

Benefit Definitions



FURMAN

Definitions

In-Network—Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses. Also, providers in the network have contracted rates and/or discounts, which may reduce the cost for services therefore allowing your annual benefit to go further.

Out-of-Network—Use of a health care provider that does not participate in the plan's network. You will pay a much higher charge for the services when you use an out-of-network provider.

Premiums—The amount that you pay out of each paycheck for insurance coverage.

Copayment (Copay)—A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible—The annual amount you and your family must pay each year before the plan pays coinsurance benefits.

Coinsurance—The amount or percentage that you pay for certain healthcare services under your plan. This is the amount paid after the deductible is met and can vary based on the plan design. (For example, 80/20 in which the carrier pays 80% and you pay 20%)

Out-of-Pocket Expenses—Amount that you must pay towards the cost of health care services. This includes deductibles, copayments, and coinsurance.

Out-of-Pocket Maximum—The maximum amount you and your family can pay for eligible expenses each plan year: includes deductibles, copays, and coinsurance expenses. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the policy year.

Definitions

Plan Year—The 12-month period during which benefits run. For many plans, this is normally the calendar year, but does differ with some companies.

Pre-Tax vs Post-Tax—A Section 125 Plan allows premiums to be paid on a pre-tax basis, avoiding taxes saving the employee money. IRS does not allow changes during the year unless there is a qualified change in family status (job, birth, divorce). Some premiums are better to pay post tax. Ex: supplemental plans and disability. Better to tax a small premium rather than a large benefit.

Generic Drugs—Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety, and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration(FDA).

Brand Name Drugs—Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

Specialty Drugs—High cost drugs treat complex conditions and may require special handling, storage, and administration or a significant degree of patient education and monitoring.

Mail Order Pharmacy—Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Lifetime Maximum—The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime. The Affordable Care Act did away with lifetime benefit maximums for essential benefits namely medical plans.

Definitions

High Deductible Health Plan (HDHP)—A medical plan that gives you more control over your health care spending by offering lower premiums in exchange for higher deductibles and out-of-pocket limits. We will use this in conjunction with a Health Savings Account (HSA).

Health Savings Account (HSA)—A fund (personal bank account) that can be established with a qualified high deductible health plan. Furman will contribute to this fund and you may also contribute through pre-tax payroll deductions. Funds in this account are available as they are deposited throughout the year.

Flexible Spending Account (FSA)—An account that allows you to save tax-free dollars for qualified expenses that are not reimbursed:

- Medical Expenses (health care costs for you and your dependents)
- Dependent Care Expenses (child/adult day care, camp, etc.)

You determine how much you want to contribute to the FSA at the beginning of the plan year. If there are over \$500 in funds left in the account at the end of the plan year, the money will be forfeited (use it or lose it rule). Any planned contribution for the year to this account is available at the beginning of the year.

Consumer-Driven (also known as consumer-directed or consumer choice) Health Care—Health insurance programs and plans that are intended to make you more informed about your health. Under these plans, you can use health care services more effectively, have more control over your health care dollars and the plans are designed to be more affordable. These medical plans also offer reduced premium costs in exchange for higher deductibles. Generally, they include preventive coverage, such as a mammogram or annual physical, at little or no cost. Health Savings Accounts (HSAs) are common examples of CDHC plans.

Definitions

Health Insurance Portability and Accountability Act (HIPAA)—A US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers.

Consolidated Omnibus Budget Reconciliation Act (COBRA)—Gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances (such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events). Qualified individuals are required to pay the entire premium for coverage.

Self-Funded Plan—Employer assumes all or a portion of the risk/cost for health benefits. The employer selects a benefits administrator, in our case Cigna, and we purchase reinsurance protection for individual claims that exceed a stated level (Specific Stop Loss) and against an overall claims maximum for the group (Aggregate Stop loss).

Eligible Dependents—Your lawful spouse, domestic partner, and any child who is less than 26 years old or who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability, which arose while the child was covered as a dependent under this plan, or while covered as a dependent under a prior plan with no break in coverage.

Definitions

Qualifying Life Event—An event that will allow you to enroll in certain benefits outside of the open enrollment period. Some example events include: marriage, birth or adoption, employment change, dependent satisfies or ceases to satisfy eligibility requirements.

Services at a Hospital vs. Doctor's Office vs. Urgent Care—The same service might be available at all three of these locations, but you will pay a significantly higher price at a Hospital. Not only do you pay a higher amount, but the plan also pays more. If possible, do research ahead of time to determine the most cost-effective location. If the service can be performed at an Urgent Care facility, that will save you significant dollars versus going to the Emergency Room.

Diagnostic vs. Preventive Services—Diagnostic services provide a diagnosis to promote and maintain health, while preventive services are routine health care services that includes check-ups and patient counseling and screenings to prevent illness, disease and other health-related problems.

Health Risk Assessment (HRA) vs. Biometric Screening vs. Health Coach Provider (HCP) Visit—

- The HRA is completed online via workforcehealth.com prior to scheduling a time at the on-campus sessions for the biometric screening. It is composed of questions in which you answer to determine your health risk.
- The biometric screening is a measurement of physical characteristics. This can be completed onsite at the Employee Clinic, at the Fall Onsite Screenings, or with your personal doctor.
- If biometric screening results stratifies you in a category 4 or a 5, you will be required to complete a HCP Visit before September 30 of the following year in order to keep your premium discount.

Definitions

Telehealth—A collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Teladoc is Furman’s Telehealth vendor.

Dental Calendar Year Maximum—The maximum amount your dental insurance will pay in calendar year for which you are enrolled.

Volume—The amount of life insurance coverage you have in place.

Medical Questionnaire or Evidence of Insurability (EOI) —An instrument designed to evaluate a patient’s health status to determine approval or denial of certain benefits.

Guaranteed Issue (GI)—A set or defined amount of life insurance that is offered to an eligible applicant regardless of health status. Guaranteed Issue amounts are only available for when you are first offered life insurance coverage.

Whole Life Insurance—Life insurance that pays a benefit on the death of the insured and also accumulates a cash value.

Term Life Insurance—Life insurance that pays a benefit in the event of the death of the insured during a specified term. Term life is most affordable because it offers protection for a specific number of years.

Definitions

Accident Insurance—Insurance against loss through accidental bodily injury to the insured.

Critical Illness Insurance—An insurance product in which the insurer is contracted to typically make a lump sum cash payment if the policyholder is diagnosed with one of the specific illnesses on a predetermined list as part of an insurance policy.

Onsite Clinic— A clinic onsite that is available to all employees and spouses. The onsite clinic at Furman that is managed by Greenville Health System (GHS). Currently it is open Tuesday mornings and Monday and Thursday afternoons. To schedule an appointment, please call 864-455-2455.

Plan Document—A formal, written, legal statement listing the provisions of the insurance plan.

Summary Plan Description (SPD)—The main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is a summary of the material provisions of the plan document, and it should be understandable to the average participant. It is available on the Human Resources website.

Summary of Benefits and Coverage (SBC)—This is the easiest of these three documents to understand. This is a short summary using plain language, and is available on the Human Resources website.



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