FINANCIAL ASSISTANCEPOLICY

AdventHealth – Chicago, Illinois Facilities Only

PURPOSE

The purpose of this Policy is to specify the requirements for administering Financial Assistance at AdventHealth facilities located in the greater Chicago, Illinois metropolitan area.

POLICY

It is the policy of the organizations listed below this paragraph (each one being the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who need financial assistance and receive care from the Organization.

This policy applies to each of the following within AdventHealth:

AdventHealth Bolingbrook
AdventHealth Glen Oaks
AdventHealth Hinsdale
AdventHealth LaGrange
AdventHealth Employed Physician Practices

A. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

B. This policy applies to all emergencies and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.

C. The *List of Providers Covered by the Financial Assistance Policy* provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

Policy-Specific Definitions

A. "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

B. "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have

insurance covering such care.

C. "**Community**" means the State of Illinois. To "live in the Community," for purposes of this Policy, means to be an Illinois resident – a person who lives in Illinois and who intends to remain living in Illinois indefinitely, but not someone who has relocated to Illinois for the purpose of receiving health benefits. A patient will also be deemed to be a member of the Organization's Community if the emergency and medically necessary care the Patient requires is continuity of emergency and medically necessary care received at another AdventHealth facility where the patient has qualified for financial assistance for such emergency and medically necessary care.

D. "**EmergencyCare**" meanscareto treat amedical conditionmanifestingitselfbyacute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.

E. "**Medically Necessary Care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.

F. "**Organization**" means AdventHealthand theentities thatarecovered bythis Financial Assistance Policy as set forth above in Section II.

G. "**Patient**" means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

H. **"Presumptive Scoring**" means the use of third-party sources of information, which may include public records, or other objective and reasonable accurate means of assessing a patient's eligibility for financial assistance.

I. **"UninsuredPatient"**means apatient who isnotcovered underapolicy of healthinsurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third-partyliability.

REQUIREDPROCEDURES

A. Financial assistance described in this section is limited to patients that live in the Community:

1. Patients with income less than or equal to 250% of the Federal Poverty Level income ("FPL"), will be eligible for 100% discount on the portion of the charges in which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an "Application") on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. An uninsured patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

2. Subject to the other provisions of this Financial Assistance Policy, uninsured Patients with incomes above 250% of the FPL but not exceeding 600% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided. Patients with insurance and with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible, per the insurance plan's explanation of benefits. Such discounts shall apply after the Patient applies on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after considering any payments made on Patient's account. An uninsured patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

   The sliding scale discount is as follows: (FPL – Federal Poverty Level Income)

Uninsured Patient Sliding Scale	**%**
0% - 250% FPL	100%
251% - 400% FPL	98%
401% - 600% FPL	85%

Insured Patient Sliding Scale	%
0% - 250% FPL	100%
251% - 400% FPL	75%

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 600% (for uninsured) and 400% (for insured) of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to health care providers within AdventHealth and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 600% (uninsured) and 400% (insured) of the FPL under Paragraph 2 above, if such Patient applies on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after considering any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. Additionally, for uninsured patients who qualify for a sliding-scale discount as set forth in Paragraph 2, collections over a 12-month period shall be additionally capped at 20% of the patient's familyincome.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed 600% of such Patient's FPL amount may not be eligible for financial assistance.

5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100%charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.

   Patients demonstrating one of more of the following criteria will be deemed presumptively eligible for a 100% charity care: homelessness, deceased with no

estate**,** mental incapacitation with no one to act on patient's behalf, Medicaid eligibility, but not on date of service or for non-covered service, Medicaid enrollment in a different state where Organization is not and does not intend to become a participating provider, and Medicaid participation but exhaustion of any length of stay limits.

Additional mandated categories include enrollment in the following programs: 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 an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria; and Receipt of grant assistance for medical services.

6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.

7. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to the patient. The process for patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:

    a. Appeals should be initially received by Patient Financial Services for review and follow up questions, if applicable.

    b. A committee shall then meet on a monthly basis to review all appeals. At a minimum, the committee membership should include representation from Patient Financial Services, Care Management, and the Finance Department/Chief Financial Officer.

    c. Appeals shall be distributed to the committee members prior to the monthly committee meeting for review.

    d. A Patient Financial Services representative should be present at the committee meeting to discuss each case and provide additional input that the patient may have provided.

    e. The committee will review the applicant's FAP Application with special attention to additional information and points made by the applicant in the appeal process.

f. The committee may approve, disapprove, or table the appeal. The committee may table an appeal if additional information is required based on questions asked during the appeal discussion.

g. Patient Financial Services will communicate in writing the outcome of the appeal to the Patient or family members.

B. Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest-paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.

2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

C. Limitations on Charges for Patients Eligible for Financial Assistance

1. Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r).

2. A free copy of the AGB calculation description and percentage(s) may be obtained on the AdventHealth website https://www.adventhealth.com/legal/financial-assistance-illinois, calling 800-462-0490 or mail to:

   AdventHealth

   Attn: Financial Assistance

   PO Box 935979

   Atlanta, GA 31193

D. Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the AdventHealth website or by calling 800-462-0490 or mail to:

AdventHealth
Attn: Financial Assistance
PO Box 935979
Atlanta, GA 31193

We encourage you to download the AdventHealth app and create an account, which will allow you to apply online for financial assistance as well. If you do not have an AdventHealth account, visit account.adventhealth.com/register/.

The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be

potentially eligible in order to qualify forfinancial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than twelve months prior to any eligibility determination date in making a determination about eligibility for a current episode of care.
The Organization will not consider a FAP Application completed more than twelve months prior to any eligibility determination date.

E. Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by calling 855-241-2455.

F. Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

REFERENCES

a. Financial Assistance Application Form
b. Plain Language Summary of the Financial Assistance Policy
c. List of Providers Covered and Not Covered Under the Financial Assistance Policy
d. Amounts Generally Billed