FINANCIAL ASSISTANCE POLICY

1. PURPOSE

The mission of Beloit Health System is to be the leader in regional health and wellness services that delivers high quality value and satisfaction to our patients and the communities we serve. Beloit Health System is committed to providing services to those who qualify but are unable to pay for health care and those whose limited means make it extremely difficult to meet the expenses incurred in receiving healthcare. Financial Assistance will be granted to all eligible persons regardless of age, race, color, religion, sex, sexual orientation, or national origin.

2. Policy Availability and Publication

Beloit Health System is required to provide notice of its Financial Assistance Policy and will make a good faith effort to provide every patient with information regarding its availability. This Policy, Application and Plain Language Summary are available online at our website, at www.beloithealthsystem.org/financial-assistance-policy. Information is also posted in the registration and admitting areas and in the emergency department. Financial assistance information is also printed on monthly billing statements and in other communications to ensure information is widely publicized in the community.

If you need assistance with the application process, please call (608)363-7356 or (608)364-1606, or for long distance: 1-800-846-1150, and ask for assistance from a Patient Financial Counselor or Patient Customer Service. Copies of this Policy, Plain Language Summary and Application are all available free without charge.

3. Emergency Medical Services

Beloit Health System will not engage in any actions that discourage any individual from seeking emergency medical care, such as by demanding that emergency room patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

4. Definitions

Amounts Generally Billed (AGB): AGB means the amounts generally billed by the hospital for emergency or other medically necessary care to preserve life or limb to individuals who have insurance covering such care. All patients who are eligible for financial assistance at Beloit Health System will not be charged more than the amounts that are generally billed to insured patients for emergency or other medically necessary care to preserve life or limb.

Currently, Beloit Health System determines AGB using the Look-Back Method. AGB is based on amounts allowed for Medicare fee-for-service and all private health insurers paying claims to Beloit Health System, over a 12-month period, divided by the gross charges for those claims. Beloit Health System calculates the AGB at least annually. The updated AGB will be applied by the 120th day after the end of the 12-month measurement period. Patients may obtain the current AGB percentage and accompanying description of the calculation in writing and free of charge by calling (608)363-7356 or (608)364-1606, or for long distance, 1-800-846-1150.

Emergency Medical Condition: A medical condition manifesting to itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Extraordinary Collection Action: Actions taken against an individual to obtain payment of a bill for care that requires judicial or legal process, involves selling an individual's debt to another party, or involves reporting adverse information about an individual to a consumer credit reporting agency or credit bureau.

Family: Using the U.S. Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on his or her income tax return, that person may be considered a dependent for purposes of the provision of financial assistance. If IRS tax documentation is not available, family size will be determined by the number of dependents documented on the financial assistance application and verified by the hospital.

Family Income is determined consistent with the U.S. Census Bureau definition, which uses the following information when computing the federal poverty guidelines:

- Income includes earnings, unemployment compensation, worker's compensation, social security, supplemental security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources, on a before-tax basis;
- Income excludes noncash benefits (such as food stamps and housing subsidies)
- Income excludes capital gains or losses; and
- Income includes the income of all family members if the person lives with a family, but excludes non-relatives, such as housemates.

Federal Poverty Guidelines (FPG): Means the guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. The current guidelines can be found at https://aspe.hhs.gov/poverty-guidelines.

Financial Assistance means the assistance provided to patients for whom it would be a financial hardship to fully pay for expected out-of-pocket expenses for emergency or other medically necessary care to preserve life or limb that is provided at the hospital and who meet the eligibility criteria for such assistance.

Medically Necessary Care means a medical service that is:

(1) Required to prevent, identify or treat life or limb threatening conditions; and

(2) Meets the following standards:

(a) Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

(b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

(c) Is appropriate with regard to generally accepted standards of medical practice;

(d) Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

(e) Is of proven medical value or usefulness and is not experimental in nature;

(f) Is not duplicative with respect to other services being provided to the recipient;

(g) Is not solely for the convenience of the recipient, the recipient's family or a provider;

(h) Is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

(i) Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Presumptive Financial Assistance means the determination of eligibility for financial assistance that may be based on information provided by a third-party and/or other publicly available information.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including, without limitation, Medicare, Medicaid, SCHIP and CHAMPUS), Worker's Compensation, or other third-party assistance that provides assistance with meeting the individual's payment obligations for health care.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for emergency or other medically necessary care to preserve life or limb under this Policy.

