Insurance Terminology for Brokers

Insurance Terms and Definitions

Group insurance contracts provide coverage to a number of persons under a single contract that is issued to someone other than the persons insured. The group insurance contract provides benefits to a group of individuals who have a specific relationship to the policy owner. Group contracts usually cover individuals who are full-time employees, and although the employees are not actual parties to the master contract, they have legally enforceable rights.

In group insurance, individuals may become eligible for coverage long after the inception of the group contract, and may lose their eligibility under the contract long before the contract terminates. This differs markedly from individual insurance where the coverage of the insured normally begins with the inception of the insurance contract and ceases with its termination.

Insurance Terminology

As with many other industries, the insurance industry uses industry-specific terminology. The table below provides a glossary of some commonly used insurance terms. Please note, these are general definitions – individual carriers may have different interpretations.

TERM	DEFINITION
Actuarial Assumptions	Assumptions that actuaries make in regard to earnings, mortality, turnover, interest, and other areas necessary for calculating premium rates.
Actuarial Department	The department in an insurance company responsible for statistically calculating risk, premium rates, life expectancies, etc., and doing research to develop the necessary statistics.
Actuary	An expert in the technical aspects of insurance, such as calculating mortality rates, premium rates, and other important values.
Affiliation Period	The time an HMO may require an individual to wait after enrollment before coverage begins. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods.

Ancillary Insurance	Non-medical insurance products that enhance and fill in the gaps of medical insurance. Examples include: Dental, Life and Disability Insurance.
Application	The initial forms used when applying for insurance.
Assignment of Benefits	The transfer of benefits to another. This could be used to pay a physician directly, instead of having the insurance company pay the policyholder, who will then pay the physician.
Beneficiary	The individual or party designated to receive policy proceeds.
Benefits	Payments made by an insurance company when an insurance claim is approved, such as at time of death, retirement, or disability.
Binder	A temporary agreement that provides coverage until a policy is written or delivered.
Book of Business	A financial term used to refer to the sum of the various plans and insurance products sold to groups and consumers.
Break in Service	Amount of time between leaving a company and returning to work at the same company; used in calculating benefits in regard to leaves of absences, short-term disability, and other extended periods of unemployment.
Broker / Agent	An insurance professional who, for compensation, solicits, negotiates or procures insurance or the renewal or continuance thereof on behalf of insureds or prospective insureds.
Cancellation	Termination of an insurance policy or coverage while the policy is still in effect.
Career Agent	An agent who works full-time out of the insurance company's field office instead of being an independent contractor who has an agreement to do business with the insurance company.
Carrier	An insurance company which "underwrites" and assumes the risk of insurance.
Certificate of Creditable Coverage	A document provided by the health plan that proves that an individual had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when an individual leaves a health plan, but they can be obtained at other times as well.
Certificate of Insurance	A certificate specifying the type and amount of insurance coverage as well as the beneficiary.

COBRA	The federal Consolidated Omnibus Budget Reconciliation Act of 1985, which established, among other things, the Group Health Plan continuation coverage rules.
Co-insurance	The percentage of covered expenses under a major medical plan that will be paid once a deductible is satisfied. OR A cost-sharing arrangement under which a covered person pays a specified percentage of the cost of a specified service, such as 20% of the cost of a doctor's office visit.
Community Rating	Using the same premium rates for a specific group without considering loss experience.
Comprehensive Health Insurance	Sometimes called "Comprehensive Major Medical." A form of health insurance that combines the coverage of Major Medical and Basic Medical Expense contracts into one broad contract that provides coverage for almost all types of medical expense with few internal limits, usually subject to a small deductible for some or all expenses and to a percentage participation clause (sometimes called "co-insurance") applicable to all or some of the covered expenses.
Continuous Coverage	Generally health insurance coverage that is not interrupted by a break of 63 or more consecutive days. However, continuous coverage is defined differently in different states. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous.
Coordination of Benefits Clause	A provision in insurance policies stating benefits will not be paid if another insurance policy has already covered the expenses in addition to paying eligible expenses that were not covered by the coordinating plan.
Co-pay	A set fee for medical expenses that is required to be paid by the insured for specific services such as doctor's office visits. The co-pay generally does not count toward deductible, co-insurance or out-of-pocket maximum.
Death Benefit	The amount of money paid to the beneficiary upon the death of the insured.
Deductible	The initial amount of medical expenses an individual must pay before he/she will receive benefits under a medical expense plan. Some services may be excluded.
Dependent	Employee's legal spouse; and/or any unmarried children of the insured, whether natural or adopted who are within the age limits as described in the group application; and not in active military service.

