

2006 - 2007

Rice University

Student Health Insurance Plan Brochure

Offered by:

Chickering Benefit Planning Insurance Agency, Inc.

Administered by:

Chickering Claims Administrators, Inc.

Underwritten by:

Aetna Life Insurance Company (ALIC)

Policy No. 890436

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The Rice University Student Health Insurance Plan

Good health is essential to your academic success, and adequate insurance makes sure you get the care you need to maintain your good health. Consequently, Rice University requires all students to have health insurance. All full-time students are required to have health insurance either through the Rice University Student Health Insurance Plan or through another individual or family plan.

The Rice University Student Health Insurance Plan has been developed especially for Rice University students. The Plan provides coverage for illnesses and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. Rice University is pleased to offer the Plan as described in this Brochure.

Where To Find Help

Got Questions? Get Answers with Chickering's Aetna Navigator™

As a Chickering Student Health Insurance Plan member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging on to Aetna Navigator, you can:

- Review who is covered under your Plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your Plan.
- Send an e-mail to Chickering Customer Service at your convenience.
- View the latest health information, news and more!

How do I register?

- Go to www.chickering.com.
- Click on "Find Your School."
- Enter your school name or Policy Number (**890436**), and then click on "Search."
- Click on Aetna Navigator and then the "Access Navigator" link.
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

Need help with registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

For Questions About:

- Insurance Benefits
- Enrollment
- Claims Processing
- Pre-Certification Program

Please contact:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-7908

For Questions About ID Cards:

Permanent ID cards will be mailed to your local address approximately three weeks from the time Chickering receives the enrollment file from Rice University. If you need medical attention before the permanent ID card is received, benefits will be payable according to the Policy.

You do not need an ID card to be eligible to receive benefits. Once you've received your permanent ID card, present it to the provider to facilitate prompt payment of your claims.

Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

For lost ID cards, contact:

Chickering Claims Administrators, Inc.
(877) 375-7908 or visit www.chickering.com, click on "Find Your School" and enter **890436** as your Policy Number.

For Questions About:

- Enrollment Forms
- Waiver Process
- Dependent Enrollment

Please contact:

Chris Zalesky, Assistant Cashier for Technology
Rice University
Cashier's Office-MS 55
P.O. Box 1892
Houston, TX 77521-1892
(713) 348-4946

For Questions About:

- On-Campus Health Services

Please contact:

Rice University

Student Health Services

Morton L. Rich Health and Wellness

6100 Main St. MS#760

Houston, TX 77005

(713) 348-4966

For Information About:

- Provider Listings

A complete list of providers is available by using Aetna's DocFind® Service at:

www.chickering.com.

For Questions About:

- Worldwide Emergency Travel Assistance Services

Please contact:

Assist America, Inc.

(800) 873-1414 (within U.S.)

If outside the U.S., call collect **by dialing the U.S. access code plus (301) 656-4152**

E-mail address: ***medservices@assistamerica.com***

For Worldwide Web Access:

- The Chickering Group ***www.chickering.com***
- Rice University Health Services ***http://www.rice.edu/health/***
- Student Health Insurance at Rice ***www.studenthealthinsurance.rice.edu***

Rice University Student Health Insurance Plan
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This is a brief description of the Accident and Sickness Medical Expense benefit available for Rice University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy. See the Rice University Student Insurance Office for additional information. The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

Eligibility

Student

All registered, full-time, degree-seeking students, as verified by the Cashier, taking credit hours are required to have health insurance either through the Rice University Student Health Insurance Plan or through another individual or family plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

Dependents

Covered students may also enroll their lawful spouse/domestic partner and unmarried dependent children under age 25 who are fully supported by the covered student. A dependent child includes any grandchild, stepchild or legally adopted child, and/or a child for whom the covered student must provide medical support under a Court Order.

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the Rice University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Person for 31 days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium, if necessary, starting from the date of placement.

For further assistance and premium information, please contact Chickering Benefit Planning Insurance Agency, Inc. at **(877) 375-7908**.

Enrollment/Waiver Process

Students

All full-time students are required to maintain health insurance through the school, or provide proof of comparable coverage. To ensure compliance with this University policy, all students are required to either enroll in the Rice University Student Health Insurance Plan, or file a Waiver Form indicating that other coverage is in place.

