

# Employee Benefit Terminology Glossary

## A

**ACCELERATED BENEFITS** - Riders on life insurance policies allow the life insurance policy's death benefits to be used to offset expenses incurred in a convalescent or nursing home facility.

**ACCIDENT AND SICKNESS** - Insurance against bodily injury, disability or death by accidental means, or expense thereof, or against disability or expense resulting from sickness, and the insurance thereof.

**ACCIDENTAL DEATH INSURANCE** - A form of health insurance that provides payment if death of the insured results from an accident. Accidental death insurance is often combined with dismemberment insurance in a form called Accidental Death & Dismemberment.

**ACCUMULATION PERIOD** - The period of time, prior to retirement, during which an annuitant is making payments or investments in an annuity. Such payments will accumulate on a tax-deferred basis.

**AUTOMATIC REINSTATEMENT** -A clause providing for automatic reinstatement of the full value of the policy after payment of a loss.

## B

**BENEFICIARY** - A person who may become eligible to receive, or is receiving, benefits under an insurance policy, other than as a participant.

**BROKER** - One who represents an insured in the solicitation, negotiation or procurement of contracts of the insurance, and who may render services incidental to those functions. By law the broker may also be an agent of the insurer for certain purposes such as delivery of the policy or collection of the premium.

**BUSINESS INSURANCE** - Life or health insurance written to cover business situations such as key man, sole proprietor, partnership, corporations, etc.

## C

**CAPITATION (CAP)** - A rate paid, usually monthly, to a health care provider. In return, the provider agrees to deliver health care services agreed upon to any covered person.

**CARRIER** - An insurance company which "carries" the insurance. (The term's "insurance company" or "insurer" are preferred because of the possible confusion of "carrier" with transportation terminology.)

**COINSURANCE** - (1) In property insurance, a clause under which the insured shares in losses to the extent that he is underinsured at the time of loss.(2) In health insurance, a provision that the insured and insurance company will share covered losses in agreed proportion. In health insurance, the preferred term is "percentage participation."

**COMPREHENSIVE MAJOR MEDICAL (PPO & HMO)** - A plan of insurance which has a low deductible, high maximum benefits, and a coinsurance feature. It is a combination of basic coverage and major medical coverage that has virtually replaced separate hospital, surgical and medical policies with each having its own deductible requirements.

**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1986** - Legislation providing for a continuation of group health care benefits under the group plan for a period of time when benefits would otherwise terminate. Continuation rights apply to enrolled persons and their dependents. Coverage may be continued for up to 18 months if the insured person terminates employment or is no longer eligible. Coverage may be continued up to 29 months for disability and 36 months in nearly all other cases, such as loss of dependent eligibility because of death of the enrolled person, divorce, or attainment of the limiting age.

**CONTRIBUTORY** - A general term used to designate any plan of insurance (usually group or franchise) in which the insured pays at least part of the premium.

**CONVERTIBLE** - A policy that may be changed to another form by contractual provision and without evidence of insurability. Usually a Term Life Insurance policy that may be changed to permanent form.

**COST SHARING** - A situation where covered persons pay a portion of the health costs such as deductibles, coinsurance, or co-payment amounts.

**COVERAGE** - Scope of the protection provided under a contract of insurance.

## D

**DECLINATION** - Rejection of an application for insurance by the insurer.

**DEDUCTIBLE** - A provision or clause in an insurance policy that the first given number of dollars or percentage of expense will not be reimbursed.

**DEFERRED COMPENSATION** - Usually a nonqualified plan where an employee elects to defer receipt of current compensation; which deferral is later paid by the employer due to retirement, death or disability.

**DEFINED BENEFIT PLAN** - A qualified plan in which the retirement benefit is specified and the employer's liability is to assure that adequate funding is completed to provide the benefits.

**DEFINED CONTRIBUTION PLAN** - A qualified plan in which the amount of the plan contribution is specified but the retirement benefits will be the amounts accumulated in the participants' accounts at retirement.

**DISABILITY BENEFIT** - The benefit payable for disability under a Disability Income policy of provision.

**DISABILITY INCOME INSURANCE** - A form of health insurance that provides periodic payments to replace income, actually or presumptively lost, when the insured is unable to work as a result of sickness or injury.

**DISMEMBERMENT** - Loss, or loss of use of specified members of the body, resulting from accidental bodily injury.

## E

**EFFECTIVE DATE** - The date on which an insurance policy or bond goes into effect, and from which protection is furnished.