Direct Response Marketing	A way in which insurance carrier sell directly to the customer without using insurance agents, generally through direct mail, telephone, or media advertisements such as television commercials.
Disability Income Insurance	A form of health insurance that provides periodic payments to replace income lost when the insured is unable to work as a result of sickness or injury.
Doctrine of Reasonable Expectations	Court rulings stating that the reasonable expectations of policy holders and their beneficiaries will be honored even if the insurance policy does not support them. These serve to eliminate fine-print clauses that alter the meaning of the policy from what the insured was led to believe.
Double Indemnity	A doubling of the basic death benefit if the insured's death is precipitated in a certain manner, most often through an accident.
Election Period	The period following notification of an insured's eligibility for COBRA continuation coverage, during which the individual can accept or decline the coverage.
Eligibility Period	For group health insurance, the period of time in which a new employee may enroll in the group coverage.
Eligibility Requirements	Requirements for joining a group health-insurance plan or another insurance/financial plan.
Eligible Employees	Those employees who have met the eligibility requirements for insurance set forth in the policy. OR The Small Group Market Reform definition of an eligible employee is an employee who is working full-time with a normal work week of 30 or more hours.
Employee	Actively at work, full-time, employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is actively at work for the minimum hours per week as stated in the Application and is reported on the employer's records for Social Security and withholding tax purposes.
Enrollment Period	The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage.

ERISA	The Employee Retirement Income Security Act of 1974. This law, which deals primarily with pensions and retirement plans, includes a section exempting self-funded employer and union health plans from state regulation. Washington's health-care reform law - the Health Services Act of 1993 - required a congressional waiver of this law so that the state could mandate employer-provided health coverage. The waiver did not pass, and the state law was subsequently changed.
Evidence of Insurability (EOI)	Statement of medical history to determine if employee is approved for coverage when amount of life insurance is in excess of the guarantee issue amount for group or late enrollees under a contributory plan or enrollees under a supplemental life program which does not meet minimum participation requirements.
Exclusion	Specific conditions, causes, or issues listed in the policy that are not covered by an insurance policy.
Experience	The loss record of an insured.
Experience Rating	A method used by insurers to determine the premium to be charged based on the actual utilization of individual large groups. Federal qualification guidelines for HMOs do not permit this rating method, but it is common in other health insurance plans.
Expiration Date	The date when an insurance policy ends.
Family Deductible	A single group deductible covering all insurance polices within a family instead of multiple separate deductibles.
Federally Qualified HMOs	Health maintenance organizations (HMOs) that meet certain federal requirements designed to protect consumers, such as providing a broad range of basic health services, financial solvency, and a system to monitor the quality of care. The qualification process is administered by the Health Care Financing Administration in the U.S. Department of Health and Human Services (DHHS).
Fiduciary	A person or organization that manages or controls money or financial assets belonging to others, or that offers financial advice for a fee.
Fraudulent Claim	A claim in which the claimant knowingly uses false information in order to collect on the policy.
Fully Contributory	A situation in which the insured individual in a group plan pays the entire cost of the insurance.
Fully Insured Plan	The employer pays an annual premium as negotiated with a carrier. If claims exceed the premium, the carrier is liable for any claim experience in excess of premium paid. The employer or purchasing group has no further liability or sharing of risk. If premiums exceed claims, the carrier keeps the overpayment as profit.