5. Service Area Residency

Financial assistance is available to individuals for services required for an Emergency Medical Condition regardless of whether the patient resides within Beloit Health System's service area. For non-emergent medically necessary services to preserve life or limb, financial assistance is based on the nature of the care required and the patient's proximity to the nearest health care provider. However, consideration will be given to patients with a long-standing relationship with a Beloit Health System physician, or the absence of providers at the nearest health care provider or those in the patient's insurance network. The patient's primary health care provider may be asked to verify the availability of health care services and financial assistance.

6. Applicant Eligibility

Financial assistance is generally secondary to all other financial resources available to the patient, including insurance, government programs, public assistance, litigation or third-party liability. The determination for financial assistance is based on an application, written and oral communications, and other documentation used to conduct an assessment of an individual's eligibility, based on one or more of the below criteria:

- Your family income, in relation to Federal Poverty Guidelines will be considered.
- Insurance or financial capacity to purchase insurance
- Your assets (*e.g.* home, bank account, stocks, etc.) must be disclosed to us.
- Third-party resources available through public or other charitable means.
- Any additional financial hardship should be disclosed to us.
- You must be receiving non-elective, medically necessary care to preserve life or limb.
- You must consult with one of Beloit Health System's Financial Counselors.
- Applications may be made in person, orally or in writing.
- Please see the "Timeline For Establishing Financial Eligibility" section regarding the 240 day application period.

7. Presumptive Eligibility

Beloit Health System may determine eligibility for financial assistance by using information obtained from other sources even though a financial assistance application or supporting documentation is not provided by the patient. Presumptive eligibility discounts are granted only for free care (100% discount). Presumptive eligibility may be determined on the basis of individual life circumstances that may include being a recipient of state-funded prescription programs; medically necessary services not covered or payable under a government program such as Medicaid or Medicare; homeless or one

who received care from a homeless clinic; qualification and effective date for Medicaid subsequent to service dates; food stamp eligibility; subsidized school lunch program eligibility; eligibility for other state or local assistance programs; low income/subsidized housing is provided as a valid address; or patient is deceased with no known estate and no surviving spouse.

8. Covered Services

Services eligible for financial assistance under this Policy are emergency services to treat an Emergency Medical Condition and other Medically Necessary Services to preserve life or limb.

9. Excluded Services

The following are excluded from consideration for financial assistance under this Policy: Cosmetic procedures, hearing aids, podiatric products, sterilization procedures, reversals of sterilization procedures, fertility treatment, bariatric procedures, Restor, Toric, and Crystalens lens procedures, and most elective procedures. Other exclusions include services found to be unnecessary or disallowed by government or third-party payers, accounts pending settlement from a liability claim, DME, routine or non-emergent office visits, and Home Health. Some elective cases may be considered upon attestation by the procedure physician that the condition being addressed is medical necessary care to preserve life or limb, which will be subject to review and approval through Utilization Review in consultation with the Department Chair and Vice President of Medical Affairs.

10. Beloit Health System Providers

Only services provided at Beloit Health System facilities by providers employed by Beloit Health System are eligible for financial assistance under this Policy. Non-employed providers who provide contracted services to Beloit Health System are not covered under this Policy. Contracted providers who are not eligible for financial assistance through Beloit Health System are Beloit Radiology, Southern Wisconsin Emergency Associates, Stateline Anesthesia, and Hart Road Pathology.

11. Financial Assistance Discounts

Beloit Health System will not charge patients who are eligible for financial assistance under this Policy more than the amounts generally billed to patients with insurance for emergency or other medically necessary care to preserve life or limb. Patients may receive the following assistance based on the procedures outlined in this Policy.

- Free Care/100% Discount: Uninsured patients whose family income is at or below 200% of the current Federal Poverty Guidelines will receive a 100% discount for emergency and other medically necessary care to preserve life or limb, as shown on Attachment 1.
- Discounted Care: Uninsured patients whose family income is greater than 200% but less than 400% of the current Federal Poverty Guidelines will receive a discount for emergency and other medically necessary care to preserve life or limb, as shown on Attachment 1. Uninsured patients will receive discounts applied against their gross charges for care. Underinsured patients qualify only when the balance exceeds $2500, in which case the discounts are applied to the patient's balance that is remaining after insurance.

