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Health and insurance benefits terms & general definitions

Accidental Death & Dismemberment (AD&D): Insurance that pays benefits when you suffer certain accidental injuries or death resulting from a covered accident.

Affordable Care Act (ACA): Under the Affordable Care Act, medical coverage is offered to caregivers who are per-diem, temporary or part-time and working less than the minimum number of hours to qualify for regular benefits. These caregivers are offered the HSA medical plan for caregiver only or caregiver and eligible dependent child(ren) and the caregiver is responsible for the full monthly premium cost for this coverage. This coverage does not qualify for medical premium assistance or health incentives.

Benefits Service Center (BSC): The Benefits Service Center is the caregiver's one-stop for caregiver benefits questions or assistance enrolling in benefits.

BenefitConnect (BC): The system used by caregivers to enroll in their health and insurance benefits.

Caregiver Assistance Program (CAP): A free, confidential resource for all caregivers and their eligible family members. The program provides information, resources, guidance and support 24/7/365.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that grants caregivers and their families the right to continue their group health insurance coverage.

Coordination of Benefits (COB): A clause included in health plans to determine the order of who should pay for benefits when a participant or dependent has coverage under more than one plan (for example, your plan and a spouse's plan).

Dental Health Maintenance Organization (DHMO): A comprehensive dental plan offered to caregivers (where available) where dental services are offered through the plan's smaller, specialized network. The DHMO plan offered to caregivers is insured by DeltaCare USA.

Explanation of Benefits (EOB): A document provided by your health insurance claims administrator to clarify what medical treatments or services were covered on your behalf.

Exclusive Provider Organization (EPO): A comprehensive medical plan that only allows you to get health care services from providers and facilities who are within the plan's smaller network. Generally, if you are enrolled in the EPO plan, your plan will not cover costs when you get care from a provider or facility outside of your network, ***except in case of true emergency***. Emergency services are covered as in-network even if the provider is not in network.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

Evidence of Insurability (EOI): Also referred to as statement of health; evidence of insurability is a health questionnaire that may be required by the life or long-term disability insurance company if a caregiver wants to enroll themselves or their eligible dependent in a higher level of coverage.

Flexible Spending Accounts (FSA): A plan where the caregiver has the option to set pre-tax money aside from each paycheck to pay for eligible health care or dependent daycare expenses. There are two types of FSAs - health care FSA and dependent care FSA, and there is an annual plan limit for each type of account that is set by the Internal Revenue Service.

Frequently Asked Questions (FAQ): A question and answer document that introduces a topic or answer to commonly asked questions.

Group Term Life (GTL): Because your basic life insurance is paid by your employer, the value of basic life insurance coverage over $50,000 is imputed income to you. If this applies to you, you will see a line item on your pay slip called "GTL", which stands for group term life – this represents the imputed income for your basic life insurance above $50,000. Taxes are calculated on that value and are part of the taxes withheld. The GTL amount itself is not withheld from your pay.

Health Maintenance Organization (HMO): A comprehensive medical plan offered to caregivers where the health services are offered to members through the plan's smaller network. Generally, if you are enrolled in an HMO medical plan, your plan will not cover costs when you get care from a provider or facility outside of your network, ***except in case of true emergency***. Emergency services are covered as in-network even if the provider is not in the plan's network. The Kaiser of Washington HMO or Blue Shield of California HMO are examples of HMO plans offered to caregivers (where available).

Health Reimbursement Account (HRA): A tax-advantaged account for caregivers enrolled in the HRA medical plan.

Health Savings Account (HSA): A tax-advantaged savings account for caregivers enrolled in the HSA medical plan.

Internal Revenue Service (IRS): A revenue service for the United States federal government that collects U.S. taxes and administers the Internal Revenue Code, the main body of federal statutory tax law.

Long-Term Disability (LTD): A paid leave program that replaces a portion of your monthly earnings when a caregiver is disabled and cannot work.

Medical Plan Assistance Program (MPAP): This program provides medical coverage with no premiums or reduced premiums to many caregivers. This program is administered by our partner, Brightside.

Open Enrollment (OE): A defined period of time each year when you are able to make changes to the benefits plans you are enrolled in and the eligible dependents you cover on those plans.

Providence Health Plan (PHP): The current third-party administrator for most medical plans offered to caregivers.

Preferred Provider Organization (PPO): A comprehensive medical plan that allows caregivers to choose their own providers and facilities within a large network of providers.

Short-Term Disability (STD): A paid leave program that provides added financial protection if a caregiver cannot work due to a non-work-related illness or injury, including pregnancy.

Statement of Health (SOH): Also referred to as evidence of insurability; statement of health is a health questionnaire that may be required by the life or long-term disability insurance company if a caregiver wants to enroll themselves or their eligible dependent in a higher level of coverage.

Summary Annual Report (SAR): A document that provides plan participants with a condensed version of the financial and administrative information contained in a welfare benefit plan's annual filing with the Department of Labor.

Summary of Benefits and Coverage (SBC): A document that gives an overview of the costs, covered services and other details of a health insurance plan.

Summary of Material Modification (SMM): A document that outlines significant changes to an employee benefits plan, as required by ERISA to inform plan participants of changes to their benefits, eligibility, coverage or plan rules.

Summary Plan Description (SPD): A document that employers must make available to caregivers who participate in health benefits plans that are covered under ERISA. The SPD is a detailed guide to the benefits the program provides and how the plan works.

Transition of Care (TOC): Coordination and continuity of health care during a movement from one health care provider to another health care provider. A transition of care may be available for a specified period of time for a serious health condition where the claims from an out-of-network provider are covered at the in-network provider level.

Third-Party Administrator (TPA): A medical plan claims administrator or insurer designated by the plan administrator to review and process claims for benefits under the medical plans, manage the provider network and provide customer service to those enrolled in the plan.

Total Rewards Summary (TRS): Offers a comprehensive view of your compensation, health & insurance benefits, paid time off, well-being resources, retirement and more.

Vision Service Plan (VSP): The claims administrator for the vision plan offered to caregivers and their eligible dependents.