General Agent	An insurance general agency (GA) partners with various insurance carriers to market and distribute their products to agents and brokers. They are an expert on the carrier's various product portfolios, underwriting guidelines, eligibility rules, rates, and all other relevant information. A general agent is also referred to as a "Broker's Broker".
Grace Period	The period of time after a premium due date has passed during which the policy remains active even though payment has yet to be made.
Group	A true group is one in which an employer-employee relationship exists, not one formed for the purpose of obtaining health care coverage. Independent contractors sometimes qualify as members of a true group.
Group Insurance	Insurance policy or health services contract covering a group of employees (and often their dependents) under a single contract issued to an employer or other group.
Health Insurance	An insurance policy that protects the insured in case of illness or injury, and that pays for the appropriate medical treatments required, based upon limits established within the individual policies.
HIPAA	The Health Insurance Portability and Accountability Act is federal legislation that offers protections for American workers to improve the privacy, portability and continuity of health insurance coverage.
HMO	Health Maintenance Organization. Insureds are required to use a primary care physician in order to receive ANY benefits and there is a network to use. In general, there is only a co-pay requirement.
HMO Opt-out	This is an HMO plan that offers out of network benefits for an additional premium charge. Just as with a regular HMO plan, insureds are required to use a primary care physician in order to receive in network benefits. If an insured fails to use a primary care physician, benefits will be paid at the out of network benefit level. In general there is a co-pay requirement in network and deductible, co-insurance and co-pay requirements out of network.
Hospital Benefits	Benefits payable when an insured is hospitalized.
HRA – Health Reimbursement Arrangement	Employers may use HRA plans to fund accounts on behalf of employees for items governed by sections 105 and 106 of the tax code, which relate to health expenses and insurance premiums. They are typically coupled with a high deductible insurance plan.
HSA – Health Savings Account	IRA type accounts that individuals covered by qualified high deductible health plans can establish to reimburse themselves for qualified medical and certain other expenses.

Indemnity Plan	An insurance health plan that allows absolute freedom in selecting physicians or medical facilities, and unlike other health plans, self-referral to a specialist. The insurance company pays a predetermined fee or percentage of cost. Also referred to as a "fee for service".
Individual Health Insurance	Policies held in the name of an individual and not associated with an employer group.
Insurance	(1) A contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies. (2) A device for the transfer of the risks of individual entities to an insurance company, which agrees, for a consideration, to assume to a specified extent, losses suffered by the insured.
Insurance Policy	Broadly, the entire written contract of insurance. More narrowly, the basic written or printed document, as distinguished from the forms and endorsements added thereto.
Insured	The party to an insurance agreement to whom, or on behalf of whom, the insurance company agrees to indemnify for losses, provide benefits, or render service. Sometimes also called the subscriber.
Insurer	The insurance company or party that provides the insurance policy.
Key Person Insurance	Insurance designed to protect a business firm against the loss of business income resulting from the disability or death of an employee in a significant position.
Lapse	Termination of an insurance policy because premiums were not paid on time.
Large Group Health Insurance	A health insurance group with more than 50 eligible employees.
Late Remittance Offer	An offer by the insurance company to accept overdue premiums, even if past the grace period, without requiring additional applications or paperwork in order to reinstate a lapsed policy.
Level Premiums	Premiums that remain the same for the life of the policy.
Life Insurance	Insurance on human lives including endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits for disability, and annuities.
Lifetime Maximum	The maximum amount of benefit available under a major medical plan.
Limits	Maximum amount of benefit payable for a given situation or occurrence.

Loss Ratio	The ratio of claims to premiums (claims divided by premiums).
Long-Term Care (LTC)	Coverage available on an individual or group basis to provide medical and other services to patients who need constant care in their own homes or in nursing homes.
Long-Term Disability (LTD)	(1) A disability having a duration longer than a short-term disability, the exact duration being variable and a matter of reference; commonly 90 or 180 days. (2) A form of group disability insurance paying benefits for more than the customary 13 to 26 weeks; more commonly, benefits of five years' duration or more, but again depending on terms of reference.
Loss	Any diminution of quantity, quality or value of property. With reference to policies of indemnity, this term means a valid claim for recovery. In its application to liability policies, the term refers to payments made on behalf of the insured.
Mail Order Pharmacy	An establishment where prescription drugs are legally dispensed by mail.
Major Medical Insurance	A type of health insurance that provides benefits for most types of medical expenses incurred up to a high limit, subject to a deductible. Such contracts may contain internal limits and a percentage participation clause (sometimes called co-insurance clause). A major medical policy pays expenses both in and out of the hospital.
Managed Care	Managed care is a philosophy of health care coverage that streamlines health services and creates a health-care system that includes both the financing and delivery of services to the consumer. It also takes more responsibility for maintaining subscribers' health, not just curing them once they are sick. It attempts to lower costs by matching the patient with appropriate care as efficiently as possible. Different insurance carriers use different kinds of managed care. Although the philosophy is popularly associated with Health Maintenance Organizations (HMOs), other kinds of carriers also employ it.
Master Policy	The contract between an insurance company and a group insurance policyholder that provides insurance for more than one person.
Matching Contributions	Contributions by the employer made to an employee benefits plan, such as a 401(k), that match the employee contributions at a set percentage.
Maximum Benefit	The largest benefit amount available to a plan participant, IRS regulations determine this amount.
Maximum Out-Of-Pocket (OOP)	The amount equal to the required deductible plus co-insurance payable up to the stop loss amount under a major medical plan before the plan pays 100%.

