

Key Employee Concentration Test	A test that demonstrates that no more than 25% of non-taxable benefits are provided to key employees including officers or owners who meets specific compensation and/or ownership criteria.
Late Enrollee	An employee eligible for coverage on a group health plan who failed to enroll when first eligible and during the time allocated for enrolling usually within 30 days after the eligibility date.
Lifetime Maximum	The maximum dollar amount an insurance company will pay in claims during the lifetime of an insurance policy. A policy may have provisions to credit back a portion on an annual basis.
Limitations	Refers to services that have a limited benefit either in terms of a dollar amount or a number of occurrences.
Look Back Period	That period of time, when determining a pre-existing condition exclusion period, used to define what is a pre-existing condition based on when it occurred.
Major Medical Policy	A comprehensive insurance policy that covers most medical expenses up to a maximum limit, usually after a deductible and coinsurance (shared expenses) have been met.
Managed Care	A system of delivering health care where care is delivered through a specified network of doctors and hospitals contracted with an HMO or Preferred Provider Organization.
Mandated Benefits	Benefits required to be included in a policy by virtue of state or federal insurance regulations.
Medical Providers	Persons or firms providing medical care including, but not limited to, physicians, hospitals, surgical centers, urgent care clinics, ambulance services, skilled nursing homes and durable medical equipment suppliers.
Medical Savings Account	A Medical Savings Account or MSA is a combination of a high deductible health insurance policy and a separate savings account for payment of medical expenses on a tax-free basis. It is limited to self-employed business owners and companies employing from two to 50 employees.
Medically Necessary	Considered necessary by a physician to treat a medical condition and not to include preventive care or elective services unless otherwise covered by an insurance policy.
Member Provider	A provider of medical services belonging to a network of providers contracted with a certain insurance company or health plan.
MSA	See Medical Savings Account
Network	An insurance company's group or list of approved or contracted providers from which you can obtain service at the plan's highest benefit level.
Non-Formulary	Not on an insurance company's approved drug list and usually only available at a highest cost (lower benefit level).

Out-Of-Network	Outside an insurance company's list or group of contracted providers where services received, if covered at all, are covered at a lower benefit level.
Out-Of-Pocket	The maximum dollar amount of shared expenses (coinsurance) you will pay in a year before the insurance company or health plan begins paying at the 100% level of benefits. This is usually in addition to a deductible you may have paid prior to sharing expenses.
PCP	See Primary Care Physician
Percentile	Expressed as a percentage that an insurance company will pay on a usual, customary and reasonable basis. A percentile of 90% means that an insurance company will pay up to the charge for a specified service that is greater than 90% of the charges in the area.
Point-Of Service	A managed care plan that provides maximum benefits through an HMO network and reduced benefits through a second list of participating or preferred providers.
Policy	The actual contract of insurance defining the coverage, terms and conditions between you and the insurance company or health plan.
POP	See Premium Only Plan
Portability	The right to purchase, from one of two plan choices, a guaranteed-issue individual policy within 63 days of losing your group health plan coverage provided you have been covered on the group health plan for a specified period of time.
POS	See Point-Of-Service
PPO	See Preferred Provider Organization
Pre-Authorization	A requirement by an insurance company or health plan that certain services must be approved in advance to be covered or to be covered without a penalty.
Pre-Existing Condition	A condition for which you were diagnosed with or received treatment for and, in some cases, for which a prudent person should have sought treatment that occurred in the look-back period established by an insurance company or state law.
Preferred Provider	A provider of medical services belonging to a network of providers contracted with a certain insurance company or health plan.
Preferred Provider Organization	A managed care company that uses a network of preferred or member providers, but allows for services from other providers at a higher utilization cost to you.
Premium	The monthly amount due to an insurance company or health plan to cover the cost of the policy. (Your share of the group's expenses - See Health Insurance)
Premium Only	A Flexible Spending Account limited to covering an employees'

Plan	share of group health plan premiums and that of any dependents and allowed supplemental insurance policy premiums.
Preventive Care	Care rendered in advance of a medical condition to prevent a condition from occurring or to detect a condition early enough to prevent it from becoming a serious condition.
Primary Care Physician	A personal physician selected by you to supervise and manage all of your health care services, referred to as a PCP and used by HMO plans and some PPO plans. Referral to specialists is usually required by HMO plans while not a requirement of PPO plans using a PCP to receive the best benefits for certain services.
Referrals	A written referral from your PCP authorizing you to visit a specified specialist.