Students electing to enroll in the Rice University Student Health Insurance Plan may opt to be billed annually or semi-annually. Only newly registered students may waive coverage in the Spring. Enrollment and Waiver elections must be made online at www.studenthealthinsurance.rice.edu, and must be submitted by **September 4, 2006 (January 16, 2007** for newly registered Spring students).

Students who do not complete an Enrollment or Waiver Form by **September 4, 2006** will be considered non-compliant with University policy, and will have their registration put on hold. If it is determined that the student is uninsured, and needs to be covered under the Plan, coverage will be effective the date after the Enrollment/Waiver Form is received.

Dependents

To enroll eligible dependent(s), a covered student must complete the Dependent Enrollment Form at www.studenthealthinsurance.rice.edu. Dependent Enrollment Forms will not be accepted after **September 4, 2006**, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The Spring enrollment deadline is **January 16, 2007**.

Please note: Previously Covered Persons must re-enroll for dependent coverage by **September 4, 2006**, for the Fall Semester and by **January 16, 2007**, for the Spring Semester in order to avoid a break in coverage.

Policy Period

1. Coverage for all insured students enrolled in the Rice University Student Health Insurance program will become effective at 12:01 a.m. on **August 15, 2006**, and will terminate at 12:01 a.m. on **August 15, 2007**.
2. **Fall Semester Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on **August 15, 2006**, and will terminate at 12:01 a.m. on **January 16, 2007**. (Please note that students expecting to graduate in December are encouraged to select the Fall Semi-Annual period to avoid paying the annual premium.)
3. **Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **January 16, 2007**, and will terminate at 12:01 a.m. on **August 15, 2007**.
4. **Insured Dependents:** Coverage will become effective on the same date the covered student's coverage becomes effective.
5. **Mid-Year Enrollment:** Students who had previously waived coverage may enroll themselves and their eligible dependents after the deadline date only if there has been a significant life change (i.e., loss of prior coverage). If the completed Enrollment Form is submitted within 30 days of the qualifying event, coverage will be backdated to the date of the qualifying event. If the completed Enrollment Form is submitted after the 30 days of the qualifying event, it will not be accepted, and the student and/or dependent(s) will have to wait until the next annual open enrollment period to enroll. Please note that the completed Enrollment Form and premium should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc. Premiums are not pro-rated other than below.

Premium Rates

	Annual 8/15/07-8/15/07	Fall Only 8/15/06-1/15/07	Spring/Summer 1/16/07-8/15/07
Student	\$2,150	\$ 896	\$1,254
Spouse/Domestic Partner	\$3,109	\$1,285	\$1,824
Each Child	\$2,288	\$ 944	\$1,344

Continuation Plan

	Fall 8/15/06-2/14/07	Spring Only 1/15/07-7/14/07
Student	\$2,193	\$2,193
Spouse/Domestic Partner	\$3,109	\$3,109
Each Child	\$2,288	\$2,288

Premium Refund Policy

Refunds will be made upon the entry of any insured person into the armed forces of any country.

A pro-rata refund will be returned to such person, and any covered dependents, upon request. Students who withdraw for non-medical reasons during the first 31 days after the date for which coverage is purchased are not eligible for the Student Health Insurance Plan. Students must notify the Cashier's Office of such withdrawal and the entire cost of the coverage will be refunded (including dependent's coverage). Such a student or dependent will not be entitled to any benefits and no claims will be honored.

No other refunds will be issued. (Please note that students expecting to graduate in December are encouraged to select the Fall Semi-Annual period to avoid paying the annual premium.)

Pre-Existing Conditions

Definition of a Pre-Existing Condition:

Any Injury, Sickness or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person's effective date of insurance.

Pre-Existing Conditions are not covered under the Plan until the individual takes no medication or is not treated for the condition for six months, or until he or she has been covered under the Plan for 12 months.

Special Rules As To Pre-Existing Conditions:

If a Covered Person had creditable coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) for coverage in the Policy (31 days if previously insured under the Rice University Student Health Insurance Plan), then any limitation as to a Pre-Existing Condition under this Policy will not apply for that person.

"Creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employee's Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Limitation:

Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered Covered Medical Expenses unless no charges are incurred or treatment rendered for the condition for a period of six months while covered under the Plan, or, the Covered Person has been covered under the Plan for 12 consecutive months, whichever happens first.

Continuously Insured:

Persons who have remained Continuously Insured under the Policy and other prior health insurance policies will be covered for any Pre-Existing Condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of the Policy. Previously Covered Persons must re-enroll for coverage by the indicated enrollment deadlines in order to avoid a break in coverage for conditions that existed in the prior Policy Year. Once a break in continuous coverage occurs for more than 63 days (31 days if previously insured under the Rice University Student Health Insurance Plan), the definition of Pre-Existing Conditions will apply.

Rice University Student Health Service

A Student Health Service referral is not required under this Plan. The Student Health Service does not charge for professional services (doctor's fees). Utilizing the Student Health Service usually means fewer out-of-pocket expenses for you. Students may obtain a well-woman exam and Pap smear through Student Health Services, or through a community provider which is payable under the Rice University Student Health Insurance Plan. For more information on services available at the Student Health Services please visit www.rice.edu/health.

Once enrolled in the Rice University Student Health Insurance Plan, the coverage is worldwide, available 24 hours a day year round. When you're in need of medical care and wish to reduce your out-of-pocket expenses, see a medical provider at the Rice University Student Health Service. Students seen in the Student Health Service will incur limited out-of-pocket expenses. Certain services which must be sent to outside providers (i.e., some lab services and Pap smears) will result in a minimal out-of-pocket expense. Please note that dependents are not eligible to use the Rice University Student Health Service.

For appointments and general information, call **(713) 348-4966**. The Student Health Service hours of operation are Monday through Friday 8:30 a.m.-5:00 p.m. The center is closed for lunch from 12:30-1:00 p.m. For summer and holiday hours, visit www.rice.edu/health.

Preferred Provider Network

The Rice University 2006-2007 Student Health Insurance Plan has a Preferred Provider network through Aetna. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Rice University, Chickering Claims Administrators, Inc., or Aetna.

A Preferred Provider will file all necessary claims on your behalf. However, you are responsible for the payment of the Copay, the balance above any Coinsurance amount, and any medical expenses not covered by the Plan.

A complete listing of participating providers is available by contacting Chickering Claims Administrators, Inc. at **(877) 375-7908**. Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing DocFind at: www.chickering.com.

Pre-Certification Program

You are required to obtain pre-authorization/pre-certification by calling **(877) 375-7908** or (TDD) **(800) 466-5996** before receiving the following services:

- **All Inpatient (Non-Emergency) Admissions:** The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.
- Notification of Emergency Admissions must be provided by the patient, patient's representative, Physician, or hospital, telephoning within two business days following admission. Please note that pre-authorization/pre-certification of inpatient and/or listed services/procedures does not constitute a promise of benefits.

Description of Benefits

To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

The payment of any applicable Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

A complete listing of Preferred Providers is available by contacting Chickering Claims Administrators, Inc. at **(877) 375-7908** or by accessing the Internet and Aetna's DocFind at: www.chickering.com.

Summary of Benefits Chart

The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on Reasonable Charges unless otherwise specified.

This Plan always pays benefits in accordance with any applicable Texas Insurance Law(s).

Benefit Summary	
Aggregate Maximum	\$100,000 per Accident and Sickness For Covered Medical Expenses: <i>Preferred Care:</i> 70% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge.
Deductible	\$250 in-network/\$750 out-of-network per insured person, per Policy Year.
Out-of-Pocket Maximum	\$3,000 per insured person Once the Individual or Family Out-of-Pocket Limit has been satisfied; Covered Medical Expenses will be payable at 100%, for the remainder of the Policy Year, up to any benefit maximum; that may apply.
Pre-Existing Conditions Coverage	Not covered except for those who have been continuously insured under the school's student insurance policy for at least 12 consecutive months. Credit will be given for those students covered under a credible policy, if the plan was continuous to a date no more than 63 days prior to the insured's effective date under this Policy. For students covered by a prior policy offered by the University, a break of coverage will not be considered if the plan was continuous to a date no more than 31 days prior to the insured's effective date under this Policy.
Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, use of special equipment, medicines and use of operating room.

