Policy:	Financial Assistance Policy		
Division:	Corporate Finance	**Original Date:**	August 2003
Department:	Corporate Finance	**Review/Revision Effective Date:**	April 15, 2024
Category:	Compliance	**Adopted By:**	Executive Vice President and Chief Financial Officer of Sentara.
Location(s):	See below	**Owner:**	Revenue Cycle

Previous Review/Revision Dates: January 2009, March 2013, October 2019, May 2020, February 2021

Policy Statement:

As part of the Sentara Health("Sentara") mission to improve health every day, Sentara is committed to providing Emergency Services and other Medically Necessary Services to all patients within their respective communities, regardless of a patient's ability to pay for such services.

Purpose:

This Financial Assistance Policy ("Policy") establishes the policy to be followed by each Hospital Facility, Post Acute Facility, Urgent Care Facility, and Medical Group in: (1) determining the eligibility for Financial Assistance for those patients receiving Emergency Services and other Medically Necessary Services; (2) calculating amounts charged to a patient eligible for Financial Assistance; and (3) facilitating the patient application process for Financial Assistance. In addition, this Policy outlines Sentara Health's billing and collections practices for medical care services, including the efforts that a Hospital Facility, Post Acute Facility, Urgent Care Facility, and Medical Group will make to determine a patient's eligibility for Financial Assistance prior to engaging in Extraordinary Collection Actions in the event of non-payment.

Definitions:

Amounts Generally Billed or AGB – The AGB is the maximum amount that a Hospital Facility can collect from a patient who is eligible for Financial Assistance under this Policy. It is calculated on a facility-by-facility basis using all claims allowed by Medicare and private health insurers over a specified 12-month period divided by the associated Gross Charges for those same Hospital Facility claims.

Application Period – Period of time beginning on the service date through 240 days after the provision of the patient's first billing statement for the service date.

Available Assets – The Household's total amount of assets available, including any liquid and/or fixed assets, for use in paying for medical care including, but not limited to: cash and cash equivalents, bank accounts, certificates of deposit, investments, trust accounts, automobiles, recreational vehicles and other forms of leisure transport, and real estate equity in real property other than the principal place of residence. Specifically excluded from Available Assets is the equity in an applicant's principal place of residence, primary source of transportation, IRS recognized retirement savings accounts, business assets, and 3.99 acres of land.

Covered Entity – A Hospital Facility, Post Acute Facility, Urgent Care Facility, or Medical Group covered under this Policy. Sentara Reference Lab Solutions, LLC. is also a Covered Entity under this Policy.

Covered Services - Emergency Services and other Medically Necessary Services provided by a Covered Entity.

Emergency Services – Care or treatment provided by a Covered Entity for an "emergency medical condition," as such term is defined in EMTALA.

EMTALA – Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd; 42 C.F.R. § 489.24).

Extraordinary Collection Actions (ECAs) – Extraordinary Collection Actions as defined in Treas. Reg. Sec. 1.501(r)-6(b). In the event of non-payment and the absence of financial assistance a Covered Entity may sell an individual's debt to another

party, report adverse information to a consumer credit reporting agency or credit bureaus, defer or deny services, or take actions which involve a legal or judicial process to include filing a lawsuit seeking judgment(s), record judgment(s), or deeds of trust, dock lien(s) on reality, foreclose on real property, attach or seize an individual's bank account or other personal property, and garnish an individual's wages.

Federal Poverty Guidelines - Federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. *See* http://aspe.hhs.gov/poverty/index.cfm for the current guidelines.

Financial Assistance – A reduction in the amount of Covered Entity Gross Charges for those patients who are eligible for financial relief under this Policy. This may also be referred to and is synonymous with the terms 'Charity','Charity Care', or 'Charity Assistance' for financial reporting, regulatory reporting, and compliance purposes.

