

**WILLIAM MARSH RICE UNIVERSITY
MEDICAL PLAN**

APPENDIX B

**RiceCare POS Plan
(RiceCare FlexPlan (POS))
Summary of Coverage**

EFFECTIVE: JULY 1, 2003

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Benefits Summary Attachment

Introduction

Benefits under the William Marsh Rice University Medical Plan are provided under one or more Coverage Options. This Summary of Coverage for the RiceCare POS (FlexPlan) Coverage Option (the “Plan” for purposes of this Appendix B) shall govern the types and amounts of benefits offered under the Plan, including, but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, effective as of July 1, 2003. This Summary of Coverage replaces any Summary of Coverage previously in effect for the Plan.

The University shall have the right at any time to add, amend, or terminate for any or no reason the Plan without written notice to Participants or Employees.

Benefits provided under the Plan are not insured with Aetna Life Insurance Company (“Aetna”) but will be paid from the general assets of the University. Aetna is the Claims Administrator for the Plan and provides certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the University.

How the Plan Works

The Choice Is Yours

The Plan offers you the convenience and cost savings of a health maintenance organization (HMO)-type plan with the freedom and flexibility of a traditional medical plan. You have access to a network of Primary Care Physicians (PCPs), specialists, and hospitals. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards, and ongoing training.

Each participant in the Plan is encouraged to select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and provides your basic and routine care.

As a Plan participant, you have a choice each time you need medical care:

In-Network Care

When your PCP provides your care, or you receive care from a participating specialist or hospital, you receive the maximum benefits available under the Plan for covered services. After making a **copayment** for certain types of in-network care, you have no further out-of-pocket expenses, up to the limits shown in the "Benefits Summary." Once your copayments (excluding prescription drug copays) reach the **in-network out-of-pocket maximum**, the Plan pays 100% of your covered in-network expenses for the remainder of that Plan Year.

You don't have to meet a deductible for in-network care and there are no claim forms to fill out.

Out-of-Network Care

You can directly access doctors or hospitals of your choice outside of the Aetna Choice POS network. Your care is "out-of-network" if you don't obtain care from a provider in the network. The Plan covers out-of-network care, but your expenses will be higher:

- You must satisfy an annual **deductible** before the Plan begins to pay benefits. Once you've met the deductible, you must pay a portion of the covered out-of-network expenses you incur (your **out-of-network coinsurance** share), up to the **out-of-network out-of-pocket maximum**. The out-of-network out-of-pocket maximum controls your annual out-of-network expenses. Your deductible does not apply toward the out-of-network out-of-pocket maximum.
- If the provider you select charges more than the reasonable and customary expense determined by the Plan Administrator, you must pay any expenses above reasonable and customary. That excess amount does not apply toward your out-of-pocket maximum.
- Certain types of medical care require precertification. When you receive care outside of the network, you are responsible for obtaining the necessary precertification. If you don't, your benefits will be significantly reduced.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. He or she can provide primary care, as well as keep track of your overall care.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your selected PCP can provide preventive care and treat you for illnesses and injuries. The Plan includes coverage for routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You are only subject to the PCP copay when accessing care from your selected PCP. Please note that care received from any other network physician is subject to the specialist copay.

Coverage for out-of-network primary and preventive care is limited. Refer to the “Benefits Summary” for details.

Specialty and Facility Care

In-Network

The Plan provides you with the freedom to choose any participating provider for medically necessary services. When accessing any participating physician other than your selected PCP, the specialist copay will apply.

Out-of-Network

Receiving care within the network can minimize your out-of-pocket expenses and help you find appropriate care more quickly. The Plan offers you the option, however, of seeking care outside of the network. When doctors and facilities that are outside of the network provide your covered care, you will be subject to the out-of-network deductible, coinsurance and maximum benefits shown in the “Benefits Summary.” You must also obtain any necessary precertification, and you will probably have to file a claim form for reimbursement.

Precertification

You are covered for specialty care when you obtain care at participating specialists or facilities. If, however, you choose to access care outside of the network, you must obtain authorization prior to receiving the following out-of-network care:

<p>Inpatient Hospital and Hospital Alternatives:</p> <ul style="list-style-type: none"> • Home health services. • Hospice care – inpatient and outpatient. • Hospital admissions. • Private duty nursing. • Skilled nursing care – inpatient and outpatient. <p>Behavioral Health:</p> <ul style="list-style-type: none"> • Mental health services – inpatient. • Substance abuse services – inpatient and outpatient. <p>Emergency services within 24 hours of emergency room admission or as soon as possible.</p> <p>Durable medical equipment and prosthetic devices – precertification required for equipment leased or purchased over \$1,500.</p>	<p>Outpatient Therapy:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation – outpatient. • Cognitive therapy. • Occupational therapy – outpatient. • Physical therapy – outpatient. • Pulmonary rehabilitation – outpatient. • Respiratory therapy – outpatient. • Speech therapy – outpatient. <p>Other Procedures, Treatments and Services (Inpatient or Outpatient):</p> <ul style="list-style-type: none"> • Chiropractic care. • Infertility services. • Maternity care. • Organ transplants. • Outpatient surgery. • Reconstructive surgery.
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How to Precertify

