2024 Benefits Enrollment Guide

Furman University

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Legislative regulatory notices are posted on the HR website
Printed copies are available free of charge by calling HR 864-294-2217.
https://www.furman.edu/offices-services/human-resources/benefits/insurance/

ABOUT THIS BENEFIT GUIDE

This guide describes the benefit plans available to you as a full-time employee of Furman University. The details of these plans are contained in the official Plan Documents, including insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your Summary Plan Descriptions (SPDs) as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan Documents, the formal wording in the Plan Documents will govern.

Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of Furman University.

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FURMAN BENEFIT PROGRAM OVERVIEW

Furman University is pleased to offer you a comprehensive benefit package. The goal of our benefits program is to provide benefit options that allow you to choose the coverage that best meets your needs and the needs of your family. It is important to understand all the options available to you. Our informative enrollment process will educate you about your benefits so you can select the options that are right for you. The following chart shows your benefits offerings and the corresponding plan providers.

Benefit	Carrier
Medical/Prescription	BCBS
Concierge	Health Advocate
Dental	UNUM
Vision	UNUM
Medical and Dependent Care Flexible Spending Accounts	Flores and Associates
Basic Life/AD&D and Supplemental Life/AD&D	UNUM
Long and Short Term Disability	UNUM
Voluntary Benefits – Accident, Critical Illness, Hospital Indemnity and Whole Life	UNUM
Employee Assistance Program	Health Advocate
Legal with Identity Theft	MetLife

ENROLLMENT

The Office of Human Resources (HR) will continue to use the Workday enrollment system for this year's Open Enrollment. Workday is accessible from the MyFurman website. Once logged into the MyFurman portal, click the "Workday" icon. You have access 24/7 to view your current benefit information, obtain information on benefit offerings, view information on different benefit topics, complete annual enrollment, and make changes to your benefits for qualifying life events.

IMPORTANT ENROLLMENT ITEMS

You will need the following to enroll:

- Social Security number(s) and date(s) of birth of everyone to be enrolled in the plan(s).
- Beneficiary information for all life insurance benefits. Once completed, print a copy for your records.

If you have any questions during enrollment, please contact HR at 2217.

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ELIGIBILITY AND QUALIFYING EVENTS

ELIGIBLE EMPLOYEES

Employees will become eligible for benefits if they are working at least 30 hours per week for 39 weeks per year or more.

EFFECTIVE DATES

Benefits will become effective the 1st of the month following date of hire. If date of hire is on the 1st of the month, benefits are effective on the 1st of the same month in which the individual was hired.

ELIGIBLE DEPENDENTS

1. Your lawful spouse

2. Your domestic partner (*See "Pre-tax Advantage" paragraph on page 5)

3. Any child of yours who is less than 26 years old **or** 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.

BENEFIT BASICS

Once you elect your Furman benefit options, your elections remain in effect for the plan year **(January 1 – December 31)**. You may only change coverage due to a qualified life event (see below) and must do so within 60 days for the loss/gain of Medicaid or CHIP (State Childrens Health Program) or 30 days for all other events. Furman University encourages you to review all your benefits and make selections wisely.

Life Events

- Change in: employment status of self, change in status of spouse or dependent, marriage, birth, adoption, placement for adoption, divorce, death
- Dependent employer's Open Enrollment or change in spouse's employment that effects benefits coverage
- HIPAA special enrollment rights
- FMLA special requirements
- Changes due to a judgment, decree, or court order
- Elect to enroll in Medicare, Gain or loss of Medicaid coverage, or Children's Health Insurance Program (CHIP) coverage

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TAXATION INFORMATION

PRE-TAX ADVANTAGE

Under the pre-tax premium plan, you pay medical, dental, vision, health savings account, flexible spending account, and dependent care spending account contributions with pre-tax dollars. This means that your share of the cost is taken off the top of your gross pay before taxes are withheld. With this advantage, you save state, federal and FICA taxes, which amounts to about 25% to 30% of the contributions, depending on your tax bracket. (*Note: In the case of a domestic partner who is not a qualifying dependent, these benefits are paid with post-tax dollars.)

QUALIFYING DEPENDENT RULES FOR DOMESTIC PARTNERS

In order for health benefits to be provided on a pre-tax basis to your domestic partner, he or she must be your dependent. This generally means that your partner must have lived with you for the entire year and must be a member of your household. You must have paid over half of your partner's support for the year. Additionally, your partner must be a U.S. citizen, resident alien, U.S. national, or a citizen of Canada or Mexico.

YOUR BENEFITS AND COSTS

Furman provides a selection of benefits that help protect your health and well-being. Some benefits you pay for, and other benefits are a shared cost between Furman and you. This benefits program helps you make selections that fit your needs.

Benefit	Who Pays?	Taxation
Medical	Furman & You	Pre-Tax*
Health Savings Account	Furman & You	Pre-Tax*
Dental	You	Pre-Tax*
Vision	You	Pre-Tax*
Flexible Spending and Dependent Care Accounts	You	Pre-Tax*
Basic Life and AD&D	Furman	Post-Tax
Supplemental Life and AD&D	You	Post-Tax
Long -Term Disability	You	Post-Tax
Short-Term Disability	You	Post-Tax
Voluntary Benefits – Accident, Critical Illness, Hospital Indemnity and Whole Life	You	Post-Tax
Employee Assistance Program	Furman	Post-Tax
Legal with Identity Theft	You	Post-Tax
Concierge	Furman	Post-Tax

*Only the premium for the qualified domestic partner will be deducted on a pre-tax basis. For employees with domestic partners that are not qualified, only the employee portion of the premium will be pre-taxed.

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MEDICAL BENEFITS

Furman University offers three medical plan options from which you may choose based on you and your family's needs. Each plan includes coverage for medically necessary services including office visits, preventive care, hospitalization, and more.

The available medical plan options are:

Plus Plan

Basic Plan

High Deductible Health Plan (HDHP) with a Health Savings Account (H.S.A)

Plus Plan

The Plus plan provides coverage for in and out-of-network providers. For in-network providers, this plan features an $800 individual ($1,600 family) deductible and a $4,000 individual ($8,000 family) out-of-pocket maximum.

This plan begins paying coinsurance according to the benefits schedule once the deductible is met. In some cases, such as preventive care, expenses are paid for by the plan without a deductible requirement, or you could pay a copay that applies toward your out-of-pocket maximum and does not apply towards your deductible.

Basic Plan

The Basic Plan provides coverage for in and out-of-network providers. For in-network providers, this plan features a $1,500 individual ($3,000 family) deductible and a $6,000 individual ($12,000 family) out-of-pocket maximum.

This plan begins paying coinsurance according to the benefits schedule once the deductible is met. In some cases, such as preventive care, expenses are paid for by the plan without a deductible requirement, or you could pay a copay that applies toward your out-of-pocket maximum and does not apply towards your deductible.

High Deductible Health Plan with a Health Savings Account (HDHP/HSA)

The High Deductible Health Plan (HDHP) with a Health Savings Account provides coverage for in and out-of-network providers. For in-network providers, this plan features a $3,200 individual ($6,400 family) deductible and a $6,950 individual ($13,900 family) out-of-pocket maximum.

Once the deductible is met, the plan begins paying coinsurance according to the benefits schedule. Some preventive care expenses are paid for by the plan without a deductible requirement; however, there are no copays associated with this plan. You are responsible for all other costs and those costs are applied towards meeting your deductible.

