FINANCIAL ASSISTANCE PROGRAM DEFINITIONS – ATTACHMENT B

Amounts Generally Billed (AGB): The amount generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with Section 1.501(r) – 5(b). The Prospective Medicare Method is used to determine AGB

Amounts Returned by Collection Agencies: After a certain time period as elapsed, the collection agency will return any accounts deemed to be uncollectable. Their returned accounts should be written off as a form of charity provided the professional agency has determined that the guarantor is unable to pay the outstanding bill.

Application Period: The period during which a hospital facility must accept and process an application for assistance under its financial assistance policy (FAP) submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the application period begins on the date the care is provided to the individual and ends on the 240th day after the hospital facility provides the individual with the first billing statement for the care.

Assets: Property, real or personal, and tangible or intangible, that has monetary value. Asset value, other than the value of the primary residence and a primary vehicle, will be considered in determining eligibility and may serve as the basis for denying eligibility for charity care discounting despite eligible household income.

Authorization / Pre-certification: The process of obtaining authorization from all applicable insurances (i.e., primary, secondary, and tertiary payers) for medical services, which often involves an appropriateness review against medical criteria. Pre-certification is also known as pre-admission certification or pre-admission review.

Bad Debt: Gross charges incurred in providing services to guarantors who were determined to have the ability to pay for such services, but eventually do not. This determination can be made upon admission or any time subsequent thereto.

Bankruptcy: Outstanding accounts for a person who declares bankruptcy.

Catastrophic Hardship: Financial assistance that is provided as a discount to eligible applicants with annualized household income in excess of 200% of the Federal Poverty Guidelines and the out of pocket expense or guarantor's/patient liability resulting from medical services provided by Monument Health exceeds 15% of annual household income.

Deceased with No Estate: Outstanding accounts for person, who expires with no recovered estate as determined by a third-party vendor or assigned collection agency, should be written off as Financial Assistance. If partial payment from the estate is received, the remainder of the bill should be considered Financial Assistance.

Elective Procedure/Non-Emergent Condition: Patient condition is such that a reasonable delay in treatment to permit the physician to exercise scheduling choices will typically not unfavorably affect outcome.

Episode of Care: Course of treatment prescribed by a Physician or Ancillary Provider delivered over a finite period of time.

Extraordinary Collection Action (ECA): As described in Section 501(r)(6) of the Internal Revenue Code, it is an action that requires a legal or judicial process or involves selling an individual's debt to another party or reporting adverse information to a credit reporting agency or credit bureau. Examples of ECAs include, but are not limited to, placing a lien on an individual's property, foreclosing on an individual's real property, attaching or seizing an individual's bank account or any other personal property, commencing a civil action against an individual, causing an individual's arrest or causing an individual to be subject to a writ of body attachment.

Federal Poverty Level: A measure of income issued every year by the Department of Health and Human Services (HHS)

Financial Assistance (Charity care**/Charity Discount):** Financial assistance is the provision of healthcare services free of charge or at a discount to individuals who meet the established criteria. The terms 'Financial Assistance' and 'Charity Care' are used interchangeably and describes the provision of services to patients who *were* determined *not* to have the ability to pay for such services for which Monument Health ultimately does not expect payment. This determination can be made upon admission or any time subsequent thereto.

Financial Clearance: Guarantors/Patients who have met the following criteria are considered financially cleared:

A. Necessary demographic and insurance information has been provided to facilitate billing and reporting requirements, and outstanding balances have been reviewed.
B. Insurance benefits have been verified for 100% coverage. Determine whether the services are covered, based on the verification of the benefits with the insurance carrier and on the determination made by the insurance carrier.
C. Pre-certifications/authorizations and/or provider referrals as required have been obtained.
D. Acceptable payment arrangements have been made for any identified financial liabilities.
E. Alternative funding sources, community-based programs and services are explored.
F. Medicaid applications are completed as appropriate.
G. The applicant(s) is/are compliant with providing required information necessary to complete the financial clearance process.
H. All identified guarantor/patient responsible amounts and/or deposits will be collected pursuant to accepted protocols to include prior to service, at the time of service, and at discharge.
Source: Electronic Code of Federal Regulations, Title 42: Public Health PART 405
FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED Subpart D—Private Contracts

Financial Support: Will be defined as money, shelter, or food and the costs associated that is provided for an applicant by a party other than a party of the household for a period of six (6) months or less due to a short term medical situation, unemployment, relocation, etc. The monetary value of support will be determined by the total of the average cost of community rent, the average cost of household utilities, and the average cost of food as determined by the use of an external, publically available data source. This value will be translated into a monthly income benefit for the applicant. If the support is provided for a term longer than six (6) months, the support will be deemed to be permanent and the applicant(s) considered being a member of the other parties' household.

