

Glossary of Group Life, Accident and Health Terms:

Accounting: The process of recording, summarizing, and allocating all items of income and expense of the company and analyzing, verifying, and reporting the results.

Actuarially Fair: The price for insurance which exactly represents the expected losses.

Actuary: A person professionally trained in the technical aspects of pensions, insurance and related fields. The actuary estimates how much money must be contributed to an insurance or pension fund in order to provide future benefits.

Adjudicating: The process of settling claims or losses with or by an insurer or Third Party Administrator.

Administrative Services Only (ASO) Plan: An arrangement under which an third party claims administrator an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection: The tendency of persons who present a poorer-than-average risk to apply for, or continue, coverage to a greater extent than do persons with average or better-than-average expectations of loss.

Age Limits: Stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent: An insurance company representative licensed by the state who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Deductible: Deductible in some property and health contracts in which all covered losses during a year are added together and the insurer pays only when the aggregate deductible amount is exceeded.

Aggregate Stop-loss Limit: (1) A limit in a policy stipulating the most it will pay for all covered losses sustained during a specified period of time, usually one year.

Allocated Benefits: Benefits for which the maximum amount payable for specific services is itemized in the contract.

Alternate Delivery Systems: Health services provided in other than an in-patient, acute-care hospital. Examples include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner.

Ambulatory Care: Medical services that are provided on an outpatient (nonhospitalized) basis. Services may include diagnosis, treatment, and rehabilitation.

Amendment: A formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policy holder or his authorized representative.

Antiselection: The tendency of persons who present a poorer-than-average risk to apply for, or continue, insurance to a greater extent than do persons with average or better-than-average expectations of loss.

Application: A signed statement of facts made by a person applying for life insurance and then used by the insurance company to decide whether or not to issue a policy. The application becomes part of the insurance contract when the policy is issued.

Arbitration: A form of alternative dispute resolution where an unbiased person or panel renders an opinion as to responsibility for or extent of a loss.

Assessment: The ability of a Pool to charge its members periodically to pay its losses. Through and assessment, a Pool or self-insurer can usually collect an advance contribution which is estimated to cover losses and expenses, but reserve the right to make additional assessments whenever the contributions are insufficient.

Assets: All funds, property, goods, securities, rights of action, or resources of any kind owned by an insurance company. Statutory accounting, however, excludes non-admitted assets, such as deferred or overdue premiums, that would be considered assets under [Generally Accepted Accounting Principles \(GAAP\)](#).

Association Captive: Type of captive insurer owned by members of a sponsoring organization or group, such as a trade association.

Association Group: A group formed from members of a trade or a professional association for group coverage under one master health benefit contract.

Association Group Plan: Pool plans designed for members of a professional association or trade association. Members may be protected under a group health policy.

Assumption of Risk Doctrine: Defense against a negligence claim that bars recovery for damages if a person understands and recognizes the danger inherent in a particular activity or occupation.

Assumptions: Conditions and rules underlying the calculation of a pension benefit, including expected interest, mortality and turnover.

B

Beneficiary: The person or entity designated or provided for by an insurance policy's terms to receive any benefits provided by the policy or plan upon the death of the insured.

Benefit Period: A period of time, typically one to three years, during which major medical benefits are paid after the deductible is satisfied. When the benefit period ends, the members must then satisfy a new deductible in order to establish a new benefit period.

Benefits: The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.

Binder: A written or oral contract issued temporarily to place coverage in force when it is not possible to issue a new policy or endorse the existing policy immediately. A binder is subject to receipt of the contribution and all the terms of the policy to be issued. It is a legal agreement that serves to effect coverage for a specified period of time until the actual insurance policy can be issued.

Blue Cross and Blue Shield: An independent, nonprofit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Broker: A marketing specialist who represents buyers of insurance and who deals with either agents or companies in arranging for the coverage required by the customer.