Call the Member Services telephone number on your ID card to request precertification at least 14 days before:

- A scheduled admission to a hospital, skilled nursing facility, or hospice care facility; or
- Any of the other procedures or treatments listed above.

You or your PCP must call Member Services within 24 hours after an emergency admission, or as soon thereafter as reasonably possible. If you are unable to call, a family member or friend can make the call on your behalf.

When you call Member Services to precertify medical care, a nurse consultant will ask for some information, including:

- The name of the patient;
- The condition being treated;
- The doctor's name, address and telephone number;
- The medical facility's name, address and telephone number; and
- The scheduled date for admission or delivery of services.

Confirmation of Precertification

The length of a hospital confinement is certified based on common practice and usual rates of recovery. For a hospital stay, you, your physician, and the hospital will receive a letter verifying your certified length of stay (LOS). If your physician subsequently recommends a longer period of time in the hospital, you, your physician, or the facility must call Member Services to certify the extra days. This must be done no later than the last day previously certified.

For a proposed procedure or other treatment, Aetna will send a written notice of the precertification decision to both you and the provider performing the procedure or treatment. The decision will be valid for 60 days from the date you receive the notice. If more than 60 days pass before the procedure or treatment is performed, you must request precertification again.

If You Don't Precertify

If you don't precertify as required, your benefits will be reduced by 50%.

You are responsible for expenses that are excluded because you did not obtain the required precertification. These penalties do not count toward your deductible or out-of-pocket maximum.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in the Plan's network using the Internet. With DocFind[®] you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to www.aetna.com/docfind. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Benefits Summary

For each Plan Year, a “Benefits Summary” or schedule(s) designated as such by the University shall be attached hereto and made a part of the Plan. The University may amend the Benefits Summary at any time and for any or no reason during the Plan Year and may effect such changes by the publication and distribution of separate written materials designed to communicate the changes.

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Primary and Preventive Care

One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations, and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by participating providers.

Out-of-network primary and preventive care coverage is limited; refer to the “Benefits Summary.”

The Plan covers the following primary and preventive care services:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your physician.
- Well-child care from birth, including immunizations and booster doses, as recommended by your physician.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear.
- Annual mammography screening for asymptomatic women age 35 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP. Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider as follows:
 - If you wear eyeglasses or contact lenses:*
 - age 1-18 years - one exam every 12 months.
 - age 19 or over - one exam every 12 months.
 - If you do not wear eyeglasses or contact lenses:*
 - age 1-45 years - one exam every 12 months.
 - age 46 or over - one exam every 12 months.
- Routine hearing screenings.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

The following services and supplies are covered after the applicable copayment. If these services are obtained on an out-of-network basis, they are subject to the Plan's deductible, coinsurance, and maximum benefit limitations, shown in the "Benefits Summary." Some out-of-network services may also require precertification; refer to the listing under the "Precertification" section.

- Participating specialist office visits by appointment.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance (precertified) by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy and cancer hormone treatments and services that have been approved by the U.S. Food and Drug Administration (FDA) for general use in the treatment of cancer.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis when medically necessary following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis when medically necessary for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a home health care agency, including:
 - skilled nursing services provided by, or supervised by, an RN.
 - services of a home health aide for skilled care.
 - medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
 - counseling and emotional support.
 - home visits by nurses and social workers.
 - pain management and symptom control.
 - instruction and supervision of a family member.

Note: The Plan does *not* cover:

- bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
- homemaker or caretaker services, and any service not solely related to the care of the terminally ill patient.
- respite care when the patient's family or usual caretaker cannot, or will not, attend to his or her needs.
- Oral surgery (limited to extraction of bony impacted teeth, treatment of bone fractures, and removal of tumors and orthodontogenic cysts).
- Reconstructive breast surgery following a mastectomy, including:
 - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
 - medically necessary physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist:
 - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
 - evaluation of ovulatory function,
 - ultrasound of ovaries at an appropriate participating radiology facility,
 - postcoital test,
 - hysterosalpingogram,
 - endometrial biopsy, and
 - hysteroscopy.

Semen analysis at an appropriate participating laboratory is covered for male Plan participants; preauthorization by Aetna is required.