Inpatient Hospitalization Benefits (continued)	
Physical and Occupational Therapy Expenses	Covered Medical Expenses when treatment is received within 30 days immediately prior to or following surgery are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Benefits are payable to a maximum of \$1,000 per Policy Year.
Physician Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Anesthetist Expenses	Covered Medical Expenses for the charges of an anesthetist during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Outpatient Benefits	
Physician's Office Visits Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 70% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 50% of the Reasonable Charge after a \$20 Deductible per visit.
Emergency Care (Copay waived if admitted)	Covered Medical Expenses for treatment of an Emergency Medical Expenses Condition are payable as follows: Preferred Care: 70% of the Negotiated Charge after a \$50 Copay per visit. Non-Preferred Care: 70% of the Reasonable Charge after a \$50 Deductible per visit.
Lab and X-ray Expenses (Non-Hospital)	Covered Medical Expenses are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.

Outpatient Benefits (continued)	
Durable Medical Equipment Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Physical and Occupational Therapy Expenses	Covered Medical Expenses when treatment is received within 30 days immediately prior to or following surgery are payable as follows: Preferred Care: 70% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Benefits are payable to a maximum of \$1,000 per Policy Year.
Mental Health and Substance Abuse Benefits	
Inpatient Expenses – Mental Health	Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness. Treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related mental health condition.
Outpatient Expenses – Mental Health	Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 70% of the Negotiated Charge to a maximum of \$50 per visit. Non-Preferred Care: 50% of the Reasonable Charge to a maximum of \$50 per visit. Outpatient treatment is payable up to a maximum of \$500 per Policy Year.
Inpatient Expenses – Substance Abuse	Covered Medical Expenses for the treatment of substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness. Inpatient: treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related substance abuse condition.
Outpatient Expenses – Substance Abuse	Covered Medical Expenses for the care or treatment of substance abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable as follows: Preferred Care: 70% of the Negotiated Charge to a maximum of \$50 per visit. Non-Preferred Care: 50% of the Reasonable Charge to a maximum of \$50 per visit. Outpatient treatment is payable up to a maximum of \$500 per Policy Year.

Maternity Benefits	
Maternity Expenses	Covered Medical Expenses for pregnancy, childbirth and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.
Additional Benefits	
Women's Health Benefit Expenses	<p>Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women age 40 and older have coverage for an annual mammogram per Policy Year. Covered Medical Expenses are payable on the same basis as any X-ray expense.</p> <p>Covered Medical Expenses include an annual Pap smear screening and all cervical cancer diagnostic tests for women age 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense. If follow-up diagnostic Pap smears are Medically Necessary, they will be covered on the same basis as any outpatient expense.</p>
Ambulance Expenses	<p>Covered Medical Expenses for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness are payable as follows:</p> <p>Preferred Care: 70% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p>
Prescription Drug Benefit Expenses	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident occurring during the Policy Year, are payable as follows following a \$100 Deductible per Policy Year:</p> <p>Preferred Care: 100% after a \$25 Copay for each Brand-Name Prescription Drug or a \$15 Copay for each Generic Prescription Drug.</p> <p>Non-Preferred Care: 100% of the Reasonable Charge after a \$25 Copay for each Brand-Name Prescription Drug or a \$15 Copay for each Generic Prescription Drug.</p> <p>Covered Expenses are payable up to a maximum of \$1,500 per Policy Year.</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p> <p>Covered medications include oral contraceptives, Lunelle, Depo-Provera, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered Prescription contraceptive are provided under the Medical portion of the Plan.</p> <p>Prior authorization is required for growth hormones, drugs which are for treatment of malaria, and more than a 30-day supply per Prescription or refill.</p>