C

Cafeteria Plan: Generic term for an employee benefit plan that allows employees to select among the various group life, medical expense, disability, dental, and other plans that best meet their specific needs. Also called flexible benefit plans.

Calendar-Year Deductible: Amount payable by an insured during a calendar year before a group or individual health insurance policy begins to pay for medical expenses.

Cancelable: A contract of coverage that may be canceled during the policy term by the insurer or insured.

Cancellation: The discontinuance of a policy before its normal expiration date, either by the insured or the company.

Capitation: A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount for each person served regardless of the actual number of services provided to each person.

Captive Insurance Company: A company owned solely or in large part by one or more non-insurance entities for the primary purpose of providing insurance coverage to the

owner or owners. The company's stock is controlled by one interest or a group of related interests so as to provide coverage for their business operations. A captive insurance company may be a nonadmitted, nonresident, or foreign insurer. Sometimes it may provide reinsurance to a self-insured or a domestic company.

Captive: Company established and owned by a parent firm in order to insure its loss exposures while reducing premium costs, providing easier access to a reinsurer, and perhaps easing tax burdens. See also [Association Captive](#).

Catastrophic Coverage: Event which causes a loss of extraordinary magnitude, such extended hospital stay in ICU.

Certificate of Insurance: A statement of coverage issued to a individual under a group health plan, outlining the benefits and principal provisions applicable to the member often showing the date of coverage provided.

Chartered Financial Consultant (ChFC): An individual who has attained a high degree of technical competency in the fields of financial planning, investments, and life and health insurance and has passed ten professional examinations administered by The American College.

Chartered Life Underwriter (CLU): An individual who has attained a high degree of technical competency in the fields of life and health insurance and who is expected to abide by a code of ethics. Must have minimum of three years of experience in life or health insurance sales and have passed ten professional examinations administered by The American College.

Chartered Property and Casualty Underwriter (CPCU): Professional who has attained a high degree of technical competency in property and liability insurance and has passed ten professional examinations administered by the American Institute for Property and Liability Underwriters.

Claim: A request for payment of a loss which may come under the terms of a policy.

Class Rating: Rate-making method in which similar members are placed in the same underwriting class and each is charged the same rate. Also called manual rating.

CLU: See [Chartered Life Underwriter](#).

COBRA: Consolidated Omnibus Budget Reconciliation Act. Contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer formerly paid a part of the premium.

Coinsurance: (1) A provision under which a member who carries less than the stipulated percentage of coverage value, will receive a loss payment that is limited to the same ratio which the amount of coverage bears to the amount required; (2) a policy provision frequently found in medical coverage, by which the member and the plan share the covered losses under a policy in a specified ratio, i.e., 80 percent by the plan and 20 percent by the member.

Combined Ratio: Basically, a measure of the relationship between dollars spent for claims and expenses and contributions dollars taken in; more specifically, the sum of the ratio of losses incurred to contributions earned and the ratio of expenses incurred to contribution written. A ratio above 100 means that for every dollar taken in, more than a dollar went for losses and expenses.

Commission: The part of an insurance premium paid by the insurer to an agent or broker for his services in procuring and servicing the insurance.

Commissioner of Insurance: A state officer who administers the state's insurance laws and regulations. In some states, this regulator is called the director or superintendent of insurance.

Comprehensive Major Medical Insurance(CMM): A policy designed to give the protection offered by both a basic and a major medical health policy. It is characterized by a low deductible amount, a coinsurance feature, and high maximum benefits.

Concealment: Deliberate failure of an applicant for coverage to reveal a material fact to the insurer.

Confining Sickness: An illness that confines an insured person to his home or to a hospital.

Conservation: The attempt by the member to prevent the lapse of a policy.

Contract: A binding agreement between two or more parties for the doing or not doing of certain things. A contract of insurance is embodied in a written document called the policy.

Contract Holder: The group, entity or person to whom a group contract is issued.