Note that the monthly premium cost of coverage is significantly less for the HDHP/HSA Plan than for the Plus or Basic Plans.

Medical co-pays, prescription drug co-pays, and the deductible apply toward your out-of-pocket maximum in the Basic Plan, Plus Plan and the HDHP.

MEDICAL BENEFITS

Furman University 2024 Medical Benefits – BCBS	Plus Plan (In/Out-of-Network)	Basic Plan (In/Out-of-Network)	HDHP/HSA (In/Out-of-Network)
Lifetime Maximum	Unlimited		
Calendar Year Deductible Individual Family	 $800 / $2,400 $1,600 / $4,800	 $1,500 / $4,500 $3,000 / $9,000	 $3,200 / $8,400 $6,400 / $16,800
Out-of-Pocket Maximum *Includes deductible and Coinsurance* Individual Family	 $4,000 / $12,000 $8,000 / $24,000	 $6,000 / $18,000 $12,000 / $36,000	 $6,950 / $19,650 $13,900 / $39,300
Hospital and Hospital-Based Services	80%* / 50%*	80%* / 50%*	80%* / 50%*
Outpatient Clinic Services	80%* / 50%*	80%* / 50%*	80%* / 50%*
Outpatient Hospital Services	80%* / 50%*	80%* / 50%*	80%* / 50%*
Emergency Treatment **ER (co-pay waived if admitted)** **Ambulance** **Urgent Care**	 $250 copay then 80%* 80%* $50 copay / 50%*	 80%* 80%* 80%* / 50%*	 80%* / In-Net Ded 80% 80%* / In-Net Ded 80% 80%* / 50%*
Office Visit: **PCP** **Specialist** **Telemedicine – BlueCare on Demand** ***General Consultation***	 $30 copay / 50%* $50 copay / 50%* $30 copay / not covered	 $30 copay / 50%* 80%* / 50%* $30 copay / not covered	 80%* / 50%* 80%* / 50%* $64 / not covered
Preventative **ACA Mandated Care** **All Other Preventive^**	 100% / not covered $500 max/not covered	 100% / not covered $500 max/not covered	 100% / not covered $500 max/not covered
Mammograms and Colonoscopies (routine) –subject to age guidelines	100% / 50%*	100% / 50%*	100% / 50%*
Well-Child Care (check-ups)	100% / not covered	100% / not covered	100% / not covered
Immunizations	100% / not covered	100% / not covered	100% / not covered
Mammograms and Colonoscopies (non-routine)	80%* / 50%*	80% / 50%*	80%* / 50%*
Lab and X-ray	80%* / 50%*	80%* / 50%*	80%* / 50%*
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc)	80%* / 50%*	80%* / 50%*	80%* / 50%*
Maternity **Hospital Services (Delivery)** **Professional Services (Delivery)**	 80%* / 50%* 80%* / 50%*	 80%* / 50%* 80%* / 50%*	 80%* / 50%* 80%* / 50%*
Mental Health/Substance Abuse Services **Office** **Inpatient**	 $50 copay / 50%* 80%* / 50%*	 80%* / 50%* 80%* / 50%*	 80%* / 50%* 80%* / 50%*

**After you pay the calendar year deductible.*

^https://www.healthcare.gov/preventive-care-adults/

Cost vary whether using an in-network or out-of-network provider. You can find an in-network provider by visiting southcarolinablues.com

Health Savings Accounts (HSA) and High Deductible Health Plans (HDHP)

How they work — and how they can work for you!

What is an HSA?

A Health Savings Account (HSA) is a triple tax-advantaged* savings account you can contribute to if you enroll in an IRS-qualified high deductible health plan (high-deductible medical plan offered with BCBS meets IRS requirements) and meet eligibility requirements. If you elect the HDHP, an HSA Bank account will be opened in your name in conjunction with the HDHP to help you save and pay for eligible health care expenses. You contribute on a pre-tax basis, you earn tax-free interest, and your withdrawals may also be tax-free. You will receive a debit card to access the funds and you may use funds from your HSA to pay any eligible health care expenses*, such as your deductible, coinsurance, and any expenses of eligible family members (even if they are covered elsewhere).

**Please visit IRS.gov for a list of eligible expenses. *Tax advantages may vary by state.*

Who is Eligible?

- ❑ Must be enrolled in the HDHP to qualify
- ❑ Cannot be claimed as a dependent on another person's tax return
- ❑ Cannot be enrolled in Medicare
- ❑ Cannot be covered under another non-qualified health plan
- ❑ Cannot be covered under a Flexible Spending Account
- ❑ Must not be enrolled in Medicare (A,B, or D) TRICARE or a Full Purpose Flexible Spending Account (including a spouses Full Purpose Flexible Spending Account)

How Does it Work?

- ❑ Funds are employer/employee provided
- ❑ Funds roll over from year to year
- ❑ Funds are portable
- ❑ Remember, while the rules allow you to cover your dependent children on the medical plan until age 26, you may not be able to use HSA funds for their expenses unless they meet the definition of a qualified tax dependent. It is important that you speak with a tax expert to determine if your dependent falls under that definition.

The annual maximum contribution for 2024 is:

– $4,150 individual coverage
– $8,300 family coverage

**Age 55 or older allows an additional $1,000 "catch up contribution"*

Employee Contributions to Health Savings Accounts:

Your ability to contribute the maximum amount to your HSA account may depend on your enrollment date for the current plan year and/or remaining active in the plan the following calendar year. Please see IRS publication 969 for complete health savings account contribution rules.

https://www.irs.gov/publications/p969

In early January, Furman will contribute $500 for individual and $1,000 for family coverage to your HSA. New hires will receive Furman contributions after benefits enrollment takes place. For individuals hired on or after July 1st, Furman will contribute $250 for individual and $500 for family coverage to your HSA.

How your HDHP and HSA work together!

Each time you receive health care services and incur a charge, you can:

- Make a tax-free withdrawal from your account to cover the costs, or
- Pay out of your own pocket and save your HSA for future eligible expenses

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HOSPITAL INDEMNITY AND PHARMACY BENEFITS

Hospital Indemnity Benefit

Employees are eligible to enroll in Hospital Indemnity coverage for you and your enrolled dependents. We all know that an unexpected or even a planned stay in the hospital can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan.

The Hospital Indemnity insurance plan is designed to provide financial protection by paying you a lump-sum benefit due to a hospitalization. You can use the benefit to meet out-of-pocket expenses and extra bills that can occur.

Admission	Benefit*	Maximum Daily Limit
Hospital	Admission: $1,000 Confinement: $100	Admission: 1 day Confinement: 365 days
Wellness	$50 per covered person	Per insured, per calendar year

**Benefit received is tax-free and received as a lump sum payment.*

Hospital Indemnity Rates	You Pay (Monthly Rates)
Employee	$24.38
Employee + Spouse	$48.15
Employee + Child(ren)	$32.67
Employee + Family	$56.44

Pharmacy Benefits	Plus Plan In-Network Only	Basic Plan In-Network Only	HDHP/HSA* In-Network Only
Retail (31 day)			
Generic	$15 Copay	$15 Copay	20%, after deductible
Preferred Brand	$40 Copay	$40 Copay	20%, after deductible
Non-preferred Brand	$70 Copay	$70 Copay	20%, after deductible
Mail Order (90 day)			
Generic	$25 Copay	$25 Copay	20%, after deductible
Preferred Brand	$90 Copay	$90 Copay	20%, after deductible
Non-preferred Brand	$175 Copay	$175 Copay	20%, after deductible
Specialty Drug^ **^Optum Specialty Pharmacy Call** *1-877-259-9428 for inquiries regarding this benefit.*	$125 Copay per 31 day supply	$125 Copay per 31 day supply	20%, after deductible

*****For HDHP/HSA, the medical deductible has to be met before pharmacy drugs are covered.

Prescription Drug Program Reminders

- Retail drugs allow for a 31-day supply at a wide range of pharmacies. Member may purchase a 90 day supply of a GENERIC prescription at a retail location, however, 3 times the regular co-pay or cost sharing will apply.

