McDonough District Hospital
525 East Grant Street | Macomb, IL 61455
(309) 833-4101 | www.MDH.org

Pricing Transparency at McDonough District Hospital and McDonough District Hospital Medical Group

Patient Responsible Balances

If you have insurance we accept, during the pre-registration process or at the time of service you will be requested to pay and or make payment arrangements for your co-pay, deductible and co-insurance for the visit. If you have a self-pay balance from prior services we will ask you to either pay them at that time or make payment arrangements.

If you do not have insurance we accept, during the pre-registration process or at the time of service you will be requested to pay and or make payment arrangements for the anticipated charges related to your visit. If you do not have insurance, effective January 1, 2023 we offer a 40% discount on all self-pay patient balances that occur as of or after January 1, 2023.

If you need help paying for care, we offer financial assistance and counseling.

State of Illinois Hospital Uninsured Patient Discount Program

If you are a resident of the State of Illinois and are an uninsured self-pay patient, you may qualify for the Illinois Hospital Uninsured Patient Discount Program.

Hospital Uninsured Patient Discount Act SB 2380

SB 2380, the Hospital Uninsured Patient Discount Act, became law September 23, 2008 and the provisions of law apply to hospitals beginning April 1, 2009. The Act requires all hospitals to provide discounts from charges to uninsured patients meeting certain eligibility criteria. The discounts must result in bills of no more than 135% of cost. There is also a maximum collectible amount of 20% of annual family income for those who meet the eligibility criteria and do not have significant assets.

Major provisions of the Act are as follows:

Eligible Patient

- A hospital patient without any health insurance or coverage.
- Patient must be an Illinois resident.
- Family income no more than 300% Federal Poverty Level.
- Example: Family of four; 300% FPL is $90,000.

Discount Allowed

- Charges are discounted to 135% of cost by applying the Cost of Charge Ratio from most recently filed Medicare Cost Report.
- Applies to charges exceeding $300 in any one inpatient admission or outpatient encounter for a rural hospital such as McDonough District Hospital.

- Hospitals shall notify patients of their ability to include health care received in the last 12 months towards the maximum collectable amount. This information shall be included clearly and in plain language on financial assistance applications, hospital bills, invoices, or summary of charges provided by the hospital.
- A rural hospital shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 125% of the Federal Poverty Guidelines.
- Maximum amount collected in a 12-month period from an eligible patient is 20% of family's annual gross income. Time period begins as of the first date of service determined to be eligible for discount. A hospital may exclude a patient from the 20% maximum collectible amount who has substantial assets. Assets not considered are primary residence, personal property exempt from collections, and any amounts held in a pension or retirement plan.
- To be eligible to have this maximum amount applied to subsequent charges, the uninsured patient will need to inform the hospital of subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from the hospital and was determined to be entitled to the uninsured discount.

Eligible Services

Medically necessary health care services that would be covered under Medicare for beneficiaries with the same clinical presentation as the uninsured patient.

Notice to Patient

Criteria of and how to apply for the uninsured discount must be included on or with each hospital bill, invoice, statement, summary of charges, Financial Assistance Application and facility website.

Patient Responsibilities

- Patient may be required to apply for Medicare, Medicaid, AllKids, SCHIP, or other public programs if there is reason to believe they would qualify for such program.
- Patient may apply for the discount within 60 days of service.
- Patient must provide third-party verification of income, information regarding assets and documentation of residency within 30 days of request.
- Patient must inform hospital that he/she had received prior services from that hospital which were determined to be eligible for discount in order for any subsequent services to be included in the 20% maximum.

Protections/Enforcements

- Law cannot be used by public or private insurers to reduce hospital payment rates.
- Law will not require a hospital to provide any particular service to an uninsured patient.
- Law will not reduce any obligations under the Fair Patient Billing Act.

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If you feel you meet the criteria stated and would like to apply for the discount, please contact the Financial Counselors in the main Hospital building.

Accepted Insurance Plans

McDonough District Hospital and the MDH Medical Group are in-network participants in the local and national health insurance plans listed below.