Medicaid	A government program that provides medical coverage for people under 65 who meet certain requirements (lower income).
Medicare	A government program that provides medical coverage for people 65 and over who meet certain requirements.
Medicare Supplement	Voluntary private insurance coverage purchased by Medicare enrollees covering the cost of services not reimbursed by Medicare.
Multi-employer Plan	Pension or other benefits plans involving more than one employer, so that if an employee moves to another employer in the plan, his/her coverage continues unabated.
Network	List of providers that a carrier has contracted to provide services to its insureds, at negotiated prices.
Noncontributory Plan	A plan in which all contributions are made by the sponsor and nothing is paid by the individual participants.
Occupation Class	A group of occupations that present a similar level of risk.
Open Enrollment	A period of time when eligible subscribers may enroll in, or transfer between available programs providing health care coverage.
Out-of-Area Services	Services received by insurance plan enrollees when they are outside their plans established geographic area of service as defined in the contract and service agreement. Usually not covered unless a delay would adversely affect the member's health.
Out-of-Pocket Maximum	A present amount that the plan participant must pay before the insurance company pays 100% of the expenses.
Outpatient Services	Non-inpatient services, i.e., no overnight stay, provided by a hospital or other qualified facility, such as a mental health clinic, rural health clinic, mobile X-ray unit or free-standing dialysis unit. Those services include physical therapy, diagnostic X-ray and laboratory tests. Also included are doctor visits.
Per Cause Deductible	A deductible that must be met for each separate illness or injury before insurance benefits are paid.
Per Cause Maximum	The maximum amount of money a medical expense policy will pay for any particular illness or injury.
Plan Document	A document outlining the terms of an employee benefits plan.
Plan Participant	An individual taking part in a plan who shares in the responsibilities and benefits listed in the plan.
Policy	A written contract of insurance.

Policy Age Limits	Ages below or above which the insurance company will not issue a new policy or above which it will not continue a policy in force.
Policy Anniversary	The annual anniversary of the dates on which a policy was issued.
Point-of-Service Plan (POS)	Incorporates features of both HMOs and PPOs, encouraging but not requiring members to choose a primary care physician. As in HMOs, primary care physicians act as "gatekeepers" to other health care services. However, members may visit non-network providers, but pay higher deductibles and co-payments. Except in the case of female OB/GYN care, self referral for specialty care is not permitted without penalty, such as deductibles and co-insurance. POS participants are eligible for certain preventative care benefits to encourage wellness.
Policy Summary	A summary of the policy, containing any data required by law, that is given to the applicant during the application process.
Policy Year	A single year, beginning when the policy is issued.
Portability	The ability of an individual to transfer out of a health insurer without regard to preexisting conditions or other risk factors. This may transfer to an individual or a group policy.
Portfolio	The collection of products offered by an insurance company.
Pre-existing Condition	A condition of health or physical condition that existed before the policy was issued. Prior to 1993, insurance coverage was denied or significantly delayed on the basis of pre-existing conditions. This remains an issue with some policies, for example, individual medical and other ancillary products.
Pre-existing Conditions Provision	A provision in an insurance plan that states that medical expenses relating to pre-existing conditions will not be covered until the insured has been enrolled in the plan for a certain length of time or possibly not at all.
Preferred Provider Organization (PPO)	A health care arrangement between purchasers of care such as employers and insurance companies and providers offering benefits at a reasonable cost using incentives, such as lower deductibles and copays to get members to use providers within a network. Use of non-preferred physicians would involve a higher cost. Preferred providers must agree to specified fee schedules and are required to comply with certain utilization and review guidelines.
Premium	Payment charged by an insurance company to establish and maintain an insurance policy.
Primary Care Physician	Primary care physicians deliver basic or general care that is intended to be the patient's first level of contact with the medical care system.

