Your Benefits for 2005–06

Rice University
Human Resources

Medical
Dental
Life
Retirement
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Welcome,

All of us in the Human Resources department are committed to providing Rice University faculty and staff with comprehensive information regarding benefits and other university services. This booklet provides a summary of the benefits available to you as a Rice University employee. Along with this booklet, separate written summaries for some of the benefits offered (e.g., a certificate of coverage) are available, which further explain the benefits provided and how you receive benefits.

These benefits are an important part of your total compensation package. We encourage you to review the booklet and separate written summaries so that you can determine how to best apply these benefits to your personal situation. If you would like more detailed information regarding your benefits, please contact HR or visit the HR website at people.rice.edu

If you are a new employee, please remember that you have 31 days from your date of hire to enroll in benefits. If you miss this enrollment window, you cannot enroll in most of the benefits until the next open enrollment period (unless you have a qualifying event).

Again this year, Rice faculty and staff will enroll in benefits via the web. You will be able to enroll at work, at home, or at any location where you have internet access. Remember that during open enrollment, the benefits you elect do not begin until July 1.

We look forward to helping you meet your professional and personal goals as a Rice University employee. The Human Resources department continues to strive to provide excellent service and competitive benefits to our customers—you.

Elaine Britt
Director of Benefits

Mary Cronin
Associate Vice President of Human Resources
Benefit Overview

Faculty and Staff Benefits Eligibility

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 eligible may still 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 non-benefits-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 at 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.

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 30 for more information about retirement benefits.

Eligible Dependents

Once you are eligible for benefits, you can also choose to cover your eligible dependents in the medical, dental, optional life insurance, and optional accidental death and dismemberment insurance.

Eligible dependents include:

- Spouse, unless you’re legally separated
- Domestic partner (for whom you have completed the Certification of Domestic Partner form)
- Unmarried dependent children up to age 25 (if living at home) for the medical or dental plans, or to age 25 and a full-time student for other plans (see each plan for details), 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 (will require documentation of dependent status)
Unmarried dependent children who live at home may continue under the medical and dental plans until they reach age 25, regardless of their status as a student.

Unmarried dependent children, age 18 or older, who are mentally or physically impaired and incapable of taking care of themselves are also eligible for coverage (disability must have begun before the dependent’s 19th birthday). You must provide proof of disability to Human Resources. 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.

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 13 for more information. You must notify HR when a dependent is no longer eligible so that the appropriate paperwork can be completed.

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. 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.

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 pre-tax dollars. (See page 4 for more information about pre-tax 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 has, consistent with tax regulations, permitted the use of pre-tax 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 upon 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>Timeframe to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hire</td>
<td>31 days from your hire date</td>
</tr>
<tr>
<td>Change in Status</td>
<td>31 days from the qualifying event</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>April 11–April 22, 2005</td>
</tr>
</tbody>
</table>

For new hires and most qualifying change in status events, coverage is effective on the first day of the month coincident with or next following the enrollment date. If the qualifying event is the birth or adoption of a child, coverage can be made effective as of the date of the event. Changes in coverage made during open enrollment are effective on July 1.

Pre-tax Versus Post-tax Deductions

What is the benefit of having the cost of your portion of the insurance deducted from your paycheck before taxes (pre-tax)? 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 event.

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 pre-tax or post-tax deductions, you sign a salary reduction agreement authorizing the university to withdraw your cost of the coverage from your paycheck.

Long-term disability (LTD) coverage 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, your 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

Pre-tax salary reduction amounts cannot be changed outside of an open enrollment period except in the case of a qualifying change in status event. 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 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.

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 a new job
- change of employment status from full-time to part-time or vice versa
- taking an unpaid leave of absence
- return to work after a leave of absence
- open enrollment of spouse’s plans

Also, as of July 1, 2005, the law allows a change of plans upon a qualifying change in status (e.g., change from HMO to PPO upon birth of a child).
Retiring from Rice University

When you consider your retirement, please contact the benefits department to discuss your options. We also recommend you meet with a representative from TIAA-CREF and/or Fidelity Investments to discuss your investment choices and distribution options. See page 30 for more information about retirement benefits.

Rice currently allows employees to continue their medical and dental benefits after leaving Rice as retirees. The retiree is required to pay 100% of the cost of the coverage for the benefit (not just the employee portion). If you decide not to elect Rice retiree benefits, you are not allowed to reenter the plans at a later date. For more information regarding the cost of coverage, see the separate benefits rate sheet. Retirees also have the option to convert to an individual life insurance, AD&D and/or Long Term care insurance policy. Contact Human Resources for more information regarding retiree benefits.
Medical Coverage

Benefits-eligible faculty and staff members may elect to enroll in one of four medical plan options each of which is administered by Aetna:

<table>
<thead>
<tr>
<th>Plan Options</th>
<th>What you pay (monthly)</th>
<th>What Rice pays (monthly)</th>
<th>Total (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RiceCare HMO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$56</td>
<td>$263</td>
<td>$319</td>
</tr>
<tr>
<td>Employee plus Spouse/Partner</td>
<td>$196</td>
<td>$488</td>
<td>$684</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$172</td>
<td>$431</td>
<td>$603</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$331</td>
<td>$655</td>
<td>$986</td>
</tr>
<tr>
<td>RiceCare Flexplan (POS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$83</td>
<td>$338</td>
<td>$421</td>
</tr>
<tr>
<td>Employee plus Spouse/Partner</td>
<td>$284</td>
<td>$632</td>
<td>$916</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$250</td>
<td>$556</td>
<td>$806</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$479</td>
<td>$840</td>
<td>$1,319</td>
</tr>
<tr>
<td>RiceCare PPO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$138</td>
<td>$535</td>
<td>$673</td>
</tr>
<tr>
<td>Employee plus Spouse/Partner</td>
<td>$410</td>
<td>$912</td>
<td>$1,322</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$396</td>
<td>$884</td>
<td>$1,280</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$701</td>
<td>$1,246</td>
<td>$1,947</td>
</tr>
<tr>
<td>RiceCare Catastrophic Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$38</td>
<td>$160</td>
<td>$198</td>
</tr>
<tr>
<td>Employee plus Spouse/Partner</td>
<td>$123</td>
<td>$264</td>
<td>$387</td>
</tr>
<tr>
<td>Employee plus child(ren)</td>
<td>$122</td>
<td>$261</td>
<td>$383</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$217</td>
<td>$355</td>
<td>$572</td>
</tr>
</tbody>
</table>

What is an HMO?
A health maintenance organization, or HMO, is a healthcare financing and delivery system that provides comprehensive healthcare 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 PCP prior to receiving services from most specialist physicians or other providers.

What is the Flexplan (POS)?
The RiceCare Flexplan is a point-of-service (POS) plan. As with HMO coverage, 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).

What is a PPO?
A preferred provider organization, or PPO, is a large group of hospitals and physicians under contract with an insurance company or plan administrator. Healthcare providers in the PPO serve plan members for negotiated fees and copayments. Members of the PPO accept responsibility for filing claims within six months of the date of service, or the claims will not be paid.

What is the “out-of-network” part of the POS and PPO plans?
When you see a provider that is not part of the POS or PPO network, you are generally charged a greater portion of the cost of your care and are subject to separate, higher deductibles.

What is a catastrophic plan?
A catastrophic plan is designed to have high deductibles, so that it is basically useful only in a “catastrophic” event. It is not designed to be a comprehensive medical plan. Because of this feature, the catastrophic plan does not have a network of physicians.
How do I contact Aetna and find out more about the provider networks?

All of Rice’s medical plans are administered by Aetna. Aetna’s Member Services phone number is:

- RiceCare HMO 800-594-9371
- RiceCare Flexplan (POS) 800-594-9371
- RiceCare PPO 888-416-2277
- RiceCare Catastrophic Plan 888-416-2277

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

You can also log on to Aetna Navigator (member.aetna.com) to:
- locate a doctor or dentist
- check claim status
- request ID cards and print temporary ID cards
- contact Aetna Member Services
- and more...

When using Aetna’s website or talking with your doctor’s office, please use the following Aetna plan names:
- RiceCare HMO = Aetna Standard Plans, HMO
- RiceCare Flexplan (POS) = Aetna Open Access Plans, Aetna Choice™ POS (Open Access)
- RiceCare PPO = Aetna Standard Plans, Open Choice® PPO
- RiceCare Catastrophic Plan does not have a network

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

What do I need to know about my medical plan options and pre-existing conditions?

A pre-existing condition is an illness or injury for which treatment has been rendered within 12 months preceding the date of enrollment in an insurance plan.

The RiceCare HMO and RiceCare Flexplan (POS) have no pre-existing condition limitations. The RiceCare PPO and RiceCare Catastrophic plans do have a pre-existing condition limitation of $4,000 unless the required proof of prior insurance is provided. As required under the Health Insurance Portability and Accountability Act of 1996, the 12-month duration of the pre-existing condition limitation is reduced one month for each month of your prior “creditable coverage” as long as you never had a break in coverage exceeding 63 days. Prior coverage is “creditable” if you were previously covered under a group health plan, a health insurance policy, Medicare or Medicaid, COBRA, or any other state or federal program. Thus, if you had 12 or more months of prior coverage without a break in coverage of more than 63 days, you may participate in the PPO without any pre-existing condition limitation. To obtain credit for your prior coverage, you must obtain proof of such coverage from your prior employer or insurance carrier and present the proof to Human Resources.

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.

Employees who decline medical coverage through one of Rice University’s medical plans must complete the proper paperwork to receive a medical spending supplement of a $120 annual contribution to the individual’s medical spending account under the flexible benefit plan. (See page 28 for more information about flexible spending accounts.) This money is available for employees to use

Did you know...
The RiceCare HMO and RiceCare Flexplan (POS) do not have pre-existing condition limitations.

Here’s a tip...
HMOs generally cost less than PPOs, but restrict your choice of doctors.

Flexplan (POS) coverage offers a more reasonably priced way to expand your freedom of choice.

PPOs generally cost more than HMOs, but give you freedom to choose doctors.

Some doctors and hospitals who are not covered under the HMO or Flexplan (POS) may be covered by the PPO network.
to help cover any eligible medical costs they might incur during the period of July 1 through June 30. To access this money, an employee who declines medical coverage at Rice by selecting “Opt-out” on an enrollment form must provide proof of an eligible medical expense and submit a claim form for reimbursement. Visit Human Resources or the HR website for more information.