- Chiropractic services. Subluxation services must be consistent with the Plan's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth) when approved by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna. The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
 - they are needed due to a change in your physical condition, or
 - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and accessed through the Plan's Patient Management Department.

Inpatient Hospital, Skilled Nursing Facility and Hospice Facility Care

If you are hospitalized by a participating physician, you are covered for the services and supplies listed below, as medically necessary. You are responsible for the copayment shown in the “Benefits Summary.” See “Behavioral Health” for inpatient mental health and substance abuse benefits.

Out-of-network inpatient hospital, extended care facility and hospice care facility admissions are subject to the annual deductible, coinsurance and maximum limitations shown in the “Benefits Summary.” When you receive care outside of the network, your benefits for the services listed in the “Precertification” section will be reduced unless you obtain the necessary precertification.

- Confinement in semi-private accommodations (or private room when medically necessary) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care medical facilities when medically necessary.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications when necessary.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - cardiac rehabilitation, and
 - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Non-experimental, non-investigational transplants. All transplants must be ordered by your participating specialist, and approved in advance by the Plan Administrator. Transplants must be performed in hospitals specifically approved and designated by the Plan Administrator to perform the procedure.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by the Plan Administrator to perform the procedure. The Institutes of Excellence (IOE) network is the Plan’s network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has

been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as a out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery, and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may - **after consulting with you** - discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You will receive the Plan's highest level of coverage if a participating obstetrician provides maternity services in a participating facility. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information").

Note: Your obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of his or her office and for visits to other specialists. Please verify that the necessary preauthorization has been obtained before receiving such services.

Out-of-network services are subject to the Plan's deductible, coinsurance, and maximum benefit limits. In addition, you must precertify certain services to avoid benefit reductions; see the "Precertification" section.

If you are pregnant at the time you join the Plan, the authorized care you receive **on and after your effective date** is covered. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. When you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse. Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan pays, subject to any limitations specified under “Your Benefits,” the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the “Benefits Summary” for each prescription at the time the prescription is dispensed.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by the Plan Administrator;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under “Prescription Drug Exclusions and Limitations,” below.

Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon the Plan’s formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug

that appears on the formulary. Your copayment will be highest if your physician prescribes a covered drug that does not appear on the formulary.

Mail Order Drugs

Participants in the Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug at a participating mail order pharmacy, if authorized by their physician. The minimum quantity dispensed by a mail order pharmacy is for a 30-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the “Benefits Summary” will apply to each mail order purchase.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are traveling outside of the Plan’s service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

Non-Participating Pharmacy

Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost, minus any applicable copayment.

Participating Pharmacy

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copay. The Plan will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Covered Drugs

The Plan covers the following:

- Medically necessary outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations, and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
 - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or

- the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
 - diabetic needles and syringes.
 - alcohol swabs.
 - test strips for glucose monitoring and/or visual reading.
 - diabetic test agents.
 - lancets (and lancing devices).
- Contraceptives and contraceptive devices, as follows:
 - oral contraceptives.
 - one diaphragm per 365-day period.
 - up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
 - Norplant and IUDs are covered when obtained from your physician. The office visit copayment will apply when the device is inserted and removed.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are not covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including:
 - biological sera.
 - blood, blood plasma, or other blood products administered on an outpatient basis.
 - allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

- Drugs labeled “Caution - Limited by Federal Law to Investigational Use” and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Drugs used to aid or enhance sexual performance, including (but not limited to):
 - Sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable, and topical (including but not limited to gels, creams, ointments and patches) forms, and
 - any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth hormones.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.
- Injectable drugs, except insulin and injectable contraceptives. The Plan does not cover injectable drugs used in the treatment of infertility.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from either a participating or non-participating pharmacy in non-emergency, non-urgent care situations.
- The Plan is not responsible for the cost of any prescription for which the actual charge to you is less than the copayment, or for any prescription for which no charge is made to you.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by the Plan Administrator.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - reconstructive surgery to correct the results of an injury.
 - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
 - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary.
- Custodial care and rest cures.
- Dental care and treatment, including (but not limited to):
 - care, filling, removal or replacement of teeth,
 - dental services related to the gums,
 - apicoectomy (dental root resection),
 - orthodontics,
 - root canal treatment,
 - soft tissue impactions,
 - alveolectomy,
 - augmentation and vestibuloplasty treatment of periodontal disease,
 - prosthetic restoration of dental implants, and
 - dental implants.

However, the Plan does cover oral surgery as described under “Your Benefits.”

- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by the Plan Administrator, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

- that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
- that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- that the Plan Administrator has determined, based upon scientific evidence, demonstrate effectiveness, or show promise of being effective for the disease.

