CentegraHealthSystem

Financial Assistance Policy (FAP)

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POLICY STATEMENT

Consistent with our mission to provide high quality health and wellness services for the community, Centegra Health System and its affiliates (CENTEGRA) are committed to providing financial assistance to CENTEGRA patients who are unable to pay for medically necessary care received from the eligible providers listed on Exhibit C of this Policy.

In accordance with the Affordable Care Act (ACA) and applicable State or Federal laws and regulations, any patient eligible for financial assistance under this financial assistance policy will not be charged more for emergency or medically necessary care than the amount generally billed (AGB) to insured patients.

CENTEGRA offers both free care and discounted care, depending on individuals' family size, insured status and income. Uninsured and underinsured patients who do not qualify for free care will receive a sliding scale discount off the gross charges for their medically necessary services based on their family income as a percent of the Federal Poverty Guidelines. These patients are expected to pay their remaining balance for care, and may work with financial counselors to set up a payment plan based on their financial situation. See *Billing and Collections Policy No.9850-28, for other discount programs, payment plan options and terms.*

Patients seeking assistance may first be asked to apply for other external programs (such as Medicaid or insurance through the public marketplace) as appropriate before eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being.

DEFINITIONS

The following terms are meant to be interpreted as follows within this policy:

1. **Financial Assistance**: Amounts attributable to free or discounted care provided to patients who meet the eligibility for financial assistance and are unable to pay for all or a portion of their eligible health care services. If you are deemed eligible for Financial Assistance within the applicable time period, such assistance may be provided to any unpaid balances, including those paid in bad debt.

2. **Medically Necessary**: Any inpatient or outpatient health care service, including pharmaceuticals or supplies covered under Title XVIII of the Federal Social Security Act for beneficiaries with the same clinical presentation as the patient. A "Medically Necessary" service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity

3. **Emergency Care:** Emergent care include services received through the Emergency Department for emergent medical conditions that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts

4. **Urgent/Immediate Care**: Medically necessary care to treat medical conditions that are not immediately life-threatening, but could result in the onset of illness or injury, disability, death, or serious impairment or dysfunction if not treated within 12–24 hours

5. **Uninsured**: Patients with no health insurance coverage and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including, but not limited to, high deductible health insurance plans, workers' compensation, accident liability insurance or other third-party assistance to help resolve their financial liability to healthcare providers

6. **Underinsured**: Insured patients who have significant out of pocket balance (i.e. High deductible or coinsurance)

7. **Amount Generally Billed (AGB)**: The amount generally billed to insured patients (i.e. insured allowable) for emergent or medically necessary care. Determined as described in section (B) of the policy below

8. **Gross/Total Charges**: The full amount charged by CENTEGRA for items and services before any discounts, contractual allowances, or deductions are applied

9. **Presumptive Eligibility**: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance

PROCEDURE

(A) Eligibility

CENTEGRA will not bill patients who have been deemed eligible for financial assistance coverage for eligible care or services, including care or services that are emergent or medically necessary, more than the amounts generally billed to insured patients.

Patients who are uninsured or underinsured and have a household income at or below the thresholds on Exhibit A will receive full or partial discount off their balance. Exhibit A will be updated on an annual basis to represent the most current federal poverty guideline levels and the appropriate sliding scale for full and partial discounts.

To be considered eligible for financial assistance, patients may be required to cooperate with CENTEGRA to explore alternative means of assistance if necessary, including Medicare and Medicaid. Patients will be required to provide necessary information and documentation when applying for hospital financial assistance or other private or public payment programs.

CENTEGRA may seek to determine eligibility for financial assistance prior to rendering non-emergent services. In certain non-emergent circumstances it may be necessary to provide care or evaluation to the patient before eligibility can be determined.

When determining patients' eligibility, CENTEGRA does not take into account race, gender, age, sexual orientation, religious affiliation, national origin or social or immigrant status.