**ELECTIVE DEFERRAL PLAN** - A type of qualified retirement plan whereby employees make before tax-plan contributions by means of a salary reduction agreement.

**ELIMINATION PERIOD** - A loosely used term sometimes designating the waiting period and sometimes the probationary period. (See also Waiting Period and Probation Period.)

**EMPLOYEE PENSION BENEFIT PLAN OR PENSION PLAN** - Any program established and maintained by an employer or an employee or organization providing retirement benefits to employees or deferred income until employment is terminated.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)** - A federal law which is designed to protect the interest of plan participants by requiring specific reporting to the IRS and the Department of Labor by plan administrators as well as disclosure information to plan participants.

**EMPLOYEE STOCK OWNERSHIP PLAN (ESOP)** - A qualified plan which is a type of profit sharing plan whereby the plan is used as an investment vehicle for the employer's stock. Plan contributions and distributions are in the form of stock.

**EMPLOYEE WELFARE BENEFIT PLAN** - Any program established or maintained by an employer or an employee organization to provide its participants or their beneficiaries with medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, death or unemployment.

**EXCLUSIONS** - Causes, conditions or property listed in the policy which are not covered and for which no benefits are payable.

**EXCLUSIVE PROVIDER ORGANIZATION (EPO)** - A type of preferred provider organization where individual members use particular preferred providers rather than having a choice of a variety of preferred providers. EPO's are characterized by a primary physician who monitors care and make referrals to a network of providers.

**EXPIRATION** - The date upon which a policy will cease to cover, unless previously cancelled.

**EXPLANATION OF BENEFITS (EOB)** - The statement sent to a participant in health plan listing services, amounts paid by the plan, and total amount billed to the patient.

## F

**401(k) PLAN** - A qualified elective deferral plan whereby employee contributions are made by means of a salary reduction agreement, with or without matching employer contributions.

**FACE AMOUNT** - In a Life Insurance policy, the death benefit stated on the first page of the policy.

**FIDUCIARY** - A person who occupies a position of special trust and confidence (for example, in handling or supervising the affairs or funds of another).

**FIDUCIARY BONDS** - Bonds issued for persons appointed by order or decree of the court to take into custody, care for, manage and settle the estate of a decedent or of a person under legal age, or of a person who is otherwise- by reason of incompetence or insolvency- legally presumed to be incapable of managing his own business affairs; or to divide by sale, or in kind, real estate or personal property belonging to another.

**FLEXIBLE SPENDING ACCOUNT (FSA)** - A salary reduction cafeteria plan whereby employee funds are used to provide various types of health care benefits.

## G

**GATEKEEPER MODEL** - Under this model of HMO and PPO organizations, the primary care physician (the gatekeeper) is the initial contact for the patient for medical care and for referrals. This is also called a closed access or closed panel.

**GRACE PERIOD** - A period of time (commonly 30-31 days) after premium-due date during which a policy remains in force without penalty even though the premium due has not been paid.

**GROUP CONTRACT** - A contract of insurance made with an employer or other entity that covers a group of persons identified by reference of their relationship to the entity buying the contract. The group contractual arrangement is generally used to cover employees of a common employer, members of a trade association or trusteeship, members of a welfare or employee benefit association, members of a labor union, or members of a professional or other association not formed only for the purpose of obtaining insurance.

**GUARANTEED INSURABILITY** - An option in life or health insurance contracts that permits the insured to buy additional prescribed amounts of insurance at prescribed future time intervals without evidence of insurability.

**GUARANTEED RENEWABLE** - A contract that the insured has the right to continue in force by the timely payment of premiums for a substantial period of time as set forth in the contract. During that period of time, the insurer has no right to make any change in any provision of the contract other than a change in the premium rate for all insured in the same class.

## H & I

**HEALTH INSURANCE (HI)** - Insurance against loss by sickness or bodily injury. The generic form for these forms of insurance that provide lump sum or periodic payments in the event of loss occasioned by bodily injury, sickness or disease, and medical expense. The term Health Insurance is now used to replace such terms as Accidental Death Insurance, and Dismemberment Insurance. The form is sometimes called Accident and Health, Accident and Sickness, Accident, or Disability Income Insurance.

**HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)** - An association supported by Life and Health insurers to provide the research, public relations, education, and legislative base for the promotion of voluntary private Health Insurance.

**HEALTH MAINTENANCE ORGANIZATION (HMO)** - An organization of health providers. Each member pays a premium for which he receives medical care when desired. The emphasis is on preventive medicine, and it is an alternative to employee benefit plans. Employers of more than 25 persons are required to offer the alternative of HMO to employees, but not if the cost exceeds that of present employee benefit plans.