EAP, Childcare and Eldercare Referral Services

The Rice University Employee Assistance Program (EAP) and Childcare and Eldercare Referral Services are provided by LifeWorks, a service of Ceridian Corporation. These plans are available to all Rice employees whether they participate in a Rice Medical plan or not.

LifeWorks – a free employee resource program to help you run your life a little more smoothly.

LifeWorks. Everybody. Every day.
You spend every day trying to make time for everything that’s important to you—your work, your family, your life. Sometimes it can seem as if there’s too much for you to handle. Whether you’re trying to find child care, trying to get out of debt, coping with a family problem or personal issue that’s weighing you down at home or at work, or just dealing with the ups and downs of everyday life—if you need a helping hand, get in touch with LifeWorks. No matter who you are, no matter what kind of issues you’re dealing with, LifeWorks is designed to help you find the support, advice, and resources you need. No question is too small, no issue is too big. The service is free and completely confidential. And because you never know when you’ll need us, we’re here 24 hours a day, 7 days a week. The program can give you information, advice, and support on a wide range of everyday issues, including:

- Parenting and child care
- Education
- Older adults
- Midlife and retirement
- Disability
- Financial
- Legal
- Everyday issues
- Work
- International
- Managing people
- Health and wellness
- Emotional well-being
- Addiction and recovery
- Grief and loss

LifeWorks offers you:

- A real person to talk to when you need help or an answer to a question
- Face-to-face sessions on specific issues
- An award-winning Web site with online articles, workshops, locators, self-assessments, and much more
- Free booklets, audio recordings, and other materials to help you get the answers you need in the format you want
- Referrals to resources, services, and support in your community
- A commitment to always being there when you have a question or need help.

Get in touch with LifeWorks today:
Online: www.lifeworks.com
(company name/user id: Rice; password: Owls)
or call 888-267-8126.
Summary of Medical Plan Options

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 and are available on the HR website.

### Benefit Category

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Network</th>
<th>Non-Network</th>
<th>Network</th>
<th>Non-Network</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Plan Provisions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>$750</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
<td>$2,250</td>
<td>$1,500</td>
<td>$3,000</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>Individual</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$5,000</td>
<td>$7,000</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$15,000</td>
<td>$21,000</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$20 copay</td>
<td>$25 copay</td>
<td>70% after deductible</td>
<td>$20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office Visit</td>
<td>($25 after hours)</td>
<td>($30 after hours)</td>
<td>deductible</td>
<td>deductible</td>
<td>deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office Visit</td>
<td>deductible</td>
<td>deductible</td>
<td>deductible</td>
<td>deductible</td>
<td>deductible</td>
</tr>
<tr>
<td>X-Ray &amp; Laboratory at facility</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>X-Ray &amp; Laboratory at doctor's office</td>
<td>Included</td>
<td>Included</td>
<td>70% after deductible</td>
<td>Included</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Physical/ Speech/Occupational Therapy</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Dialysis/ Chemotherapy</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy Testing/ Treatment</td>
<td>($20 for injection at PCP office)</td>
<td>($25 for injection at PCP office)</td>
<td>deductible</td>
<td>(80%after ded. for injection)</td>
<td>deductible</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>$20 copay</td>
<td>$25 copay</td>
<td>70% after deductible</td>
<td>$20 copay</td>
<td>60% after ded. (limits may apply)</td>
</tr>
<tr>
<td>Routine Child and Well Baby Care; Immunizations</td>
<td>$20 copay</td>
<td>$25 copay</td>
<td>70% after deductible</td>
<td>$20 copay</td>
<td>60% after ded. (limits may apply)</td>
</tr>
<tr>
<td>Routine GYN Care (one per 365 days)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Mammogram (annual females 35 &amp; older)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>100% (ded. waived, age 40+)</td>
<td>60% after deductible (age 40+)</td>
</tr>
<tr>
<td>Routine Eye Exam (freq./age limits may apply)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>Not covered</td>
<td>$50 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Pediatric Dental</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing Exam (routine screening)</td>
<td>$20 copay</td>
<td>$25 copay</td>
<td>70% after deductable</td>
<td>80% after deductable for illness/injury</td>
<td>60% after deductable for illness/injury</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$50 copay</td>
<td>80% (50% if non-emergent)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$50 copay</td>
<td>80% (50% if non-emergent)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>No copay</td>
<td>60% after deductable</td>
</tr>
<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>$350 copay</td>
<td>70% after deductible</td>
<td>80% after deductable</td>
<td>60% after ded. + $200/ confinement</td>
</tr>
<tr>
<td>Skilled Nursing Fac. (in lieu of hosp.)</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductable (limits may apply)</td>
<td>80% after ded. (limits may apply)</td>
<td>80% after ded. + $200/ confinement (limits may apply)</td>
</tr>
<tr>
<td>Benefit Category</td>
<td>RiceCare HMO</td>
<td>RiceCare Flexplan</td>
<td>RiceCare PPO</td>
<td>RiceCare Catastrophic</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
<td>Network Non-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Services continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB visit (initial visit)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospital (includes newborns)</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$100 copay</td>
<td>$150 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Home Health (Outpat.)</td>
<td>No copay</td>
<td>No copay</td>
<td>70% after ded. (limits may apply)</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Private Duty/Special Duty Nursing</td>
<td>Not covered</td>
<td>Not covered</td>
<td>80% after ded. (OP only 70 8-hr shifts per yr.**)</td>
<td>80% after ded. 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Hospice (Inpatient/Outpatient)</td>
<td>$250 copay/</td>
<td>$350 copay/</td>
<td>70% after ded.</td>
<td>100% after ded. 80% after ded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No copay/</td>
<td>No copay/</td>
<td>deductible</td>
<td>$200/confinement deductible</td>
<td></td>
</tr>
<tr>
<td>Family Planning/Reprod. Services</td>
<td>Covered with</td>
<td>Covered with</td>
<td>70% after ded.</td>
<td>80% after ded. 80% after ded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>applicable copay</td>
<td>applicable copay</td>
<td>deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Inpat. (30 days max•••)</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Mental Health Outpat. (20 visits max•••)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>50% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Serious Mental Illness Inpat. (45 days max)</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Serious Mental Illness Outpat. (60 visits max)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Detox. Inpatient</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Detox. Outpatient</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after ded. ($1,000 max)</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Rehab Inpatient (3 episodes per lifetime•••)</td>
<td>$250 copay</td>
<td>$350 copay</td>
<td>70% after deductible</td>
<td>$30 copay 60% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Rehab Outpatient (3 episodes per lifetime•••)</td>
<td>$30 copay</td>
<td>$35 copay</td>
<td>70% after deductible</td>
<td>$30 copay 50% after deductible 80% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care ($1,000 ann. max)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered Not covered</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No copay</td>
<td>No copay</td>
<td>70% after ded. (must precert.)</td>
<td>60% after ded. 80% after ded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail-Form. Generic (30 day sup.)</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Not covered</td>
<td>$10 copay 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Retail-Form. Brand (30 day sup.)</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Not covered</td>
<td>$20 copay 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Retail-Non-Form. Brand &amp; Gen. (30 day supply)</td>
<td>$35 copay</td>
<td>$35 copay</td>
<td>Not covered</td>
<td>$35 copay 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Mail Ord.-Form. Gen. (90 day sup.)</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Not covered</td>
<td>$20 copay 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Mail Ord.-Form. Brand (90 day supply)</td>
<td>$40 copay</td>
<td>$40 copay</td>
<td>Not covered</td>
<td>$40 copay 80% after ded.</td>
<td></td>
</tr>
<tr>
<td>Mail Order-Non-Form. Brand &amp; Gen. (90 day supply)</td>
<td>$70 copay</td>
<td>$70 copay</td>
<td>Not covered</td>
<td>$70 copay 80% after ded.</td>
<td></td>
</tr>
</tbody>
</table>