Gross Charges – A Covered Entities full, established price for medical care services that the Covered Entity consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

HITECH – Health Information Technology for Economic and Clinical Health Act of 2009. According to Section 13405 of Subtitle D of the HITECH Act (42 USC 17935) an Insured Patient may opt for their HIPAA protected information to not be reported to their health insurance whereby the Insured Patient elects to be a Self-Pay Patient and is therefore responsible to pay out-of-pocket for all charges.

Hospital Facility– A Sentara-operated hospital facility requiring hospital licensure under Title 32.1, Chapter 5 of the Code of Virginia. This Policy applies to the following hospital facilities of Sentara Hospitals, Halifax Regional Hospital, Sentara Princess Anne Hospital, Sentara RMH Medical Center, Martha Jefferson Hospital, and Potomac Hospital Corporation of Prince William, all charitable hospital organizations under Section 501(c)(3) of the Internal Revenue Code:

- Sentara Albemarle Medical Center
- Sentara CarePlex Hospital
- Sentara Halifax Regional Hospital
- Sentara Leigh Hospital
- Sentara Martha Jefferson Hospital (including Sentara Martha Jefferson Outpatient Surgery Center)
- Sentara Northern Virginia Medical Center
- Sentara Virginia Beach General Hospital
- Sentara Norfolk General Hospital
- Sentara Obici Hospital (including Sentara BelleHarbour Surgery Center)
- Sentara Princess Anne Hospital
- Sentara RMH Medical Center
- Sentara Williamsburg Regional Medical Center

Hospital Organization – An organization recognized or seeking to be recognized as described under Section 501(c)(3) of the Internal Revenue Code that operates one or more Hospital Facilities.

Household Income – The annualized gross income for a patient and all members of the household being claimed on the same federal tax return.

Insured Patients – Individuals with any governmental, commercial, managed care, or private health insurance.

Medical Group – A Sentara-operated group of physicians, physician assistants, nurse practitioners and other medical care providers providing primary care, pediatrics, and specialty care throughout the Commonwealth of Virginia and Northeastern North Carolina. Medical Groups and disregarded entities of Medical Groups covered under this Policy include:

- Albemarle Physician Services – Sentara, Inc.
- Dominion Health Medical Associates, Ltd.
- Martha Jefferson Medical Group, LLC.
- RMH Medical Group, LLC.
- Sentara Medical Group
- Sentara Therapy Solutions, LLC.

Medically Necessary Services– Reasonable and necessary services required for the diagnosis or treatment of an illness, injury, or pregnancy-related condition that are performed in accordance with recognized standards of care at the time of service and that are not primarily for the convenience of the patient or the patient's physician or other health care provider.

Non-Covered Services – Health care services provided by Covered Entity that are not covered under this Policy. These services include, but may not be limited to, all cosmetic, plastic surgery, bariatric surgery, weight loss clinics, elective procedures, patient convenience items, retail services or packaged price services in which a discount has already been applied, cash only priced services, clinical trials, and all services in which there is a Third-Party Liability Claim.

Non-Hospital Facility – A facility not requiring hospital licensure under Title 32.1 Chapter 5 of the Code of Virginia, including, but not limited to, the office of a physician owned and operated by a hospital organization that is exempted from hospital licensure requirements under Code of Virginia Sec. 32.1-124.

Post Acute Facility – All Sentara Enterprises (SE) operated locations providing home health, hospice, infusion, and pharmacy services throughout the Commonwealth of Virginia and Northeastern North Carolina.

Public Health Emergency (PHE) – An official declaration made by the Secretary of the Department of Health and Human Services (HHS), under section 319 of the Public Health Service (PHS) Act. The declaration can last for the duration of the emergency or 90 days but may be extended or renewed by the Secretary for subsequent 90-day terms. A Presidential declaration of an emergency or disaster order under the Stafford Act may also accompany a PHE but is not required to declare a PHE nor is it necessary that a State of Emergency be declared by a state's Governor to have a Public Health Emergency.

Self-Pay Patient – Insured Patients that choose prior to receiving Covered Services from the Covered Entity to not bill their insurance for a healthcare related service as is required under the HITECH Act.

Sentara Bill Pay (SBP) – Sentara's electronic bill payment option.

