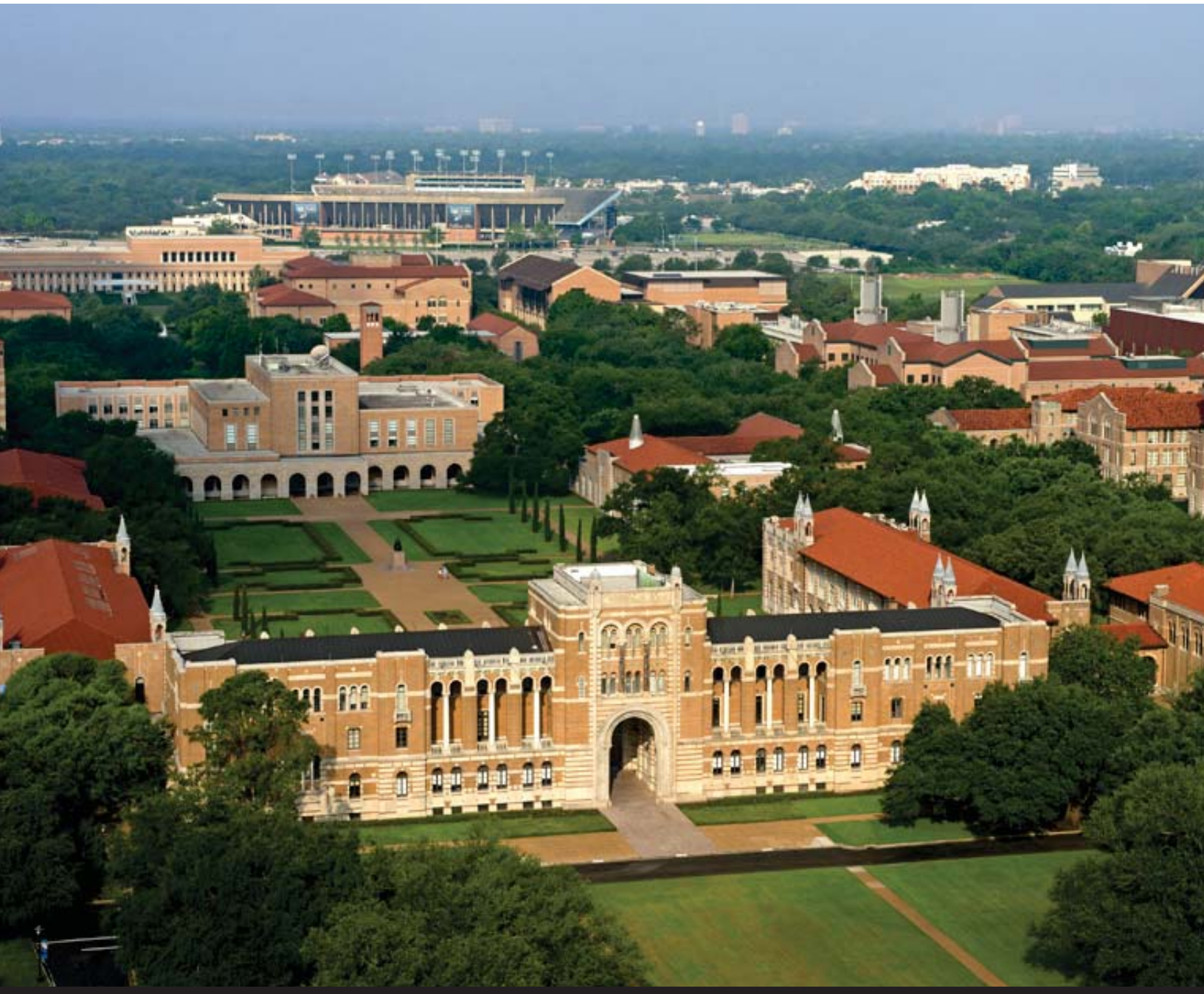
Choose the Right Plan for You

Human Resources | Benefits 2018–19



RICE

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Benefits Overview

Affordable Care Act Medical Insurance Plan Eligibility

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

If you become benefits eligible as defined by University Policy 403, you will have 30 days from the effective date of the change in eligibility to enroll in Rice's other employer-sponsored benefit plans.

Faculty and Staff Benefits Eligibility

Benefits-eligible faculty and staff members may participate in all available health and welfare benefit plans (medical and dental insurance, life insurance, etc.) as well as retirement plans. Those who are not considered benefits eligible may still participate in some benefit plans, such as the voluntary 403(b) Retirement Plan. Each benefit program may have its own eligibility requirements.

Staff

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

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

Faculty

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

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

In any event, the Retirement Plan Document (available on the HR website at http://people.rice.edu) governs eligibility for participation in the Retirement Plan. See Page 29 for more information about retirement benefits.

Eligible Dependents

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

Eligible dependents include:

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

Dependent children may continue under the benefits plan until age 26, regardless of their status as a student. As your children approach the age limit, please call the Benefits Service Center to discuss your situation.

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

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

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

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

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

What is imputed income?

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

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

Enrollment Deadlines

Rice University has strict enrollment deadlines, which are detailed in the following chart:

Event	Time Frame to Enroll
New hire	No more than 30 days from your hire date
Newly eligible	No more than 30 days from your eligibility date
Change in status	No more than 30 days from date of qualifying event
Medicaid or CHIP enrollment	No more than 60 days from date of enrollment or disenrollment
Annual enrollment	April 9–27, 2018

For new hires and most qualifying changes in status, coverage is effective on the first day of the month coincident with or following the enrollment date. You have 30 days from your date of hire to complete enrollment. For new hires, coverage is effective the first of the month following the hire date. If you are hired on the first, your coverage starts on your hire date. For life events, coverage is effective the first of the month following the change except for birth changes, which are effective on the date of birth. If you miss your 30-day window, you must wait for the next annual enrollment period. Changes in coverage made during annual enrollment are effective July 1.

Change in Status

Salary reduction amounts for Rice's insurance programs cannot be changed outside of an annual enrollment period except in the case of a qualifying change in status. Certain changes in family status or changes in a dependent's or spouse's employment may 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 within 30 days of the event. For example, if the birth of a child is the qualifying event, a consistent change would be to add your child to your medical coverage. Remember that you only have 30 days from the date of the event to make the change in your benefits coverage.

The following are examples of qualifying changes in status:

- Marriage or divorce
- Death of a spouse, partner or dependent child
- Birth or adoption of a child
- Spouse's losing or gaining eligibility for coverage due to change in employment
- Change of employment status from full time to part time or vice versa
- Taking an unpaid leave or family and medical leave
- Returning to work after an unpaid leave of absence or family and medical leave
- Annual enrollment of spouse's plan at a different time of year than Rice's annual enrollment
- Loss of other coverage, including COBRA

Also, the law may allow a change of plan options upon a special enrollment event (for example, changing from HMO to POS upon the birth of a child).

Retiring From Rice University

When considering your retirement, please contact HR to discuss your options. We also recommend you meet with a representative from TIAA and/or Fidelity Investments to discuss your investment choices and distribution options. See Page 29 for more information about retirement benefits.