- 90 day supplies are available for Home Delivery on other covered generic, preferred, and non-preferred prescriptions.

- Specialty Drugs are only available through the Optum Specialty Pharmacy program and are only available in a 31 day supply. Optum can be reached by calling 1-877-259-9428.

- The BCBS Pharmacy program requires that members fill their prescriptions with a generic drug when available. **Even if the physician writes "dispense as written", if the member chooses to get a brand name when a generic is available, the member will pay their normal cost share PLUS the difference in the price between the generic and the brand name prescription**.

- **Additional Clinical Management:** In an effort to control the rising costs of prescription drugs and ensure the appropriate use of medications, prior authorization and quantity limits will remain in effect on a larger number of medications. This applies to a wide range of drug classes, but focuses on narcotics, including migraine medications, NAISD's, and other stimulants. Please see the 2023 drug formulary for additional information.

- **My Diabetes Discount Program**
  A value based benefit program that rewards those with diabetes who effectively manage their condition with a reduced copay on diabetic supplies. Ability to receive their insulin for no more than $20. Eligible members will receive information via mail.

MEDICAL RATES

Monthly Rates					
HDHP/H.S.A Plan (Monthly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HRA)**	**Employee Pays (without BIO & HRA)**	**Employee Pays (without BIO & HRA) Partial Discount^**
Employee	92%	$600.74	$49.59	$149.59	
Employee + Child(ren)	92%	$957.27	$83.25	$183.25	
Employee + Spouse	92%	$1,369.71	$126.04	$232.04	$226.04
Employee + Family	90%	$1,754.40	$196.57	$302.57	$296.57
Basic Plan (Monthly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HRA)**	**Employee Pays (without BIO & HRA)**	**Employee Pays (without BIO & HSA) Partial Discount^**
Employee	87%	$663.23	$100.89	$200.89	
Employee + Child(ren)	89%	$1,091.67	$130.92	$230.92	
Employee + Spouse	87%	$1,526.83	$230.64	$360.64	$330.64
Employee + Family	85%	$1,941.67	$350.69	$480.69	$450.69
Plus Plan (Monthly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HSA)**	**Employee Pays (without BIO & HSA)**	**Employee Pays (without BIO & HSA) Partial Discount^**
Employee	76%	$631.12	$199.93	$299.93	
Employee + Child(ren)	71%	$942.08	$387.59	$487.59	
Employee + Spouse	73%	$1,400.40	$511.00	$711.00	$611.00
Employee + Family	70%	$1,738.71	$754.42	$954.42	$854.42
Bi-Weekly Rates					
HDHP H.S.A Plan (Bi-Weekly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HRA)**	**Employee Pays (without BIO & HRA)**	**Employee Pays (without BIO & HRA) Partial Discount^**
Employee	92%	$277.27	$22.89	$69.04	
Employee + Child(ren)	92%	$441.82	$38.42	$84.58	
Employee + Spouse	92%	$632.17	$58.17	$107.10	$104.33
Employee + Family	90%	$809.72	$90.72	$139.65	$136.88
Basic Plan (Bi-Weekly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HRA)**	**Employee Pays (without BIO & HRA)**	**Employee Pays (without BIO & HRA) Partial Discount^**
Employee	87%	$306.11	$46.56	$92.72	
Employee + Child(ren)	89%	$503.85	$60.42	$106.58	
Employee + Spouse	89%	$704.69	$106.45	$166.45	$152.60
Employee + Family	85%	$896.16	$161.86	$221.86	$208.01
Plus Plan (Bi-Weekly Rates)	**Furman University Cost Sharing**	**Furman University Pays**	**Employee Pays (with BIO & HRA)**	**Employee Pays (without BIO & HRA)**	**Employee Pays (without BIO & HRA) Partial Discount^**
Employee	76%	$291.29	$92.28	$138.43	
Employee + Child(ren)	71%	$434.81	$178.89	$225.04	
Employee + Spouse	73%	$646.34	$235.85	$328.15	$282.00
Employee + Family	70%	$802.48	$348.19	$440.50	$394.35

^One member, either employee or spouse/domestic partner completes requirements for medical premium discount.

For 2024, Furman University will continue to provide the opportunity to receive a reduced premium if the following initiatives are completed by the employee and their covered spouse/domestic partner no later than December 1, 2023. New Hires automatically receive the discount for the current plan year but must complete the initiatives during 2024 in order to maintain the discount for the following plan year.

1) Complete Health Risk Assessment (HRA) via PRISMA/GHS's Workforce Health Portal
2) Complete a Biometric Screening
3) Complete Health Care Provider (HCP) visit, if required

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24 HOUR NURSE ADVISOR

When you need immediate health care advice, call 24-Hour Nurse Advisor toll free at 877-836-0701. This service can help you avoid needless worry, out-of-pocket charges and hours sitting in an emergency room.

When you call, a registered nurse will help you decide:

- If you can take care of the problem at home.
- If you need to see your doctor.
- If it is safe to wait or if you need to get help right away.
- What you should watch for if you don't need care right away.
- In an emergency, call 911 or visit the nearest emergency room.

You can also ask the nurse about:

- Questions you forgot to ask your doctor.
- The latest health information.
- Making important health care decisions.
- Your medicines or other treatments.

877-836-0701
24 Hours a Day

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

MY HEALTH TOOLKIT

Your Health Benefits at Your Fingertips

Your health plan makes it easy to find answers about your benefits. My Health Toolkit is a one-stop destination for managing those benefits.

My Health Toolkit App

1.Learn more about your coverage: Look up your medical coverage, deductible and out-of-pocket spending.

2.Check medical claims: View the status of a current or previous medical claim, the date of services, the amount charged by your provider and the amount you may owe.

3.View your identification card: You can access and share an electronic version of your card.

4.Shop for care: Use the Find Care link to view a list of network doctors and medical facilities in your area.

Check out features like patient reviews, quality information and accepting new patients.

5. Access our full site: The link to our website allows you to order a replacement membership card and many other tasks.

South Carolina

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BLUE CAREONDEMAND

Why wait for the care you need now? Blue CareOnDemand is a faster, easier way to see doctors. You can consult U.S. board-certified physicians 24/7/365 through the convenience of video visits.

When to use it

Blue CareOnDemand is a great solution when:

- You need to see a doctor, but can't fit it into your schedule
- Your doctor's office is closed
- You, or your child, feel too sick to leave the house
- You're traveling

Doctors can treat many of the most common health conditions through video visits, including:

- Cold and flu symptoms
- Allergies
- Bronchitis and other respiratory infections
- Urinary tract infections
- Skin irritations
- Sinus problems
- Migraines
- And more!

They can even write prescriptions, when needed, according to your state's regulations.

