tr>
<td>Long-Term Care Insurance Program</td>
<td>Welfare Benefit • Health</td>
<td>Claims paid by insurer administrator</td>
<td>Unum</td>
<td>Fully insured; employees pay all premiums</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Welfare Benefit • Health</td>
<td>Services provided by insurer administrator</td>
<td>UTEAP</td>
<td>Fully insured; Rice University pays all premiums</td>
</tr>
</tbody>
</table>
Summary Plan Description

This booklet is the Summary Plan Description for the William Marsh Rice University Health and Welfare Benefits Plan (the “Plan”). The book and its charts or references are not intended to cover every detail. For example, they do not describe in complete detail the actual amount of benefits payable (which is subject to final audit at the time a benefit claim is received) or list all the circumstances under which benefits will be paid. Complete details about the Plan are in the legal documents, i.e., the plan documents, insurance contracts or policies, and other documents that may govern a benefit program's operation and administration. If there are differences between the legal documents and this Summary Plan Description or any oral representations made by any person regarding the Plan, the legal documents will govern. In addition, no rights accrue to any employee, dependent or beneficiary by any statement in or omission from this Summary Plan Description or by operation of the Plan. You can arrange to review any legal document by contacting human resources.

This Summary Plan Description also incorporates by reference separate documents, such as the certificates of coverage for fully insured benefits, and other written materials designed to communicate the benefits provided under the Plan. You can obtain additional copies of any separate document by contacting human resources.

Finally, this booklet is for informational purposes only and is not intended as an offer of employment or to set forth the terms and conditions of employment with Rice University in any way. For more information regarding the terms and conditions of employment with Rice University, please refer to the University Policies, which are available on the HR website. In addition, participation in the Plan and its Benefit Programs described in this booklet does not guarantee your continued employment with Rice University. If you terminate your employment or if you are discharged, the Plan or its Benefit Programs do not give you any right to any benefits from the Plan, except as required under COBRA (see Page 15) or otherwise provided in the legal documents for the Plan.

Plan Amendment and Termination

While it is expected that the William Marsh Rice University Health and Welfare Benefits Plan and its Benefit Programs (the “Plan”) will continue indefinitely, Rice University reserves the right to amend, modify or terminate the Plan or any benefit program established under the Plan or to discontinue its contributions to the Plan at any time and under any circumstances that it deems advisable, including, but not limited to, a need to address law changes, cost or plan design considerations. Any amendment, modification or termination of the Plan or any benefit program established under the Plan will not adversely affect any benefits accrued by you prior to the date of such amendment, modification or termination except to the extent determined by Rice University or required by applicable law.

No Guarantee of Tax Consequences

Rice University does not make any commitment or guarantee that any amounts paid to or for your benefit under the William Marsh Rice University Health and Welfare Benefits Plan and its Benefit Programs are excludable from your gross income for federal or state tax purposes or that any other federal or state tax treatment applies or is available. It is your obligation to notify human resources if you have reason to believe that any payment is not so excludable.

Subrogation

If you or a covered family member receives benefits from a Rice medical plan as the result of an illness or injury caused by another person, Rice University has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means that Rice University may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness.
Your Rights Under ERISA

All participants in the William Marsh Rice University Health and Welfare Benefits Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

**Receive Information About the Plan and Benefits Programs**
Examine, without charge, at the plan administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The plan administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**
Continue health care coverage for yourself, your spouse or domestic partner, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules concerning your COBRA continuation coverage rights.

Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the group health programs, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

**Prudent Actions by Plan Fiduciaries**
In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including Rice University or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the Plan’s latest annual reports and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for a welfare benefit that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan administrator’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the fiduciaries of the Plan misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Assistance With Your Questions
If you have any questions about the Plan, you should contact human resources. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

(Footnotes)
1All benefits provided under the Plan are covered by ERISA except for benefits provided under the Dependent Care Flexible Spending Account Program and the Short-Term Disability Program.

Other Important Information

Password Security

It is very important that you set and maintain secure passwords on all of your secure access websites, including your NetID and websites off campus, including Aetna, TIAA and Fidelity Investments.

One of the most common ways for hackers to access systems is by using weak or compromised passwords. Every system you log in to should have good, complex passwords that are changed periodically. Also, passwords should not be shared — if they are shared, the password should be changed immediately afterward. Also, the password you choose should be memorable to you. You should not choose a password that you have to write down to remember.

Summary of Other Rice Benefits

Following are general highlights of certain guidelines and benefits of working at Rice University. Some of these benefits require faculty and staff to be benefits eligible. Details of provisions are contained in the official policies — see these policies on the HR website for details.

Benefit Time — Rice University grants staff members benefit time during which an employee may be absent for any reason, including vacation, personal business, illness, religious holidays and so on. The amount of benefit time an employee may accumulate depends on the employee’s classification. At a minimum, full-time employees accrue 10.67 hours of benefit time per month (equivalent to 16 days per year), with the amount increasing based on years of service to a maximum of 17.33 hours per month (equivalent to 26 days per year). Some employees may earn more benefit time (based on their exempt or nonexempt status). For more information, please see the benefit time policy at http://professor.rice.edu/uploadedFiles/Professor/Independent_Pages/Policies/Policy_405.pdf.

Other Leaves — Various leaves of absence from work, including work-related injury, disability, family illness, bereavement, professional, primary caregiver and military service may be granted either with or without pay.

Holidays — Rice University normally observes certain holidays, including Independence Day, Labor Day, Thanksgiving (Thursday and Friday), Christmas Day, New Year’s Day, Martin Luther King Jr. Day and Memorial Day. Rice also provides a work recess between Christmas Day and New Year’s Day for most staff.

Tuition Waiver — Subject to approval of department administration, benefits-eligible employees are eligible to take one course per semester, tuition free at Rice. Discounts on classes also are available for courses offered through the Susanne M. Glasscock School of Continuing Studies or the Executive Education Program at the Jesse H. Jones Graduate School of Business.
**Tuition Reimbursement** — Faculty and staff are eligible to request reimbursement of tuition for up to one course per semester. Preapproval is required, and the employee must turn in evidence of completion with a grade of C or better to receive reimbursement. This reimbursement (75 percent of the eligible amount paid, up to $2,500 per fiscal year) applies to tuition by accredited colleges and universities other than Rice University. General Education Development (GED) courses, test preparation and testing fees are covered 100 percent. Also covered under this program are language and work-related courses in the School of Continuing Studies and the Office of Executive Education.

**Tuition Remission** — Spouses, partners and dependent children of employees working at Rice who have completed three years in benefits-eligible status may attend Rice University tuition-free as full-time students, subject to undergraduate admission and policy requirements. Additional schools may be available but under different arrangements. Contact human resources for more information or visit http://benefits.rice.edu.

**Credit Union** — Employees are eligible to be members in the Smart Financial Credit Union. For more information on the advantages of credit union membership, visit www.smartcu.org.

**Direct Deposit of Payroll Checks** — Available to most employees, for most banking institutions and credit unions.

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**Equal Employment Opportunity and Affirmative Action**

Rice University is committed to affirmative action and equal opportunity in education and employment. Rice does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, disability or veteran status.
Rice University
Human Resources–MS 92
6400 Fannin, Suite 2600
Houston, TX 77030
713-348-2514

Benefits Team:

Phone: 713-348-BENE (2363)
Fax: 713-348-5496
Email: benefits@rice.edu
Website: http://people.rice.edu or http://benefits.rice.edu