• Applies to usual and customary charges  •• Combined maximum for Network and Non-Network benefits
Dental Coverage

Rice University offers two insured dental plan options:

- **United Concordia Indemnity Dental Plan**
  - Employee only: $38.71
  - Employee plus one: $76.58
  - Employee plus two or more: $109.20

- **Aetna DMO**
  - Employee only: $11.77
  - Employee plus one: $21.44
  - Employee plus two or more: $30.02

**How do the two plans differ?**

Under the indemnity dental 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.

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 from Human Resources or via the benefits website. There are no claim forms to be filed and the cost for procedures is known in advance.

**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>$50/$150</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>$1,000</td>
</tr>
<tr>
<td>Orthodontia lifetime maximum</td>
<td>$1,000</td>
</tr>
<tr>
<td>Insured percentage of allowable charges</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive dental services</td>
<td>100%</td>
</tr>
<tr>
<td>Basic dental services (fillings, root canals &amp; oral surgery)</td>
<td>80%</td>
</tr>
<tr>
<td>Major dental services (crowns, dentures &amp; inlays)</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics (child to age 19)</td>
<td>50%</td>
</tr>
</tbody>
</table>

**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>Prophylaxis (routine, once every 6 months)</td>
<td>$5.00</td>
</tr>
<tr>
<td>2140</td>
<td>Amalgam (silver), one surface, primary</td>
<td>$16.00</td>
</tr>
<tr>
<td>2740</td>
<td>Crown/porcelain/ceramic substrate</td>
<td>$315.00</td>
</tr>
<tr>
<td>3350</td>
<td>Root canals, molar</td>
<td>$303.00</td>
</tr>
<tr>
<td>5110</td>
<td>Complete denture maxillary (upper or lower)</td>
<td>$300.00</td>
</tr>
<tr>
<td></td>
<td>Orthodontic treatment, children or adult (comprehensive)</td>
<td>$2,000.00</td>
</tr>
</tbody>
</table>

More complete details on covered procedures is available on the Human Resources website.

---

**Did you know...**

Rice offers two dental plan options.

**Here's a tip...**

Like medical HMOs, DMOs generally cost less than indemnity dental plans, but restrict your choice of dentists.
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 Member Services at 1-877-AETNA-00.

Aetna also has a website with a directory of current DMO dental providers: www.aetna.com/docfind/. 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 1-877-AETNA-00. 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 12th, you can see your new dentist after April 1st. 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 18th, you can see the new dentist after May 1st). You can continue to see your existing primary dentist until the change is effective.
Important Federal Notices
Regarding Your Health Coverage

The notices contained in this section are being provided in accordance with the requirements of the federal law.