Contractual Liability: Legal liability of another party that the business firm agrees to assume by a written or oral contract. It is common in construction and other agreements (written or oral) for one party to assume the liability of another. This is sometimes referred to as a hold harmless agreement. The extent to which one holds another harmless varies from contract to contract, job-to-job, etc.

Contribution: The amount paid by the members for coverage. Also known as premiums.

Contributory: A group policy issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be covered. (See [Noncontributory](#).)

Conversion Privilege: The right given to a plan participant to change insurance without evidence of medical insurability, usually to an individual policy upon termination of coverage under a group contract.

Coordination of Benefits (COB): The mechanism used in group health coverage to designate the order in which the multiple carriers are to pay benefits and to prevent duplicate payments.

Corridor Deductible: Major medical plan deductible that excludes benefits provided by a basic plan if both a basic and a supplemental group major medical expense policy are in force. · **Cost Basis:** An amount attributed to an asset for income tax purposes; used to determine gain or loss on sale or transfer; used to determine the value of a gift

Cost Containment: The controlled reduction of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs.

Coverage: The scope of protection provided under a contract; any of several risks covered by a policy.

Covered: A person covered by a plan is one who has fulfilled the eligibility requirements in the plan, for whom benefits have accrued, or are accruing, or who is receiving benefits under the plan.

Covered Expenses: Hospital, medical, and miscellaneous health care expenses incurred by the members that entitle him/her to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness, or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Covered Participant: A person covered by a pension plan is one who has fulfilled the eligibility requirements in the plan, for whom benefits have accrued, or are accruing, or who is receiving benefits under the plan.

CPCU: See [Chartered Property and Casualty Underwriter](#).

Credibility: A statistical measure of the degree to which past results make good forecasts of future results.

Credibility Factor: The weight given to an individual insured's past experience in computing premiums for future coverage.

CSR: Customer service representatives support the work of unit with a variety of tasks that must be done within a company to deliver services to and handle requests from clients.

D

Death Benefit: A payment made to a designated beneficiary upon the death of the employee annuitant.

Declination: The insurance company's refusal to insure an individual after evaluation of the application for insurance and any other pertinent factors.

Deductible: An amount which a policyholder agrees to pay, per claim or per accident, toward the total amount of a loss.

Dental Coverage: Individual or group plan that helps pay costs of preventative, normal dental care as well as damage to teeth from an accident.

Deposit Premium: The money paid by a prospective policy holder when an application is made for an insurance policy. It is usually equal, at least, to the first month's contribution and is applied toward the actual amount due when billed.

Diagnosis-Related Groups (DRGs): System that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Direct Writer: The industry term for a company which uses its own sales employees to write its policies. Sometimes refers to companies which contract with exclusive agents.

Disability: A physical or a mental impairment that substantially limits one or more major life activities of an individual. It may be partial or total. See [Partial Disability](#); [Total Disability](#).

Disability Benefit: Periodic payments, usually monthly, payable to participants under some retirement plans, if such participants are eligible for the benefits and become totally and permanently disabled prior to the normal retirement date. · **Disability Benefit:** A feature added to some life insurance policies providing for waiver of premium, and sometimes payment of monthly income, if the policy holder becomes totally and permanently disabled.

Disability Income Insurance: A form of health coverage that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury, or disease.

Dismemberment: Loss of body members (limbs), or use thereof, or loss of sight due to injury.

Dividend: (1) A return of part of the premium on participating insurance to reflect the difference between the premium charged and the combination of actual mortality, expense and investment experience. Such premiums are calculated to provide some margin over the anticipated cost of the insurance protection. (2) In capital stock companies, a share of the profits distributed to stockholders.

Domestic Partnership: A couple who form a union, who desire to share an exclusive life together, and are of the same sex. See also [Insurance Considerations for Domestic Partners](#).

Driver Education Credit: Student discount or reduction in premium amount for which young drivers become eligible on completion of a driver education course.

Duplication of Benefits: Overlapping or identical coverage of the same member under two or more health plans, usually the result of contracts of different carriers, service organizations, or pre-payment plans; also known as multiple coverage.