Geographical Residency and Monument Health Service Area (RHSA): Eligibility for financial assistance is based on an applicant's permanently established residence as it relates to Monument Health's primary, secondary, and tertiary service areas.

A. Service Area eligibility will be determined by Monument Health using the ZIP code of the guarantor's/patient's permanently, established residence. *Attachment – Service Area ZIP Code List*
B. Applicants whose resident county and zip code lies outside of the Monument Health primary and secondary services areas but within the tertiary Monument Health Service Area will be considered eligible for Charity Care discounting ONLY IF the patient is unable to obtain the same or alternatively acceptable services deemed medically necessary under a single encounter or plan of care within the county or a contiguous county of their permanent established residence.
C. Applicants whose permanent established residence lies outside of any of the defined RHSAs are not eligible for Charity Care discounting.

Guarantor: The responsible party for full payment of health care services provided when not covered by another payer source or third party.

Healthcare Insurance Affordability: A health insurance plan covering ***only the employee that costs 10%*** or less of the employee's household income. The plan used to define affordability is the lowest priced "self-only" plan available — meaning a plan covering **only** the employee, not dependents. This is true even if chosen plan costs more or covers dependents. The cost is **the amount the applicant would pay** for the insurance, not the plan's total premium when premiums are reduced by employer contribution, tax credits, etc. The applicant's **total household income** is used in the determination of affordability.

Hospital Setting: Services and supplies provided at or on the campus of any Monument Hospital and billed under the name of the hospital.

Household: Shall include the guarantor and all other adult and/or minor children living within a residence. It may also encompass any dependent relationship such as a child or dependent attending an educational or technical training program such as a college or technical institute, Job Corps, Outward Bound, and the like, which may require temporary absences from the physical residence.

Household Income: Household income is determined by calculating the following sources of income for all qualifying household members.

- Wages, salaries, tips
- Business, Ranching, and Farming income
- Social Security and Disability income
- Pension or Retirement Income
- Dividends and Interest
- Rent and Royalties
- Income from Estates and Trusts
- Unemployment or Workers' compensation income
- Alimony and child support
- Awards, Benefits, Public Assistance or any other Program stipends such as SNAP, TANF, Public Housing, Veteran's benefits, etc.
- Legal Awards, Judgments or Insurance and Annuity payments
- Cash, bank accounts, money market accounts, certificates of deposit, mutual funds, bonds, personal shares or other convertible investments
- Financial Support provided by another person/persons (see Financial Support definition)
- Other Income, such as income from trust funds, charitable foundations, educational assistance, grants or awards, student loan stipends, etc.
- Secondary or Recreational type vehicles (personal assets)
- Business or Farming Assets may be considered

Items that are not considered in determining income include:

- Value of Primary Residence
- Value of a Primary Vehicle

Insurance Eligibility: The process of validating a patient's insurance coverage with the payer by telephone or through online verification. The eligibility verifies: payable benefits, patient details, pre-authorization number, co-pays, co-insurance details, deductibles, patient policy status, effective date, type of plan and coverage details, plan exclusions, claims mailing address, referrals and pre-authorizations, lifetime maximum and additional information.

Liquid Assets: Resources/Possessions other than income. To include but not limited to savings, checking, and investment assets readily convertible to cash.

Medically Necessary: Medically necessary care and services include procedures and treatments necessary to diagnose and provide curative or palliative treatment for physical or mental conditions, ordered by a qualified health care professional, in accordance with professionally recognized standards of health care. The term "medically necessary" does not include the list of exclusions found on *Attachment A*. For purposes of this policy, Monument Health reserves the right to determine, on a case-by-case basis, whether the care and services meet the definition and standard of "medically necessary" for the purpose of eligibility for financial assistance. For patients seeking non-emergent services to be covered by the Financial Assistance policy, Patient Financial Services will screen the service prior to scheduling it to determine whether the service is medically necessary and notify the patient of its determination.

Miscellaneous Write-Offs: Gross charges incurred in providing services to patients who it was determined had the ability to pay but, based upon litigation's, disputes, etc.; an administrative decision was made not to require payment.