12. How to Apply for Financial Assistance

You or your representative must complete the Financial Assistance Application in its entirety. An adjustment shall be considered only after a review of the patient's accounts and a determination has been made that no third-party reimbursement is available. A Financial Assistance Application may be completed in person with the assistance of a Financial Counselor, or it may be sent by mail or dropped off at the hospital directed to the Financial Counselor's attention.

In addition to the completed application, you must also include within 15 business days:

- ☐ Copy of Federal Income Tax Return for the most recent tax year, including all schedules filed with the original return.
- ☐ Copy of most recent income information for each person in the household, including: last year's W-2 forms, two most recent paycheck stubs or a statement from the employer, Social Security, unemployment, retirement, pensions, support payments, etc.

- ☐ If self-employed, copy of most recent Federal Income Tax Return and all supporting documents.
- ☐ Proof of residency.
- ☐ Copies of two most recent financial statements (savings, checking, money market, IRA, 401k, brokerage, etc.).
- ☐ Copy of food stamp or Heat Assistance benefit(s).
- ☐ If the household is receiving assistance from family or friends, a statement from the assisting party.
- ☐ If you qualify for Social Security Disability, you must provide documentation that the application is being processed.
- ☐ Verification that you have applied for all medical-related resources:
  - **Medical Assistance/Family Planning**
    - Rock County (888) 794-5780
    - Winnebago County (815) 987-7620
  - **Wisconsin Well Woman Program**

    Provides preventive health screening services to women with little or no health insurance coverage. 608-266-8311
- ☐ Denial and appeal documentation from any liability insurance, if involved in an accident or assault.
- ☐ If you are a college student, you must supply documentation of current student status.

Please contact our Financial Counselors to discuss whether any of the above may be submitted in another form.

The application shall be completed in full, including the patient's name, address, telephone number, occupation, employer, and names of spouse and legal dependents. (Legal dependents shall be identified as such based on whether or not they are claimed as dependents on the most recent income tax return.) Also included shall be the household income for the last three months as well as the last twelve months. The income reported must include all wage earners in the household excluding minors. (Patients who are claimed as dependents on another individual's tax return must report income of the other individual(s) as well as their own.) Verification of earnings must be proved by submitting any or all of the following: income tax returns, pay stubs, W-2 forms, unemployment compensation forms, or letters from employers. If the patient indicates that no income has been earned, a copy of a letter from the Social Services Department denying unemployment compensation may be requested. Also requested may be a copy of a letter verifying that Public Aid benefits have been denied. If the patient has not yet applied for Public Aid, he or she is encouraged to do so. If the patient returns the application without sufficient proof of income, or if other information is missing or incomplete, he or she shall be contacted by the Credit Department to obtain the information. Approval may be denied for failure to complete an application. In addition, any discrepancies between name and Social Security number documentation will result in an automatic denial of the application.

Patients seeking financial assistance must comply with the Financial Assistance Application process, including submitting a copy of the most recent Federal Income Tax return, most recent income information (such as paystubs or W-2's), bank statements, as well as completing the application process for all available sources of assistance, including Medicaid or Medical Assistance.

Patients who are employed (or patients who are the spouse or dependent of an employed individual) must show proof that group health insurance benefits were not available from the employer. Patients who have chosen not to enroll in an available group health plan may be denied Charity Care benefits.

13. Timeline for Establishing Financial Eligibility

Every effort should be made to determine a patient's eligibility prior to or at the time of admission or service. If a patient expresses an inability to pay or has a need for financial assistance, the patient will be interviewed by a Financial Counselor and the patient will be provided with assistance on available third-party resources. The patient also will be offered a Financial Assistance Application with instructions and a list of all documentation that may be required. Financial Assistance applications will be accepted anytime during the application period. The application period begins the day that care is provided and ends no later than 240 days after the first post-discharge billing statement to the patient. If an account

older than 240 days from the first post-charge billing statement has proceeded to legal or judicial process, a financial assistance application will be accepted up until the date of final judgment.