Primary Care	Primary Care is the first care a patient receives. It is often from a family physician, although patients also may receive Primary Care from a nurse, a paramedic, or other types of health-care providers, depending on the situation. Managed care systems try to resolve as many health problems as possible at this level.
Quote	Estimates of the cost of insurance, based on the initial information given by the applicant.
Reasonable and Customary Fees	The standard fees charged by physicians, hospitals, or other healthcare providers. These are often used as a base for what an insurance plan will or will not cover.
Reinsurance	Insurance for insurers. A contract transferring all or part of a risk or liability already covered under an existing contract. Allows an insurer to protect itself against part or all of the losses incurred when honoring all the claims of its members or subscribers. Also referred to as "stop loss."
Renewal Premiums	Premiums payable after the initial premium.
Renewal Provision	An insurance provision stating the guidelines that a policyholder must meet to continue insurance coverage at the end of the initial term, and what actions must be taken to do so.
Replacement	Surrendering an insurance policy in order to purchase a different insurance policy.
Replacement Cost	The cost to replace an insured item.
Rider	An optional set of benefits that can be added to a policy.
Self-administered Group Insurance Plan	A group insurance plan in which the policyholder performs administrative functions, such as record keeping, request processing, and address changes, instead of the insurer.
Self-insured Group Insurance	Group insurance in which the group sponsors rather than the insurance company and is responsible for paying claims and managing the risk.
Short-Term Disability (STD)	Provides non-occupational disability benefits payable when an employee becomes disabled due to accident, sickness or pregnancy and is under the regular care of a medical provider. The benefit amount, the day benefits begin, and the maximum period for which benefits are payable are chosen by the employer.
Single Premium Method	Method of paying an entire premium at once, either in a lump sum or as additional principal to a loan.

Small Group Health Plans	Health plans with not more than 50 eligible employees.
Social Security	A federal program providing retirement income, disability coverage, and healthcare to qualified individuals.
Stand Alone Plans	Stand alone plans are ancillary insurance policies that do not need to be sold in conjunction with another policy.
Supplemental Group Life Insurance	Group life insurance providing additional coverage over the basic coverage of existing group plans.
Term	Relating to a contract of health insurance that makes no provision for renewal or termination other than by expiration of the policy term.
Term Life Insurance	Insurance in which the benefit is payable only if the loss occurs during a specific period of time.
Third-Party Administrator (TPA)	A company contracting with employers who want to pay the cost of providing healthcare for their employees. TPAs develop and coordinate self-insurance programs, process and pay claims, and may help locate stop loss insurance for the employer. They also can analyze the effectiveness of the plan and utilization of its benefits.
Third Party Insurance	Insurance coverage applied for by someone other than the proposed insured.
Total Disability	A disability in which the individual is unable to perform any of the essential duties of the position previously held, or any position for which training, education, and experience exist.
True Group	A true group is one in which the employer-employee relationship exists, not one formed for the purposes of obtaining health care coverage. Independent contractors do qualify as members of a true group.
Underwriter	The person who performs the underwriting function or an organization that ensures money is available for policies that must be paid.
Underwriting	(1) The process of assessing and classifying the potential degree of risk that a proposed insured represents. Also called selection of risks. (2) Providing guarantees that money will be available to pay for losses that are insured against.
Underwriting Requirements	Set guidelines, which may include medical records or personal history, that state what is required to determine an individual's insurability.

Uninsurable Risk Class	Individuals who cannot gain insurance due to the high level of risk associated with them.
Usual, Customary, and Reasonable Expense (UCR)	Regular charges for a particular medical service.
Utilization Review	A form of claims review in which the insurance company analyzes a case to determine if the treatment given is appropriate or necessary.
Waiting Period	The time an individual may be required to work for an employer before becoming eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous.
Waiver	(1) A rider waiving liability for a stated cause of accident or (especially) sickness. (2) Provision or rider agreeing to waive premium payment during a period of disability. (3) The giving up or surrender of a right or privilege that is known to exist.
Workers' Compensation	Government-mandated insurance for employees and their dependents if the employee suffers a job-related injury, disease, or death.
Write	In insurance terms, to insure. It also means, to underwrite or to sell.
Year of Service	Defined under ERISA, a 12-month period during which an employee works at least 1,000 hours for the employer.