Refer to the “Glossary” for a definition of “experimental or investigational.”

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs (except as described under “Prescription Drugs”).
- Infertility services, except as described under “Your Benefits.” The Plan does not cover:
 - purchase of donor sperm and any charges for the storage of sperm.
 - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
 - cryopreservation and storage of cryopreserved embryos.
 - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
 - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
 - injectable infertility drugs.
 - the costs for home ovulation prediction kits.
 - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.

- services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips, (except as described under “Prescription Drugs.”)
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan.
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - obtaining or continuing employment,
 - obtaining or maintaining any license issued by a municipality, state or federal government,
 - securing insurance coverage,
 - travel, and
 - school admissions or attendance, including examinations required to participate in athletics,
 unless the service is considered to be part of an appropriate schedule of wellness services.
- Services that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
 - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,

- needles, syringes and other injectable aids (except as described under “Prescription Drugs”),
- drugs related to treatments not covered by the Plan, and
- drugs related to the treatment of infertility, contraception, and performance-enhancing steroids (except as described under “Prescription Drugs”).
- Specific non-standard allergy services and supplies, including (but not limited to):
 - skin titration (wrinkle method),
 - cytotoxicity testing (Bryan’s Test),
 - treatment of non-specific candida sensitivity, and
 - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
 - primal therapy.
 - chelation therapy.
 - rolfing.
 - psychodrama.
 - megavitamin therapy.
 - purging.
 - bioenergetic therapy.
 - vision perception training.
 - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant’s physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under “Your Benefits.”
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers’ Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered “non-occupational,” regardless of cause.

- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
 - treatment performed by placing a prosthesis directly on the teeth,
 - surgical and non-surgical medical and dental services, and
 - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of the Plan Administrator, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by the Plan Administrator, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. The Plan has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- | | |
|-------------------------------------------|---------------------------------------|
| - Heart attack or suspected heart attack. | - Loss of consciousness. |
| - Poisoning. | - Suspected overdose of medication. |
| - Severe shortness of breath. | - Severe burns. |
| - Uncontrolled or severe bleeding. | - High fever (especially in infants). |

Whether you are in or out of the Plan's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. Services which do not qualify as an emergency under your in-network benefits will be subject to the deductible, coinsurance and maximum benefit limits shown in the "Benefits Summary."

Follow-Up Care After Emergencies

Follow-up care following emergency treatment is covered by the Plan. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain for an urgent medical condition is covered if:

- The service is a covered benefit; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other in-network follow-up care is covered, subject to the applicable copay shown in the “Benefits Summary.”

Out-of-network follow-up care is subject to the Plan’s deductible, coinsurance and maximum benefits.

What to Do Outside the Plan’s Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions at “in-network care” levels. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center, or an emergency facility. An urgent medical condition that occurs outside your Plan’s service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to Aetna by the doctors who provided care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, the Plan has a program to meet your needs. The Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit http://www.aetna.com/products/natural_alt_99.html. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

Natural Alternatives is not available in all states.

Fitness Program

Plan participants have access to discounted fitness services provided by GlobalFit™. Depending upon your location, you may be eligible for one of two GlobalFit programs.* Under **GlobalFit A**, Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. Under **GlobalFit B**, Plan participants can join included clubs directly, receiving the club's lowest corporate rate for the type of membership selected. Both programs offer Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club** to join;
- Guest privileges at other participating GlobalFit health clubs,** and
- Discounts on certain home exercise equipment.

** For current club members, participation under this program may not be available at all clubs.*

***Not available at all clubs.*

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at www.globalfit.com/fitness. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

Healthy Outlook Program[®] -- Disease Management for the 21st Century

The Plan has four programs aimed at helping Plan participants and their physicians to better manage chronic disease:

Asthma Management Program (pediatric and adult)

The Asthma Management Program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Heart Failure Management Program

The Heart Failure Management Program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines patient education with blood glucose self monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

The Low Back Pain Disease Management Program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about the Plan's Disease Management Programs can be found at http://www.aetna.com/products/extra/healthy_outlook.html.

Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, innovative Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Health Education Programs, call the toll-free number on your ID card or visit http://www.aetna.com/products/health_education.html.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent reminders listing an examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Adult Preventive Reminders

Preventive care recommendations can overlap in some cases for people age 50 and older. Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats for people in this age group.

Vaccination programs against diseases such as influenza and pneumococcal pneumonia have been shown to reduce the incidence of illness and death from these diseases.

Plan participants will receive annual reminders stressing the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping Plan participants lead longer, healthier lives. Health Education Programs provide Plan participants with an important means of early detection.