Sentara MyChart – A tool that provides secure and convenient electronic access to a patient's personal medical information and healthcare provider. With Sentara MyChart, a patient can start a financial assistance application, upload support, and submit it to Sentara Health for review and processing.

Sentara Reference Lab Solutions, LLC – The exclusive lab for Sentara Connection, a Clinical Integrated Network. On-site Anatomic Pathology Services including Surgical Pathology and Cytopathology, as well as same day lab testing for in-patient, outpatient, outreach, behavioral health, and nursing home patients.

Substantially-Related Entity – With respect to a Hospital Facility operated by a Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides Covered Services in that Hospital Facility.

Third-Party Liability Claims – Any claim a patient may have against another individual, non-health insurer, or entity responsible for covering the patient's cost of medical services.

Uninsured and Self-Pay Discount – A fixed discount percentage applied to Covered Entity Gross Charges on Covered Services of Uninsured Patients and Self-Pay Patients.

Uninsured Patients – Individuals who do not have any form of healthcare insurance (Governmental, commercial, managed care, or private health insurance).

Urgent Care Facility – A facility that provides Urgent Care Services. The following Urgent Care Facilities are covered under this Policy:

- Velocity Urgent Care, LLC.

Urgent Care Services – Care provided in an Urgent Care Facility for a Medically Necessary Service serious enough that a reasonable person would seek immediate care, but not so severe that it requires Emergency Services.

Covered Services:

Only Covered Services provided by a Covered Entity or its Substantially-Related Entity are considered eligible patient care under this Policy. Non-Covered Services, by definition, are specifically excluded as a Covered Service. A Covered Entity does not have the authority to offer Financial Assistance with respect to charges from providers not employed by Sentara Health.

A list of any providers, other than a Hospital Facility itself, delivering Emergency Services or other Medically Necessary Services in each Hospital Facility and whether or not their services are covered under this Policy is maintained in a separate document that may be obtained, free of charge: (1) from patient registration areas within each Hospital Facility; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Financial Assistance Disqualification:

Financial Assistance is not available for patients who fail to reasonably comply with applicable payor requirements, including, but not limited to, obtaining authorizations, referrals, or responding to health insurer inquiries or other requirements for claim adjudication.

Financial Assistance is not available when a related Third-Party Liability Claim is available to the patient. Exceptions are determined by the applicable Covered Entity on a case-by-case basis, based upon the particular facts and circumstances.

Financial Assistance will be denied if a patient or patient's responsible party/guarantor provides false information regarding household income, household size, assets, liabilities, expenses, or other resources available that might indicate a financial means to pay for Covered Services.

Eligibility Criteria and Determination of Financial Assistance Amount:

Patients are eligible to apply for Financial Assistance for Covered Services under this Policy at any time during the Application Period. Each patient's Household Income is evaluated in light of relevant facts and circumstances, such as reported income, assets, liabilities, expenses, and other resources available to the patient or patient's responsible party, when determining the level of Financial Assistance that an applicant qualifies for under this Policy.

The following Household Income criteria is used to determine what amount, if any, of the outstanding patient account balance related to Covered Services for a patient will be written off as Financial Assistance:

- Uninsured Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines and with less than $50,000 in Available Assets are eligible for a full, 100% write-off of Covered Entity Gross Charges related to Covered Services under this Policy.

- Self-Pay Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines and with less than $50,000 in Available Assets are eligible for a full, 100% write-off of Covered Entity Gross Charges related to Covered Services under this Policy.

- Insured Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines and with less than $50,000 in Available Assets are eligible for a full, 100% write-off of any remaining patient responsibility balance after insurance has paid on Covered Services under this Policy.

- Uninsured Patients and Self-Pay Patients with a Household Income above 300%, but at or below 400%, of the then-current Federal Poverty Guidelines and with less than $50,000 in Available Assets qualify for a discount of 80% off Covered Entity Gross Charges related to Covered Services under this Policy.