(B) Applying for Financial Assistance – Application Requirements

Determinations for financial assistance eligibility will require patients to submit a completed financial assistance application (including all documentation required by the application) within the application period and may require appointments or discussion with CENTEGRA financial counselors.

Application Period: This is the period in which CENTEGRA must accept and process an Application submitted by a patient in order to have made reasonable efforts to determine whether the patient is eligible for financial assistance. The application period begins on the date the care is provided to the patient and ends of the 240th day after CENTEGRA provides the patient with the first post-discharge billing statement for that care.

Applications and this Policy can be accessed in the following locations/methods:

- At the front desk or patient registration area of any Centegra Health System location
- At the offices of CENTEGRA Financial Counselors or Financial Assistance Coordinators located at McHenry, Woodstock and Huntley Hospital & Centegra Accounting/Finance Department, 527 W South Street, Woodstock, IL 60098
- By mail:

  Centegra Health System
  Attention: Financial Assistance Coordinator
  PO Box 1990
  Woodstock, IL 60098

- By telephone to: 815-334-5578
- Online at https://www.nm.org/
- By email at CentegraFinancialAssistance@centegra.com

Copies of the Financial Assistance Application and this policy are also available in Spanish. If translations are needed in other languages please contact a financial assistance counselor at the telephone numbers above.

Patients must submit a complete application (including supporting documents) within the Application Period by mail to:

Centegra Health System
Attention: Financial Assistance Coordinator
PO Box 1990, Woodstock, Illinois 60098

In addition to completing an application, individuals should be prepared to supply information and documentation to support the following:

- Patient information
- Family/household information
- Income and employment information
  - Bank statements
  - Proof of income for applicant (and spouse if applicable), such as recent pay stubs, unemployment insurance payment stubs, or sufficient information on how patients are currently financially supporting themselves
  - Copy of most recent federal tax return and/or most recent W2

        - Disability payments
        - Pension payments
        - Workers' compensation
        - Child support, maintenance or other spousal support
        - Payment history of any outstanding accounts for prior hospital services
    - Insurance/Benefit Information as applicable
        - Insurance coverage
        - Medicare Coverage
        - Medicaid Coverage
        - Veterans Benefits
    - Documentation of qualification for:
        - Monthly expense Information
        - In some cases, information on available assets or other financial resources
        - External, public sources like credit scores may also be used to verify eligibility.

Individuals who do not have any of the documentation or information listed above; have questions about CENTEGRA financial assistance application; or would like assistance with completing the financial assistance application may contact our financial counselors or financial assistance coordinator(s) either in person at 527 W. South Street, Woodstock, IL 60098, or, at any of our Centegra Locations or over the phone as listed below.

Centegra Accounting/Finance, 527 W South Street, Woodstock, IL 60098 – 815-334-5578
Office hours: 8:00 am – 4:30 pm, Monday through Friday.

McHenry Hospital – Financial Counselors/Eligibility Specialists at 815-759-4637, 815-759-4638, 815-759-4145 Office hours: 6:00 am to 5:00 pm.

Woodstock Hospital – Eligibility Specialist at 815-334-3144 Office hours: 8:30 am to 5:00 pm.

Huntley Hospital – Financial Counselors/Eligibility Specialists at 224-654-0253 or 224-654-0256 or 224-654-0252. Office hours: 6:30 am to 5:00 pm.

(C) Determining Discount Amount

Once eligibility for financial assistance has been established, CENTEGRA will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) to insured patients for eligible care, including emergency or medically necessary care.

To calculate the AGB, CENTEGRA uses the "look-back" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. This is published annually and amended to this policy under Exhibit B.

In this method, CENTEGRA uses data based on claims sent to Medicare fee- for-service and all private commercial insurers for emergency and medically necessary care over the prior 12 months to determine the percentage of gross charges that is typically allowed by these insurers. The AGB percentage is then multiplied by gross charges for eligible care, including emergency and medically necessary care to determine the AGB.