Blue Cross Blue Shield
Blue Choice
Champva – requires pre-authorization
Champus – requires pre-authorization
Tricare – requires pre-authorization
VA CCN Optum by United – requires pre-authorization
All Savers United Health Care
BSSI HFN
Unicare Healthlink 90001
Unicare Healthlink 96475
HFN
Humana
Magellan
UMR, United Health Care
United Healthcare
United Healthcare Student Resources
Consociate, Unicare-Healthlink
LPMG, HFN
Midlands Choice
Mutual Medical, McDonough Co Employees
North America Administrators, Unicare Healthlink
NTCA, United Health Care
UHSS, United Health Care
Unicare
Health Alliance
Medicaid Illinois
Medicaid Aetna Better Health
Medicaid Meridian
Medicaid Molina
Medicaid Youth Care, IlliniCare Health
Medicare
Medicare Railroad PGBA

Medicare Health Alliance
Medicare Humana
Medicare Molina
Wellfleet (8/1/2022)

Please note: McDonough District Hospital and the MDH Medical Group may not participate in all products offered by an insurance carrier. We encourage you to contact your insurance company to verify your coverage for care delivered at a McDonough District Hospital and the MDH Medical Group.

Some health plans require a pre-authorization for us to be paid for the services provided. If you participate in the following plans, please obtain a prior authorization number from your insurance plan or your referring physician and bring it with you to your appointment. Payment for services provided without an authorization will be expected from the patient and/or guarantor.

The following insurance plans require pre-authorization for services at McDonough District Hospital and MDH Medical Group. Please make sure you have a pre-authorization number and either call us with it or bring it with you at the time of your service.

Champva – requires pre-authorization
Champus – requires pre-authorization
Tricare – requires pre-authorization

At this time, we do not participate in the following health plans. Because we do not participate with these insurance plans, if you do not have a pre-authorization number prior to your service, you will be requested to pay for the service in advance.

Aetna
Aetna Medicare
Blue Cross Community Health

A note for those on Medicare: If you are covered by Medicare, you should have received a new Medicare number and card in the mail to help protect your identity. In order to bill your Medicare policy we will need your new Medicare number. Your new number will contain multiple numbers and letters. It will not contain your social security number. If you do not have your new Medicare number, please call Medicare and request your number and a new card.

As a cautionary note, please be aware of medical identity theft scams. Medicare will never call and ask you to provide personal or private information to get your new Medicare Number or card.

Estimating Your Out-of-Pocket Costs

Knowing what you're going to be responsible for paying out of pocket is essential to planning for your healthcare. You can find a posting of our charges and the estimated payments

received from contracted carriers on our web site under Patients & Visitors/Financial Assistance. This posting of charges are available for you to use to create an estimate of your personal out-of-pocket costs for many common procedures and services.

You also have the ability for our system to generate a self-pay estimate or an insurance estimate for those plans in which we participate. Please follow the link for the Patient Price Estimator on the right hand side of the Patients & Visitors link. Input the requested data and the system will generate an estimate of the cost of the indicated services and your out-of-pocket responsibility. If you need assistance in estimating out of pocket costs, our Registration staff will be available to help provide you an estimate.

It's just one more way we're personalizing care for you. We will work hard to provide accurate and personal estimates of your out-of-pocket costs. Please though recognize that an estimate is just that – an estimate. It is not a guarantee of the exact amount you will be responsible for paying. Many things affect your out-of-pocket costs, including what your insurance covers and what co-pays, co-insurance and deductibles you may owe.

Your care will be based on your specific needs. If the services you need change during your treatment, your out-of-pockets costs may change too. If you need help paying for care, we offer financial assistance and counseling.

Please remember:
An "apples-to-apples" comparison of costs between hospitals can be challenging. Many things influence pricing, including:

- Some hospitals or their clinics may not include everything in an estimate. For example, the price you are quoted may not include the "professional fees" for the surgeon to do the operation, the radiologist to read the scan or other doctors' services.
- Whether the hospital or clinics offers specialized, complex care.
- The type of hospital or clinic at which you are receiving your services.
- What your insurance covers. Coverage provided by your health plan may differ among hospitals.

List of Standard Charges and Patient Estimator

As part of their Pricing Transparency initiative, the federal government requires hospitals to post certain information about charges for their services.

To comply with the federal requirement, we have posted our charge list and provided access to an automated Patient Estimator. You can find these on our web site under Patients & Visitors/Financial Services.