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% 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>

Please contact Human Resources should you or your dependent become eligible for COBRA coverage or if your dependent should no longer qualify for coverage.

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.

Here’s a tip...

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since Rice pays a part of the active employee’s premium. It is ordinarily less expensive, though, than comparable individual health coverage.
Protection From Loss of Medical Coverage

Another federal law called HIPAA – the Health Insurance Portability and Accountability Act – protects you from loss of medical coverage if you change jobs. Your new employer's plan cannot deny or postpone coverage for “preexisting conditions” before notifying you, in writing, of: (1) the existence and terms of any preexisting 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 will also 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, and
- 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 may also 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 caesarean 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...
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% 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; and
• 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, 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 pre-authorizations). 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 post-marketing surveillance. If authorized by law, PHI may also 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 Benefits Manager, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), 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” PHI 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 about 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 Benefits Manager, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), 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 Benefits Manager, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), 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 will rarely 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 will also 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 Benefits Manager, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), 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 is not individually identifiable health information.

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, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), 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 Benefits Manager, 713-348-2514, mailing address: P.O. Box 1892 (M.S. 92), Houston, TX 77251-1892.

Conclusion
PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). 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.
Survivor Protection

Basic Life Insurance

Rice University pays for basic life insurance of 100% 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. 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.

Can I continue my coverage if I leave the university?
A conversion option is available upon termination of employment, including retirement. The employee should contact the plan insurer, ING, regarding the conversion option if interested.

For more detailed information, you can request a copy of the Summaries and Certificates of Coverage published by ReliaStar from Human Resources.

Optional Life Insurance

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

- 100% of annual base salary
- 200% of annual base salary
- 300% of annual base salary
- 400% of annual base salary
- 500% of annual base salary (with approval of evidence of insurability)

If you are an existing employee adding or changing coverage, any changes you make are subject to approval of evidence of insurability.

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

<table>
<thead>
<tr>
<th>Age (benefit reduction)</th>
<th>Non-Smoker Rates (monthly)</th>
<th>Smoker Rates (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$0.06</td>
<td>$0.07</td>
</tr>
<tr>
<td>30 to 34</td>
<td>$0.08</td>
<td>$0.09</td>
</tr>
<tr>
<td>35 to 39</td>
<td>$0.09</td>
<td>$0.11</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$0.11</td>
<td>$0.18</td>
</tr>
<tr>
<td>45 to 49</td>
<td>$0.20</td>
<td>$0.32</td>
</tr>
<tr>
<td>50 to 54</td>
<td>$0.30</td>
<td>$0.52</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$0.45</td>
<td>$0.74</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$0.66</td>
<td>$1.18</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$1.27</td>
<td>$1.89</td>
</tr>
<tr>
<td>70 to 74 (45%)</td>
<td>$2.06</td>
<td>$3.38</td>
</tr>
<tr>
<td>75 to 79 (35%)</td>
<td>$2.79</td>
<td>$3.38</td>
</tr>
<tr>
<td>80 to 84 (15%)</td>
<td>$2.79</td>
<td>$3.38</td>
</tr>
<tr>
<td>85 and older (10%)</td>
<td>$2.79</td>
<td>$3.38</td>
</tr>
</tbody>
</table>

The maximum amount of coverage available under this plan is $750,000. Beneficiaries are the same as those selected for the basic life insurance.

At initial enrollment, participants may select 100% to 400% without providing evidence of insurability. Initial enrollment in the 500% option is subject to approved

Did you know...
Rice pays for a basic life insurance for all benefits-eligible employees.

Did you know...
Benefits-eligible employees may also choose to purchase additional life insurance.

Benefit reduction
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 75, 45%
- From age 75 to 80, 35%
- From age 80 to 85, 15%
- From age 85 on, 10%.
evidence of insurability for the amount over 400% of earnings. Each year during the annual enrollment period, participants may apply to increase the amount of additional life insurance contingent upon 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. Participants in optional life insurance must indicate whether they are smokers or nonsmokers.

**What is “evidence of insurability”?**
When you choose certain amounts of optional life insurance for yourself, you must provide evidence of insurability (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. The EOI questionnaire seeks medical information about you or your dependents and must be completed by you and/or your physician. When EOI is required, deductions are not made until the carrier approves it.

You may be required to pay for any costs associated with obtaining EOI. This includes, but is not limited to, the cost of a physical, lab work, or the cost of copying your medical records.

**Optional Spouse/Domestic Partner Life Insurance**
A spouse or domestic partner must be a U.S. resident in order to be insured under the spouse life insurance plan.

The spousal/partner plan offers any amount of life insurance from $5,000 to $50,000 in $5,000 increments. If you elect less than $25,000 for your spouse/partner, you may increase that amount by $5,000 each year (to a maximum of $25,000) without evidence of insurability. Any increase of more than $5,000 annually or any amount of coverage over $25,000 is subject to approval of evidence of insurability. (The amount elected for a dependent cannot exceed 50% of the employee’s basic life plus optional coverage.) 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.

**Optional Child Life Insurance**
The child(ren) optional life insurance choices are:

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>What you pay monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$0.54</td>
</tr>
<tr>
<td>$10,000</td>
<td>$1.08</td>
</tr>
</tbody>
</table>

The rate is the same regardless of the number of children covered under the coverage amount. The $10,000 amount requires approval of evidence of insurability for each child. The cost of coverage is the same regardless of the number of children. Unmarried children are eligible for coverage to age 19 (or until age 25 if the child is a full-time student). Additional dependents will be eligible for a flat $5,000 from date of birth. When initially enrolled, the $5,000 will be guaranteed issue, subject to dependents not being hospital confined (other than newborn) or in a totally disabled condition. 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.