**INDIVIDUAL RETIREMENT ACCOUNT (IRA)** - A qualified retirement plan for anyone under the age of 70 with earned income. The trust, or custodial account is created for the exclusive benefit of an individual or his or her beneficiaries who are not otherwise covered by a qualified employee retirement plan. Such accounts may also be established by purchasing individual retirement annuities or individual retirement bonds issued by the federal government.

**IN-FORCE** - Insurance on which the premiums are being paid or have been fully paid. In life insurance, usually refers to insurance by face amount. In health, usually refers to premium volume being paid to insurance company or insurance companies in aggregate.

**INSURABILITY** - Acceptability of an applicant for insurance to the insurance company.

**INSURANCE COMPANY** - (1) Every person or company engaged in the business of making contracts of insurance. (2) The party to an insurance arrangement who undertakes to indemnify for losses, provide other pecuniary benefits, or render service.

**INSURED** - The party to an insurance arrangement to whom, or on behalf of whom, the insurance company agrees to indemnify for losses, provide benefits, or render service. In pre-paid hospital service plans, the insured is called the subscriber.

**INVESTMENT COMPANY ACT OF 1940** - A federal law which regulates the organization and activities of investment companies and requires the registration of investment companies with the federal government.

**INVESTIGATIVE CONSUMER REPORT** - A report ordered on an insured or applicant under which information about the person's character, reputation, or lifestyle is obtained through personal interviews with the person's neighbors, friends, associates or acquaintances. Contrast with Consumer Report.

## **K & L**

**KEY MAN (KEY EMPLOYEE) INSURANCE POLICY** - An insurance policy on life of a key employee whose death would cause the employer financial loss, owned by and payable to the employer. In health insurance, the term Key Employee A&H policy is also

used to designate salary continuation insurance payable to that employee paying all or part of the premium.

**LAPSE** - Termination of policy because of failure to pay the premium. In life insurance, the term sometimes confined to non-payment before the policy has developed any non-forfeiture value, being called termination if premium failure is after non-forfeiture values develop or surrender if cash value is withdrawn.

**LIABILITY LIMITS** – The sum or sums beyond which a liability insurance company does not protect the insured on a particular policy.

**LIMITATIONS** – Exclusions, exceptions, or reductions of coverage contained in a health policy.

**LONG-TERM DISABILITY** – A disability income plan with a long elimination period and a long benefit period. Benefits are usually provided as a percentage of salary.

**LOSS** – Generally refers to (1) flat amount of reduction in the value of an insured's property caused by an insured peril, (2) the amount sought through an insured's claim, or (3) the amount paid on behalf of an insured under an insurance contract.

**LOSS-OF-INCOME BENEFITS** – Benefits paid for inability to work for remuneration because of disability resulting from accidental bodily injury or sickness. The loss of income may be real or presumptive.

## M

**MANAGED CARE** – A system of health care where the goal is a system that delivers quality, cost effective health care through monitoring and recommending utilization of services, and cost of services.

**MEDICAID** – A medical benefits program administered by states and subsidized by the federal government. Under this plan, various medical expenses will be paid to those who qualify. It is technically referred to as Title XIX Benefits.

**MEDICARE BENEFITS** – Benefits provided by a Federal program as part of the Social Security program. It applies to persons over 65 years of age and certain disabled beneficiaries under the Social Security program. Benefits provide hospital insurance and supplementary medical insurance.

**MEDICARE SUPPLEMENT INSURANCE** – Insurance coverage sold on an individual or group basis which helps to fill the gaps in the protection provided by the Medicare program. Medicare supplements cannot duplicate any benefits provided by Medicare, but may pay part or all of Medicare's deductibles and copayments, and may cover some services and expenses not covered by Medicare.

**MIB** – Medical Information Bureau. An organization serving as a clearing house of medical information on impaired risks reported to it by insurance companies which are members of the service and reported to them as a source of underwriting information on applicants.

## N

**NAMED INSURED** – Any person, firm or corporation, or any member thereof, specifically designated by name as insured (s) in a policy as distinguished from the others who, though unnamed, are protected under some circumstances. A common application of this latter principal is in liability policies wherein by a definition of “insured” protection is extended to interests (not designated by name) according to their status or in particular situations or circumstances.

**NON-CONTRIBUTORY** – Any plan or program of insurance (usually group) for which the employer pays the entire premium and the employee contributes no part of the premium.