Additional Benefits (continued)		
Prescription Drug Benefit Expenses <i>(continued)</i>	For assistance, or for information on excluded medications and drugs available with prior authorization, please contact (800) 238-6279 . Please use your Chickering ID card when obtaining your Prescriptions.	
Dental Expenses	Covered Medical Expenses per Accident for the treatment of an Injury to sound, natural teeth are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge. Benefits are payable to a maximum of \$100 per tooth.	
Consultant Physician Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge.	
Home Health Care Expenses	Covered Medical Expenses incurred within 12 months from the date of the first home health care visit are payable as follows: <i>Preferred Care:</i> 70% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge. The maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.	
Optional Dental Program		
All students have the option of purchasing an optional dental program offered through Aetna. The Aetna Advantage™ Dental Plan is a fully insured Dental Maintenance Organization. Visit the Student Connection at www.chickering.com (be sure to enter 890436 as the Policy Number) for more information, and to enroll online.		
Insurance Plan – Aetna Advantage™ Dental Plan	The emphasis of this plan is on preventive care. This plan offers coverage for most routine preventative and diagnostic services, as well as basic restorative care – all this for an office visit Copay. Also, many other services are available at a reduced fee.	
		Annual 9/1/06-8/31/07
		Spring 1/1/07-8/31/07
	Student	\$141.89
	Student plus one dependent	\$279.09
Student plus two or more dependents	\$531.36	\$354.24

Additional Services and Discounts

As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts, and programs. These services, discounts, and programs are not underwritten by Aetna.

Discount Program – Vital Savings by Aetna SM	Vital Savings by Aetna SM offers students and their families a way to get significant discounts on a wide array of dental services – even without insurance and with no maximum benefit! It puts important dental care within affordable reach, along with access to one of the largest dental discount networks, Aetna’s Dental Access Network. With Vital Savings, administration is easy, it avoids paperwork and once students receive their ID cards, they’re empowered for on-the-spot savings.
Vision One [®] Discount Program	The Vision One [®] Discount Program helps you save on many eye care Discount Program products, including eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions, and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call (800) 793-8616 for additional Program information and provider locations, or simply log on to www.chickering.com to find a Vision One Center provider near you.
Informed Health [®] Line	<p>Aetna’s Informed Health[®] Line gives you easy access to credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from any touch-tone phone or computer within the United States (including Alaska and Hawaii).</p> <p>1. 24-Hour Nurse Line</p> <p>Call our toll-free number to access registered nurses who are experienced in providing information on a variety of health topics.* The nurses can help you:</p> <ul style="list-style-type: none"> • Learn about medical procedures and possible treatment options. • Improve the way you communicate with your health care providers. Find out how to describe health symptoms more effectively, ask the right questions and provide a clear history of your eating, exercise and lifestyle habits. <p>To reach an Informed Health[®] Line Nurse, please call (800) 556-1555. For TDD (hearing and speech impaired only), please call (800) 270-2386.</p>

Additional Services and Discounts (continued)

Informed Health® Line
(continued)

2. Audio Health Library

The Informed Health® Line audio health library contains information on thousands of health topics such as common conditions and diseases, gender- and age-specific health issues, dental care, mental health and substance abuse, weight loss and much more.

To access the audio health library system, call the Informed Health Line toll-free number and simply enter the topic codes you're interested in. And if you have questions, you can transfer easily to an Informed Health Line nurse at any time.

To access the Informed Health Line audio health library, please call **(800) 556-1555**.

For TDD (hearing and speech impaired only), please call **(800) 270-2386**.

3. Healthwise® Knowledgebase

If you prefer to view health information online, simply log on to your Aetna Navigator account and click on "Take Action On Your Health" which will link you to the Healthwise® Knowledgebase, one of the most advanced health databases available. The Healthwise Knowledgebase contains detailed information about health conditions, medical tests and procedures, medications and treatment options. It also features illustrations and decision-focused tools to help you make more informed health care decisions.

**Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your Physician with any questions or concerns regarding your health care needs. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health plan.*

General Provisions

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable Texas Insurance Law(s).

Subrogation/Reimbursement/Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that Injury or illness up to and including the full amount the Covered Person receives, from all potentially responsible parties. A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's Injuries or illness or any insurance coverage responsible for making such payment, including but not limited to:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers compensation coverage;
- No-fault automobile insurance coverage; or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights.