Completed applications should be mailed or hand-delivered to the following:

Beloit Health System

1969 West Hart Road, Beloit WI 53511

(hospital lobby level) Attention: Financial Counselors

or

1905 East Hebbel Parkway, Beloit WI 53511

(main clinic lobby level) Attention: Financial Counselors

14. Confidentiality of Information Received and Record Retention

Beloit Health System will uphold the confidentiality and dignity of each patient, and any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Copies of documents that support the application will be kept with the financial assistance application form and retained for seven years.

15. Contact for Information and Assistance

Additional information about the Financial Assistance Policy and assistance with the application process can be obtained from Patient Financial Counselors:

- Online at www.beloithealthsystem.org/financial-assistance-policy or
- Patient Financial Counselors at 1-800-846-1150 or 1-608-363-7356 or
- You may also call Patient Customer Service at 1-608-364-1606 or
- You may visit a Business Services location at or mail a completed application with supporting documents to:
    - 1969 West Hart Road, Beloit WI 53511 (hospital lobby level) Attention: Financial Counselors
    - 1905 East Huebbe Parkway, Beloit WI 53511 (main clinic lobby level) Attention: Financial Counselors

16. Health Insurance Benefits

Patients who are employed (or patients who are the spouse or dependent of an employed individual) must show proof that group health insurance benefits were not available from the employer. Patients who have chosen not to enroll in an available group health plan shall be denied Charity Care benefits. Exceptions may be considered for instances where the individuals' payroll premium contribution is close to or exceeds the actual wages. Patients eligible for ACA Marketplace benefits are expected to enroll for coverage in an available plan.

17. Excessive Financial Burden

Beloit Health System recognizes that there may be instances in which a patient's income exceeds the previously mentioned guidelines, but the patient's expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burdens. Additional Charity Care adjustments may be appropriate for these individuals if the excessive expenses are for medical services or necessary living expenses (such as medication, food, housing, and utilities).

18. Initial Financial Assistance Determination

Beloit Health System will not initiate Extraordinary Collection Actions until an initial determination of Financial Assistance eligibility status is made. Where Beloit Health System initially determines that a patient may be eligible for Financial

Assistance, all Extraordinary Collection Actions (including civil actions, garnishments, and report to collections or credit agencies) shall cease pending a final determination of Financial Assistance eligibility, and further action will not be taken on existing Extraordinary Collection Actions.

19. Patient Responsibility

The patient or their representative is responsible to complete the application and procedures as indicated in this policy. Upon receipt of an incomplete application, a written notice will be provided to the patient outlining the additional information that is required for the application to be complete. A reasonable time for completion of the application shall be provided. Should there be a failure to do so, collection efforts will begin against the patient. Should the patient or their representative reengage in the application process, collection efforts will cease as stated herein.

20. Final Financial Assistance Determination

Beloit Health System will make a final determination within a reasonable time, typically 14 business days of the receipt of the complete Financial Assistance Application and all supporting documentation.

Upon review of the Financial Assistance application, the Financial Counselor shall determine eligibility and notify the patient of the outcome in writing. If the application receives partial approval, the amount owed by the patient shall be indicated in the appropriate location on the determination notice letter. Also indicated on the letter shall be 100% approvals or denials. In cases of partial approvals or denials, notification will be provided in writing and will include the reasons for the partial approval or denial. Thereafter, routine collection procedures shall be followed. If the patient is not able to make payment in full within 45 days, payment arrangements may be made in accordance with the Beloit Health System Payment Plan Policy/Procedure.

Approvals shall be in effect for additional services rendered within 90 days of the date of approval. After 90 days, updated financial information may be requested.

21. Refund

If a responsible party pays a portion or all of the charges for services eligible for Financial Assistance, such payments will be refunded to the responsible party unless the amount is less than $5.

22. Payment Plans

All patients qualify for a short-term interest free payment plan with defined payment time frames based on the outstanding account balance.

23. Billing and Collection Process

While a patient's application is being reviewed for a determination of financial assistance, a standard monthly statement of account activity will be provided. A financial assistance approval shall continue for 6 months from the date of approval for financial assistance. Future eligible services received during the 6 month time period shall receive financial assistance on the same basis as the initial approval. Patients must notify a Financial Counselor in the event their financial circumstances change, in which case the patient may be requested to provided updated information. In the event a patient who qualifies for financial assistance fails to timely pay any remaining balance due, such as payments under an agreed payment plan, Beloit Health System may take any of the actions described below to collect the balance due.