How to use it

There are two easy ways to use Blue CareOnDemand:

1. Download the Blue CareOnDemand mobile app from the App Store or Google Play
2. Visit www.BlueCareOnDemandSC.com

Register Now

You will need to register and create a patient profile on your first visit to the mobile app or website. So grab your BlueCross membership card and register now — the next time you need care, the doctor is only a few clicks away!

DENTAL BENEFITS

Taking care of your teeth is as important as taking care of the rest of your body. That's why Furman offers dental plans needed for your health. You have a choice of two plans through Unum.

BENEFIT	Standard Plan *In/Out-of-Network*	Premium Plan *In/Out-of-Network*
Deductible	$50 per person $150 per family	
Calendar year maximum benefit(per person)	$750	$1,500
Class I: Diagnostic & Preventive Services – 100%		
Exams	2 per calendar year	2 per calendar year
Cleanings	2 per calendar year	2 per calendar year
Space Maintainers (under age 16)	1 per tooth per lifetime	1 per tooth per lifetime
Sealants (under age 16)	1 per tooth, every 3 years	1 per tooth, every 3 years
Bitewing X-Rays	2 per calendar year	2 per calendar year
Full Mouth X-Rays	1 every 3 calendar years	1 every 3 calendar years
Class II: Basic Services – 80%		
Fillings	80% *	80% *
Simple Extractions	80% *	80% *
Class III: Major Services – 50%		
Oral Surgery	50% *	50% *
Crowns	Every 7 years	Every 7 years
Pontics	Every 7 years	Every 7 years
Complete Dentures	Every 7 years	Every 7 years
Implants	Every 7 years	Every 7 years
Endodontics	50% *	50% *
Periodontics	50% *	50% *
Class IV: Orthodontic Services		
Orthodontia Services	Not covered	50% * ($1,500 lifetime maximum which includes any orthodontia services received from previous carriers)
Orthodontia Age Limit	Not covered	Dependent children to age 26

*After deductible is met.

Please note: Any diagnostic and preventative services are included as part of your calendar year maximum benefit. Cost varies whether using an in-network or out-of-network provider. Visit www.unumdentalcare.com to look for an in-network dental provider.

DENTAL RATES

	Employee Cost (Monthly)	Employee Cost(Bi-Weekly)
Standard Plan		
Employee Only	$45.58	$21.04
Employee + Spouse	$61.74	$28.50
Employee + Child(ren)	$73.93	$34.12
Employee + Family	$93.78	$43.28
Premium Plan		
Employee Only	$54.67	$25.23
Employee + Spouse	$120.59	$55.66
Employee + Child(ren)	$144.55	$66.72
Employee + Family	$183.38	$84.64

DENTAL BENEFITS

CARRYOVER BENEFIT

During each benefit year as a part of the Unum dental plan, if a member receives at least one cleaning, one regular exam, and their total dental claims are below the threshold limit, a portion of the annual maximum will automatically carry over to the next year.

Plan	Base Annual Maximum	Threshold Limit	Carryover Amount	Carryover Maximum	Total Potential Annual Maximum
Option 1: Passive PPO	$750	$300	$150	$500	$1,250
Option 2: Passive PPO	$1,500	$700	$350	$1,250	$2,750

Carryover Benefit Additional Details

- Each covered family member receives their own carryover benefit
- The group carryover benefit must be in effect for one benefit year before any members can utilize carryover benefits.
- A member must be on the plan for a minimum of three months before accruing carryover benefits.
- The carryover benefit cannot be used towards orthodontia.
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break in coverage for any length of time or any reason.

Reimbursements

In-network: Reimbursement is based on our schedule for participating provider maximum allowable charges. This I the amount that the dentist has agreed to accept as payment in full for covered dental services.

Out-of-Network: The maximum allowable charge for a non-participating provider is equal to the lesser of: (1) the dentist's actual charge or the (2) customary charge of dentists in the same geographic area for the same or similar services, as determined by Us.

Dependent Children

Dependent children guidelines vary by state.

Alternate Treatments

There are multiple options for dental treatment, all of which provide acceptable results. An Alternate Benefit may be applied if there is a less expensive Covered Procedure appropriate for the course of treatment, capable of producing acceptable results. When an Alternate Benefit is applied, the less expensive Alternate Benefit is used to determine the amount payable under the certificate.

Unum Dental Takeover Benefits

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included, the waiting periods for service listed as subject to takeover will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to Unum Dental. Application of takeover benefits is subject to Underwriting review and approval.

Takeover is also available to new hires, those who enroll during open enrollment, or due to a Qualifying Life Event with prior-like group dental coverage, provided there has not been a lapse in coverage greater than 63 days. Individuals are responsible for providing proof of Prior Plan which should include, but not limited to, coverage effective dates, a benefit summary, certificate of coverage, etc.

Exclusions and Limitations

The following services are not covered unless stated otherwise in the Certificate of Coverage: 1.)Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior elective or cosmetic restorations. 2.) Replacement of a removable device or appliance that is lost, missing or stolen, and for the replacement of removable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures. 3.) Replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional an is older that the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns. 4.) Any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion. 5.) Any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bit analysis. 6.) Charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, over dentures and any associated surgery, or other customized services or attachments, and related procedures.

Services provide for any type of temporomandibular joint (TMJ) dysfunction, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.

Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. On any given day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph.

Pre-Estimates are recommended for any treatment expected to exceed $300.

VISION BENEFITS

Furman University provides the opportunity to keep your eyes healthy. The vision administrator is Unum, utilizing the EyeMed Vision Network. There are two plans to choose from. The low option allows for new frames 24 months. **The vision network is EyeMed**, and can be viewed at: member.eyemedvisioncare.com/unum/en.

Low Plan		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses	Once every 12 months	
Coverage & Co-pays	EyeMed Network	Out-of-Network
Exam	$20 Copay	Up to $40
Retinal imaging benefit (subject to provider availability)	$39	Not Covered
Materials		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal / Lenticular	$25 copay	Up to $70
Standard Progressive Lens	$25 copay	Up to $50
Premium Progressive Lenses Tier 1	$45 copay	Up to $50
Tier 2	$55 copay	Up to $50
Tier 3	$70 copay	Up to $50
Tier 4	$25 copay, 80% of charges less than $120 allowance	Up to $50
Polycarbonate Lenses (Under age 19)	Covered	Up to $32
Standard Polycarbonate lenses	Covered	Up to $32
Standard Anti-Reflective Coating	Covered	Not Covered
Premium Anti-Reflective - Tier 1	$12 copay	Not Covered
Premium Anti-Reflective - Tier 2	$23 copay	Not Covered
Premium Anti-Reflective - Tier 3	80% of charge	Not Covered
Standard Scratch Resistant Coating	Covered	Up to $12
Tints	Covered	Up to $12
UV Coating	Covered	Up to $12
Frames		
Members may select any frame available	$130 retail allowance	Up to $91
Contact Lenses (in lieu of eyeglass lenses)		
Elective (standard Contacts)	$130 allowance	Up to $130
Medically Necessary	Covered	Up to $210
Standard contact lens fitting exam fee*	$60 copay	Up to $40
Specialty contact lens fitting**	$55 allowance	Up to $40

*The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear or extended wear lenses only.

**The specialty contact lens fitting exam fee applies to a new or existing contact lens user who wears toric, gas-permeable, mono-fit or multi-focal lenses.

VISION BENEFITS

Furman University provides the opportunity to keep your eyes healthy. The vision administrator is Unum, utilizing the EyeMed Vision Network. There are two plans to choose from. The high option allows for new frames every 12 months. **The vision network is EyeMed**, and can be viewed at: member.eyemedvisioncare.com/unum/en.