The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to Injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue

the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Effect of Other Plan Coverage

This provision applies if a covered student:

- a) Is covered by any other group or blanket health care plan; and
- b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred. In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

Definitions

Accident: An occurrence, which (a) is unforeseen, (b) is not due to or contributed to by Sickness or disease of any kind, and (c) causes Injury.

Actual Charge: The Actual Charge made for a covered service by the provider that furnishes it.

Aggregate Maximum: The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person that accumulate from one year to the next.

Brand-Name Prescription Drug or Medicine: A Prescription Drug, which is protected by trademark registration.

Coinsurance: The percentage of Covered Medical Expenses payable by Aetna under the Student Health Insurance Plan.

Covered Medical Expenses: Those charges for any treatment, service, or supplies covered by the Policy which are: (a) not in excess of the Reasonable Charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

Covered Person: A covered student, or dependent, whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Deductible: A specific amount of Covered Medical Expenses that must be incurred and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Elective Treatment: Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction (unless otherwise provided in the Policy); immunization (unless otherwise provided in the Policy); vaccines; and routine physical examinations.

Emergency Medical Condition: This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus. It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

Generic Prescription Drug or Medicine: A Prescription Drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

Injury: Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

Medically Necessary: A service or supply that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

- Be care or treatment which is likely to produce a significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information relating to the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any health care provider or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office, or other less costly setting.

Negotiated Charge: The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna: (a) the service or supply could have been provided by a Preferred Care Provider; and (b) the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Non-Preferred Care Provider (or Non-Preferred Provider): A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Out-of-Pocket Limit: The amount that must be paid, by the covered student, or the covered student and their covered dependents, before Covered Medical Expenses will be payable at 100%, for the remainder of the Policy Year.

The following expenses do not apply toward meeting the Out-of-Pocket Limit:

- Deductibles;
- Copays;
- Expenses that are not Covered Medical Expenses;
- Penalties;
- Expenses for Prescription Drugs; and
- Other expenses not covered by this Policy.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

Physician: A legally qualified Physician licensed by the state in which they practice, and any other practitioner who must, by law, be recognized as a doctor legally qualified to render treatment.

Pre-Existing Condition: Any Injury, Sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person's effective date of insurance.

Pre-Existing Conditions are not covered under the Plan until the individual takes no medication or is not treated for the condition for six months, or until he or she has been covered under the Plan for 12 months.

If a Covered Person has continuous coverage under the Rice University Student Health Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

Preferred Care: Care provided by a Preferred Care Provider, or any health care provider for an emergency condition when travel to a Preferred Care Provider is not feasible.

Preferred Care Provider (or Preferred Provider): A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

Prescription: An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Reasonable Charge: Only that part of a charge which is reasonable is covered. The Reasonable Charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth as provided elsewhere in the Policy.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, infirmary, or hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.

4. Expenses incurred as a result of Injury due to participation in a riot.
5. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person's entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
10. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
 - (a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
 - (b) Repair an Injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident, which causes the Injury, or in the next Policy Year.
11. Expenses for Injuries sustained as a result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
12. Expenses incurred as a result of allergy shots and injections, preventive medicines, serums, vaccines or oral contraceptives unless otherwise provided in the Policy.
13. Expense incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna.

14. Expenses incurred for any services rendered by a family member of a Covered Person's immediate family or a person who lives in the Covered Person's home.
15. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.
16. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces or orthotic devices.
17. Expenses incurred for custodial care.
18. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
19. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities are not excluded).
20. Expenses covered by any other valid and collectible medical, health or Accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
21. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first-party medical benefits payable under any other mandatory no-fault law.
22. Expenses for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in vitro fertilization or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless otherwise provided in the Policy.
23. Expenses incurred as a result of commission of a felony.
24. Expenses incurred for voluntary or elective abortions unless otherwise provided in the Policy.
25. Expenses incurred for which no member of the Covered Person's immediate family has any legal obligation to pay.
26. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational.
27. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

28. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.
29. Expenses incurred for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services or supplies is specifically provided in the Policy.
30. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
31. Expenses incurred for breast reduction/mammoplasty.
32. Expenses incurred for gynecomastia (male breasts).
33. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
34. Expense for charges that are not reasonable charges, as determined by Aetna.
35. Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.
36. Expenses for Pre-Existing Conditions.