E

Earned Premium: The portion of the annual contribution which is the property of the coverage provider, based on the expired portion of the policy period. For example, a carrier is considered to have earned 75 percent of the total annual contribution after a period of nine months of an annual policy has elapsed.

Effective Date: The date on which the coverage under a policy begins.

Eligibility Date: The date on which an individual member of a specified group becomes eligible to apply for coverage under a group life or health plan.

Eligibility Period: A specified length of time, such as one month, following the eligibility date during which an individual member of a particular group will remain eligible to apply for coverage under a group life or health policy without evidence of insurability.

Eligibility Requirements: The conditions which an employee must satisfy to participate in an employer-sponsored health plan, for instance, full-time employment working over thirty hours per week.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health plan.

Employee Benefit Plan Insurance: Coverage designed to protect the employer against claims by employees or former employees resulting from negligent acts or omissions in the administration of the member's employee benefits programs. Coverage is intended to extend to the administration of these plans, including counseling employees, interpreting

employee benefits programs, handling records, enrolling, terminating or canceling employees in specified plans on a timely basis, etc

Employee Benefit Programs: Programs designed to benefit employees, arranged by the employer, which are not paid for primarily or directly by the employee, including for instance group life and group accident and/or health plans; profit sharing plans; employee stock subscription plans; workers' compensation; unemployment insurance; social security benefits; disability benefits, etc..

Employee Dishonesty Insurance: Coverage designed to protect an employer from financial loss due to the fraudulent activities of one or more employees. The coverage includes protection for loss of money, securities, and other property of the insured. Some scheduled policies are still available, but the majority is written on a blanket basis. This provides coverage for all employees, subject to the policy definitions. The limit of liability is "per loss" and is applied on an occurrence basis. All acts involving the same employee or group of employees is considered one occurrence.

Employee Retirement Income Security Act (ERISA): Legislation passed in 1974 applying to most private pension and welfare plans that require certain minimum standards to protect participating employees. · **Employment Practices Liability Insurance:** Coverage designed to protect the corporation, directors & officers and employees for claims resulting from wrongful termination, discrimination, sexual harassment, wrongful discipline and failure to employ or promote.

Enrollment Card: A document signed by an employee as notice of his/her desire to participate in the benefits of a group health or life plan.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusive Provider Organization (EPO): People who belong to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed. See also [Health Maintenance Organization](#).

Experience: A term used to describe the relationship, usually expressed as a percent or ratio, of contribution to claims for a plan, coverage, or benefits for a stated time period.

Experience Rating: The process of determining the contribution premium rate for a group risk, wholly or partially on the basis of that group's experience.

F

Fidelity Bond: A form of protection which reimburses an employer for losses caused by dishonest or fraudulent acts of employees.

Fiduciary: A person who holds something in trust for another.

Fiduciary Liability Insurance: Coverage designed to protect against loss for any alleged wrongful act by an insured or by any other person for whom the insured is legally responsible. It also covers the defense costs in connection with a covered claim. The policy is written on a claims made form. A wrongful act includes any violation of the responsibilities, obligations, or duties imposed on fiduciaries by the Employee Retirement Income Security Act (ERISA), as well as acts, errors, or omissions in the performance of the duties of the plan administrator. Also known as pension trust liability.

401(k) Plan: A salary reduction plan that allows employees to contribute a portion of their salaries on a tax-deferred basis. See also [Defined Contribution Plan](#).

Fully Insured: A group health policy that carries no risk to the member group other than the annual contributions developed at renewal.

G

Generally Accepted Accounting Principles (GAAP): Principles of accounting and reporting business results developed by the American Institute of Public Accountants.

Grace Period: A specified period after a payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Gross Negligence: the intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another

Gross Premium: The premium paid by the policyholder.