High Plan		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 12 months	
Contact Lenses	Once every 12 months	
Coverage & Co-pays	EyeMed Network	Out-of-Network
Exam	$10 Copay	Up to $40
Retinal imaging benefit (subject to provider availability)	$39	Not Covered
Materials		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal / Lenticular	$25 copay	Up to $70
Standard Progressive Lens	$25 copay	Up to $50
Premium Progressive Lenses Tier 1	$45 copay	Up to $50
Tier 2	$55 copay	Up to $50
Tier 3	$70 copay	Up to $50
Tier 4	$25 copay, 80% of charges less than $120 allowance	Up to $50
Polycarbonate Lenses (Under age 19)	Covered	Up to $32
Standard Polycarbonate lenses	Covered	Up to $32
Standard Anti-Reflective Coating	Covered	Not Covered
Premium Anti-Reflective - Tier 1	$12 copay	Not Covered
Premium Anti-Reflective - Tier 2	$23 copay	Not Covered
Premium Anti-Reflective - Tier 3	80% of charge	Not Covered
Standard Scratch Resistant Coating	Covered	Up to $12
Tints	Covered	Up to $12
UV Coating	Covered	Up to $12
Frames		
Members may select any frame available	$200 retail allowance	Up to $91
Contact Lenses (in lieu of eyeglass lenses)		
Elective (standard Contacts)	$200 allowance	Up to $130
Medically Necessary	Covered	Up to $210
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Specialty contact lens fitting**	$55 allowance	Up to $40

*The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear or extended wear lenses only.

**The specialty contact lens fitting exam fee applies to a new or existing contact lens user who wears toric, gas-permeable, mono-fit or multi-focal lenses.

Vision Benefits and associated optical Discounts and Hearing Savings Plan

Vision Premium Rates	Employee Cost (Monthly)	Employee Cost (Bi-weekly)
Low Plan		
Employee Only	$6.35	$2.93
Employee + Spouse	$10.18	$4.70
Employee + Child(ren)	$10.40	$4.80
Employee + Family	$16.77	$7.74
High Plan		
Employee Only	$11.91	$5.50
Employee + Spouse	$19.05	$8.79
Employee + Child(ren)	$19.46	$8.98
Employee + Family	$31.21	$14.40

Lasik Discount

Unum offers nationwide access to discounts on LASIK surgery through a partnership with TLC Vision. Discounts are also available with participating local providers. This is not insured benefits. Visit our website to find the specialist closest to you.

Discounts on Optical Materials

Unum Vision Members(Powered by Eyemed) will receive the following discounts on materials at in-network providers only:

- 40% off for a complete second pair of glasses.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.

Unum Vision members will also receive additional savings on lens options at in-network providers.

- UV Treatment - $15
- Tint (solid and gradient) - $15
- Standard Plastic Scratch Coating - $15
- Standard Polycarbonate – Adults - $40
- Standard Anti-Reflective Coating - $45
- Premium Anti-Reflective Coating
  - Tier 1 - $57
  - Tier 2 - $68
- Photochromic / Transitions - $75

*Non-insured options unless listed in the Plan Description as a covered benefit and subject to change.

Hearing Savings Plan

Unum offers a Hearing Savings Plan at no additional cost to all of its Unum Vision members (powered by EyeMed). Partnering with Amolifon the Hearing Savings Plan provides:

- 40% off hearing exams at thousands of convenient locations nationwide
- Discounted set pricing on thousands of hearing aids, including those with the newest, most advanced technology
- Low price guarantee – if you find the same product at a lower price elsewhere, Amplifon will beat it by 5%
- 60-day hearing aid trial period with no restocking fees
- Free batteries for 2 years with initial purchase
- 3-year warranty plus loss and damage coverage

FLEXIBLE SPENDING ACCOUNT (FSA)

Flores Simply Better Service

Furman University employees are eligible to participate in the Health Care Flexible Spending Account (FSA) and/or Dependent Care Flexible Spending Account (FSA). These benefit plans allow you to redirect a portion of your pre-tax income to provide reimbursement for eligible expenses.

- A Health Care FSA can be used to pay for certain health care expenses.
- A Dependent Care FSA can be used to pay for child care expenses for your child(ren) under the age of 13 or a spouse that is physically or mentally incapable of caring for him or herself.

**If you are participating in the High Deductible Health Plan with an HSA, you cannot participate in the Health Care FSA benefit. However, you may choose to contribute to a limited-purpose FSA. Please be aware that limited-purpose FSA funds will only be available for use toward eligible dental and vision expenses.*

FSA Contribution Limits:

- **Health Care (or Limited-Purpose) FSA:** Minimum: $100 Maximum: $3,050
- **Dependent Care FSA:** Minimum: $100 Maximum: $5,000

Debit Card Guidelines

- A debit card will automatically be issued for each employee who elects to participate in a Health Care FSA or Limited-Purpose FSA. If you wish to order a debit card for a spouse or eligible dependent, visit the Flores website at www.flores247.com.
- If you already have a Flores debit card, keep it! Cards do not expire for 5 years. Your current card will be reloaded with your newly elected contribution when the new plan year begins in January.
- To be eligible for reimbursement, an expense must be related to care provided to you or an eligible dependent, during the period of coverage.
- Some health care services are not reimbursable (i.e. non-reconstructive cosmetic surgery). For inquiries about which services may not be eligible for reimbursement, call 800-532-3327.
- If you enroll in a Dependent Care FSA, this balance will not be linked to a debit card. To receive reimbursement for eligible daycare expenses, you will need to submit a completed claim form to Flores along with either supporting invoice or a provider's signature.
- Dependent Care reimbursements are issued daily, Monday thru Friday, and will be sent by check to your home address, or by direct deposit if you have provided your banking information to Flores.

USE IT OR LOSE IT!
ANNUAL ROLLOVER BENEFIT

Your Flexible Spending Account (FSA) elections are effective from January 1 through December 31. Please plan your contributions carefully. Our Health Care FSA allows you to carry over $610 in unused funds to the 2024 plan year. The carryover only applies if you remain benefit eligible. Any money over $610 remaining in your Health Care FSA and any amount in your Dependent Care FSA as of 3/31/2023 will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

BASIC LIFE and AD&D BENEFITS

Furman provides basic employee life and accidental death and dismemberment for all benefit eligible employees at no cost. Basic dependent life (spouse & child) is also offered. Cost for this coverage is split between Furman and you. You also have the opportunity to purchase additional supplemental life and/or AD&D insurance for you and your dependents. Your carrier for these benefits will continue to be Unum in 2023.

BASIC LIFE & AD&D BENEFITS	
Basic Life/AD&D - Employee	Furman offers two options for the Employee Basic Life: **Option One:** 1.5 times your annual earnings, to a maximum of $400,000 • Furman will pay for the entire premium and the employee will be responsible for the imputed tax on coverage amounts over $50,000 **Option Two:** Flat $50,000 benefit • Furman will pay the entire premium with no imputed tax • This option only applies to employees making more than $33,334 annually
Dependent Life & AD&D * Available for children from age 14 days to age 26	**Spouse:** $10,000 **Child:** 14 days - 6 months: $500 / 6 months - 26 years: $10,000 **Rate (per family unit):** $.98 monthly • Furman pays 50% of the monthly premium

*You may not cover your spouse/domestic partner as a dependent if your domestic partner is enrolled for coverage as an employee. No dependent child may be covered by more than one employee in the plan and no dependent child can be covered as both an employee and a dependent.