**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 and the amount of coverage. 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 cancelled effective the first of any month, but the employee is not eligible for reapplication until the next annual enrollment and would have to show evidence of insurability when reapplying.

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 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 19 or until age 25 if they are full-time students).

What is AD&D insurance?
Accidental death and dismemberment (AD&D) insurance protects you and your family in case of a death or loss of a bodily function 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.

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). The maximum available for persons earning less than $15,000 per year is $150,000. If a coverage amount in excess of $150,000 is selected, that amount may not be more than 10 times the employee's annual salary.

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>What you pay monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$0.02 per $1,000 (available in multiples of $10,000)</td>
</tr>
<tr>
<td>Employee and family</td>
<td>$0.04 per $1,000 (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 &amp; Spouse (no children)</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Spouse</td>
<td>60% of employee coverage</td>
</tr>
<tr>
<td>Employee, Spouse &amp; Children</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Spouse</td>
<td>50% of employee coverage</td>
</tr>
<tr>
<td>Each child</td>
<td>10% of employee coverage</td>
</tr>
<tr>
<td>Employee &amp; Children (no spouse)</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>100% of employee coverage</td>
</tr>
<tr>
<td>Each child</td>
<td>15% of employee coverage</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% of the elected benefit amount; at age 75, to 35%; at age 80, to 15%; and at age 85, to 10%. 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 CIGNA 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://www.professor.rice.edu/professor/Travel_Insurance.asp

Here’s a tip...
Unlike life insurance, AD&D coverage does not pay benefits if you die from illness—only from a covered accident.
Short-Term Disability

Benefits-eligible faculty and staff members who become unable to work for medical reasons that are not work related may have their current salary continued for a specified period under the terms of Rice University’s short-term disability (STD) program. Benefits also continue, 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 work days. If the person 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.

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>0–6 months</td>
<td>1/2 Academic Year Salary</td>
<td>0 days</td>
<td>0 hours</td>
</tr>
<tr>
<td>6 months–1 year</td>
<td>Same as above</td>
<td>40 days</td>
<td>320 hours</td>
</tr>
<tr>
<td>1 year–2 years</td>
<td>Same as above</td>
<td>60 days</td>
<td>480 hours</td>
</tr>
<tr>
<td>2 years–3 years</td>
<td>Same as above</td>
<td>80 days</td>
<td>640 hours</td>
</tr>
<tr>
<td>3 years–4 years</td>
<td>Same as above</td>
<td>100 days</td>
<td>800 hours</td>
</tr>
<tr>
<td>4 years–5 years</td>
<td>Same as above</td>
<td>120 days</td>
<td>960 hours</td>
</tr>
<tr>
<td>5+ 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://www.professor.rice.edu/professor/Short-Term_Disability.asp) for more details about this benefit.

Did you know...
Rice provides a short-term disability benefit to allow employees to continue their salary if they are unable to work due to medical reasons.
Long-Term Disability

Benefits-eligible faculty and staff members are enrolled in long-term disability (LTD) insurance that provides coverage of 60% 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 (any amount over $20,000 per month is subject to a pre-existing condition limitation). 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 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</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 0.42% 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 Sun Life Insurance Company from Human Resources.

Long-Term Care Insurance

All faculty and staff are eligible to apply for long-term care (LTC) insurance. LTC premiums are deducted on a post-tax basis.

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).

Why would I need LTC insurance?
Long-term care 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.
Whom can I cover with LTC insurance?
You can cover yourself, your spouse, parents or grandparents under the LTC policy. Depending on the coverage you desire, a completed medical questionnaire may be required.

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.

Flexible Spending Accounts
Flexible spending accounts allow participants to set aside pre-tax dollars for qualifying medical and/or dependent care expenses. Claims for reimbursement must be submitted no later than October 31 following the end of the plan year (June 30). Money remaining in either account must be used 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.

What is a medical spending account?
Employees may set aside money on a pre-tax basis to pay for qualified, uninsured medical expenses. By setting the money aside on a pre-tax 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 $5,000 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.

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 1st and June 30 of the covered period.

You must submit your expenses no later than four months after the end of the plan year (the plan year ends June 30), and your services must have been received within the plan year 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. The controller’s office suggests consulting IRS publications regarding the deductibility of medical and dental expenses at http://www.irs.gov/pub/irs-pdf/p502.pdf. There is an exception to the general rule—nonprescription (over-the-counter) medicines and drugs that alleviate or treat personal injuries or sickness (but excluding dietary supplements such as vitamins) and herbs that are merely beneficial to your general health now qualify for reimbursement.