Rice defines a retiree as an employee with at least 10 years of continuous benefits-eligible employment at the university when age plus years of service equals at least 65. More on the definition of a university retiree, plus the advantages of retiring from Rice, can be found in University Policy 422 (see http://bit.ly/policy422).

Rice currently allows qualifying employees to continue their current medical and dental benefits after leaving Rice as retirees. You must complete the appropriate HR form to enroll in retirement benefits. You have 30 days from your retirement date to complete these forms. You cannot elect new coverage as a retiree but may change your current plan elections (i.e., from one medical or dental plan to another) at the time of retirement or during the annual retiree open enrollment in May. The retiree is required to pay 100 percent of the cost of coverage for the benefit (not just the employee portion), and if the retiree and dependents are age 65 or older, they must enroll in Medicare parts A and B upon retirement.

If you decide not to elect Rice retiree benefits, you are not allowed to enter the plans at a later date. For more information regarding the cost of coverage, see the separate benefits rate sheet located at http://benefits.rice.edu. Retirees also have the option to convert to an individual life insurance, accidental death and dismemberment and/or long-term care insurance policy. Contact HR for more information regarding retiree benefits.

For more information on planning for your retirement, please visit http://people.rice.edu.

There are important deadlines and rules around selecting Medicare supplements, and timing is important. We recommend that you thoroughly investigate all coverage options before retiring to ensure you obtain the coverage that will best meet your needs.

Medical Coverage

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

	What You Pay (monthly)	What Rice Pays (monthly)	Total (monthly)
• **Aetna Memorial Hermann ACO**			
Employee only	$83	$477	$560
Employee plus spouse/partner	$318	$885	$1,203
Employee plus child(ren)	$277	$782	$1,059
Employee plus family	$541	$1,196	$1,737
• **Aetna Select HMO**			
Employee only	$101	$544	$645
Employee plus spouse/partner	$377	$1,011	$1,388
Employee plus child(ren)	$329	$891	$1,220
Employee plus family	$642	$1,360	$2,002
• **Aetna Consumer-Driven Health Plan (CDHP)**			
Employee only	$128	$882	$1,010
Employee plus spouse/partner	$388	$1,602	$1,990
Employee plus child(ren)	$375	$1,552	$1,927
Employee plus family	$665	$2,263	$2,928
• **Aetna POS II**			
Employee only	$172	$684	$856
Employee plus spouse/partner	$611	$1,253	$1,864
Employee plus child(ren)	$537	$1,106	$1,643
Employee plus family	$1,035	$1,654	$2,689

Employees paid over 12 months will have 24 deductions each year. Deductions will be taken from the first and second paycheck of the month, creating a deduction "holiday" for nonexempt (hourly) employees who receive 26 paychecks a year. The rates above are based on 12 months of pay. Should you receive pay over nine months, your monthly deductions will be higher to accommodate the fewer deductions, but your coverage will be intact in the summer months (or through June 30 if leaving Rice at the end of the academic year).

What is an ACO?

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

What is an HMO?

Our health maintenance organization (HMO) is our plan option that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific plan providers and require the election of a PCP to direct all care. This physician serves as a "gatekeeper" to all medical services, meaning that you need to consult with your Aetna PCP prior to receiving services from most Aetna specialist physicians or other providers.

What is a CDHP?

A consumer-driven health plan (CDHP) is a plan with a deductible that meets certain government-required criteria and is allowed to have a health saving account. Rice's CDHP uses a preferred provider organization (PPO) network. Employees are encouraged to use in-network providers since costs are less, but are able to use out-of-network providers for a lower level of coverage. Health care providers in the network serve plan members for negotiated fees after meeting the plan deductible. Members of the CDHP accept responsibility for paying the upfront deductible for medical services and prescriptions before coinsurance/copayments begin and for filing claims within six months of the date of service, or the claims may not be paid. The CDHP (a qualified high-deductible health plan, or HDHP) also allows you to elect a health sav-

ings account (HSA). An HSA is similar to a flexible medical savings account, but does not have the "use it or lose it" provisions and it allows for more pretax contributions. See the Health Savings Account section on Page 28 or http://benefits.rice.edu for more information.

What is the POS?

The point of service (POS) plan is similiar to a PPO. The plan has a deductible, but many services are provided for a copay only. The POS allows you to seek care outside the network at a lower level of coverage and you can see an in-network specialist without a PCP referral.

What is the "out-of-network" part of the POS and CDHP plans?

When you see a provider who is not part of the corresponding Aetna network, you are generally charged a greater portion of the cost of care and are subject to separate, higher deductibles. You will also be subject to "reasonable and customary" limits. You may be responsible for any amount the provider charges above the limit (as determined by Aetna). This cost is in addition to the percentage of coinsurance you may owe in the plan. The plan is not responsible for paying any claim for which you do not pay your patient responsibility. If the provider waives your out-of-pocket costs for a claim, the claim is not covered by the plan and will not be paid.

How do I contact Aetna to find out more about the provider networks?

All of Rice's medical plans are administered by Aetna. Aetna's Member Services for Rice is a concierge level of service. The Aetna Concierge team can be reached at 1-800-905-7670. This phone number is also located on your ID card and can be found online at http://benefits.rice.edu.

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

You also can log on to Aetna Navigator (www.aetna.com) to:

- Locate a doctor or dentist
- Designate a primary care physician (if in the ACO, HMO or POS)
- Check claim status and review your claims history
- Request ID cards and print temporary medical and dental ID cards
- Contact Aetna Concierge at 1-800-905-7670

Aetna's app gives you access to your secure member information, anytime, anywhere. Use it to:

- Search for a doctor, dentist/or facility
- Use the Urgent Care Finder to find urgent care centers and walk-in clinics
- Log in to your secure member site, where you can:
  - View claims
  - View coverage and benefits
  - View your personal health record
  - View your ID card information
  - Contact Aetna by phone or email
  - Use the Member Payment Estimator to compare cost estimates
  - Look up symptoms on iTriage
  - View and reply to secure messages
  - Enroll in an online health coaching program

The free Aetna app can be downloaded from Google Play (for Android users) or the App Store (for Apple users). Or, simply text "apps" to 23862 (message and data rates may apply).

When using Aetna's website or talking with your doctor's office, please use the following Aetna plan names:

- Aetna Memorial Hermann ACO = Aetna Whole Health Plans, Aetna Whole Health — Memorial Hermann Accountable Care Network
- Aetna HMO = Aetna Standard Plans, Aetna Select
- Aetna CDHP = Aetna Open Access Plans, Aetna Choice POS II (Open Access)
- Aetna POS II = Aetna Open Access Plans, Aetna Choice POS II (Open Access)

For all of the medical plans, should you travel outside the United States, your network coverage is limited to non-network, if available, and/or emergency care only. To obtain a letter outlining specifics about how your plan will cover you outside of the country, call the Aetna Concierge team.