Imputed tax: *The IRS allows up to $50,000 to be excluded from income. Therefore, we report on your W-2 the imputed income for amounts in excess of $50,000. The basic formula for calculating the imputed income is as follows: ((1.5 times your base salary - $50,000) / 1,000) X table 1 rate X 12. Age as of December 31.*

Example*: 50 year old with a $100,000 base salary.*
$150,000 life benefit, less $50,000 is $100,000 / 1,000 X .23 X 12 =$276 in annual imputed income. Assume 35% tax bracket, that equates to a $97 annual tax liability. If you prefer to avoid the imputed income, you may select a flat $50,000 of life insurance benefit as your coverage amount.

Table 1 values per $1,000	
Under 25	*.05*
25-29	*.06*
30-34	*.08*
35-39	*.09*
40-44	*.10*
45-49	*.15*
50-54	*.23*
55-59	*.43*
60-64	*.66*
65-69	*1.27*
70+	*2.06*

If you are no longer an active full time employee and/or your employment ends, your life coverage may be terminated. You may be eligible for conversion and/or portability which allows you to continue your life coverage per the carrier guidelines. You must apply within the carrier's specified timeframe and submit the required premiums in order to continue your life coverage. Please refer to the carrier website for conversion and/or portability forms or see your Plan Administrator for additional information.

SUPPLEMENTAL LIFE and AD&D BENEFITS

	AVAILABLE FOR YOU TO PURCHASE…
Employee	Available in increments of $10,000 to a maximum of the lesser of $500,000 or 5 times your Basic Annual Earnings. **Guaranteed Issue Amounts**: • Under age 70: $400,000 • 70 – 74: $260,000 • 75+: $200,000 *These amounts are subject to Evidence of Insurability for late entrants
Spouse*	Available in increments of $5,000 to a maximum of $150,000; not to exceed 100% of employees voluntary life amount. **Guaranteed Issue Amounts:** $50,000
Child(ren)*	• 14 days – 6 months: $500 • 6 months to age 26: Available in increments of $2,500 to a maximum of $10,000.

*You must enroll in the Supplemental Life and/or AD&D program in order to enroll your eligible dependent(s).

*You may not cover your spouse/domestic partner as a dependent if your domestic partner is enrolled for coverage as an employee. No dependent child may be covered by more than one employee in the plan and no dependent child can be covered as both an employee and a dependent.

Supplemental Employee Life Rates (by age)	Per $1,000 of coverage
15-29	$0.085
30 - 34	$0.102
35 - 39	$0.150
40 - 44	$0.165
45 - 49	$0.245
50 - 54	$0.365
55 - 59	$0.585
60 - 64	$0.685
65 - 69	$1.295
70 - 74	$2.205
75+	$5.975
Dependent Life Spouse/Child (per $1,000)	$0.310
Supplemental AD&D Rates	
Employee (per $1,000)	$0.025
Spouse/Domestic Partner/Child (per $1,000)	$0.025

Guaranteed Issue (GI) – A set or defined amount of life insurance that is offered to an eligible applicant regardless of health status, only if you enroll during the initial eligibility period.
Age Restrictions – A restriction of the amount of benefit you are eligible to enroll in due to your age.
Age Reductions – A percentage that your benefit is reduced, which is based on your current benefit election amount.

- 35% at age 70
- 50% at age 75

DISABILITY BENEFITS

LONG-TERM DISABILITY: Furman University offers Long Term Disability (LTD) through Unum. LTD is a mandatory benefit for all benefit eligible employees. Employees are automatically enrolled in the LTD benefit on the 1st of the month following date of hire. Benefits are as follows:

- **60%** of your monthly earnings
- **Maximum Benefit:** $12,000 a month
- **Minimum Benefit:** The greater of $100 or 10% of the gross monthly benefit
- Benefits start after 90 days of disability
- Cost is $0.49 per $100 of the benefit you would receive (see below)

Example: Bill was cleaning leaves out of his gutter when he fell off the ladder and hurt his back. A trip to the ER confirmed he had four herniated discs and would need intensive physical therapy before he could return to work. Bill's long-term disability insurance paid a percentage of his lost income, while he worked to regain his strength.

Bill's LTD Premium Cost Calculation

Annual Salary	**$69,600**
Gross Monthly Earnings (Annual Salary/12)	**$5,800**
# of LTD Units (Gross Monthly Earnings/100)	**58**
LTD Monthly Premium (# of LTD Units X .55)	**$28.42**
Monthly LTD Benefit (Gross Monthly Earnings x .60)	**$3,480**

*Pre-existing exclusions may apply. See contract for complete details.

SHORT-TERM DISABILITY: Furman University offers two optional Short-Term Disability (STD) choices through Unum. Benefits eligible staff members are automatically eligible for STD on the 1st of the month following date of hire. Benefits are as follows:

	Option 1	Option 2
Benefit	60%	60%
Maximum Weekly Benefit	$1,000	$1,000
Duration of Benefit	12 weeks	9 weeks
Rate	.694 per $10 of benefit	.32 per $10 of benefit
Waiting Period	7 days	30 days

Example: Michelle was showing her nephew how to block a kick, when she took an unexpected fall and broke her ankle. She needed minor surgery and a cast, which kept her away from work for several weeks. Michelle's short-term disability insurance paid her a portion of her lost income, so she could manage expenses while she was unable to work.

Michelle's STD Premium Cost Calculation

	Option 1	Option 2
Annual Salary	**$36,140**	**$36,140**
Gross Weekly Earnings (Annual Salary/52)	**$695**	**$695**
Weekly STD Benefit (Gross Weekly Earnings X .60)	**$417**	**$417**
# of STD Units (Weekly Benefit/10)	**$41.70**	**$41.70**
STD Monthly Premium (# of STD Units X .694 or .320)	**$28.94**	**$13.34**

VOLUNTARY BENEFITS

Critical Illness

Critical Illness coverage provided by Unum, can pay benefits for non-medical, critical illness-related expenses that your medical plan might not cover. The critical illness benefit is in the form of a lump sum payment, which is paid to the employee after a diagnosis is made and the claim has been approved.

- Benefits are paid directly to you.
- Individual, spouse and child(ren) coverage options are available.
- Covered conditions include heart attack, stroke, invasive cancer, coma, paralysis and more.
- Coverage does not replace other group medical benefits. It is designed to supplement your medical plan coverage.
- This coverage includes a wellness benefit that pays $50 per covered person per year with proof of a qualified health screening.

Accident

Accident coverage provided by Unum, can pay benefits for on- and off-the-job accidents, plus some benefits that correspond with medical care. The coverage can be used on its own or to fill a gap left by other coverage and pays a benefit up to a specified amount for accidental death, dismemberment, dislocation/fracture, initial hospitalization confinement, hospitalization confinement, ambulance service, medical expenses, outpatient physician's treatment and more.

- This coverage also includes a wellness benefit that pays $50 per covered person per year for proof of a qualified health screening.