24. Collection Procedures

Before pursing collection against a patient, Beloit Health System will:

1. Provide on each patient billing statement sent prominent notification that patients who meet certain income requirements may be eligible for financial assistance. The notification includes the telephone number of the Financial Counselors and Customer Service personnel who can assist as well as the web site address where copies of this Policy, Plain Language Summary, and Application can be found. The notification shall also describe the Extraordinary Collection Actions that Beloit Health System intends to take in order to collect payment for care. The notification will provide a minimum of 30 days' notice for the patient to avoid the action described therein.

2. Refrain from initiating Extraordinary Collection Actions until 120 days after providing patients the first post-discharge billing statement for the episode of care.
    a. Extraordinary Collection Actions include the following actions taken by Beloit Health System or a collection agency on our behalf:
        i. Deferring or denying or requiring a payment before providing non-emergency care because of a patient's nonpayment of one or more bills for previously provided care which qualifies under this policy.
        ii. Reporting outstanding debts to the Credit Bureau(s).
        iii. Pursuing legal action to collect a judgement (i.e. garnishment of wages, debtor's exam).
        iv. Placing liens on property of individuals.
3. Offer the opportunity for an approved payment plan.
4. Process the application on an expedited basis to ensure that medically necessary care to preserve life or limb is not unnecessarily delayed.

The following collection activities may be pursued by Beloit Health System or by a collection agency on our behalf:

1. Communicate with patients and their representatives in compliance with the Fair Debt Collections Act and HIPAA.
2. Solicit payment of estimated patient payment obligations at the time of service in compliance with EMTALA regulations and federal/state laws.
3. Report outstanding debts to Credit Bureau(s) only after all aspects of this Policy's reasonable collection efforts have been applied.
4. Pursue legal action for individuals who have the means to pay, but do not pay, or who are unwilling to pay. Legal action may also be pursued for the portion of the unpaid amount after application of the Charity Adjustments.
5. Place liens on the property of individuals who have the means to pay, but do not pay, or who are unwilling to pay. Liens may also be placed for the portion of the unpaid amount after application of the Charity Adjustments.
6. Agreements with Collection Agencies to pursue debt on our behalf will be in compliance with all pertinent laws and regulations, including those required to be followed by Beloit Health System.

Collection Agency/Judgment

Accounts assigned to a collection agency which have a judgment granted through the court system are no longer eligible for charity consideration. A patient may apply for charity at any time prior to the account receiving a court judgment.

A written copy of this policy is available upon request and on our website at: www.beloithealthsystem.org/financial-assistance-policy

ATTACHMENT 1

2018 Federal Poverty Guidelines (https://aspe.hhs.gov/poverty-guidelines)

Household Size	100%	150%	200%	250%	300%	400%
1	$12,140	$18,210	$24,280	$30,350	$36,420	$48,560
2	$16,460	$24,690	$32,920	$41,150	$49,380	$65,840
3	$20,780	$31,170	$41,560	$51,950	$62,340	$83,120
4	$25,100	$37,650	$50,200	$62,750	$75,300	$100,400
5	$29,420	$44,130	$58,840	$73,550	$88,260	$117,680
6	$33,740	$50,610	$67,480	$84,350	$101,220	$134,960
7	$38,060	$57,090	$76,120	$95,150	$114,180	$152,240
8	$42,380	$63,570	$84,760	$105,950	$127,140	$169,520

Free or Discounted Care: Applicants whose family income (as defined in the Financial Assistance Policy) is less than or equal to 400% of the current federal poverty level will be provided a discount for services. Insured patients qualify for financial assistance when the patient responsible balance exceeds $2,500.

Federal Poverty Level	Financial Assistance Discount
Less than or equal to 200%	100%
Above 200% and less than or equal to	70%

Eligible patients may be allowed a Charity Care adjustment in addition to the discounts set forth above under Beloit Health System's Charity Care Benefit Policy. Further adjustments under the Charity Care Benefit Policy are determined on a case-by-case basis.