What if I am enrolled in the ACO or HMO plan and my dependents do not have access to an Aetna network where they live or go to school?
The ACO network is limited to the Houston area, whereas the HMO uses a national network of providers. Employees who have dependents who live away from home and are in the ACO or without an Aetna HMO network provider in the area may have the option to enroll the dependent in the out-of-area dependent PPO plan. This would apply to an employee's dependents who live outside the ACO or HMO service areas. Examples of eligible out-of-area dependent enrollment include a dependent away at school, a dependent living with a custodial parent or a dependent spouse who has a "commuting" arrangement. The out-of-area dependent plan is provided at no additional cost — employees still pay the same premium for the ACO or HMO plan. Once a dependent enrolls in the out-of-area plan, we do not change that election until the dependent's situation changes. For example, if a dependent returns home from school for the summer or holiday, they cannot switch to the ACO and then switch back to the out-of-area plan when they return to school. However, if a dependent is on the out-of-area plan because they live with a parent in a remote area, we would allow them to change that plan if they come to live with the other parent on a long-term basis in Houston. Enrollment in this plan must be completed with a member of the benefits team.

Do I have to participate in a Rice medical plan?
No. Participation in a medical plan is voluntary, and Rice does not require proof of other coverage before you decline coverage in Rice medical plans. However, it is your responsibility to modify your enrollment or add dependents before the end of your 30-day limit. Be sure to contact the benefits team at 713-348-2363 or benefits@rice.edu for assistance.

Pharmacy Benefit Program for All Medical Plans

Your prescription drug benefits are administered by Express Scripts Inc. (ESI). Headquartered in St. Louis, ESI provides pharmacy benefit management services for more than 78 million Americans. Additional information about ESI and your prescription benefits can be found by registering at www.express-scripts.com. Information that your pharmacist will need to process your claims can be found on the back of your Aetna ID card. New hires will receive a card in the mail within a couple of weeks of their effective date.

The following information is an overview of the Rice University prescription drug benefits being administered by ESI.

Your prescription drug benefits feature a formulary drug list, which is a list of medications organized into groups or tiers. It also lists drugs that are not covered by the plan, along with alternatives to those noncovered drugs.

Formulary tier definitions

Tier 1: Most generics

Tier 2: Preferred (or formulary) medications are on the preferred medication list and cost less than nonpreferred medications. This list of medications is determined based on the advice of pharmacists and a group of independent doctors.

Tier 3: Nonpreferred (or nonformulary) medications are not on the preferred list of medications and may cost more.

Tier 4: Specialty medications

Please visit www.express-scripts.com and register in the member portal for more information on the formulary and other plan provisions. Accessing the portal or mobile app will allow you to:

- Price out medications under each plan
- Locate pharmacies
- Review plan design
- Review coverage details on medications
- Review the formulary
- Track your prescriptions and home delivery refills
- Refill and renew many prescriptions automatically with Worry-Free Fills®
- View claims, balances and prescription history

- Receive online alerts if there is a prescription-related safety issue
- Search information about any drug on the market
- Find lower-cost options
- Make payments or set up a payment plan

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

30-Day Retail				90-Day Mail Order		
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**
generic	formulary brand	nonformulary brand	specialty	generic	formulary brand	nonformulary brand
$10 copay	$40 copay	$60 copay	25% up to $150	$25 copay	$100 copay	$150 copay

Note: The CDHP option covers prescription drugs at the copay levels after you meet the plan deductible.

Dispense as written

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

Maintenance medications

You may fill up to two 30-day maintenance medication prescriptions at a retail pharmacy. Thereafter, you must fill maintenance medications for 90 days at a retail pharmacy or use the mail order program through Express Scripts.

Retail services

The ESI network includes more than 65,000 retail locations representing all major chains (such as Costco, CVS, Rite Aid, Sam's Club, Stop & Shop, Target, Walgreens and Walmart) as well as many independent pharmacies throughout the United States. Simply present your Aetna ID and your prescription to a participating pharmacy (the ESI information is on the back of your ID card) to receive your pharmacy benefit.

At the time of service, you must pay the required copay, deductible or coinsurance. To locate a participating retail pharmacy, visit www.express-scripts.com or download the Express Scripts mobile app and select "locate a pharmacy." For additional assistance, you may call the ESI member services at 1-800-363-9019.

Mail order services

Mail order services are provided through Express Scripts' own mail order pharmacy. Mail order is an excellent way to receive prescriptions you will be taking long term with no worries about supply availability at your local pharmacy. In addition, mail order saves you money, as you receive a 90-day supply for the price of a 75-day supply. Mail order also saves Rice money because prescriptions filled via mail order are less expensive than those purchased at retail pharmacies. Since our plan is self-funded, this saves us all money in the long run.

Getting started with home delivery

- First, speak with your doctor about getting a 90-day supply of your medication. Ask for a 30-day supply to be filled at a local pharmacy and a second script for a 90-day supply to be sent to Express Scripts. Then, either:
    - Mail the hard copy of the prescription with the mail order form. This can be done for existing renewals or new prescriptions.
    - Ask the doctor to call, fax or e-scribe the 90-day prescription to Express Scripts' pharmacy. To fax, your doctor may need to call 1-888-327-9791 for instructions to set up a secure fax. (Typically, doctors' offices are familiar with the Express Scripts setup.) Also use this number to call in a prescription.
    - Register on www.express-scripts.com and follow the steps to "transfer to home delivery." Please notify your doctor that you are requesting a 90-day supply. Note: This is for existing prescriptions filled at a retail pharmacy.
    - Call member services at 1-800-363-9019 to speak to a representative and request to transfer an existing prescription from retail pharmacy to home delivery. Note: This is for existing prescriptions filled at a retail pharmacy.
- Specialty medications will be filled and shipped through Accredo, Express Scripts' specialty pharmacy. Follow the same process as outlined above for specialty medications.
- Refills can be managed via phone, online or mobile app.

Specialty services

Accredo is the exclusive provider for your specialty medications as part of your prescription drug plan. This means that you and those covered under your benefits will receive the personalized care and expertise of Accredo's pharmacists.

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

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

As a convenience, you may choose to receive your first specialty prescription through the mail or pick it up at any network retail location. After the first fill, you will be required to use Accredo for all of your specialty medication needs.

Accredo Specialty Pharmacy can be reached at the same customer service number you use for your other pharmacy needs: 1-800-363-9019.

Identification cards

All ESI information can be found on the back of your Aetna ID card. Please show your card to the network pharmacy to receive your covered benefits. Should you misplace your ID card and need your covered prescriptions immediately, please present the following information to your pharmacy:

BIN: 003858
PCN: A4
Rx Group Number: RICEUNI

You will also need the information on the front of your Aetna ID card, which can be printed from www.aetna.com after you register and log in. Your pharmacy may call the ESI help desk for assistance as well. Please contact Aetna Concierge Customer Service at 1-800-905-7670 for a new ID card.

Employee Assistance Program (EAP)

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

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

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

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

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

Get in touch with UTEAP today at www.mylifevalues.com (company name/user ID: owls; password: owls), or call 1-713-500-3327 or 1-800-346-3549.