Self Service Patient Estimates/Shoppable Services

The federal government requires hospitals to provide patients with the ability to run their own estimates for the most common services McDonough District hospital provides. To enable you to obtain an estimate, we have installed a Patient Estimator tool. If you would like to run

your own estimate for select services we may provide please follow the link for Patient Self Service Estimates located on our web site under Patients & Visitors/Financial Services.

Disclaimer

The prices listed in our charge file and in our Patient Self Services Estimates are the list prices of hospital charges billed to contracted insurance carriers. This information does not necessarily represent what an insurance company will pay or what you will owe.

Furthermore, the pricing information in these documents and programs are not a guarantee of any amount you will be charged for services provided by McDonough District Hospital and McDonough Medical Group. It is impossible to predict the final charges that will result due to variables involved in actual services such as: the length of time spent in surgery or recovery, specific equipment, supplies and medications required, additional tests required by your physician, and/or any unusual special care or unexpected conditions or complications.

McDonough District Hospital and the McDonough District Hospital Medical Group shall not be liable for any difference between charges listed in the referenced documents and the final bill for services that you receive.

If you have insurance, your insurance benefits will ultimately determine the amount you owe (including deductibles, co-pay, co-insurance, and out-of-pocket maximums.) The charges in this document may reflect amounts owed by your insurance company for which you will not be billed. You may be eligible for financial assistance under the McDonough District Hospital financial assistance policy; financial hardship is evaluated on a case-by-case basis.

Frequently Asked Questions

Q. How are hospital charges determined?
A. McDonough District Hospital and MDH Medical Group determines charges based on costs of providing the services.

Q. How often will the displayed charges be updated?
A. We plan to refresh the data used on our website annually based on our Fiscal Year Calendar

Q. Can hospital charges help me understand my out-of-pocket costs?
A. Charge information may not help you understand your out-of-pocket costs. Health plans are the best source of information on what a covered individual's out-of-pocket costs may be for a given service.

Q. Can hospital staff help me understand my out-of-pocket costs?
A. Yes. Our team in Patient Financial Services can help patients obtain answers to these questions by working with physicians and insurers.

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Q. Are physician charges available for viewing on this website?
A. Not at this time. If you have questions in relation of physician charges, please give us a call at (309) 833-4101 and request Patient Financial Services. We will be happy to answer any questions you may have.
Q. What if I cannot locate the service I need on this website?
A. Please give us a call at (309) 833-4101 and ask for Registration, Financial Counseling or Patient Financial Services. We will be happy to answer any questions you may have.

Q. Are you considering putting in an on-line estimation tool to give patients the opportunity to do estimations on-line?
A. Yes, we have implemented an on-line estimation tool that patients will be able to use. It is available for your use on our website under Financial Services.

All About Billing

We're here to help you understand the billing process and answer your questions.

Before your hospital stay or visit

Before your appointment, you can take steps to avoid surprises:

- Review our list of health plans accepted by McDonough District Hospital.
- When making your appointment, be prepared to provide your insurance information.
- Ask about the services you will receive so you can confirm with your insurance company whether they are covered. Check with your health plan to understand these questions.
- Create or review an estimate of your out-of-pocket costs.
- Consider paying your estimated balance due before your appointment to make your appointment check-in faster.

When making your appointment

You, the patient, can contact the Hospital or your physician’s office directly to schedule an appointment. You will be asked to provide some information to the provider, such as identification and insurance information. Once the provider has this information, the scheduling team can help you set an appointment time and date.

Before your appointment, you are encouraged to ask about the services you will receive. Asking for additional information can be helpful, as you can contact your insurance company to ensure that the services you will receive are covered by your insurance plan.

Before your appointment, the provider may contact your insurance company to obtain preauthorization of services or medications and to verify your insurance coverage. At this point, your insurance company collects information about your appointment and medical records prior to determining whether the services or medications will be covered.

On the day of your appointment

When you arrive for your appointment or admission, you'll probably need to complete paperwork required for registration. Be sure to bring your insurance card(s), your prescription list and a valid picture ID. Be prepared to pay any co-pay, deductible or out of pocket amounts.
At check-in, your financial responsibility as a patient will be explained. We can discuss payment options, including a payment plan. We also can connect you to a financial assistance counselor.

After your appointment

After your appointment or visit, MDH/MDH Medical Group sends an insurance claim to your insurance provider. This claim covers all the services, prescriptions and supplies used during your stay or appointment.