Recent Development!
The IRS recently ruled that medical spending accounts can reimburse expenses for nonprescription or (over-the-counter) medicines and drugs. Expenses that are covered include expenses for Claritin, pain relievers, such as Tylenol, Motrin, and antibiotics. Expenses that are not covered include items that are merely beneficial to your general health such as dental products, and herbal supplements.
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 pre-tax 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 $1.00 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 1st of the following month. Contact Human Resources to make a change.
Retirement Benefits

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/College Retirement Equities Fund (TIAA-CREF). Contributions are made for eligible employees from date of hire. Employees are vested in the Retirement Plan after 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 once you qualify to start distributions from the Retirement Plan. If you do not become “vested” in the Retirement Plan before you leave Rice, you forfeit 100% 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) and/or to CREF (investments in stocks, bonds, or money markets). If you do not complete an application within 31 days of the start of your participation in the plan, an application is submitted to TIAA-CREF on your behalf and your money is invested in money market funds (which are the lowest risk of the available funds).

How much does the university contribute for me?
The university contributes to each individual account an amount determined according to the following schedule:

<table>
<thead>
<tr>
<th>Salary</th>
<th>Under Age 50</th>
<th>Age 50 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Social Security Wage Base</td>
<td>7%</td>
<td>An additional 3% for age (=10%)</td>
</tr>
<tr>
<td>Above Social Security Wage Base</td>
<td>An additional 5% for compensation</td>
<td>An additional 5% for compensation</td>
</tr>
<tr>
<td>over wage base (=12%)</td>
<td>over wage base + 3% for age (=15%)</td>
<td></td>
</tr>
</tbody>
</table>

The Social Security Wage Base for calendar year 2005 is $90,000. The maximum salary considered for the Retirement Plan is set by the federal government. For 2005, the maximum salary is $210,000.

What if I terminate my employment at Rice?
Retirement income is available from vested accumulations in various options upon termination of employment with at least 10 consecutive, benefits-eligible years of service and as early as when your age plus years of service at Rice equals at least 65. Payment from the plan can only start once you are considered a retiree, based on the plan definitions. Payments are taxed as income and may be subject to IRS penalty if withdrawn early.

If you leave Rice prior to qualifying as a retiree, you can withdraw your retirement plan investment only if your account balance is less than $4,000. 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 and reach the age of 50. Contact the Human Resources department 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 the Retirement Plan. 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 pre-tax dollars and the earnings accumulate on a tax-deferred basis.

**How much can I contribute to the SRA?**
For calendar year 2005, you may contribute up to $14,000. Employees 50 years or older may also contribute an additional $4,000. 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. Individual participants remain responsible for monitoring contribution limits.

The contribution limits may increase each calendar year. 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 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 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 pre-tax 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 pre-tax basis, your reduction in take-home pay is only $42 (if you are in the 15% tax bracket). The extra $8 is due to the reduction in taxes you pay.

Finally, from 2002 to 2006, a single filer or married person filing separately whose adjusted gross income is less than $25,000 will qualify for a tax credit on up to $2,000 in 403(b) retirement plan contributions. The credit is also available...
to joint filers with an adjusted gross income under $50,000. 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-CREF. 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 Human Resources or 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-CREF</td>
<td>800-842-2776</td>
<td><a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a></td>
</tr>
</tbody>
</table>

**Once I enroll, can I 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 each time you wish to change your contributions.

**Do I have to be benefits-eligible to participate?**
Supplemental retirement accounts are open to all employees, 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 www.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 (SRA).

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**Did you know...**
Rice offers two forms of financial counseling.
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 advisor 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 advisor to permit him to construct the financial plan. There is an initial registration fee of $65 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 $65 in taxable income.

Information is available at the Human Resources benefits website for review. This benefit is offered through arrangement with ING Benefits.
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.

Aetna decides all claims filed under the Rice Medical and Dental Programs and Rice University decides all claims filed under the Medical 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 its decision within the following time frames:

- **Post-service claims.** A post-service 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 post-service claim will be denied.

- **Pre-service claims.** A pre-service 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 pre-service 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 pre-service 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 who will applying 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 timeframes for approval or denial.

If you request an extension ongoing treatment in a non-urgent care situation, your request will be considered a new claim and will be approved or denied within the post-service or preservice timeframes, 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 Dental Program and Rice University reviews all appeals filed under the Rice Medical and Medical Flexible Spending Account Programs (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 healthcare 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 such individual.

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

• **Post-service appeals.** The appeals administrator will provide notice of its appeal decision within 60 days following receipt of your appeal.

• **Pre-service 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 circum-
stances, 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 upon 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 will also 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 will also 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 non-death claims under Accidental Death and Dismemberment and Business Travel Accident Programs**

For information on filing claims for benefits under the 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. For information on filing claims for benefits under the Short Term Disability Program, contact Human Resources.
Claims Procedures

Rice University has designated the insurer administrators to decide all claims filed under the LTD, AD&D, and Business Travel Programs and Rice University decides all claims filed under the Short Term Disability Program (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 healthcare 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 such 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 administrator. 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 upon 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 will also 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 LTD, AD&D, and Business Travel Programs.