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

Summary of Medical Plan Options

Benefit Category	Aetna Memorial Hermann ACO	Aetna Select HMO	CDHP Network	CDHP Non-Network•	Aetna POS II Network	Aetna POS II Non-Network•
General Plan Provisions						
Deductible						
Individual	None	None	$2,700	$7,800	$500	$2,000
Family	None	None	$8,100	$23,400	$1,000	$4,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out of Pocket Maximum						
Individual	$1,500	$3,000	$5,000	$9,000	$4,000	$6,000
Family	$3,000	$6,000	$12,500	$27,000	$8,000	$18,000
Preventive Services						
Routine Physical Exam (limits may apply)	Covered 100%	Covered 100%	Covered 100%	60% after ded. (limits may apply)	Covered 100%	60% after deductible
Routine Child and Well Baby Care; Immunizations	Covered 100%	Covered 100%	Covered 100%	60% after ded. (limits may apply)	Covered 100%	60% after deductible
Routine GYN Care (one per 365 days)	Covered 100%	Covered 100%	Covered 100%	60% after deductible	Covered 100%	60% after deductible
Mammogram (annual for females 35 and older)	Covered 100%	Covered 100%	Covered 100%	60% after deductible	Covered 100%	60% after deductible
Routine Colorectal Cancer (for adults 50 and older)	Covered 100%	Covered 100%	Covered 100%	Covered 60%	Covered 100%	Covered 60%
Pediatric Dental	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Exam (routine screening)	Covered 100%	Covered 100%	Covered 100%	60% after ded. for illness/injury	Covered 100%	60% after ded. for illness/injury
Hearing Aids	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Physician Services						
Primary Care Office Visit	$30 copay	$35 copay	80% after deductible	60% after deductible	$40 copay	60% after deductible
Specialist Office Visit	$40 copay	$45 copay	80% after deductible	60% after deductible	$50 copay	60% after deductible
X-Ray & Laboratory at Facility	$40 copay	$45 copay w/PCP referral	80% after deductible	60% after deductible	$50 copay after ded.	60% after deductible
Laboratory at Doctor's Office	Included w/OV copay	Included w/OV copay	80% after deductible	60% after deductible	Included w/OV copay	60% after deductible
Outpatient Physical/ Speech/Occupational Therapy	$40 copay	$45 copay	80% after deductible	60% after deductible	$50 copay	60% after deductible
Outpatient Dialysis/ Chemotherapy	$40 copay	$45 copay	80% after deductible	60% after deductible	$50 copay after ded.	60% after deductible
Allergy Testing/ Treatment	$40 copay ($30 for injection at PCP office)	$45 copay ($35 for injection at PCP office)	60% after deductible	60% after deductible	$50 copay ($40 for injection at PCP office)	60% after deductible
Emergency Services						
Emergency Room	$200 copay	$200 copay	80% after deductible	Same as preferred care	$200 copay	Same as preferred care
Urgent Care	$50 copay	$50 copay	80% after deductible	60% after deductible	$50 copay	60% after deductible
Ambulance	No copay	No copay	80% after deductible	Same as preferred care	No copay after ded.	No copay

•Applies to usual and customary charges

Summary of Medical Plan Options, Continued

Benefit Category	Aetna Memorial Hermann ACO	Aetna Select HMO	CDHP Network	CDHP Non-Network•	Aetna POS II Network	Aetna POS II Non-Network•
Hospital Services						
Inpatient Hosp. Visit (semiprivate room)	$300 copay	$350 copay	80% after deductible	60% after deductible	$450 copay after ded.	60% after deductible
Skilled Nursing Fac. (in lieu of hosp. limits may apply)	$300 copay	$350 copay	80% after deductible	60% after deductible	$450 copay after ded.	60% after deductible
Maternity						
OB visit (initial visit)	$40 copay (initial visit)	$45 copay (initial visit)	80% after deductible	60% after ded. (initial visit)	$50 copay after ded. (initial visit)	60% after deductible
Hospital (includes newborn services)	$300 copay	$350 copay	80% after deductible	60% after deductible	$450 copay after ded.	60% after deductible
Outpatient Surgery	$100 copay	$175 copay	80% after deductible	60% after deductible	$200 copay after ded.	60% after deductible
Home Health (outpat.) (limits may apply)	No copay	No copay	80% after deductible	60% after deductible	No copay after ded.	60% after deductible
Hospice (inpatient/ outpatient)	No copay	$350 copay/ No copay	80% after deductible	60% after deductible	$450 copay/ No copay after ded.	60% after deductible
Mental Health & Substance Abuse						
Mental Health Inpat.	$300 copay	$350 copay	80% after deductible	60% after deductible	$450 copay after ded.	60% after deductible
Mental Health Outpat.	$40 copay	$45 copay	80% after deductible	60% after deductible	$50 copay	60% after deductible
Other Services						
Chiropractic Care (20 visits ann. max)	$40 copay	$45 copay	80% after deductible	60% after deductible	$50 copay	60% after deductible
Durable Medical Equipment	No copay	No copay	80% after deductible	60% after deductible	No copay after ded.	60% after deductible
Prescription Drugs						
Retail Form. Generic (30-day supply)	$10 copay	$10 copay	$10 copay	Not covered	$10 copay after deduct.	Not covered
Retail Form. Brand (30-day supply)	$40 copay	$40 copay	$40 copay	Not covered	$40 copay after deduct.	Not covered
Retail Nonform. Brand & Gen. (30-day supply)	$60 copay	$60 copay	$60 copay after ded.	Not covered	$60 copay	Not covered
Specialty Medications	25% up to $150	25% up to $150	25% up to $150 after ded.	Not covered	25% up to $150	Not covered
Mail Ord. Form. Gen. (90-day supply)	$25 copay	$25 copay	$25 copay after ded.	Not covered	$25 copay	Not covered
Mail Ord. Form. Brand (90-day supply)	$100 copay	$100 copay	$100 copay after ded.	Not covered	$100 copay	Not covered
Mail Ord. Nonform. Brand & Gen. (90-day supply)	$150 copay	$150 copay	$150 copay after ded.	Not covered	$150 copay	Not covered

•Applies to usual and customary charges

Dental Coverage

Rice University offers two insured dental plan options:

	What You Pay (monthly)
• **Aetna Dental PPO**	
Employee only	$48.37
Employee plus spouse	$98.05
Employee plus child	$102.14
Employee plus family	$140.95
• **Aetna Dental HMO**	
Employee only	$13.68
Employee plus spouse	$24.64
Employee plus child	$25.67
Employee plus family	$35.42

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

What is the dental PPO plan?

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

What are the indemnity dental plan coverage amounts?

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

How do I locate a dentist in the Aetna PPO network?

Visit www.aetna.com/docfind and select the dental PPO/PDN with PPO II network.

What is the dental HMO?

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

What are some examples of the costs in the dental HMO?