Group Contract: A contract of coverage made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Group Health Plan: Type of employer provided policy to provide coverage to employees' protection against financial losses resulting from sickness or accidental bodily injury. Coverages may include accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Guaranteed Renewable Contract: A provision in an insurance policy that gives the insured the right to continue the policy in force by the timely payment of premiums for a substantial period of time, during which period the insurer is prohibited from making unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Guaranty Fund: A fund, derived from assessments against solvent insurance companies, to absorb losses of claimants against insolvent insurance companies.

H

Hard Market: That part of the insurance sales cycle in which competitive pricing is at a minimum as companies charge the premiums necessary to meet their underwriting losses in order to avoid insolvency and boost capacity; usually associated with a sharp decline in capacity. See also [Soft Market](#).

Hazard: Condition that creates or increases the chance of loss.

Health Insurance: Coverage designed to protect against financial losses resulting from sickness or accidental bodily injury. Health insurance coverages include accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be contracted with and sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was the result of efforts by the Clinton Administration and congressional healthcare reform proponents to reform healthcare. The goals and objectives of this legislation are to streamline industry inefficiencies, reduce paperwork, make it easier to detect and prosecute fraud and abuse and enable workers of all professions to change jobs, even if they (or family members) had pre-existing medical conditions.

Hospice: Health care facility providing medical care and support services such as counseling to terminally ill persons.

I

Incurred Losses: Expense account in a carrier's Income Statement reflecting the claims paid during the policy year plus the loss reserves as of the end of the policy year, minus the corresponding reserves as of the beginning of the policy year. The difference between the year end and beginning of the year claim reserves is called the increase in reserves and may be added directly to the paid claims to produce the incurred losses.

Incurred-but-not-Reported (IBNR) Reserves: Liability account on an insurer's balance sheet reflecting claims that are expected based upon statistical projections but which have not yet been reported to the insurer.

Independent Agent: An independent business person who usually represents two or more insurance companies in a sales and service capacity and who is compensated by commissions.

Individual Contract: A contract of health coverage made with an individual called the policyholder or the insured, which normally covers the individual and, in certain instances, members of his family.

Individual Deductible: Amount that an insured and each person of his or her family covered by the policy must pay before the group or individual medical insurance policy begins to pay for medical expenses.

Insolvent: Having insufficient financial resources (assets) to meet financial obligations (liabilities).

Insurance Company: (1) An organization chartered to operate as an insurer. (2) Any corporation primarily engaged in the business of furnishing insurance protection to individuals or organizations.

Insurance Commissioner: The top insurance regulatory official in the state.

Insured: A person or organization covered by an insurance policy. Also referred to as member.

Insurer: The party to the contract who promises to pay losses or benefits. Also, any corporation engaged primarily in the business of furnishing insurance to the public. See also insurance company.

Insuring Agreement: That part of an insurance contract that states the promises of the insurer.

Insuring Clause: The clause in an insurance contract which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Interlocal Agreement:

J

Joint-and-Several Liability: A legal principle that permits the injured party in a tort action to recover the entire amount of compensation due for injuries from any defendant who is able to pay, regardless of the degree of that party's negligence, once any liability by that defendant has been established.

Joint Underwriting Association: A device used to provide insurance to those who cannot obtain insurance in the voluntary market. Certain companies (called carriers) issue policies at one rate and handle claims, but the ultimate costs are borne by all companies writing insurance in that state.

L

Lapse: The termination or discontinuance of a policy due to non-payment.

Lapsed Policy: (1) A policy terminated for non-payment of premiums. (2) A policy terminated for non-payment occurring before the policy has a cash or other surrender value.

Liability: Any legally enforceable obligation.

Liabilities: Portion of an insurer's balance sheet which denotes legal obligations of the company, including anticipated future payments of losses covered under policies issued.

Life Expectancy: The average number of years of life remaining for a group of persons of a given age according to a particular mortality table.

Liquidation: The process of dissolving a company by selling its assets for cash.

Living Benefits Rider: A rider that allows insureds who are terminally ill or who suffer from certain catastrophic diseases to collect part of their life insurance benefits before they die, primarily to pay for the care they require.

