ACQUISITION INTEGRATION TOOLKIT

COMPANION REFERENCE

Benefits Terms, Acronyms and FAQs

A plain-language companion to the Benefits Acquisition Guide

Companion Reference · Version 1.0 · November 2026

Use this reference alongside the Benefits Acquisition Guide when reviewing seller records, comparing benefit programs and planning employee transitions. Terms are simplified for business owners, HR, benefits, finance and integration teams.

How to use this reference

Terms are grouped in four sections, followed by sixteen frequently asked questions. Acronyms are spelled out under each term, and bracketed numbers point to the official sources at the end. Confirm the actual plan terms and requirements before acting.

Section	Covers
1. Plans, people and providers	Who sponsors, administers, receives and services benefits.
2. Coverage, cost and claims	Distinguish the cost of coverage from the risk of paying claims.
3. Rules, records and eligibility	Common acronyms in benefit due diligence.
4. Retirement and spending accounts	Similar labels can describe very different arrangements.
Frequently asked questions	Reviewing the seller's program and planning the employee transition

SECTION 1

Plans, people and providers

Who sponsors, administers, receives and services benefits.

Term	What it means and what to check
Plan sponsor / plan administrator	The sponsor establishes or maintains the plan. The administrator is the person or entity designated to administer it. A service vendor is not automatically the legally designated administrator.
Participant / beneficiary / dependent	A participant is a person participating in or entitled to participate under applicable plan rules and law. A beneficiary receives or may receive benefits. A dependent meets the plan's applicable dependent-eligibility rules.
Employee census / enrollment roster	A census describes the employee population and relevant eligibility information. An enrollment roster identifies elections and covered people. Reconcile both to payroll and carrier records; headcount alone does not establish enrollment.
Coverage tier / waiver	A tier describes an enrollment category, such as employee only or family. A waiver records a decision to decline a benefit. Check the actual elections instead of assuming every eligible employee enrolled.
Carrier / broker / consultant	A carrier issues insurance. A broker helps place or service coverage. A consultant provides advice under an engagement. Confirm authority and disclosure permissions before contacting seller advisors.
TPA / PBM *Third-Party Administrator / Pharmacy Benefit Manager*	A TPA performs contracted administrative functions; a PBM manages pharmacy-related services. Duties, fees, data rights and termination terms depend on the contracts.
PEO *Professional Employer Organization*	A provider of specified employment-related services under a contractual arrangement, which may include access to benefit arrangements. Do not assume coverage or plan participation follows employees when the arrangement ends.

SECTION 2

Coverage, cost and claims

Distinguish the cost of coverage from the risk of paying claims.

Term	What it means and what to check
Premium / employee contribution	A premium is the charge for insurance. An employee contribution is the amount an employee pays toward a benefit, often through payroll. A self-funded contribution is not necessarily an insurance premium.
Deductible / copayment / coinsurance	A deductible is the amount paid for specified covered services before the plan begins paying under its terms. A copayment is a fixed amount; coinsurance is a share of covered costs. Exceptions and network rules matter.
Out-of-pocket maximum / accumulator credit	The maximum limits specified participant cost sharing for covered care under plan terms. Accumulators track amounts applied toward deductibles or limits. Credit under a replacement plan requires confirmation; do not assume it transfers.

Term	What it means and what to check
Fully insured / self-funded / level-funded	In a fully insured arrangement, the insurer assumes covered claim risk under the policy. A self-funded sponsor bears claim risk. Level-funded arrangements commonly package estimated claims funding, fees and stop-loss into regular payments; examine the actual contracts.
Stop-loss / attachment point / laser	Stop-loss insurance reimburses eligible sponsor losses under its terms. An attachment point is the threshold for reimbursement. A “laser” is a person-specific exclusion or higher threshold. Review individual and aggregate provisions; stop-loss is not the employee health plan.
Incurred date / paid date / claim lag	The incurred date identifies when a claim obligation arises under the relevant terms; the paid date is when payment occurs. Claim lag is the delay between the event and payment. Definitions may differ between the health plan and stop-loss contract.
IBNR *Incurred But Not Reported*	An estimate of claims incurred but not yet reported. Review unpaid reported claims separately and confirm what any reserve estimate includes. Qualified actuarial or financial help may be needed.
Claims run-out / run-in	Run-out generally concerns claims incurred during an earlier coverage period and processed or paid later. Run-in generally concerns earlier-incurred claims paid under a later arrangement. Contract windows determine what is covered and who funds it.
Network / formulary / transition of care	A network identifies participating providers. A formulary lists covered drugs and associated rules. Transition-of-care processes may support ongoing treatment during a change; availability and conditions require confirmation.