In the case of a Notice of Denial on Appeal, the notice will also 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 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 upon 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 or plan provisions on which the determination was based,
In the case of a Notice of Denial, the notice will also 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 will also 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
PO. Box 1892 (M.S. 92)
Houston, TX 77251-1892; (713) 348-2514
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
PO. Box 1892 (M.S. 92)
Houston, TX 77251-1892
(713) 348-2514

Human Resources Department (Benefits Team):
Gloria O’Bryan
Benefits Coordinator, (713) 348-4080, gloobry@rice.edu

Elaine Carrasco
Benefits Coordinator, (713) 348-4663, carrase@rice.edu

Elaine Britt
Director of Benefits, (713) 348-6074, britt@rice.edu

Agent for Service of Legal Process:
William Marsh Rice University.
Attn: General Counsel
PO. 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 their benefit programs as well as any uncertain terms, to decide all questions of eligibility and participation under the Plan and their benefit programs, to determine the manner, time, and amount of payment of any benefits under the Plan and their benefit programs, and to determine any disputes arising under and all questions concerning administration of the Plan and their 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 towards their benefits. Rice University then contributes the difference between 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</td>
<td>Claims paid by</td>
<td>Aetna Life Insurance Company (“Aetna”)</td>
<td>Combination unfunded/stop loss insured; Rice and employee contributions</td>
</tr>
<tr>
<td>• Prescription Drug</td>
<td>• Health</td>
<td>contract administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>Aetna and United Concordia</td>
<td>Fully insured; employees pay all premiums</td>
</tr>
<tr>
<td>• Health</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Flexible Spending Account Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>Wage Works</td>
<td>Unfunded; employees make all contributions</td>
</tr>
<tr>
<td>• Health</td>
<td></td>
<td>contract administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account Program</td>
<td>Fringe Benefit</td>
<td>Claims paid by</td>
<td>Wage Works</td>
<td>Unfunded; employees make all contributions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>contract administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>ReliaStar</td>
<td>Fully insured; Rice University pays premiums for basic coverage; employees pay premiums for optional coverage</td>
</tr>
<tr>
<td>• Life</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>CIGNA</td>
<td>Fully insured; employees pay all premiums</td>
</tr>
<tr>
<td>• Life/Health</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Travel Accident Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>Hartford Life Insurance</td>
<td>Fully insured; Rice University pays all premiums</td>
</tr>
<tr>
<td>• Life</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>Self-Administered</td>
<td>Unfunded; Rice University makes all contributions</td>
</tr>
<tr>
<td>• Disability</td>
<td></td>
<td>Rice University</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>Sun Life Insurance Company</td>
<td>Fully insured; employee chooses whether Rice University or employee pays premiums</td>
</tr>
<tr>
<td>• Disability</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care Insurance Program</td>
<td>Welfare Benefit</td>
<td>Claims paid by</td>
<td>UNUM</td>
<td>Fully insured; employees pay all premiums</td>
</tr>
<tr>
<td>• Health</td>
<td></td>
<td>insurer administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Welfare Benefit</td>
<td>Services provided by</td>
<td>Ceridian Corporation</td>
<td>Fully insured; Rice University pays all premiums</td>
</tr>
<tr>
<td></td>
<td>• Health</td>
<td>insurer administrator</td>
<td></td>
<td></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 information 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 13) 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 preexisting 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. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

(Footnotes)
1 All 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 Benefits

U.S. Savings Bonds

Arrangements may be made in Human Resources at the time of initial benefits enrollment or later with the payroll department for purchase of U.S. savings bonds through payroll deduction.

What is the minimum amount I can purchase?
Rice now offers two types of savings bonds: Series EE and I Bonds. EE Bonds are issued at 50% face value and mature to 100% of the face value within 17 years. The I Bonds are purchased at 100% of face value and earn interest that is calculated as an earning of a fixed rate of return and a semiannual inflation rate, but has no guaranteed level of earnings. When the accumulation reaches the purchase value selected by the employee, the university purchases the bond and has it sent to the employee.

What is the advantage of buying savings bonds?
The Education Savings Bond Program, which became effective in January 1990, should be of particular interest to parents of small children. For a household with an adjusted gross income of less than $60,000 per year, the interest earned from bonds purchased after December 31, 1989, and redeemed for the purpose of education is tax-free. The tax “break” occurs at the time that the bonds are redeemed. A copy of the tuition bill must be retained as evidence. There is a reduced tax benefit for households whose adjusted gross income is between $60,000 and $90,000 per year.
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 work at least 50% time and/or teach a certain number of courses and have an annual appointment. 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 on the web: www.professor.rice.edu/images/professor/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 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 are also available for courses offered through Continuing Studies or the Executive Development Program at the Jesse H. Jones Graduate School of Management.

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 “B” or better to receive reimbursement. This reimbursement (75% of the eligible amount paid, up to $1,000 per fiscal year) applies to tuition by accredited colleges and universities other than Rice University. 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 one year 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.

ID Card Benefits—With their ID card, employees may apply for membership at the Faculty Club, receive discounts at the Campus Store, and use all facilities on campus (gym, library, free computer classes, etc.).

Credit Union—Employees are eligible to be members in the First Educators Credit Union. For more information on the advantages of credit union membership, visit www.firstedcu.org.

Direct Deposit of Payroll Checks—Available to most employees, for most banking institutions and credit unions.
Equal Employment Opportunity and Affirmative Action

It is the policy of Rice University to attract qualified individuals of diverse backgrounds to its faculty, staff, and student body. Accordingly, Rice University does not discriminate against any individual on the basis of race, color, religion, sex, sexual orientation, national or ethnic origin, age, disability, or veteran status in its admissions, educational programs, or employment of faculty or staff. The university takes affirmative action in employment by recruiting, hiring, and advancing women, members of minority groups, Vietnam-era veterans, and special disabled veterans.