Long-Term Care: The continuum of broad-ranged maintenance and health services to the chronically ill, disabled, or retarded. Services may be provided on an inpatient (rehabilitation facility, nursing home, mental hospital), outpatient, or at-home basis.

Long-Term Disability Income Insurance: Insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career.

Loss: The occurrence of the event for which insurance pays.

Loss Avoidance: A risk management technique whereby a situation or activity that may result in a loss for a firm is avoided or abandoned.

Loss Control: Any conscious action (or decision not to act) intended to reduce the frequency, severity, or unpredictability of accidental losses.

Loss Expense: Allocated: Handling expenses, such as legal or independent adjuster fees, paid by an insurance company in settling a claim which can be definitely charged to that particular claim. Unallocated: Salaries and other expenses incurred in connection with the operation of a claim department of an insurance carrier which cannot be charged to individual claims.

Loss Ratio: The percent which losses bear to premiums (either earned or written) for a given period.

Loss Reserve: The amount set up as the estimated cost of a claim. See [IBNR Reserve](#).

M

Major Medical Expense Insurance: A form of health insurance that provides benefits for most types of medical expense up to a high maximum benefit, such as \$250,000 or higher after a substantial deductible, such as \$500 or more. Such contracts may contain internal limits and are normally subject to coinsurance.

Major Medical Insurance: Health insurance designed to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to \$250,000 or higher above an initial deductible, which reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs, and medicines. The insured person pays the remainder.

Managed Care: Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services.

Manual Rate: The premium rate developed for a group's insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Market Price (or Market Value): The price at which a security can be bought or sold at any particular time.

Master Coverage Document: A document that is issued to a group, establishing a group insurance plan for designated members of an eligible group.

Medicaid: State programs of public assistance to persons whose income and resources are insufficient to pay for health care. Title XIX of the Federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare: A program of Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) protection provided under the Social Security Act.

Medigap: A term sometimes applied to private insurance products that supplement Medicare insurance benefits.

Minimum Benefits: A provision that a minimum amount of annuity will be paid if the regular benefit formula produces less. This minimum is usually payable only if certain service requirements are met at retirement.

Minimum Group: The least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Morbidity: The incidence and severity of sicknesses and accidents in a defined class or classes or persons.

Morbidity Tables: Actuarial statistics showing the frequency and duration of disability.

Mortality Table: A chart showing how many members of a group, starting at a certain age, will be alive at each succeeding age. It is used to calculate the probability of dying in, or surviving through, any period, and for determining the value of an annuity. To be appropriate for a specific group, it should be based on the experience of individuals having common characteristics, including such variables as sex and occupation.

Mortality: The rate at which members of a group die in a specified period of time. Actual mortality rates are compared to the mortality table.

N

Net Premium: (1) The portion of the premium rate which is designed to cover benefits of the policy, but not expenses, contingencies, or profit. (2) The portion of the premium remitted to the home office by an agent after deduction of the agent's commission. (3) Net written premium.

Noncancellable: A clause stating that the insured has the right to continue a policy in force by the timely payments of premiums set forth in the contract for some extended period of time specified, during which period the insurer has no right to make unilaterally any change in any provision of the contract while the contract is in force.

Nonconfining Sickness: A sickness that disables the insured person but does not confine him to his home or a hospital.

Noncontributory: A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. Generally, under noncontributory policies one hundred percent of the eligible employees must be insured.

Nonprofit Insurers: Persons organized under special state laws to provide hospital, medical, or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

O

Operating Ratio: The sum of expenses and losses expressed as a percent of earned contribution.

P

Participation Agreement: The contract between the Pool and its Member Groups to provide coverage through one of the three NCAC Risk management Pools.

Percentage Participation: A provision in a health insurance contract that the insurer and insured will share covered losses in agreed proportions. Also see [Coinsurance](#).