ADA Code	Procedure	Patient Pays
	Office visit (during regular hours)	$5
1110	Prophylaxis (routine, once every six months)	$8
2140	Amalgam (silver), one surface, primary	$16
2740	Crown/porcelain/ceramic substrate	$315
3330	Root canals, molar	$303
5110	Complete denture maxillary (upper or lower)	$300
	Orthodontic treatment, children or adult (comprehensive)	$2,000

More complete details on covered procedures are available on the HR website.

What else do I need to know about the Dental HMO?
Should you need a specialty dentist (i.e., endodontist, oral surgeon, periodontist, prosthodontist or pediatric dentist), you must be referred by your participating general dentist. Services performed that are not on the dental benefits copayment list are not covered procedures. If you have any questions concerning coverage or fees, obtain a written treatment plan and call Aetna Member Services at 1-877-238-6200.

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

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

How do I contact my dental insurance provider?
The Aetna Member Services telephone number is 1-877-238-6200.

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

Vision Coverage

Rice University offers a vision plan administered by Aetna. In addition to the coverage described below, there is out-of-network coverage at a lower level of coverage.

	What You Pay (monthly)
Employee only	$4.87
Employee plus spouse/partner	$9.25
Employee plus child(ren)	$9.73
Employee plus family	$14.31

What does the vision plan cover?	In-Network
Exam copay	$20
Frames	
Copay	$0
Amount covered	$100, then 20% discount
Frequency	Every two calendar years
Standard Lenses	
Copay	$20
Frequency	Every 12 months
Contacts (in lieu of frames and lenses)	
Amount covered	$105, then 15% discount
Frequency	Every calendar year

This is a short summary. More complete details are available on the HR website.

Wellness

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

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

Healthy RICE. Healthy Life.

Important Federal Notices Regarding Your Health Coverage

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

Continuation of Benefits (COBRA)

Should you leave Rice for reasons other than "gross misconduct," or if your spouse or dependent has a COBRA qualifying event, you have the option to continue medical and dental benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a limited period of time.

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

Rice University treats domestic partners as spouses for purposes of COBRA coverage under the Rice medical and dental plans. Please contact HR 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:

Qualifying Event	Beneficiary	Coverage
Termination or reduced hours from or at Rice	Employee Spouse Dependent child	18 months 18 months 18 months
Divorce or legal separation	Spouse Dependent child	36 months 36 months
Death of covered employee	Spouse Dependent child	36 months 36 months
Loss of "dependent child" status	Dependent child	36 months

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) under a Rice medical 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 30 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 30 days after the marriage, birth, adoption or placement for adoption.

Also, the Rice medical plan will allow an employee or dependent who is eligible but not enrolled for coverage to enroll if either of the following events occurs:

1. Termination of Medicaid or CHIP Coverage: If the employee or dependent is covered under a Medicaid plan or a Children's Health Insurance Program (CHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the Rice medical plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, or the date you or your dependent's Medicaid or CHIP coverage ends.

To request special enrollment or obtain more information, please contact the benefits team at benefits@rice.edu or call 713-348-2363.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the genetic information protections included under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents the Rice medical plans from imposing a pre-existing condition exclusion provision based solely on genetic information and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information). GINA provides that group health plans cannot base premiums for a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) GINA also generally prohibits group health plans from requesting or requiring you to undergo a genetic test. However, your health care provider is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although GINA limits the scope of the request to only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that you undergo a genetic test. GINA also prohibits group health plans from collecting genetic information (including family medical history) prior to or in connection with enrollment. Thus, under GINA, group health plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a health risk assessment. An exception is included for incidental collection, provided the information is not used prior to or in connection with enrollment. However, this exception is not available if it is reasonable for group health plans to anticipate that health information will be received in response to a collection unless the collection explicitly states that genetic information should not be provided.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the next page, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, dial 1-877-KIDS-NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible for your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-3272.

If you live in one of the following states, you may be eligible for assistance in paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) &
Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19–64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

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

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

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

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

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

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

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

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

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health and Cancer Rights Act of 1998

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

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

To the extent permitted by applicable law, this coverage 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 HR.

Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery and less than 96 hours following a cesarean section. However, federal law does not generally prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Rice medical plans may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Qualified Medical Child Support Order

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

Continuing Health Coverage During a Military Leave (USERRA Rights)

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

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

Notice of Privacy Practices

Your information. Your rights. Our responsibilities.

This notice applies to the group health plan benefits under the William Marsh Rice University Health and Welfare Benefits Plan. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our uses and disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at benefits@rice.edu or by calling 713-348-4663.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference (for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our uses and disclosures

We typically use or share your health information in the following ways:

- *To help manage the health care treatment you receive*
  We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

- *To run our organization*
  We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

- *To pay for your health services*
  We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

- *To administer your plan*
  We may disclose your health information to your health plan sponsor for plan administration.
  Example: Your company contracts with us to provide a health plan, and we provide your company with certain health information to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, visit http://bit.ly/hipaa-rights.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, visit http://bit.ly/noticepp.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website, and we will mail a copy to you.

Effective date of this notice: July 1, 2017
Susan Prochazka, benefits director: 713-348-4663 or sprochazka@rice.edu

Survivor Protection

Basic Life Insurance

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

How do I designate a beneficiary?
Faculty and staff designate a beneficiary when enrolling in the plan in the Benefits Portal. 1) Visit http://benefits.rice.edu. 2) Select the Enroll in Benefits icon located on the far right to access the Enrollment Portal. 3) After logging in using your NetID and password, you will be directed to the Benefits Portal. 4) Select Benefits on the left navigation bar. 5) Scroll down to Your Life Coverage. 6) Click the Add or Edit to the right of Beneficiaries. 7) You will be presented with a screen listing all of your current beneficiaries (if applicable). If you do not see any beneficiaries, go to step nine. 8) Enter beneficiary's information. First name, last name and relationship are required fields. 9) You will designate a beneficiary type (primary or secondary) and allocation percentage of each. 10) Click Next. 11) Click Save. 12) Repeat for supplemental life and supplemental accidental death and dismemberment (AD&D) insurance if applicable.

Can I continue my coverage if I leave the university?
A conversion and portability option is available upon termination of employment, including retirement. You will receive information to your home address we have on file about how to port or convert your coverage.

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

Optional Life Insurance

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

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

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

Employee and spouse optional life insurance rates (per $1,000 of coverage):

Age (benefit reduction)	Rates (monthly)
Under 30	$0.040
30–34	$0.056
35–39	$0.064
40–44	$0.080
45–49	$0.120
50–54	$0.185
55–59	$0.337
60–64	$0.522
65–69	$0.972
70–74 (45%)	$1.582
75–79 (35%)	$1.991
80–84 (15%)	$1.991
85 and older (10%)	$1.991

The maximum amount of coverage available under this plan is $1,000,000. Beneficiaries are the same as those selected for the basic life insurance unless otherwise designated.

Beginning on and after your 70th birthday, your life insurance benefit decreases. A percentage of the elected amount will be paid based on the age schedule below:

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

What is "evidence of insurability"?