**NON-QUALIFIED PLAN** – A retirement plan, which is not, qualified for special tax considerations by the IRS. The plan may discriminate as to participation and is not filed with the IRS.

## O

**OCCUPATIONAL ACCIDENT** – An accident occurring in the course of one’s employment and caused by hazards inherent or related thereof.

**OCCUPATIONAL HAZARD** – A condition in an occupation that increases the peril of accident, sickness, or death therefrom.

**OPEN ACCESS** – Allows a participant to see another participating provider of health services without a referral. Also called Open panel.

**OUTPATIENT** – A patient who is not a bed patient in the hospital in which he receives treatment.

## P

**PARTIAL DISABILITY** – A condition in which, as a result of injury or sickness, the insured cannot perform all of the duties of his occupation but can perform some. Exact definitions vary from policy to policy.

**PENSION PLAN** – A retirement income program (related to life insurance because of the use of life insurance and annuities in setting up pension plans.)

**PERMANENT & TOTAL DISABILITY** – Total disability from which the insured does not recover. When used as a definition in a policy (usually a life insurance policy rider), “permanent” is presumed after a stated period of time, commonly six months.

**PRECERTIFICATION AUTHORIZATION** – A cost containment technique which requires physicians to submit a treatment plan and an estimated bill prior to providing treatment. This allows the insurer to evaluate the appropriateness of the procedures, and lets the insured and physician know in advance which procedures are covered and at what rates benefits will be paid.

**PRE-EXISTING CONDITION** – A condition of health or physical condition (and sometimes moral condition) that exists before the policy was issued.

**PREFERRED PROVIDER ORGANIZATION (PPO)** – An organization of hospitals and physicians who provide, for a set fee, services to insurance company clients. These providers are listed as preferred and the insured may select from any number of hospitals and physicians without being limited as with an HMO. Coverage is 100%, with a minimal copayment for each office visit or hospital stay. Contrast with Health Maintenance Organization.

**PREFERRED RISK** – An insurance classification indicating a risk that is superior to the average risk on which the rate has been calculated and thus eligible for reduced rate.

**PREMIUM** – (1) Part of the consideration for the insurance, by whatever name called. (2) The periodic payment made to keep a policy in force. Premium and rate are sometimes incorrectly used interchangeably. Technically, rate is the amount charged for a given unit of insurance coverage, and premium is the sum of the unit rates for a given policy. (3) In annuities, the purchase payment.

**PRE-PAID HOSPITAL SERVICE PLAN** – The common name for Health Maintenance Organization plan (HMO). It provides comprehensive health care, usually by salaried personnel, for members who pay a flat fee for the services, whether outpatient or hospital treatment is needed.

**PRIMARY BENEFICIARY** – The beneficiary named first to receive proceeds or benefits, if living when proceeds of benefits are due.

**PRINCIPAL SUM**—The amount payable in one sum in the event of accidental death or certain accidental dismemberments. When a contract provides benefits for both accidental death and accidental dismemberment, each dismemberment benefit is an amount equal to the principal sum or some fraction thereof. Examples would be half the principal sum for loss of one arm, half the principal sum for the loss of one leg, etc.

**PROBATIONARY PERIOD** – A period of time between the effective date of health insurance policy and the effective date coverage begins for certain conditions.

**PROFESSIONAL LIABILITY INSURANCE** – Liability insurance to indemnify professionals, doctors, lawyers, architects, etc. for loss or expense resulting from claim on account of bodily injuries because of any malpractice, error, or mistake committed or alleged to have been committed by the insured in his profession.

**PROFF OF LOSS** – A formal statement made by the insured to the insurance company regarding a loss. The purpose of the proof of loss is to place before the company sufficient information concerning the loss to enable it to determine its liability under the policy or bond.

## Q

**QUALIFIED PLAN** – A retirement plan, which does qualify for special tax advantages due to filing with and approved by the IRS. Qualified plans must meet certain IRS requirements to be classified as qualified.

**QUALIFIED PLAN** – A plan under which contributions by the employer are allowed as a deduction from taxable income, and which provides that the deposits for his employees, future benefits are not to be considered as taxable income to them in the year in which they are made.

## R

**RATE** – The per unit cost of insurance.

**RATED** – Usually used in combination, rated-up or rated policy. A policy issued with an extra premium charge because of physical or moral impairment. A form of substandard.

**REDUCTION OF RISK** – Taking steps to reduce the probability or severity of a possible loss. For example, installing alarms and sprinkler systems to reduce the risk of fire loss to a building. One of the four major risk management techniques.