- ***Breast Cancer Screening***

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

- ***Cervical***

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female Plan participants, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, women are sent information stressing the importance of annual gynecological exams and instructions on how to perform breast self-examination.

- *Colorectal*

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Plan participants receive annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

**Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Healthy Breathing[®] Program

Quitting smoking is one of the biggest steps people can take to improve their health. Millions of people successfully quit smoking each year. That's why the Plan offers the Healthy Breathing Program, which provides access to the GlaxoSmithKline's Committed Quitters[®] service. The program is available to Plan participants. The program is an 8- to 12-week smoking cessation program that uses nicotine replacement therapy and a personal quit plan to help smokers break their addiction to cigarettes.

Eligible Plan participants who call Member Services using the toll-free telephone number on their ID card can obtain a brochure that contains a \$5 coupon redeemable for the purchase of either a Nicorette[®] (nicotine gum) or NicoDerm[®] CQ[®] (nicotine patch) Starter Kit.* These products can help ease the craving for nicotine and improve the chances of quitting successfully. They are available without a doctor's prescription, although you should discuss use of these products with your physician.

You can call the 1-800 number in the Starter Kit to begin a quit program or register on line at **www.committedquitters.com**. A personal quit plan usually arrives within a week after calling the 1-800 number. Over the following weeks, you are then sent materials that include information on coping strategies and how to use GlaxoSmithKline's Nicorette or NicoDerm CQ safely and effectively.

If you are an eligible Plan participant, you may call the Member Services number on your ID card to request the Healthy Breathing brochure.

**Committed Quitters[®], Nicorette[®], NicoDerm[®], and CQ[®] are registered trademarks owned by and/or licensed to GlaxoSmithKline and are used under license.*

Healthy Eating[™] Program

The *Healthy Eating* booklet provides an easy-to-follow approach to overall better health through good nutrition. The information provides you and your family with tools you can use to develop a healthy eating plan that's realistic. Following a nutritious diet can help you:

- Reduce your risk of illness and disease
- Manage your weight
- Boost your ability to fight illness
- Increase your energy levels
- Look and feel your personal best
- Improve your performance

The *Healthy Eating* booklet outlines the benefits of a healthy diet and how to get started. It's geared toward helping you understand and use the Food Guide Pyramid, read the "Nutrition Facts" labels on most foods, lower the amount of fat you eat, and become more physically active. Sensible weight management is also addressed. The booklet is available to all Plan participants.

Call the Member Services number on your ID card to request the Healthy Eating booklet.

Healthy Insights Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health[®] Line

Informed Health[®] Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe, or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise[®] Knowledgebase[™] (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know[™] -- Hypertension and Cholesterol Management

Aetna created *Numbers To Know[™]* to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication, and dosage information.

Hypertension and high cholesterol are never “cured” but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay “heart healthy” by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

National Medical Excellence Program®

The National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants
- National Special Case Program, developed to make arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will arrange for covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per episode of care. Lodging expenses are subject to a \$50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are *not* covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

- One year after the day a covered procedure was performed;
- The date you cease to receive any services from the Program provider in connection with the covered procedure; or

- The date your coverage terminates under the Plan.

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies, and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by the Plan Administrator) is *not* covered by the Plan. Refer to the *Glossary* for a definition of “experimental.”

Vision One[®] Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses, and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider’s usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Vision One is a registered trademark of Cole Vision.

Women’s Health Care Program

The Plan is focused on the unique health care needs of women and offers a variety of benefits and programs to promote good health throughout each distinct life stage, and is committed to educating female Plan participants about the lifelong benefits of preventive health care.

Breast Cancer Case Management

The Plan’s breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities.
- Educational materials, including *The Wellness Community Guide to Fighting for Recovery From Cancer*.
- Second opinions at participating facilities.

Case Management and Education for Diabetics Considering Pregnancy

The Plan provides diabetic women considering pregnancy with educational materials and nurse case management to help better manage their blood sugar levels prior to pregnancy, which can decrease the chance of delivering babies with birth defects.

Confidential Genetic Testing for Breast and Ovarian Cancers

The Plan covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Infertility Case Management and Education

Infertility treatment can be an emotional experience for couples. The Plan's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

Menopause Education

Beginning at age 40, each female Plan participant (who has selected a primary care physician) receives educational information about menopause with her annual mammography reminder. This includes a take-at-home osteoporosis self-evaluation, which she can complete and discuss with her provider.