Plan Administrator: The person or persons controlling the money or property contributed to a pension, health or other plan, usually designated in the plan agreement.

Point-of-Service Plans: Often known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan yet are designed to encourage the use of network providers.

Policy: The legal document issued by a the company to a member, which outlines the conditions and terms of the coverage; also called the policy contract or the contract.

Policy Reserves: The measure of the funds that a company holds specifically for fulfillment of its policy obligations. Reserves are required by law to be so calculated that, together with future premium payments and anticipated interest earnings, they will enable the company to pay all future claims. Compare [Reserve](#).

Policy Term: That period for which an insurance policy provides coverage.

Policyholder: A person who pays a premium to an insurance company in exchange for the insurance protection provided by a policy of insurance.

Policyholders' Surplus: Sum left after liabilities are deducted from assets. Sums such as paid-in capital and special voluntary reserves are included in this term. This surplus is an additional financial protection to policyholders in the event a company suffers unexpected or catastrophic losses.

Pool: An organization of insurers or reinsurers through which particular types of risk are underwritten and premiums, losses and expenses are shared in agreed-upon amounts.

Portability: The right to transfer pension rights and credits when a worker changes jobs.

Preadmission Certification: Process in which a health care professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

Preexisting Condition: A physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO): An arrangement whereby a third-party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium: The sum paid by a policyholder to keep an insurance policy in force, also known as, contribution.

Primary Insurance: Insurance that pays compensation for a loss ahead of any other insurance coverages the policyholder may have.

Probationary Period: A period from the policy date to a specified time, usually 15 to 30 days, during which no sickness coverage is effective. It is designed to eliminate a sickness actually contracted before the policy went into effect.

Professional Review Organization (PRO): An organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under [Medicare](#) and [Medicaid](#).

Proration: The adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Prospective Payment: An advancement of payment for health care charges that are likely to occur.

Provision: A clause, sentence or paragraph of an insurance contract that describes or explains a feature, benefit, condition, requirement, etc. of the insurance protection afforded by the contract.

R

Rate Exhibit: The rate example provided to the Member Groups through which they indicate the set of group health rates to be charged for the fiscal year.

Rate: The pricing factor upon which the insurance buyer's premium is based.

Ratemaking: The statistical process by which insurers determine probability of loss and pricing for the basic classes of insurance.

Reasonable and Customary Charge: A charge for health care which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Claim Provision: A provision in some health plans which specifies a length of time during which the recurrence of a condition is considered to be a continuation of a previous period of disability or hospital confinement.

Recurring Clause: A provision in some health insurance policies, which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Reimbursement: The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

Reinstatement: The resumption of coverage under a policy which has lapsed.

Reinsurance: The acceptance by one or more insurers, called reinsurers, of a portion of the risk accepted by another insurer who has contracted for the entire coverage. Reinsurance can be treaty or facultative.

Renewal: Continuance of coverage under a policy beyond its original term by the member executing a contract to renew and the company's acceptance of the contributions premium for a new policy term.

Replacement: The substitution of health coverage from one policy contract to another.

Representation: Statements made by an applicant on their enrollment card, which he represents as being substantially true to the best of his knowledge and belief, but which are not warranted as exact in every detail.

Rescission: Termination of a contract by the company on the grounds of material misstatement on the application for coverage. The action of rescission must take place within the contestable period or Time Limit on Certain Defenses clause set forth in the policy, but takes effect as of the effective date of the policy, thus voiding the contract from its inception.

Reservation of Rights: An arrangement whereby a company defends a case without commitment to provide coverage in the event that the facts disclosed during the trial reveal that the occurrence is not covered.

Reserve: (1) An amount representing an insurer's estimate of its liabilities on future commitments under policies outstanding. (2) An amount allocated for a special purpose.

Retention: The net amount of risk retained by an insurance company for its own account or that of specified others, and not reinsured.

Retrocession: The process by which a reinsurer obtains reinsurance from another company.