**REDUCTIONS** – Decreases in benefits from a health insurance policy as a result of specified conditions.

**REIMURSEMENT** – Payment of an amount of money related to the amount of the loss to or on behalf of the insured upon the occurrence of the defined loss.

**REINSTATEMENT** – (1) Putting a lapsed policy back in force. (2) The payment of a claim under some forms of insurance reduces the principal amount of the policy by the amount of the claim. Provision is usually made for a method of reinstating the policy to its original amount. This may be done automatically either with or without premium consideration or at the request of the insured.

**RENEWAL** – The continuation in full force and effect of something that is about to expire. With an insurance policy it is made either by the issuance of a new policy or renewal receipt or certificate, to take effect upon the expiration of the old policy.

**REPRESENTATION** – On an application, facts that the applicant represents as true and accurate to the best of his or her knowledge and belief. In contrast to warranty.

**RIDER** – An amendment attached to a policy that modifies the conditions of the policy by expanding or decreasing its benefits or excluding certain conditions from coverage.

## S

**SALARY SAVINGS OR DEDUCTION** – Insurance issued to individual employees whose employer agrees to deduct the premiums from their paychecks and remit to the insurance company.

**SCHEDULE** – (1) A list of specified amounts payable for, usually, surgical procedures, dismemberments, ancillary expenses or the like in Health Insurance policies. (2) The list of individual items covered under one policy as the various buildings, animals and other property in property insurance or the list of rings, bracelets, etc., insured under a jewelry floater.

**SECONDARY BENEFICIARY** – The second person named to receive benefits upon death of the insured if the first named (Primary Beneficiary) is not alive or does not collect all benefits before his or her own death.

**SERVICE INSURER** – Relating to an agreement by the insurance company (insurer) to pay certain vendors of health care services, under arrangements with them for rendering such services to covered persons. These arrangements may preclude or limit any additional charges for the defined services. (Blue plans are the best known, but not the only form of service insurers.)

**SERVICE PLANS** – Plans of insurance where benefits are the actual services rendered rather than a monetary benefit, such as the benefits provided by Blue Cross and Blue Shield.

**SHORT-TERM DISABILITY INCOME POLICY** – A Disability income policy with benefits payable for “Short Term,” usually less than two years, as opposed to Long Term Disability Income policy.

**STANDARD** – A risk that meets the same conditions of health, physical condition, and morals as the tabular risks on which the rate is based.

**STANDARD PROVISIONS** – (1) Provisions prescribed by state law that must appear in all policies issued in that jurisdiction. (2) Provisions adopted by the NAIC to apply to group

life insurance as minimum protection. They are required by law in most states. (3) Formerly, a set of prescribed provisions regulating the operating condition of a health insurance policy by law in most jurisdictions between about 1912 and 1950. They are now superseded by uniform provisions for Individual Accident and Health Insurance policies, which contain an NAIC model bill. These have been enacted in virtually all jurisdictions.

**SUBSCRIBER** – The insured, when speaking of prepaid hospital plans.

## T

**TAX SHELTERED ANNUITY** – A type of qualified retirement plan for employees of nonprofit organizations characterized by employee contributions being made to the plan on a salary reduction basis.

**THIRD PARTY ADMINISTRATOR** – An organization which administers qualified plans by providing accounting and actuarial services as well as reporting services required by the IRS and the department of labor.

**TRANSFER OF RISK** – Shifting all or part of a risk to another party. Insurance is the most common method of risk transfer, but other devices, such as hold harmless agreements, also transfer risk. One of the four major risk management techniques.

## U & V

**UNIFORM PROVISIONS** – A set of provisions relating to the “operating conditions” of a Health Insurance policy that are specified by state law. Uniform Provisions Law is the National Association of Insurance Commissioners model law entitled, “Uniform Individual Accident and Sickness Policy Provisions Law”

**UTILIZATION REVIEW** – A cost control mechanism by which the appropriateness, necessity, and quality of health care is monitored by both insurers and employers.

## W

**WAITING PERIOD** – A period of time between the beginning of a disability and the date benefits begin.

**WAIVER** – (1) A rider waiving (excluding) liability for a stated cause of injury or sickness. (2) A provision or rider agreeing to waive premium payment during a period of disability of the insured. (3) The act of giving up or surrendering a right or privilege that is known to exist. In property and liability fields, it may be effected by an agent, adjuster, company, employee, or company official, and it can be done either orally or in writing.