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. Under the program, all care during your pregnancy is access through your participating obstetrical care provider and Moms-to-Babies case managers. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, arrange for covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Coordination of Benefits

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. “Other group plans” include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- “No-fault” and traditional “fault” auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
 - The plan that covers the person as a dependent of a working spouse will pay first;
 - Medicare will pay second; and
 - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents’ birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn’t have the parent birthday rule, the other plan’s COB rule applies.
- When the parents of a dependent child are divorced or separated:
 - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, immediately above, applies.
 - If a court decree gives financial responsibility for the child’s medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent’s dependent determines its benefits before any other plan that covers the child as a dependent.
 - If there is no such court decree, the order of benefits will be determined as follows:
 - the plan of the natural parent with whom the child resides,
 - the plan of the stepparent with whom the child resides,
 - the plan of the natural parent with whom the child does not reside, or
 - the plan of the stepparent with whom the child does not reside.

- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan,
Less
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Right of Recovery (Subrogation and/or Reimbursement)

If you or a covered family member receives benefits from this plan as the result of an illness or injury caused by another person, the Plan 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 the Plan 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, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or
- Any first party insurance coverage

What You Need to Know

Here are some important points about the right of subrogation:

The Plan has a lien on any payments you receive.

The Plan automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid by Aetna under this Plan for treatment of the illness, injury, or condition for which the other person is responsible.

Your cooperation is required.

You may not do anything to interfere or affect the Plan's subrogation rights.

You also must fully cooperate with the Plan's efforts to recover benefits it has paid. This includes providing all information requested by the Plan Administrator or its representatives. As part of this process, Aetna may ask you to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you.

You must notify the Plan Administrator.

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify the Plan Administrator. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney,

The Plan is paid first.

The Plan's subrogation rights are a first priority claim against all potentially responsible person(s), and must be paid before any other claim for damages.

The Plan is entitled to full reimbursement.

The Plan is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this Plan provision apply and the Plan is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the plan. The Plan may be reimbursed from **any and all** settlements and judgments, even those for pain and suffering or non-economic damages only.

The Plan Administrator chooses the court for any legal action.

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction the Plan Administrator selects. When you receive benefits under this Plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

The Plan is not responsible for your attorneys' fees.

The Plan is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

Interpreting this provision.

If there is any question about the meaning or intent of this plan provision or any of its terms, the Plan Administrator will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

Glossary

Coinsurance - means the sharing of a covered expense by the Plan and the Plan participant. For example, if the Plan covers an expense at 70% (the Plan's coinsurance), your coinsurance share is 30%.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as shown in the "Benefits Summary."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Deductible - means the amount of covered, out-of-network expenses that a Plan participant must pay each Plan Year before the Plan begins paying benefits.

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational - means services or supplies that are determined by the Plan Administrator to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of the Plan participant's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of the Plan participant's particular condition; or
- It is provided or performed in special settings for research purposes.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the Plan Administrator as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation, or specialty institution.

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

In-network provider - means a provider that has entered into a contractual agreement with the Plan to provide services to Plan participants.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic, and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the “Your Benefits” section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Plan participant’s overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by the Plan Administrator;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the Plan participant’s overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician’s office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is medically necessary, the Plan's Patient Management Medical Director or its physician designee will consider:

- Information provided on the Plan participant's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to the Plan Administrator's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by the Plan Administrator.

Mental or nervous condition - means a condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and

- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

NME patient - means a person who:

- Requires any National Medical Excellence Program procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by the Plan Administrator as the most appropriate facility.

In-network out-of-pocket maximum - means the maximum amount a Plan participant must pay for covered in-network expenses in a Plan Year. Once you reach your in-network out-of-pocket maximum, the Plan pays 100% of covered in-network expenses for the remainder of the Plan Year. Copays (except prescription drug copays) apply toward the in-network out-of-pocket maximum.

Certain expenses do *not* apply toward the in-network out-of-pocket maximum:

- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.
- Out-of-pocket expenses incurred for out-of-network services.

Out-of-network out-of-pocket maximum - means the maximum amount a Plan participant must pay for covered out-of-network expenses in a Plan Year. Once you reach your out-of-network out-of-pocket maximum, the Plan pays 100% of covered out-of-network expenses for the remainder of the Plan Year. Certain expenses do not apply toward the out-of-network out-of-pocket maximum:

- Expenses that exceed reasonable and customary limits.
- Charges for services that are not covered by the Plan.
- Penalties for failure to obtain the necessary precertification for the out-of-network services listed under “Precertification.”
- Amounts applied toward your deductible.
- Copayments for prescription drugs.
- Out-of-pocket expenses incurred for in-network services (copays).

Outpatient - means:

- A Plan participant who is registered at a practitioner’s office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse, or mental illness treatment program by the appropriate regulatory authority.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled.