Whole Life

Whole Life insurance, provided by Unum, provides valuable benefits that you can use during times of need. You can also keep your Whole Life coverage after you retire, making it an essential complement to your Term Life insurance. The policy accumulates cash value and you can borrow funds from this value as needed. Your plan will include:

- **A Living Benefit Option:** If you are diagnosed with a terminal illness, you can request up to 100% of your policy's benefit amount and use if for any purpose.
- **Long Term Care Option**
- **Premiums vary by age, coverage amount and tobacco use**

Whole Life Pricing Example:

Sample Rates - based on a $25,000 benefit amount		
Issue Age	**Weekly Premium**	**Guaranteed cash value at age 65**
25	$4.19	$9,840
35	$6.44	$8,851
45	$10.79	$7,140

VOLUNTARY BENEFITS RATES

Enrollment for Unum Voluntary Products

- Enroll or make changes to coverage – Call Unum at 877-752-7432.
- Cancel coverage – Email Kristin Austin at kristin.austin@furman.edu

Accident Rates	Monthly
Employee	$15.52
Employee + Spouse	$24.84
Employee + Child(ren)	$27.74
Employee + Family	$37.06

Critical Illness Rates	$10,000 employee and $10,000 Spouse (Monthly Rates)			
	Employee or Employee + Children Cost		Spouse Cost	
Issue Ages	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
<25	$3.64	$3.64	$3.64	$3.64
25-29	$4.44	$4.94	$4.44	$4.94
30-34	$5.54	$6.44	$5.54	$6.44
35-39	$7.04	$9.24	$7.04	$9.24
40-44	$9.24	$12.74	$9.24	$12.74
45-49	$12.34	$18.44	$12.34	$18.44
50-54	$17.04	$26.14	$17.04	$26.14
55-59	$23.44	$36.54	$23.44	$36.54
60-64	$33.24	$51.94	$33.24	$51.94
65-69	$49.24	$70.34	$49.24	$70.34
70-74	$75.44	$100.34	$75.44	$100.34
75-79	$108.44	$134.54	$108.44	$134.54
80-84	$153.24	$185.44	$153.24	$185.44
85+	$243.84	$286.84	$243.84	$286.84

$20,000 & $30,000 coverage amounts also available. See rates in the Workday System.

Whole Life Rates	
Employee, Spouse and Child(ren)	Rates based on age and benefit amount selected.

Legal with Identity Theft

There are many times in life when you may need the services of a qualified attorney, such as: purchasing a home, drafting a will, dealing with elder care or debt issues, etc. If you ever had to hire an attorney, you know that the fees can quickly add up. The legal plan is serviced by MetLife.

MetLaw could save you hundreds of dollars in attorney fees for common legal services such as:

- Estate planning documents, including Wills and Trusts
- Real estate matters
- Identity theft defense
- Financial matters, such as debt-collection defense
- Traffic offenses
- Document review
- Family law, including adoption and name change
- Advice and consultation on personal legal matters
- And more!

Enrolling in the legal plan also gives you access to MetLife's Identity Theft services, FraudScout. Many of life's milestones, such as buying a house, getting married, having children, or retiring creates new opportunities for identity thieves. FraudScout scours millions of identity sources and alerts you of changes to your credit, personal, or financial information. Services include:

- Credit report and monitoring
- Credit score summary
- Credit monitoring

The monthly rate for the combined service of MetLaw and FraudScout is $24 per month.

**Covers spouses and dependents*

For more information:
Visit: www.legalplans.com **Call:** 800-821-6400

MetLife | Legal Plans

FURMAN

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your Employee Assistance Program (EAP) will continue to be provided by Health Advocate. An EAP gives you confidential access to a licensed professional counselor who will provide short-term assistance with issues that are having an impact on your life and ability to focus on work. Licensed professional counselors can help address:

- Anger, grief, loss, depression
- Job stress, burnout, work conflicts
- Marital relationships, family/parenting issues
- Addiction, eating disorders, mental illness
- And more!

When is it available?

The program is available 24/7.

Who can use it?

The EAP +Work/Life program is available to you, your spouse or domestic partner, dependent children, parents, and parents-in-law. Each of you are entitled to **6 FREE** counseling sessions annually.

Work and Life Balance

You can also reach out to a Work/Life Specialist for help with managing your time, locating resources and connecting you with experts for better balancing work and life. Specialists can help with: childcare centers, babysitter tips, preschools, assisted living, identity theft, and financial consultations or debt management, budgeting, and credit issues.

Balance is a call or click away:

HealthAdvocate

Contact: 866-799-2485

Website:
www.HealthAdvocate.com/members

Email:
answers@healthadvocate.com

With BCBS, You've Got a Health Coach in Your Corner!

What is a Health Coach?

Our team of nationally accredited health coaches includes registered nurses, dietitians, health educators, respiratory therapists, certified diabetes educators, licensed behavioral health specialists, and other health and well-being professionals. Wherever you are in your journey, we can connect you to the right coach. He or she will work with you to make positive, meaningful changes at your own pace.

Health Coaching is Available for:

Back Care - Maternity - Stress Management - Tobacco Free Living - Weight Management

Ready to Become a Healthier You?

Log into **My Health Toolkit**, select the **Wellness** tab, then click **Health Coaching.** To enroll, call the health coaching team at 855-838-5897.

MyWellness

The Furman Employee Wellness Committee is pleased to announce the launch of an exciting new initiative called MyWellness. This comprehensive program offers a wide variety of campus programming and resources that are designed to support multiple dimensions of wellness—physical, social, environmental, spiritual, occupational, financial, emotional, and intellectual. MyWellness is designed exclusively for Furman faculty, staff, and dependents.

Visit the website at http://www2.furman.edu/sites/hr/Pages/Wellness-Program.aspx for more information.

Physical Activities Center
http://www2.furman.edu/ATHLETICS/ATHLETICS/PAC/Pages/default.aspx
One of the biggest benefits of being a student, faculty or staff member at Furman is that you have access to the Physical Activities Center—free of charge. This includes: Fitness Center, Basketball Court , Dance Studio, Racquetball courts, Swimming pool and Therapy pool

Group Exercise Program: To locate the latest Group Exercise schedule, visit: http://www2.furman.edu/athletics/athletics/PAC/Pages/GroupExercise.aspx

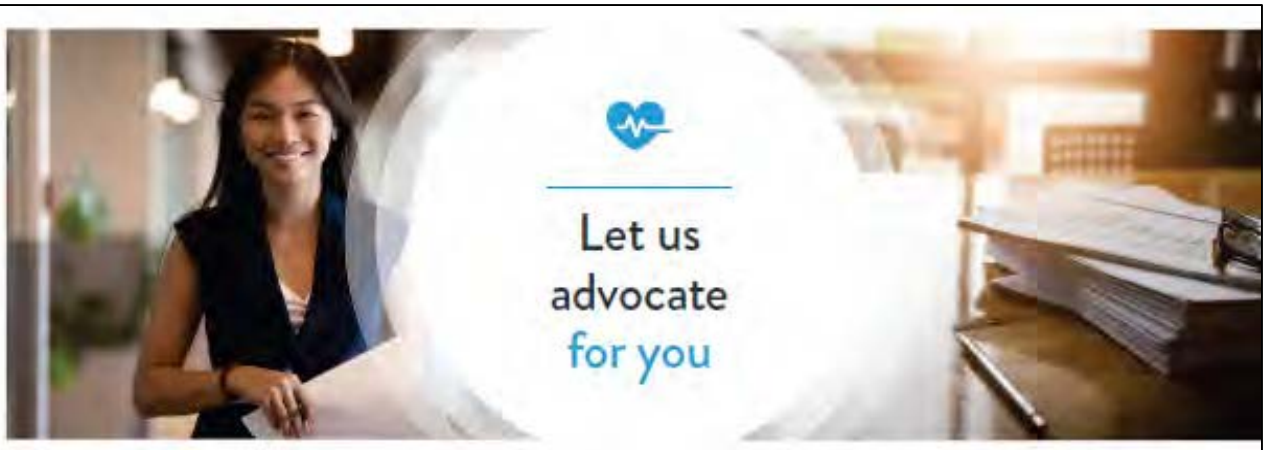
Any questions regarding wellness can be directed to Employeewellness@furman.edu.