Your insurance provider reviews this bill and checks whether the services are covered by your plan. The insurance company may contact you or us to get more details. At this point, your insurance company decides to accept or deny the claim.

If the claim is accepted, your insurance company pays us. If it is denied, the company must give us a detailed reason for the denial. Then we will send you a bill for the balance.

When you receive your bill

You will receive monthly bill(s) that we determine are your responsibility after insurance payments have been applied. You may receive more than one bill for your hospital or clinic visit based on the type of care you receive.

We do our best to get things right the first time. But given the coordination involved, mistakes sometimes happen. It is important that you read your bills carefully and contact us and/or insurance company if you feel you may have been billed in error.

You have the right to dispute your charges and to have your bill reviewed to make sure charges are accurate and supported by your medical record. You may request this review in writing to the correspondence address listed on your statement or by calling the billing team at (309) 833-4101, Patient Financial Services.

After this review, we'll let you know the findings and make any corrections needed.
You have the right to appeal the decision. Request an appeal by writing to the address listed on your statement or by contacting customer service.

You also can request a detailed statement. You can do this by calling (309) 833-4101 and ask for Patient Financial Services.

If your bill is not paid

We will send you monthly bills for any unpaid balances for up to 120 days after you received services. During this 120-day period, we will contact you multiple times via statements, phone calls and/or emails to remind you about your unpaid balance.

During this period, you are expected to pay the bill in full or set up a payment plan.

To set up a payment plan

To set up a payment plan for bills from McDonough District Hospital or MDH Medical Group, call (309) 833-4101 and ask for Financial Counseling.

For any other statements you may receive, contact the phone number shown on the bill. If the balance due is unpaid or otherwise unresolved after the 120-day period, your account may be sent to a collection agency for further collection action. Your credit rating may be affected if the balance is not resolved after collection agency placement.

If you have Medicare

By law, we must ask you a series of questions at each visit. The questions help us determine whether Medicare or another payer should be filed as your primary insurance.

You will be asked:

- If your visit is related to a non-work-related accident
- Other benefits you may have, including other insurance you may have
- Your employment and or your spouse's employment
- Your retirement date and or your spouse's retirement

If you are covered by Medicare, we will submit your claims to Medicare on your behalf. We will also ask you to sign a notice that you are financially responsible for the services we provide. This is just in case Medicare deems the services not medically necessary and does not cover the services.

Expect a bill to you and/or your supplemental insurance carrier for services not covered by Medicare, such as medications you give yourself and routine health exams. Expect to pay if Medicare or your supplemental insurance does not cover the services we provided.

Common Questions about Billing, Insurance and Estimates

Do you accept my insurance?

McDonough District Hospital and MDH Medical Group participates in many local and national health insurance plans. We may not participate in all products offered by an insurance carrier.

It is best to contact your insurance plan to verify your coverage for care at a McDonough District Hospital or MDH Medical Group location prior to your date of service.

Can you tell me how much I'll have to pay?
If requested, we will try our best to give you an accurate estimate of your out-of-pocket costs before a visit or procedure. It's part of our commitment to personalized care.

An estimate is not a guarantee of exactly what you'll be responsible for paying. Many things go into your final bill. If your care changes during treatment, your out-of-pocket costs may change, too.

What if I need help paying my bill?
Please tell us if you cannot pay your bill in full — we can help.
We will discuss our financial assistance policy and payment plan options. We'll also help you find community and government resources. Financial hardship is decided on a case-by-case basis. Learn more and contact us.

Why am I being billed for something I thought my insurance covered?
A common reason for this is having inaccurate or incomplete insurance information in our system. Other reasons include a change in your coverage or denial of coverage.
Make sure we have your current and accurate insurance information. Verify this information during check-in for any appointment or procedure.

Can you help me understand my bill or my out-of-pocket costs?
Yes. Our team in Patient Financial Services or Registration can help you. Call us at (309) 833-4101.

Do I have to pay before receiving care?
By policy, we collect the amount you are responsible for paying before or at the time of service. You can discuss payment options when you arrive for your visit or by phone before your visit.

I paid too much. How can I get a refund?
Confirmed over-payments will be refunded to the payer. If you have questions about a refund, call (309) 833-4101. We may also apply over-payments to outstanding balances.

Questions to ask your insurance company
Your insurance coverage has the greatest effect on what you will pay for care at McDonough District Hospital and MDH Medical Group.