Plan participant - means an Eligible Employee or Covered Dependent who is properly enrolled in the William Marsh Rice University Medical Plan and who has properly elected coverage under the RiceCare POS (FlexPlan) Coverage Option.

Primary Care Physician (PCP) - means a participating physician who provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Reasonable and customary - means the charge for a service or supply that is the lower of:

- The provider's usual charge for furnishing it; and
- The prevailing charge for it in the geographic area where it is furnished, as determined by the Plan Administrator.

In determining the reasonable and customary charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Plan Administrator may take into account factors such as:

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

Expenses for covered out-of-network services which exceed reasonable and customary limits are not covered by the Plan, and the excess cannot be applied to the Plan's out-of-pocket limit.

Service area - means the geographic area, established by the Plan and approved by the appropriate regulatory authority, in which you must live or work or otherwise meet the eligibility requirements in order to be eligible to participate in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the Plan Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which the Plan participant has a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.



PLAN DESIGN AND BENEFITS

ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDERS	
Deductible (per plan year)	None	Individual	\$750	Individual
	None	Family	\$2,250	Family

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Member Coinsurance	Covered 100%		40%	
Out-of-Pocket Maximum (per plan year)	\$1,500	Individual	\$5,000	Individual
	\$3,000	Family	\$15,000	Family

Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum.

Only those participating providers and non-participating providers out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum.

Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year.

Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
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Primary Care Physician Selection	Not Required	Not applicable
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Precertification Requirement Certain non-participating services require precertification or benefits will be reduced.

Refer to your plan documents for a complete list of services that require precertification.

Referral Requirements	None	None
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PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)	\$25 copay	40% after deductible
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Well Child Exams / Immunizations (Age and frequency schedules apply)	\$25 copay	40% after deductible
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Routine Gynecological Care Exams Includes routine tests and related lab fees. One routine exam per 365 days.	\$35 copay	40% after deductible
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Routine Mammograms One annual mammogram for females age 35 and over.	\$35 copay	40% after deductible
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Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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Routine Eye Exam Age/Frequency Schedule may apply.	\$35 copay	Not Covered
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Routine Hearing Screening	\$25 copay	Not Covered
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PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Office Visits to member's selected Primary Care Physician	Office Hours : \$25 copay After Office Hours/Home : \$30 copay	40% after deductible
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Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	\$35 copay	40% after deductible
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Maternity OB Visits	\$35 copay; for initial visit only, thereafter covered 100%	40% after deductible
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PLAN DESIGN AND BENEFITS

ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF FUNDED

Allergy Treatment	Same as applicable participating provider office visit member cost sharing	40% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	40% after deductible
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory	\$35 copay	40% after deductible
If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.		
Diagnostic X-ray	\$35 copay	40% after deductible
Outpatient hospital or other Outpatient facility		
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care	\$50 copay	40% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay	Refer to participating provider benefit; after deductible
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	Refer to participating provider benefit; after deductible
HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	\$150 per visit copay	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Biologically Based Mental Illness	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	\$35 per visit copay	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	\$35 per visit copay	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	\$35 per visit copay	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Rehabilitation	\$35 per visit copay	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS



PLAN DESIGN AND BENEFITS

ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF FUNDED

Skilled Nursing Facility	\$350 per admission copay	40% per admission (Limited to 240 days and 35 physician visits per plan year) after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	40% per visit after deductible
Hospice Care - Inpatient	\$350 per admission copay	40% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	40% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	40% per visit after deductible
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	\$35 per visit copay	40% per visit after deductible
Subluxation	Not Covered	40% per visit (\$1,000 plan year maximum.) after deductible
Durable Medical Equipment	Covered 100% (of contracted rate)	40% (must pre-certify if over \$1,500 plan year maximum) after deductible
Diabetic Supplies	Not Covered	Not Covered
Dental	Not Covered	Not Covered
Transplants	\$350 per admission copay Coverage is provided at an Institute of Excellence contracted facility only	40% per admission Coverage is provided at an Non-IOE contracted facility only; after deductible
FAMILY planNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing after deductible
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in school.	

Members may directly access participating providers for certain services as outlined in the plan documents.

Exclusions and Limitations

PLAN DESIGN AND BENEFITS

ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- Durable medical equipment.
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Hearing aids.
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Nonmedically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and therefore, cannot guarantee any results or outcomes. Consult the plan document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at www.aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription



PLAN DESIGN AND BENEFITS

ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF FUNDED

plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage. Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage.

Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification), inpatient and outpatient rehabilitation). When the Member obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc.. Employer-funded plans are administered by Aetna Life Insurance Company or Aetna Health Administrators, LLC. While this material is believed to be accurate as of the print date, it is subject to change.