Furman Onsite Clinic

The onsite clinic is available to employees and spouses. For employees who elect the HDHP medical plan, there will be a $45 copay that does not apply towards your deductible. For all other employees, the clinic is free of charge. Office hours are currently Monday 8:30am - 12:30pm and Thursday from 12:30pm-4:30pm. and is located on campus at the Earle Student Health Center. Appointments are strongly recommended. To schedule an appointment, call 864-455-2455.

If you have any questions concerning Furman's Employee Wellness Clinic, contact Human Resources at ext. 2217.

HEALTH CONCIERGE PROGRAM



Let us advocate for you

Your Health Advocate services give you access to Personal Health Advocates who can support you in handling a wide range of healthcare-related and insurance issues **to save you time, money and worry.**

Find doctors and arrange second opinions
We can help locate in-network doctors and specialists, as well as coordinate the transfer of medical records and all aspects related to your care.

Resolve claims and billing issues
We'll research the claim or bill, and work on your behalf to sort out the issue with your insurance company and healthcare provider.

Clarify health conditions
We answer questions about diagnoses, test results, treatment options, medications, and more to help you make informed decisions.

Help you understand your insurance
We will answer questions about your coverage, including medical, prescription, dental and vision.

Explain costs for services you may need
This includes the deductibles you have to meet, as well as the copays/coinsurance for doctor and medical appointments.

Support for the whole family
We can help you, your spouse, dependent children, parents and parents-in-law.

Help when you need it most
Quickly reach us by phone, email, live chat online or through our mobile app.

We'll work on your behalf to get to the heart of your issue, no matter how complex.

866-695-8622
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

HealthAdvocate℠

CONTACT INFORMATION

Need additional information? Have a question about one of your benefits? Keep this brochure handy for a quick reference for all your benefitneeds.

PLAN	PROVIDER	WEBSITE	PHONE NUMBER
Medical Benefits	BCBS	www.southcarolinablues.com	855-819-0960
Dental Benefits	Unum	www.unumdentalcare.com	888-400-9304
Vision Benefits	Unum (Powered by EyeMed)	www.member.EyeMedVisioncare.com/Unum/en	855-652-8686
Basic & Supplemental Life and AD&D	Unum	www.unum.com	800-421-0344
Long-Term & Short-Term Disability	Unum	www.unum.com	800-421-0344
Critical Illness, Accident, Hospital Indemnity and Whole Life	Unum	www.unum.com	800-635-5597
Flexible Spending Account	Flores	www.flores247.com	800-532-3327
Health Savings Account	Accrue Health	www.accruehealth.com	800-997-1654
Legal with Identity Theft	MetLife	www.info.legalplans.com	800-821-6400
Employee Assistance Program	Health Advocate	www.HealthAdvocate.com/members	866-799-2485
Concierge	Health Advocate	www.HealthAdvocate.com/members	866-695-8622
Human Resources	Furman University	www.furman.edu/HR	864-294-2217

Women's Health and Cancer Rights Act (WHCRA) Notice

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements), nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:
If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or

If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.
To request special enrollment or obtain more information, contact Furman University's Office of Human Resources at 864-294-2217.

REQUIRED NOTICES

Notice of the Furman University Health Plan Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of the Furman University Health Plan Health Information Privacy Practices (the "Notice") is January 1st, 2024.

The Furman University Health Wrap Plan (the "Plan") provides health benefits to eligible employees of **Furman University** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice. The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.
Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others:

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.
Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.
Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes:

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.
Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

AUTHORIZATION TO USE OR DISCLOSE YOUR PHI
Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone**.**

THE PLAN MAY CONTACT YOU

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interesttoyou.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice.

In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

REQUIRED NOTICES, CONTINUED

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement.

To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify:(1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated Kristin Austin as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact at: (864) 294- 3105, kristin.austin@furman.edu or 3300 Poinsett Highway Greenville, SC 29609.

Important Notice from Furman University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Furman University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

REQUIRED NOTICES

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:
1.Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2.Furman University has determined that the prescription drug coverage offered by BCBS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Furman University coverage will be affected.

If you decide to join a Medicare drug plan, your current Furman University coverage will be affected. If you are an active employee, you may have prescription drug coverage under Furman University's Medical Plan and under a Medicare drug plan. All inactive employees will not be eligible to enroll in both Medicare Part D and Furman University's Medical Plan.

If you do decide to join a Medicare drug plan and drop your current Furman University coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Furman University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Please contact Kristin Austin at (864) 294-3105. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Furman University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as the one set outbelow.

Notice Of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Furman University's Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

•Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Furman University
Human Resources
3300 Poinsett Hwy
Greenville, SC 29613

Protection from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Furman University may use aggregate information it collects to design a program based on identified health risks in the workplace, The Furman University Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is a BCBS health coach, in order to provide you with services available to you under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Kristin Austin at 864-294-3105 or Kristin.Austin@Furman.edu.

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New Health Insurance Marketplace Coverage Options & Your Health Coverage

Part A: General Information
To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. Premiums savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact the Office of Human Resources at Furman University.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name: Furman University
2. Employer Identification Number (EIN): 57-0314395
3. Employer address: 3300 Poinsett Highway
4. Employer phone number: 864-294-2217
5. City: Greenville
6. State: SC
7. Zip: 29613
8. Employer Health Plan Contact: Kristin Austin
9. Phone Number of Contact: 864-294-3105
10. Email address: kristin.austin@furman.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ❑ All employees. Eligible employees are:
  - ✓ Some employees. Eligible employees are:

    employees who are active and full-time with a regular weekly work schedule of 30 or more hours for 39 weeks or more per year.
- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are:

    eligible employees are able to enroll themselves and any spouse or dependent(s), as further defined by the Summary Plan Description for the group health plan.
  - ❑ We do not offer coverage.

✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

Notice Regarding Wellness Program

Furman University's Wellness Program is a voluntary wellness program available to all full time benefits eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol (HDL, LDL, Triglycerides) and blood glucose. All information provided is confidential and not shared with your employer. You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will receive a reduced medical monthly premium incentive of $100 for Employee only and Employee/Children coverage and $106 per month for Employee Spouse or Employee Family coverage on the HDHP plan, $100 for Employee only and Employee/Children coverage and $130 per month for Employee Spouse or Employee Family coverage on the Basic PPO plan, and $100 for Employee only and Employee/Children coverage and $200 per month for Employee Spouse or Employee Family coverage on the PPO Plus plan.

Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive this incentive. Additional incentives may be available for employees who participate in certain health-related activities such as receiving routine preventative exams, wellness lessons, coaching and various physical activities. If you are unable to participate in any of the health-related activities to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Kristin Austin at 864-294-3105 or Kristin.Austin@Furman.edu. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as working with a personal health coach. You also areencouraged to share your results or concernes with your own doctor.

Newborns' Act Disclosure Requirement

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available on the web at:
https://www.furman.edu/offices-services/human-resources/benefits/insurance/

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