The following are some questions you can ask your insurance provider to help you understand the out-of-pocket costs for which you are responsible.
- What type of insurance plan do I have?
- Is McDonough District Hospital and MDH Medical Group in my provider network?

If McDonough District Hospital and MDH Medical Group is in network, here are some follow-up questions:

- Does my insurance plan cover physician costs, as well as inpatient and outpatient hospital services? These are sometimes called professional fees and facility fees.
- Does my insurance plan cover prescription medications and chemotherapy medications?
- Do I need a pre-authorization for the services I'm seeking? If so, what do I need to do to obtain the pre-authorization number and how long should the process take?
- If your service has already been pre-authorized, what is the pre-authorization number? Please write the number down and bring it to your appointment.
- What percentage of my bill does my insurance cover?
- What, if any, are my co-payments and/or deductible amounts?

If McDonough District Hospital and MDH Medical Group is not "in network," here are some follow-up questions:

- Does my plan offer access to McDonough District Hospital and MDH Medical Group through a pre-authorization process? If so, what do I need to do to obtain that pre-authorization and how long should it take?
- Does my plan have out-of-network benefits? If yes, and I choose to go out-of-network, what percentage of my bill will be paid by the insurance company?
- Does my insurance plan offer any additional coverage through special networks for treating medical conditions such as mine?

PLEASE REMEMBER: If your plan is out-of-network and you do not have out-of-network benefits that can be paid to McDonough District Hospital and/or MDH Medical Group, you will be held responsible for the payment of your bills.

Other questions to ask:

- Does my plan have an out-of-pocket maximum? If yes, and I reach the maximum, will my claims then be paid in full?
- Before I see a doctor at McDonough District Hospital or MDH Medical Group, do I need a referral from my primary care physician? Will I need an authorization from my insurance carrier?
- Do I need any prior authorization for elective services?
- Will I be covered for any testing, pathology, or radiology charges that may be incurred as part of my initial consultation with a McDonough District Hospital/MDH Medical Group doctor?

Types of Bills

You may receive more than one bill from McDonough District Hospital or MDH Medical Group on the services you received.

Physician/provider services (sometimes called "professional fees")

Bills for MDH Medical Group physician services cover things like:

- Physical examinations
- Interpretation of tests
- Surgical procedures
- Consultations by physicians and sometimes nurse practitioners and physician assistants

Physician services also include, but are not limited to, the services of anesthesiologists, psychiatrists, podiatrists, radiologists, and pathologists. These services may be provided in clinics or in the hospital but will be billed by the physician group.

Bills for hospital/clinic services (sometimes called "technical or facilities fees")

Hospital-based clinics
For clinics under the management of McDonough District Hospital, you may see a charge on your bill for the equipment, supplies, and services provided in the "hospital-based clinic." These charges are separate from the services provided by your physician/provider. Any amount you owe will be based your specific insurance plan. Please contact your insurance company for information about your plan's coverage and what you owe.

Hospital bills
If you have a hospital stay, your hospital bill may include:

- Laboratory
- Radiology and other testing services (sometimes called ancillary services)
- Operating room services
- Emergency department costs
- Pharmacy services
- Medical supplies
- Inpatient room and board
- Other services provided by the hospital

You may receive a bill each time you visit the hospital.

McDonough District Hospital Home Health Care
You may receive bills from McDonough District Hospital Home Health Care, which is our provider for home health and home health infusion services. For questions related to these bills, please call (309) 836-1543.

McDonough District Hospital Hospice
You may receive bills from McDonough District Hospital Hospice, which is our provider for hospice services. For questions related to these bills, please call (309) 836-1543.

Emergency Room Physician bills

If you visited the Emergency Room, you may receive bills from the Emergency Room physicians group who staffs our facility and McDonough District Hospital.
Community-based physician bills
You may receive separate bills from certain community-based physician groups that provide professional services and bill separately from McDonough District Hospital or MDH Medical Group. Please contact these physician groups separately with any questions.

Itemized statements for attorneys
If services billed on your account are the result of an automobile accident or other accident caused by someone else, you can request that itemized statements be sent to any attorney involved in the matter.

However, you will remain responsible for making payment on the account until the dispute is settled. We will follow all regulations related to accident coverage for patients covered by Medicare or Medicaid.