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

Optional spouse/domestic partner life insurance

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

Optional child life insurance

The child(ren) optional life insurance offers coverage at $5,000 or $10,000 at a cost of 50 cents per $5,000.

The rate is the same regardless of the number of children covered under the coverage amount. Unmarried children are eligible for coverage to age 26, regardless of student status. To be covered, a child must be dependent on you for support, as defined by the IRS.

What does "guaranteed issue" mean?

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

How is the cost for optional life insurance determined?

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

The cost of this insurance is paid in post-tax dollars, and the proceeds from any claim are not taxable.

Can I drop my life insurance coverage at any time?

Insurance may be canceled effective the first of any month, but the employee is not eligible for reapplication until the next annual enrollment period or a qualifying event. Reapplication for coverage will require EOI, and you can be turned down.

Can I cover my domestic partner or domestic partner's child(ren)?

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

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

If your eligible dependent is totally disabled, your dependent's coverage will begin on the date your eligible dependent is no longer totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

What benefits are available to me should I become terminally ill?

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

Optional Accidental Death and Dismemberment Insurance

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

Individuals may elect coverage for themselves only or for themselves and their eligible dependents under the family plan. For this plan, the term "eligible dependents" covers a spouse (under age 70) and children, including step, foster and legally adopted children (under age 26, regardless of student status). AD&D coverage does not require any EOI.

What is AD&D insurance?

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

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

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

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

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).

Coverage Amount	What You Pay Monthly
Employee only	$0.20 per $10,000 (available in multiples of $10,000)
Employee and family	$0.40 per $10,000 (available in multiples of $10,000)

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:

Family Members Covered	Benefit Amount
Employee and spouse (no children)	
Employee	100% of employee coverage
Spouse	60% of employee coverage up to a max of $250,000
Employee, spouse and children	
Employee	100% of employee coverage
Spouse	50% of employee coverage up to a max of $250,000
Each child	10% of employee coverage up to a max of $25,000
Employee and children (no spouse)	
Employee	100% of employee coverage up to a max of $250,000
Each child	15% of employee coverage up to a max of $25,000

Is there a reduction in AD&D benefits as I get older?

If you are age 70 or older at the time you sustain injuries in a covered accident, your benefit reduces to 45 percent of the elected benefit amount; at age 75, to 35 percent; at age 80, to 15 percent; and at age 85, to 10 percent. Coverage for your spouse or domestic partner ends once he or she reaches age 70.

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

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://people.rice.edu/benefits-rewards/other/travel-insurance.

Additional information regarding your benefits while traveling either on Rice business or for leisure can be found online at http://people.rice.edu/benefits-rewards/other/travel-insurance.

Short-Term Disability

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

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

How long do STD benefits last?
The maximum amount of leave time covered by STD 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:

Length of Employment	Faculty	Professional Staff	Technical/ Support Staff
0–1 year	1/2 academic year salary	0 days	0 hours
1 year–3 years	Same as above	65 days	520 hours
3+ years	Same as above	130 days	1,040 hours

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

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

You can submit your claim to Unum by either calling their toll-free number — 1-888-857-0157 from 7 a.m. to 7 p.m. Central time — or visiting them online at http://unum.com/claims.

Rice's group number is **129790**.

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

Long-Term Disability

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

When do LTD benefits begin?

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

How long do LTD payments last?

Benefit payments will continue until the earliest of:

1. the date you are no longer totally disabled,
2. the date you die, or
3. the date you reach one of the following age and/or time limits:

Age When Maximum Disability Starts	Duration of Benefits
Under 60	To age 65 (but not less than five years)
60, but under 65	60 months
65, but under 70	To age 70 (but not less than 12 months)
70 and over	12 months

Does the university pay for the cost of the LTD coverage?

The university can pay the full cost of 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 LTD insurance by post-tax payroll deduction. If you choose to pay, your benefits (should you become disabled) will not be taxable. The cost of the coverage is 0.33 percent of your monthly base salary.

For more detailed information, you can request a copy of the Summaries and Certificates of Coverage published by Unum from HR or visit http://benefits.rice.edu.

Long-Term Care Insurance

All faculty and staff are eligible to apply for long-term care (LTC) insurance at any time during their employment. LTC premiums are deducted on a post-tax basis. Guaranteed issue amounts are only available during the employee's initial 30-day hire enrollment period.

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

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

Whom can I cover with LTC insurance?
You can cover yourself, your spouse, parents, stepparents or grandparents under the LTC policy. Depending on the coverage you desire and when you apply, a completed medical questionnaire may be required. You are able to continue your LTC coverage after your group coverage terminates, but you must notify a member of the benefits team. You have 30 days from when coverage terminates to complete the appropriate paperwork.

How do I find out more about LTC coverage?
To learn more about LTC and if it is right for your needs, contact HR or visit www.unuminfo.com/wmru.

Flexible Spending Accounts

Flexible spending accounts (FSAs) allow participants to set aside pretax dollars for qualifying medical and/or dependent care expenses. Claims for reimbursement must be submitted no later than Nov. 30 following the end of the plan year (June 30). Claims for a plan year must be incurred by Sept. 15 (grace period) following that plan year to be eligible for reimbursement. Claims for that plan year, including the grace period, must be submitted by Nov. 30. Money remaining in either account after that time 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. FSAs at Rice are administered by WageWorks (www.wageworks.com).

What is a medical spending account?
Employees may set aside money on a pretax basis to pay for qualified, unreimbursed medical expenses. By setting the money aside on a pretax basis, you are reducing your take-home pay and therefore reducing the taxes you pay. The funds cannot be used to pay insurance premiums. The maximum contribution is $2,650 per plan year. This account can be used to pay for medical and dental plan deductibles and copayments, uninsured medical expenses and other eligible expenses, such as contact lenses and eyeglasses for you or any member of your immediate family (family member must be an IRS dependent). Faculty and staff enrolled in the HDHP medical plan are not eligible to enroll in the medical spending account.

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

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

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

Why must I keep my receipts when I use my WageWorks Visa?
You may be required to show that your charges were for eligible expenses, and the IRS may request them upon audit. Visit www.wageworks.com/card for more information.

What is a dependent care spending account?

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

Which dependents qualify under the dependent care spending account?

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

What if the costs of my child's care change within a plan year?

If your dependent's cost of care changes during the plan year, you may be able to change your dependent care election starting the first of the following month. Contact HR within 30 days of the change to determine if you can modify your dependent care spending account contribution.

Health Savings Account

What is a health savings account?

A health savings account (HSA) is a pretax medical savings account available to taxpayers in the United States who are enrolled in a consumer-driven health plan (CDHP, a qualified high-deductible health plan). You can use the funds to pay for eligible health care expenses for you, your spouse and your tax dependents. Or you can save the funds for the future. Under current IRS rules, the 2018 annual contribution limits are $3,450 for individuals and $6,900 for families (or $4,450/$7,900 if age 55+). The HSA plan is administered by PayFlex (www.payflex.com). Carefully review your HSA election with your spouse/partner to avoid going over the annual contribution limits. There are tax penalties for excess HSA contributions. Rice will not withdraw excess funds from your HSA account if you go over your calendar year maximum. You cannot have an HSA and FSA at the same time unless the FSA is a limited purpose FSA. Rice does not offer a limited purpose FSA, but your spouse might have one. You cannot have an FSA if your spouse has a qualified high-deductible health plan. For questions, contact PayFlex, your tax advisor or the benefits office.