Any exclusion above will not apply to the extent that coverage is required under any law that applies to the coverage.

Extension of Benefits

If a Covered Person is confined to a hospital on the date their insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are incurred during the 90-day period following such termination of insurance.

Termination of Insurance

Benefits are payable under the Policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Continuation Privilege

Once a student's eligibility through the Rice University Student Health Insurance Plan expires, a student may be eligible to continue coverage in the Plan for a maximum of six months, or until **August 14, 2007**, whichever occurs first. To continue coverage, you must enroll and make the first premium payment within 31 days after the termination of eligibility under the active Student Health Insurance Plan. You must have been insured under the active Student Health Insurance Plan for at least three months prior to termination of your coverage in order to be eligible for the Continuation Plan. Information on the Continuation Plan is available by contacting Chickering Claims Administrators, Inc. at **(877) 375-7908**.

Claim Procedure

In the event of an Accident or Sickness, you should report to a qualified provider or hospital to secure treatment. As described in the Preferred Provider section of the Brochure, it is to your advantage to utilize Preferred Providers because of the savings for services and reduced out-of-pocket expenses.

Most providers of service will file a claim for you. In the event your provider of service does not file a claim on your behalf, it is your responsibility to initiate a claim in order to obtain reimbursement. Please send all itemized medical bills as soon as possible after treatment is rendered to Chickering Claims Administrators, Inc. Your name, Social Security Number, ID Number, and University name should be written clearly and attached to your medical bills. All information should be mailed to:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-7908
(617) 218-8400 (for calls from outside the U.S.)

Subsequent itemized medical bills should also be mailed promptly to the above address. Payment for Covered Medical Expenses will be made directly to the hospital or Physician unless you submit paid receipts attached to the itemized bills.

For assistance in filing a claim or to inquire about the status of a claim, please contact the Customer Service Department at Chickering Claims Administrators, Inc. directly at **(877) 375-7908** or **(617) 218-8400** (outside the U.S.) between the hours of 8:30 a.m. and 5:30 p.m. (ET), Monday through Friday.

General coverage questions and claims questions should also be directed to the Customer Service Department at Chickering Claims Administrators, Inc. You will receive an "Explanation of Benefits" form after your claim is processed. The Explanation of Benefits will explain how your claim was processed according to the benefits of your Student Health Insurance Plan. If you have any questions regarding the Explanation of Benefits, please contact the Customer Service Department at Chickering Claims Administrators, Inc.

Appeals and Complaints Procedure

Our complaints and appeals process is designed to address member coverage issues, complaints and problems. If you have a coverage issue or other problem, call the Customer Service toll-free number on your ID card or review your Plan documents for more information.

You can also contact Customer Services at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan.

You may also submit your request in writing, along with all pertinent correspondence, to:

Chickering Claims Administrators, Inc.
P.O. Box 15717
Boston, MA 02215-0014

You may also seek additional information on the web page for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of member concerns. The applicable Internet address for the State Insurance Department for your plan is: www.tdi.state.tx.us/

External Review

Aetna has developed an external review process to give members an added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, eligible members may elect external review if the coverage denial for which the member would be financially responsible involves more than \$500 and is based on lack of Medical Necessity or on the experimental or investigational nature of the proposed service or treatment.

An external review organization will refer the case to review by a neutral, independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review generally will be decided within 30 days of the request. Expedited reviews are available when a member's Physician certifies that a delay in service would jeopardize the Covered Person's health. Once the review is complete, the Plan will abide by the decision of the external reviewer.

Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for Medical Necessity and experimental/investigational coverage decisions. For further details regarding your Plan's grievance and external review process, call the Customer Services toll-free number on your ID card, or visit Aetna's website at www.aetna.com, where you may obtain an external review request form. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.

Accidental Death and Dismemberment Benefit

This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by Unum Provident Life Insurance Company of America.

Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of \$10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech, or hearing, please refer to your Master Policy available at your school.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at **(877) 375-7908** for the appropriate claim forms.

Worldwide Emergency Travel Assistance Services

These services are provided by Assist America, Inc. and designed to protect Rice University students and/or eligible dependents when traveling more than 100 miles from home anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the participant's campus location.