SECTION 3

Rules, records and eligibility

Common acronyms in benefit due diligence.

Term	What it means and what to check
ERISA *Employee Retirement Income Security Act*	A federal law governing many private-sector employee benefit plans. It addresses matters such as fiduciary responsibilities, disclosures and claims procedures. Applicability and exceptions require review. [1]
SPD / SMM / SBC *Summary Plan Description / Summary of Material Modifications / Summary of Benefits and Coverage*	The SPD explains the plan; an SMM describes changes; an SBC summarizes key health coverage features. A benefit brochure is not a substitute for all required documents. [1]
ACA / ALE *Affordable Care Act / Applicable Large Employer*	ACA duties vary by employer and plan. ALE status concerns specified employer obligations; related-employer aggregation can matter. Do not use the acquired business’s headcount alone. [2]

Term	What it means and what to check
COBRA *Consolidated Omnibus Budget Reconciliation Act*	In benefits discussions, usually refers to federal continuation coverage after specified qualifying events. State continuation laws may also matter. Determine the responsible party for the actual transaction and population. [3]
HIPAA / PHI *Health Insurance Portability and Accountability Act / Protected Health Information*	HIPAA regulates specified covered entities and information; it does not apply to all employer records in the same way. Other privacy obligations may apply. [4]
QLE / special enrollment / election change *Qualifying Life Event*	QLE is common administrative shorthand. Special enrollment rights and permitted cafeteria-plan election changes have distinct conditions. Do not assume an acquisition automatically creates every right or election opportunity.
Eligibility date / effective date / waiting period	Eligibility determines when a person qualifies under plan rules. The effective date is when coverage begins. A waiting period delays coverage under applicable terms and law. Confirm all three for each benefit.
EOI / active-at-work / portability / conversion *Evidence of Insurability*	EOI may require health information for certain life or disability coverage. Active-at-work provisions can affect when coverage begins. Portability and conversion describe different ways to continue or replace coverage under contract terms; deadlines and options vary.
STD / LTD / EAP *Short-Term Disability / Long-Term Disability / Employee Assistance Program*	Disability coverage addresses qualifying income loss; an EAP provides specified support services. Benefit approval and job-protected leave are separate determinations.

SECTION 4

Retirement and spending accounts

Similar labels can describe very different arrangements.

Term	What it means and what to check
401(k) / DC / DB *Defined Contribution / Defined Benefit*	A 401(k) is a defined contribution retirement arrangement permitting employee salary deferrals. A defined benefit plan promises benefits under a formula. Pension and multiemployer arrangements need specialist review. [5]
Deferral / match / vesting	A deferral is an employee contribution from compensation. A match is an employer contribution based on specified conditions. Vesting determines the participant's nonforfeitable right to employer-funded benefits. Employee deferrals are fully vested. [5]
Service credit / entry date	Service credit recognizes prior employment for specified purposes, such as eligibility or vesting. An entry date is when eligible employees may join under the plan. Recognition for one purpose does not automatically establish recognition for every purpose.
Recordkeeper / blackout period	The recordkeeper maintains participant account records. A blackout period temporarily limits specified participant transactions during certain plan changes. Confirm the scope, timing and required notices before communicating it.

Term	What it means and what to check
Plan merger / termination / rollover	A plan merger combines plans. Termination formally winds down a plan. A rollover moves an eligible distribution to an eligible receiving arrangement. These are different processes; an acquisition does not automatically permit a distribution. [5, 6]
IRA / QDRO *Individual Retirement Arrangement / Qualified Domestic Relations Order*	An IRA is an individual retirement account or annuity arrangement. A QDRO allocates specified plan benefits under a qualifying domestic-relations order; include applicable restrictions in specialist record review.
HSA / HDHP *Health Savings Account / High Deductible Health Plan*	An HSA is an individually owned tax-favored account. Contribution eligibility depends on qualifying coverage and other conditions. The health plan and the account are separate. [7]
FSA / HRA *Flexible Spending Arrangement / Health Reimbursement Arrangement*	A health FSA commonly uses employee salary-reduction elections; an HRA is employer-funded. They differ from an individually owned HSA. Health and dependent-care FSAs have different purposes and rules. [7]
Run-out period / carryover / grace period	For spending accounts, a run-out period allows submission of qualifying claims. A carryover permits specified unused amounts to move forward; a grace period extends a permitted expense-incurrence period. These are distinct and plan-specific. [7]

FREQUENTLY ASKED QUESTIONS

Reviewing the seller's program

1. What should we request first?

Start with the plan inventory, sponsor and participating-employer list, coded census, current plan terms, vendor contracts and cost summary. Reconcile enrollment to payroll before relying on totals.