Key Billing Terms
Adjustment: A portion of your bill that your healthcare provider has agreed to write off.

Co-insurance: A method of cost-sharing between you and your insurance provider. You pay a percentage of costs as part of your contract with your insurance provider. You pay this amount even if your deductible has been met. For example, you may pay 20% of the costs of your services even after you have met your deductible.

Co-payment: The fixed dollar amount that you must pay out-of-pocket prior to or at the time of service. This amount is pre-determined and varies by insurance provider. It is based on your plan type and the type of service being provided. We are contractually obligated to collect co-payments from patients when a co-payment applies to the services being provided.

CPT code: Current Procedural Terminology code. A 5-digit standard for how medical professionals document and report medical services and procedures. Insurance companies use CPT codes to help determine reimbursement amounts for practitioners. Using CPT codes enables healthcare providers and insurance companies to communicate and track billing more efficiently.

Deductible: The specified amount the patient must pay for healthcare expenses before insurance covers the remaining costs. It is your part of the contract with your insurance provider.

Guarantor: The individual responsible for paying the bill. Guarantors are usually the patient except in cases where the patient is incapacitated, sponsored through foster care or the legal system or not an emancipated minor in which case the guarantor is the patient's parent or legal guardian as designated by the courts. May also be referred to as the responsible party.

Health plan: refers to the type of insurance you have. You may be a part of a group health plan provided through your employer, or you may have purchased and individual plan on the Health Insurance Exchange. You could also be covered under workers' compensation for a work-related injury or have coverage through a government health plan such as Medicare or Medicaid.

HIPAA: Health Insurance Portability and Accountability Act. HIPAA sets standards for protecting the confidentiality of your health information.

HMO: Health maintenance organization. HMO health insurance plans require that enrolled patients received all healthcare from a specific group of providers, barring some emergency care. If you go outside of the HMO's network for non-emergency care, coverage disappears.

ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification is the tenth revision of the ICD coding system. ICD codes classify diagnoses and health issues of patients four to seven digit alphanumeric codes, which denote signs, symptoms, diseases, conditions, and injuries. Both CPT and ICD-10-CM codes must be provided to insurance companies for the provider to be reimbursed appropriately.

In-network: The hospitals, doctors or other health care providers who have a contract with your insurance provider. The plan you have covers the costs of these health care providers. You may still have to pay a co-payment.

Insurance provider: A company you pay to help you cover your health care costs. This company has different plans and policies for its members. It makes payments to hospitals and health care providers on your behalf.

Managed care: A type of insurance plan that requires patients to see only providers that have a contract with the managed care company, barring exceptions such as emergency or urgent care when the patient is outside of the plan's service area.

Medicaid: Jointly funded by federal and state governments, Medicaid provides free or low-cost health coverage to low-income individuals, families and children, pregnant women, the elderly, and people with disabilities.

Medicare: A federal health insurance program for those ages 65 and over, certain younger people with disabilities, and qualifying individuals with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Find complete information at https://www.medicare.gov/

Out-of-network: Hospitals, physicians or other health care providers who do not have a contract with your insurance provider. Your insurance will not cover the costs, so you will be responsible for paying for the services provided to you.

Out-of-pocket costs: Health care costs, such as deductibles, co-payments and co-insurance that are not covered by insurance. Out-of-pock costs do not include premium costs.

Out-of-pocket maximum: A yearly cap on the amount of money you are required to pay out-of-pocket for healthcare costs, but not including the premium cost. Some insurance companies do not include certain costs in this limit; examples might include fertility treatments or prescription drugs.

Payer: Another name for an insurance company

Pre-admission approval or certification (pre-authorization): An agreement made by your insurance company and you or your healthcare provider stating that the insurance company will pay their portion of your medical costs. Providers ask your insurance company for pre-admission approval before providing medical services.

PPO: Preferred Provider Organization. A healthcare organization that covers a larger amount of a patient's healthcare costs if they use the services of a provider on their preferred provider list. Unlike HMOs, PPOs do not restrict patients to only the providers within their network in order for costs to be covered.

Premium: The amount you pay, often monthly, for health insurance. The cost of the premium may be shared between employers and government purchasers and patients.

Provider: A hospital or physician who provides medical care.

Waiting period: The amount of time members must wait after enrolling in an insurance plan before they become eligible to receive certain benefits.