What is the advantage of an HSA over a traditional medical spending account?

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

Commuter Benefits

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

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

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

Visit www.wageworks.com and log in if you are an existing WageWorks FSA user or register as a first-time user, or call 1-877-WageWorks (1-877-924-3967) Monday through Friday, 8 a.m.–8 p.m. EST.

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

Retirement 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 (TIAA) or Fidelity Investments. Contributions are made for eligible employees from their date of hire. Employees are vested in the Retirement Plan after the completion of one year of continuous benefits-eligible service.

What does the term "vested" mean?
Vesting means that you have ownership in the money Rice has put into your 401(a). Rice will make contributions into your 401(a) from the time you are eligible to participate. You do not own that money until you are vested. If you do not become vested in the Retirement Plan before you leave Rice, you forfeit 100 percent of your 401(a) retirement benefits.

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

How much does the university contribute for me?
The university contributes to each individual account an amount determined according to the following schedule, regardless of whether or not you make contributions to the 403(b) plan.

Plan Contributions as a Percentage of Compensation

Salary	Under Age 50	Age 50+
Within Social Security Wage Base	7%	An additional 3% for age (=10%)
Above Social Security Wage Base	An additional 5% for compensation over wage base (=12%)	An additional 5% for compensation over wage base + 3% for age (=15%)

The Social Security Wage Base for calendar year 2018 is $128,400. The maximum salary considered for the Retirement Plan is set by the federal government. For 2018, the maximum salary is $275,000.

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

If you leave Rice prior to qualifying as a retiree, you can withdraw your Retirement Plan investment. If you request this withdrawal to be paid directly to you, IRS penalties and taxes may apply. You can roll over this money into another qualifying plan or individual retirement account (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 are required to take distributions.

There are other options for withdrawing a portion of your Rice retirement money once you terminate employment at Rice. Contact TIAA at 1-800-842-2776 or Fidelity Investments at 1-800-343-0860 for more information on your withdrawal options.

How can I get more information about the Retirement Plan?

The previous description of the Retirement Plan is intended only to be a brief overview and is not intended to be the summary plan description. For more detailed information, you can request a copy of the Retirement Plan's Summary Plan Description from HR 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 better understanding their retirement accounts and preparing for retirement.

Supplemental Retirement Contributions 403(b)

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

Automatic enrollment

For newly hired benefits-eligible faculty and staff, Rice will automatically enroll you in the 403(b) with TIAA at a 4 percent contribution rate. You may opt out of or change this election at any time, effective the first of the month following submission of the form to HR. Forms can be found on the HR website at http://people.rice.edu.

How much can I contribute to the 403(b)?

For calendar year 2018, you may contribute up to $18,500. Employees 50 years or older may contribute an additional $6,000. Also, there is a "catch-up" provision for an employee with 15 or more years of service with the university that may permit an increased contribution of an additional $3,000 for up to five years. Faculty and staff using the catch-up provision should realize that a separate prior contribution limit might reduce the maximum they may contribute under this provision before they reach the full catch-up amount. Any contribution over the 403(b) limits made by an employee who is 50 years old or older counts first toward the catch-up contribution limits. Individual participants remain responsible for monitoring contribution limits.

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

What if I contribute more than the limits?

Contributions in excess of the maximums listed above may subject the individual to penalties with the IRS and/or may necessitate payment of additional taxes or filing an amended return.

What are the advantages of investing in a 403(b)?

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

Secondly, by placing pretax dollars into a 403(b) account, you reduce your take-home pay, which reduces the taxes you owe. For example, if you put $50 per month into the 403(b) on a pretax basis, your reduction in take-home pay is only $42 (if you are in the 15 percent tax bracket). The extra $8 is due to the reduction in taxes you pay.

Finally, a single filer or married person filing separately whose adjusted gross income is less than $30,500 in 2017 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 $61,000 in 2018. Another reason to save for your future!

Where can I invest my 403(b)?

You may direct 403(b) contributions to accounts with Fidelity Investments or TIAA. Both administrators have a variety of investment options with varying degrees of risk. Once you have money in your account, you can alter your investments based on your needs. Please contact the appropriate administrator for more information.

Administrator	Phone Number	Web Address
Fidelity Investments	1-800-343-0860	www.fidelity.com
TIAA	1-800-842-2776	www.tiaa.org

How do I enroll or change my payroll deduction amount?
You can change your contribution amount to the 403(b) on a monthly basis. The amounts you elect will be in effect on the first of the following month. You must complete a salary reduction agreement to initiate your enrollment or each time you wish to change your contributions, and this form can be found online at http://people.rice.edu.

Do I have to be benefits eligible to participate?
Supplemental retirement accounts are open to all employees and paid students, regardless of benefits eligibility. Rice University encourages the use of the 403(b) 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. The most commonly used financial counseling resource is that provided by TIAA and Fidelity. This service is free to employees. To make an appointment, contact TIAA or Fidelity as described on the previous page.

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 (the "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 HR. For information on filing claims and deadlines for filing claims for the Medical Flexible Spending Account Program, see the Flexible Spending Accounts section in this booklet.

The insurer decides all claims filed under the Rice dental and LTD programs. Rice University decides all claims filed under the Medical Flexible Spending Account Program. For claims filed under the medical program, Aetna is the appropriately named fiduciary of the plan for all appeals, level one and two. Aetna is collectively referred to as the claims administrator and will provide written or electronic notice of its binding decision within the following time frames. For additional information about the claim and appeal procedure details under the medical program required by the ACA, including additional denial notice content and external review, options, please see the Aetna benefits booklets available on the HR website.

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

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

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

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

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

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

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

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

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

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

If additional information is needed to process your urgent care claim, you will be notified within 24 hours following receipt of your claim, and you will have no less than 48 hours to provide the information. Aetna will then have 48 hours from the earlier of: the claim administrator's receipt of the requested information or the end of the additional 48-hour period. If you do not provide the requested information within 48 hours of when it is requested, your urgent care claim will be denied.

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

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

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

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

Appeal procedures

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

Aetna reviews all appeals filed under the Rice medical and dental programs. Rice University reviews all appeals under the Medical Flexible Spending Account Program (collectively referred to as the "appeals administrator" for purposes of these appeals procedures). All appeals must be filed with the appropriate appeals administrator within 180 days of the receipt of the written or electronic notice of denial.

Your appeal must be made in writing and may include written comments, documents, records and other information relating to your claim, even if you didn't include that information with your original claim. In the case of notice of denial of an urgent care claim, you may submit an appeal orally or in writing, and all necessary information may be transmitted by telephone, facsimile or other available similarly expeditious method. You may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records and other information relevant to your claim.