If you experience a medical emergency while traveling more than 100 miles from home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible participants have immediate access to doctors, hospitals, Pharmacies, and other services when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; prescription assistance; lost luggage assistance; legal and interpreter assistance; and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container, as well as, paying for transport. **Please note:** Any third party expenses incurred are the responsibility of the Participant.

An Assist America ID card will be supplied to you once you enroll in The Rice University Student Health Insurance Plan. Please remember to carry your Assist America card and call toll free within the U.S. at **(800) 872-1414** or outside the U.S. call collect **(dial U.S. access code) plus (301) 656-4152** in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

NOTE: Assist America pays for all Assistance Services it provides. All Assistance Services must be arranged and provided by Assist America. Assist America does not reimburse for services not provided by Assist America.

The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by Assist America, Inc.

Important Note

Please retain a copy of this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

The Plan is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. Please feel free to contact Chickering with any questions about coverage or the Policy.

This student plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

Offered by:



Chickering Benefit Planning Insurance Agency, Inc.
1 Charles Park
Cambridge, MA 02142

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-7908
www.chickering.com

Underwritten by:



Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. 890436

The Chickering Group is an internal business unit of Aetna Life Insurance Company

Notice of Mandatory Benefits

This notice is to advise you of certain coverage/benefits provided by your contract with Chickering Claims Administrators, Inc.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by the Plan has either a mastectomy or a lymph node dissection, the Plan will provide coverage for inpatient care for a minimum of:

- (a) 48 hours following a mastectomy; and
- (b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew the Plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered by the Plan has questions concerning the above, please call Chickering Claims Administrators, Inc. at **(877) 375-7908**, or write us at P.O. Box 15708, Boston, MA 02215-0014.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer.

Benefits include:

- (a) a physical examination for the detection of prostate cancer; and
- (b) a prostate-specific antigen test for each covered male who is:
 - (1) at least 50 years of age; or
 - (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by the Plan has questions concerning the above, please call Chickering Claims Administrators, Inc. at **(877) 375-7908**, or write us at P.O. Box 15708, Boston, MA 02215-0014.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery; and
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance, and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse, or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office, or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any Covered Person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a Physician for recommending inpatient care for the mother or the newborn child.

If any person covered by the Plan has questions concerning the above, please call Chickering Claims Administrators, Inc. at (877) 375-7908, or write us at P.O. Box 15708, Boston, MA 02215-0014.

Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including: a) All stages of the reconstruction of the breast on which the mastectomy has been performed; b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and c) Prosthesis and treatment of physical complications, including lymphedemas, at all stages of mastectomy. The coverages and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending Physician.

Benefits will be payable on the same basis as any other expense.

Prohibition: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the Plan or fail to renew this Plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a Covered Person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by the Plan has questions concerning the above, please call Chickering Claims Administrators, Inc. at (877) 375-7908, or write us at P.O. Box 15708, Boston, MA 02215-0014.

Colon Cancer Screening

Covered Medical Expenses include tests for any non-symptomatic person, age 50 or more, for the following:

- One fecal blood test every 12 months;
- A sigmoidoscopy at age 50 and one every three years thereafter;
- One digital rectal exam every 12 months;
- A double barium enema once every five years; and
- A colonoscopy once every 10 years.

Benefits will be payable on the same basis as any other expense.

Telemedicine/Telehealth Services

Benefits will be paid for services provided through telemedicine and telehealth on the same basis as services provided through a face-to-face consultation. Telemedicine means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine.

“Telehealth” means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

Compressed digital interactive video, audio, or data transmission, clinical data transmission using computer imaging by way of still-image capture and store and forward, and other technology that facilitates access to health care services or medical specialty expertise.

Benefits shall be subject to all Deductible, Copay, Coinsurance limitations or any other provisions of the Policy.

If any person covered by the Plan has questions concerning the above, please call Chickering Claims Administrators, Inc. at **(877) 375-7908**, or write us at P.O. Box 15708, Boston, MA 02215-0014.

Notice

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, Pharmacies, hospitals and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's Student Connection Link on the Internet at: www.chickering.com.