MPPR : Medicare Participating Provider Rate

Non-Elective Procedures/Emergency: The care or treatment for emergency medical conditions as defined by Emergency Medical Treatment and Active Labor Act (EMTALA): Term used to describe a medical condition manifesting 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:

- Placing the health of the individual or unborn child in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Notification Period: The period during which a hospital facility must notify an individual about its FAP in accordance with Section 501(r)-6(c)(2) in order to have made reasonable efforts to determine whether the individual is FAP eligible. With respect to any care provided by a hospital facility to an individual, the notification period ends on the 120th day after the facility provides the individual with the first billing statement for the care.

Plain Language Summary: A written statement that provides information to the individual about the Financial Assistance Policy in a clear, concise and easy to understand format.

Presumptive Charity: In lieu of a completed application, Financial Assistance may be approved based upon the information gather from the patient's history and current socio-economic data.

Resident: For the purposes of eligibility, the terms resident/residence/residency are defined as a person who:

- Resides somewhere on a permanent, long-term basis, has no present intention of leaving, and whenever absent, intends to return,
- Is not a dependent of another person(s) residing outside of the Monument Health service area
- Has established residency for a minimum of 60 days
- Can demonstrate the proceeding by providing evidence of residence eligibility documentation when requested including but not limited to a current rental, lease, or mortgage agreement, a current homeowner's or renter's insurance policy, a copy of a property tax assessment, proof of employment, utility billing statement for electricity, water, natural gas, propane or waste collection, a residential rent receipt, or a letter of financial support of a person who meets the definition of a resident.

Service Area: Eligibility for financial assistance is based on an applicant's location of their permanently established residence as it relates to Monument Health's primary, secondary, and tertiary service areas.

- Service Area eligibility will be determined by Monument Health using the ZIP code of the guarantor's/patient's permanently, established residence. *Attachment E – Service Area ZIP Code List*
- Applicants whose resident county and zip code lies outside of the Monument Health primary and secondary services areas but within the tertiary Monument Health Service Area will be considered eligible for Charity Care discounting ONLY IF the patient is unable to obtain the same or alternatively acceptable services deemed medically necessary under a single encounter or plan of care within the county of their permanent established residence.
- Applicants whose permanent established residence lies outside of any of the defined RHSAs are not considered eligible for Charity Care discounting.

The *PRIMARY* Monument Health Service Area (RHSA) represents the area as defined in the most recent Community Health Needs Assessment (CHNA) and includes those postal zip codes within the counties from which 80% of the Monument Health hospital's admissions are derived. The area is comprised of all ZIP codes within:
South Dakota counties: Butte, Custer, Fall River, Lawrence, Meade, Oglala Lakota (formerly Shannon) and Pennington
Wyoming counties: Crook

The *SECONDARY* Monument Health Service Area includes those ZIP codes within the county boundaries where a Monument Health healing environment is physically located. This area is comprised of all ZIP codes within:
South Dakota counties: Harding **Wyoming counties:** Weston

The *TERTIARY* Monument Health Service Area includes those ZIP codes among those counties whose boundaries lie within 35 miles of a Monument Health healing environment. This area is comprised of all ZIP codes within:
Montana counties: Carter **North Dakota counties:** Bowman
Nebraska counties: Sioux, Dawes **Wyoming counties:** Campbell, Niobrara

Third Party Payer: Any commercial insurance, health benefit plan, employer-sponsored program, health maintenance organization or similar arrangement that is or may be legally liable for payment of charges incurred for medical services is referred to in this policy as a Third-Party Payer. Third Party Payers for purposes of this policy do not include Medicare, Medicaid or similar Federal or state health insurance programs. Persons who opt out of any/all available insurances, health benefit plans, employer sponsored programs, health maintenance organization, Health Insurance Marketplace or similar will be excluded from consideration under the Financial Assistance Program.

Underinsured: The patient has some level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. but still has out-of-pocket expenses that exceed his/her financial ability to pay for health care services at Monument Health.

Uninsured: An individual who does not have "coverage" related to payment for their health care expense through a non-governmental third-party commercial and/or managed care payer, or through a government-sponsored payer such as Medicare or Medicaid.

Urgent: Term used to describe the condition of a patient requiring admission to the hospital for a clinical condition that would typically require admission for diagnosis and treatment within 48 hours; otherwise the patient's life or well-being could be threatened.