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

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

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

Notice of denial and notice of denial on appeal

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

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

In the case of a notice of denial, the notice also will include:

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

In the case of a notice of denial on appeal, the notice also will include:

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

Short-Term and Long-Term Disability Programs and Nondeath Claims Under Accidental Death and Dismemberment and Business Travel Accident Programs

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

Claims procedures

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

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

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

Appeals procedures

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

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

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

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

The insurer administrator will provide written or electronic notice of its appeal decision within the 45-day period following receipt of your appeal. This 45-day period may be extended up to an additional 45 days if an extension is necessary to process your claim due to matters beyond the control of the insurer 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 on appeal

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

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

In the case of a notice of denial, the notice also will include:

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

In the case of a notice of denial on appeal, the notice also will include:

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

Life Insurance, Dependent Care Flexible Spending Account, 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 HR. For information on filing claims and deadlines for filing claims for the Dependent Care Flexible Spending Account Program, see the Flexible Spending Accounts section in this booklet.

Claims procedures

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

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

Appeals procedures

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

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

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

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

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

Notice of denial and notice of denial on appeal

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

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

In the case of a notice of denial, the notice also will include:

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

In the case of a notice of denial on appeal, the notice also will include:

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

Review Procedures for Eligibility Determination

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

Plan Information

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

Plan References

Plan Sponsor:
William Marsh Rice University
Benefits–MS 92
P.O. Box 1892
Houston, TX 77251-1892
713-348-4663
Employer Identification Number: 74-1109620

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

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

Office of Human Resources (Benefits Team): benefits@rice.edu
Gloria O'Bryan, benefits specialist
713-348-4080, gloobry@rice.edu

Verónica Villaseñor, benefits specialist
713-348-3557, vdv@rice.edu

Marian Phillips, benefits specialist
713-348-6074, marians@rice.edu

Susan Prochazka, director of benefits
713-348-4663, sprochazka@rice.edu

Rice Benefits Service Center:
713-348-2363, ricebenefits@benefitfocus.com

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

Plan Year: July 1–June 30

Plan Administrator

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

Benefit Programs, Funding and Types of Administration

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

William Marsh Rice University Benefit Program	Type of Benefit	Type of Administration	Contract or Insurer Administrator	Funding
Medical Program • Prescription Drug • Mental Health	Welfare Benefit • Health	Claims paid by contract administrator	Aetna Life Insurance Company ("Aetna")	Combination unfunded/ stop loss insured; Rice and employee contributions
Prescription Drug Program	Welfare Benefit • Health	Claims paid by contract administrator	Express Scripts (ESI)	Unfunded; Rice and employee contributions
Vision Program	Welfare Benefit • Vision	Claims paid by contract administrator	Aetna	Fully insured; employees pay all premiums
Dental Program	Welfare Benefit • Health	Claims paid by insurer administrator	Aetna	DHMO is fully insured; DPPO is self-funded; Rice and employees pay all premiums
Medical Flexible Spending Account Program	Welfare Benefit • Health	Claims paid by contract administrator	WageWorks	Unfunded; employees make all contributions
Health Savings Account Program	Welfare Benefit • Health	Claims paid by contract administrator	PayFlex	Unfunded; employees make all contributions
Dependent Care Flexible Spending Account Program	Fringe Benefit	Claims paid by contract administrator	WageWorks	Unfunded; employees make all contributions
Life Insurance Program	Welfare Benefit • Life	Claims paid by insurer administrator	Unum	Fully insured; Rice University pays premiums for basic coverage; employees pay premiums for optional coverage
Accidental Death and Dismemberment Program	Welfare Benefit • Life/Health	Claims paid by insurer administrator	Unum	Fully insured; employees pay all premiums
Business Travel Accident Program	Welfare Benefit • Life	Claims paid by insurer administrator	Hartford Life Insurance	Fully insured; Rice University pays all premiums
Short-Term Disability Program	Welfare Benefit • Disability	Claims paid by Rice University	Unum	Unfunded; Rice University makes all contributions
Long-Term Disability Program	Welfare Benefit • Disability	Claims paid by insurer administrator	Unum	Fully insured; employee chooses whether Rice University or employee pays premiums
Long-Term Care Insurance Program	Welfare Benefit • Health	Claims paid by insurer administrator	Unum	Fully insured; employees pay all premiums
Employee Assistance Program	Welfare Benefit • Health	Services provided by insurer administrator	UTEAP	Fully insured; Rice University pays all premiums

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 HR.

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 HR.

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

Plan Amendment and Termination

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

No Guarantee of Tax Consequences

Rice University does not make any commitment or guarantee that any amounts paid to or for your benefit under the William Marsh Rice University Health and Welfare Benefits Plan and its Benefit Programs are excludable from your gross income for federal or state tax purposes or that any other federal or state tax treatment applies or is available. It is your obligation to notify HR 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).[1] ERISA provides that all participants shall be entitled to:

Receive information about the Plan and benefits programs

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

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

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

Continue group health plan coverage

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

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

Prudent actions by plan fiduciaries

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

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the Plan's latest annual reports and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for a welfare benefit that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the fiduciaries of the Plan misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions
If you have any questions about the Plan, you should contact HR. 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 Ave., NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

(Footnotes)
[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 Information

Password Security

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

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

Summary of Other Rice Benefits

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

Paid Time Off (PTO) — 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 PTO an employee may accumulate depends on the employee's classification. At a minimum, full-time employees accrue 10.67 hours of benefit time per month (equivalent to 16 days per year), with the amount increasing based on years of service to a maximum of 17.33 hours per month (equivalent to 26 days per year). Some employees may earn more benefit time (based on their exempt or nonexempt status). For more information, please see the benefit time policy at http://bit.ly/rice-benefit-policy.

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

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

Tuition Assistance (visit the HR website for more details, including the governing policy)
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 may also be available for courses offered through the Susanne M. Glasscock School of Continuing Studies or the Executive Education Program at the Jesse H. Jones Graduate School of Business.

***Tuition Reimbursement* —** Faculty and staff are eligible to request reimbursement of tuition for up to one course per semester. Preapproval is required, and the employee must turn in evidence of completion with a grade of C or better to receive reimbursement. This reimbursement (75 percent of the eligible amount paid, up to $2,500 per fiscal year) applies to tuition by accredited colleges and universities other than Rice University. General Education Development (GED) courses, test preparation and testing fees are covered 100 percent. Also covered under this program are language and work-related courses in the School of Continuing Studies and the Office of Executive Education.

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

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

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

Equal Employment Opportunity and Affirmative Action

Rice University is committed to affirmative action and equal opportunity in education and employment. Rice does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, disability or veteran status.

RICE
Unconventional Wisdom

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Benefits Team:

Phone:	For questions regarding qualifying change in status or health and welfare plans — 713-348-BENE (2363)
Fax:	713-348-5496
Email:	For questions regarding retirement, leaves and paid time off — benefits@rice.edu
Website:	http://people.rice.edu or http://benefits.rice.edu