2. Is a benefit brochure enough?

No. Obtain applicable plan documents, amendments, insurance policies, adoption agreements, summaries and notices. Compare them to actual practice and have advisors resolve conflicts. [1]

3. Does a lower premium mean a better deal?

No. Compare employer costs, employee contributions, cost sharing, networks, exclusions, funding risk and transition expenses. For self-funded arrangements, assess unpaid claims and stop-loss terms.

4. How far back should we look?

The guide suggests 12 to 24 months of costs and generally three years of applicable compliance records, plus older unresolved matters. These are starting points for diligence, not legal retention periods.

5. Can we share a full census and claims file with everyone on the deal?

No. Start with aggregate or coded data where sufficient. Limit identifiable information to what is necessary, authorized and lawfully permitted. A confidentiality agreement does not independently authorize every health-data disclosure. [4]

6. Do all benefits continue until the same date?

Do not assume so. Medical, dental, life, disability, spending accounts and retirement may follow different terms. Confirm the end date, replacement start date and required actions for each benefit.

7. Do deductibles and out-of-pocket balances transfer?

Only if the replacement plan or carrier approves the applicable credit. Obtain written details, required data and processing dates, and explain any limits accurately.

8. Who pays claims received after closing?

Determine when the claim was incurred, which plan and contract apply, and the transaction's allocation of costs. Confirm administration, funding and stop-loss reimbursement separately; payment date alone does not answer responsibility.

FREQUENTLY ASKED QUESTIONS

Planning the employee transition

9. Can we waive waiting periods or recognize prior service?

Confirm what the plan, carrier and law permit, and obtain any necessary approvals or amendments. Health eligibility, retirement eligibility, vesting and employer match may use different rules.

10. Does an acquisition automatically trigger COBRA?

No single answer applies to every transaction. Structure, employment events, coverage loss and continuation of plans matter. Counsel should determine duties for current and prior qualified beneficiaries. [3]

11. Must we terminate the seller's 401(k)?

No. Continuation, merger, termination or another approach may be appropriate. Obtain specialist review before closing where timing matters. Termination and distributions have formal requirements and possible restrictions. [5, 6]

12. Will retirement balances and loans move automatically?

Do not assume they will. Confirm the approved plan strategy, receiving-plan terms, participant choices, loan handling and recordkeeper instructions. Do not promise an automatic rollover or tax result.

13. Can HSA, FSA and HRA balances all be transferred the same way?

No. HSAs are individually owned; FSA and HRA treatment depends on plan terms and applicable rules. Review elections, claim periods, contributions and permitted transition methods separately. [7]

14. What about employees on leave or receiving disability benefits?

Use a restricted case review. Confirm continued eligibility, premium arrangements, active-at-work conditions and which carrier administers each claim. Communicate individual next steps without exposing medical details broadly.

15. Does submitting enrollment mean coverage is active?

Submission alone is not confirmation. Reconcile carrier or administrator acceptance, effective dates and covered people. Establish a support process for missing identification cards, rejected records or urgent access-to-care issues.

16. What should we check after the transition?

Reconcile the first payroll, carrier bills, employer funding and retirement deposits. Resolve enrollment errors, monitor claims run-out and complete notices and corrections. Use the guide's 30, 60 and 90 day checkpoints without postponing earlier required deadlines.

REFERENCE

Sources and reference notes

Bracketed references support the identified legal and technical distinctions. Other entries explain common benefit-administration usage. Definitions are simplified; actual plan documents, contracts and applicable requirements govern decisions.

#	Source	Web address
[1]	DOL: Plan information and disclosures	https://www.dol.gov/general/topic/health-plans/planinformation
[2]	IRS: Applicable large employer determinations	https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer
[3]	DOL: An employer's guide to COBRA continuation coverage	https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra
[4]	HHS: Employers and health information in the workplace	https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html
[5]	DOL: What you should know about your retirement plan	https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/what-you-should-know-about-your-retirement-plan
[6]	IRS: 401(k) plan termination	https://www.irs.gov/retirement-plans/plan-sponsor/401k-plan-termination
[7]	IRS: Publication 969, health and spending accounts	https://www.irs.gov/publications/p969

Reference pages reviewed November 5, 2026. This companion intentionally avoids fixed annual contribution limits and universal legal deadlines. Verify current requirements before implementing a change.

ABOUT THIS REFERENCE

A companion to the Benefits Acquisition Guide, Version 1.0, November 2026; the request periods and transition checkpoints follow that guide. This is a general educational resource, not legal, insurance, tax, investment, medical or regulatory advice, a compliance certification or a substitute for plan-specific professional review. Requirements vary by employer group, plan, transaction and jurisdiction. Protect employee and dependent information and use authorized secure channels.