Toll-Free: 1-800-361-4542

Fax: 330-405-8081

Your prescription drug benefit is administered by EnvisionRxOptions. Headquartered in Twinsburg, Ohio, EnvisionRxOptions has been providing pharmacy benefit management services nationally since 2001. Additional information about EnvisionRxOptions and your prescription benefit can be found by registering at www.envisionrx.com. The following information is an overview of the Rice University prescription drug benefit being administered by EnvisionRxOptions.

Your prescription drug benefit features a formulary drug list. A formulary is a list of preferred medications organized into groups or "Tiers". Enclosed is a pocket formulary which lists the most frequently prescribed medications. For a full formulary listing please visit www.envisionrx.com.

Copays, the portion of the drug cost that you are responsible to pay, are listed in the table below.

	30-Day Retail				90-Day Mail Order		
	Tier 1 Generic	Tier 2 Formulary Brand	Tier 3 Non-Formulary Brand	Tier 4 Specialty Medications	Tier 1 Generic	Tier 2 Formulary Brand	Tier 3 Non-Formulary Brand
Copay	\$10.00	\$30.00	\$50.00	25% up to \$75.00	\$20.00	\$60.00	\$100.00

Your benefit plan may have certain restrictions regarding refills. Please refer to the Summary Benefit Plan provided by your plan or contact your Plan Administrator. You may also call our Customer Service Help Desk at 1-800-361-4542.

To access our Pharmacy Locator, please visit www.envisionrx.com. You may also call the EnvisionRxOptions Help Desk at 1-800-361-4542 to see if your pharmacy is in the network.

Orchard Pharmaceutical Services

As a valued client of EnvisionRxOptions, we are pleased to provide mail order services through our affiliate company, Orchard Pharmaceutical Services, located in North Canton, Ohio.

Mail order is an excellent way to receive prescriptions you will be taking for a long time with no worries about weather or availability of supply at the local pharmacy. For individuals who are taking maintenance medications, you may want to consider utilizing the mail order service for the convenience of home or office delivery.

Please refer to the enclosed Orchard Pharmaceutical Services Brochure for instructions on how to use the Orchard Mail Order Pharmacy. **You will need to obtain NEW 90 Day supply prescriptions from your physician.** Mail the original prescription(s) written for a 90 day supply of your medication (plus refills, if applicable) with the enclosed brochure, along with your first payment or payment information.

Before you mail in a new prescription, you must REGISTER your information with Orchard Mail Order Pharmacy. You may use any of the following 3 easy registration options:

1. **Online: (Recommended method)** Visit www.orchardrx.com and select **Not registered? Click here to register.** Your account will activate within 24 hours. By registering online, members can also track the progress of their orders.
2. **Phone:** Call Orchard Pharmaceutical Services Customer Service at 1-866-909-5170 to speak with a representative.
3. **Mail:** Complete the Registration and Prescription Order Form enclosed in this packet.

Once registered, your Physician can fax your prescription(s) to Orchard at 1-866-909-5171. Only faxes sent from a physician's office will be valid.

Walgreens Specialty Pharmacy

EnvisionRxOptions has selected Walgreens Specialty Pharmacy as an exclusive provider for specialty medications as part of your prescription drug plan. What this means is that you and your family will receive the personalized care and expertise of Walgreens Specialty Pharmacy's dedicated pharmacists, which is essential to successful therapy. This is because Walgreens Specialty Pharmacy goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

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

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

As a convenience, you can choose to receive your first specialty prescription through the mail or pick it up at a retail Walgreens location. After that first fill you will be required to use Walgreens Specialty Pharmacy for all of your specialty medication needs. If you have any questions, or to begin taking advantage of these complimentary patient support services, please call Walgreens Specialty Pharmacy toll free at **1-866-823-2712**.

Glucometer Replacement

EnvisionRxOptions has a program available to members that allows them to receive a free glucometer. Call **1-866-224-8892** for an Abbott Diabetes Care Glucometer (FreeStyle and the Precision Xtra[®] Blood Glucose & Ketone Monitoring Systems) or **1-877-229-3777** for a Bayer HealthCare, Diabetes Care Glucometer (Ascensia[®] CONTOUR[®] and Ascensia[®] BREEZE[®]). **Please identify EnvisionRxOptions as your pharmacy benefits administrator**, and Abbott or Bayer will take care of the rest. There is a limit of one glucometer per member.

Complaints and Appeals

If you have a complaint or need assistance, please call our Customer Service Help Desk at 1-800-361-4542. Please refer to the Summary Benefit Plan provided by your plan or contact your Plan Administrator for instructions on how to file a grievance with your plan or appeal a coverage determination.

If you have any questions regarding your prescription drug benefit, please call the EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542.

Sincerely,

EnvisionRxOptions