Example

Uninsured

If the gross charge for an emergency visit is $1,000, and the AGB percentage is 45%, any patient eligible for financial assistance under this policy will not be personally responsible for paying more than $450 for the emergency room visit and may qualify for 100% discount depending on their family size and household income as defined on Exhibit A.

Patients who qualify for partial financial assistance or who do not qualify, will never be required to pay in excess of 25% of their annual household income for services within one calendar year.

Insured

If the gross charge for an emergency visit is $1,000 and the insurance carrier discount is 20% or $200, insurance carrier allowable is $800 and the insurance pays $300, leaving an out of pocket balance due of $500 for the patient. Any patient eligible for financial assistance will not be personally responsible for paying more than $450 for the emergency room visit and may qualify for 100% discount depending on their family size and household income as defined on Exhibit A.

(D) Presumptive Eligibility

If patients fail to supply sufficient information or documentation to support financial assistance eligibility, Centegra Health System may refer to or rely on external sources and/or other program enrollment resources to determine eligibility when:

- **Presumptive Homeless** – Patient demonstrates that they are currently homeless and/or living in shelter(s).
- **Presumptive Mental incapacitation** – Patient has no one to act on their behalf
- **Presumptive Scoring** – Centegra Health System will utilize publically available information as well internal payment and documentation history to determine if a patient is eligible for presumptive financial assistance without completion of an application.
- **Presumptive Deceased** – Confirmed deceased with no estate
- **Presumptive State Program** – Confirmed patients who are currently eligible for a state program which is based on FPG, including confirmed FHQC enrollees however that program does not cover the dates of service or services provided. Programs include but are not limited to:
  - Women, Infants and Children Nutrition Program (WIC)
  - Supplemental Nutrition Assistance Program (SNAP)
  - Illinois Free Lunch and Breakfast program
  - Low Income Home Energy Assistance Program (LIHEAP)
  - Enrollment in organized community-based programs which documents low-income status, including FQHC or Family Partnership Clinic in McHenry County
- **Presumptive Out of State Program** – Confirmed patients who are eligible for out of state programs which are based on FPG where CENTEGRA does not participate
- **Additional Presumptive Criteria** – Associates may also recommend presumptive eligibility for FAP based on the following or similar circumstances:
  - Recent personal bankruptcy
  - Incarceration
  - Affiliation with a religious order which includes a vow of poverty
  - Enrollment in temporary assistance for needy families (TANF)
  - Enrollment in IHDA’s Rental Housing Support Program

CENTEGRA also partners with third-parties and other eligibility vendors, to help identify patients who may be eligible for financial assistance, presumptive financial assistance under this policy or through other public and private programs including identifying other sources of third party payment, i.e. health insurance coverage.

CENTEGRA may also use previous financial assistance eligibility determinations as a basis for determining eligibility in the event that the patient does not provide sufficient documentation to support an eligibility determination. Financial assistance applications on file at CENTEGRA may be used for a time period of up to six months after the date of submission.

All patients presumptively determined to be eligible for less than the most generous amount of assistance available under this policy (free care) will be informed about how the discount amount was calculated and given a reasonable amount of time to submit an application for further financial assistance.

(E) Eligible Providers & Services

A list of providers and services included and excluded from this financial assistance policy can be found on Exhibit C. This listing of eligible providers will be updated quarterly and made available upon request.

(F) Actions in the Event of Non-Payment

The collection actions CENTEGRA may take if a financial assistance application and/or payment are not received are described in a separate policy.

In brief, CENTEGRA will make reasonable efforts, as required by law, to provide patients with information about our financial assistance policy before we or our agency representatives take certain actions to collect your bill (these actions may include wage garnishments, liens, litigation or reporting negative information to credit bureaus).

For more information on the steps CENTEGRA will take to inform uninsured and underinsured patients of our financial assistance policy and the collection activities we may pursue, please see *CENTEGRA Billing and Collections Policy no. 9850-28.*

SPONSOR

Chief Financial Officer