Retrospective Date: The first date for which claims will be paid under a claims-made policy of liability insurance.

Retrospective Rating: Rating procedure which allows adjustment of an insured's final rate on the basis of the insured's own loss experience.

Risk: (1) The chance of loss; (2) The covered individual by a health policy.

Risk Classification: The process by which a company decides how its rates for coverage should differ according to the risk characteristics of individuals insured (e.g., age, occupation, sex, state of health) and then applies the resulting rules to individual applications. See also [Underwriting](#).

Risk Control: Any conscious action (or decision not to act) intended to reduce the frequency, severity, or unpredictability of accidental losses.

Risk Retention Group: An alternative form of coverage in which members of a similar profession or business band together to self insure their risks.

S

Self-Administered Plan: A plan funded through a fiduciary, generally a bank, but sometimes a group of individuals, which directly invests the accumulated funds. Retirement payments are made from the fund as they fall due.

Self-Administration: The procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance: A form of risk management through which a firm assumes all or a part of its own losses.

Soft Market: That part of the insurance sales cycle in which competition is at a maximum as insurance companies use their excess capacity to sell more policies at lower prices. See also [Hard Market](#).

Standard Coverage: Group coverage written on the basis of regular underwriting assumptions used by the Pool and issued at normal rates.

Standard Risk: A person who, according to a company's underwriting standards, is entitled to purchase insurance protection without extra rating or special restrictions.

State Insurance Department: A department of a state government whose duty is to regulate the business of insurance and give the public information on insurance. See also [Insurance Commissioner](#).

Statutory Accounting Principles (SAP): Rules of financial computation and presentation required by statute which must be followed by an insurance company when submitting its financial statements to state insurance departments. Such principles differ from [Generally Accepted Accounting Principles \(GAAP\)](#).

Step-Rating: A rating structure in which the contributions increase periodically at pre-determined times such as policy years or attained ages.

Subrogation: Process by which one company seeks reimbursement from another insurance company or person for a claim it has already paid.

Surgical Schedule: A list of maximum amounts payable by the policy for various types of surgery, with the amount based on the severity or complexity of the operation.

Surplus: The net worth of a company, equal to the amount by which assets exceed liabilities.

T

Term Insurance: Life insurance payable to a beneficiary only when an insured dies within a specified period. The coverage expires without value if the insured survives the stated period.

Third Party: A claimant under a policy; so called because the person making the claim is not one of the two parties, insured and insurer, to the insurance contract.

Third Party Claim: A demand made by a third party against a policyholder of an insurer and any payment that will be made by that company.

Total Disability: An illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work.

Trust: A legal instrument allowing one party to control property for the benefit of another.

Twisting: The practice of inducing by misrepresentation, or inaccurate or incomplete comparison, a policyholder in one company to lapse, forfeit or surrender his insurance for the purpose of taking out a policy in another company.

U

Unallocated Benefit: A policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter: 1) a company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; 2) the company employee who decides whether or not the company should assume a particular risk.

Underwriting: The process of reviewing, selecting, and approving risks for insurance and determining in what amounts and on what terms the insurance company will accept the risk.

Underwriting Profit or Loss: The amount of money which an insurance company gains or loses as a result of its insurance operations. It excludes investment transactions and federal income taxes.

Unearned Premium: The portion of a premium that a company has collected but has yet to earn because the policy still has unexpired time to run.

Underwriting Result: See [Underwriting Profit or Loss](#)

Uninsurable Risk: One not acceptable for insurance due to excessive risk.

V

W

Waiting Period: The length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective. See [Elimination Period](#).

Waiver: An agreement attached to a policy which exempts from coverage certain disabilities or injuries that otherwise would be covered by the policy.

Waiver of Premium: A provision in some policies to relieve the insured of premium payments falling due during a period of continuous total disability that has lasted for a specified length of time, such as three or six months.

Written Premiums: The entire amount of premiums due in a year for all policies issued by an insurance company.

XYZ