- Uninsured Patients and Self-Pay Patients with a Household Income above 400% of the then-current Federal Poverty Guidelines are not eligible for Financial Assistance under this Policy. For these Uninsured Patients and Self-Pay Patients that are excluded from Financial Assistance under this Policy, a discount equal to 50% of Hospital Gross Charges will apply. For additional information refer to the separate Uninsured and Self-Pay Discount Policy.

- Catastrophic Financial Assistance is available on Covered Services for patients who do not qualify for free or reduced care based on the above criteria however due to the nature and extent of services provided have significant care-related financial obligations to Sentara Health in relation to Household Income and other potentially available resources. In such circumstances when the patient responsibility amount due on Covered Services exceeds 100% of Household Income the Covered Entity will adjust the patient responsibility balance to 25% of the applicant's Household Income.

Applicants are expected to apply for available insurance including Medicaid prior to applying for financial assistance. The Covered Entity has enlisted services of Medicaid Eligibility Vendors to assist Uninsured Patients in applying for government

programs. Covered Entity also utilizes technology and other vendor services to help identify a patient's payor information when such information is not communicated to the Covered Entity during the patient's registration process.

Applicants for Financial Assistance under this Policy may be required during the Application Period to submit any of the following documents to verify Household Income-: three most recent pay stubs at time of application; most recent annual Federal tax return or W-2 at time of application; employer verification; governmental assistance documents; social security, workers compensation, or unemployment compensation determination letters; bank statements; or such other documents that provide proof of Household Income and Available Assets. A Covered Entity may also utilize the income, asset, liability, expense, and other resource data from third-party credit inquiries and publicly available data sources as evidence in determining and validating an applicant's Household Income and Available Assets for Financial Assistance eligibility under this Policy.

A presumptive determination may be made by a Covered Entity utilizing third-party credit inquiries and publicly available data sources to determine if a patient qualifies for Financial Assistance under this Policy. If this data suggests that an Insured Patient, Uninsured Patient, or Self-Pay Patient's total Household Income is at or below 300% of the then-current Federal Poverty Guidelines, 100% of the patient's remaining balance for Covered Services may qualify to be written-off.

A patient's prior eligibility determinations with respect to Financial Assistance are not presumed to apply to new episodes of care for that patient after the eligibility approval period has expired. A new application for Financial Assistance must be completed.

Once a Hospital Facility patient is determined to be eligible for Financial Assistance under this Policy, they will not be charged more for Covered Services under this Policy than the Amount Generally Billed. AGB is determined by multiplying the Gross Charges for the provision of any Emergency Services or other Medically Necessary Services by a Hospital Facility's AGB percentage, which is based on all claims allowed under both Medicare and private health insurance. An information sheet stating the AGB percentages of each Hospital Facility covered under this Policy and how these AGB percentages were calculated may be obtained free of charge: (1) from patient registration areas within each Hospital Facility; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Uninsured Patients and Self-Pay Patients that do not satisfy the eligibility requirements for Financial Assistance under this Policy should contact Sentara Health as described in this Policy to determine if they may qualify for discounts offered outside of this Policy.

Methods for Applying for or Obtaining Financial Assistance:

The Application for Financial Assistance is available at patient registration areas of each Hospital Facility and may also be downloaded from the internet free of charge at www.sentara.com/financialassistance. The Application for Financial Assistance may also be mailed free-of-charge to patients upon request by phoning 757-233-4600, or by sending a written request to the following address:

Sentara Health
ATTN: Financial Coordinator
824 N. Military Hwy, #100
Norfolk, Virginia 23502

Completed Applications for Financial Assistance, along with proof of Household Income and all other support, should be mailed to the address set forth in this Policy or the application and support may be submitted through Sentara MyChart. Alternatively, a patient may return a completed application, along with proof of Household Income and all other support, to any patient registration area of a Hospital Facility.

Patients who need additional information about this Policy, or who need assistance with the Financial Assistance application process, may call or visit the above location Monday through Friday between 8:30AM and 4:30PM to speak with a Sentara Financial Coordinator.

Length of Eligibility:

Eligibility determinations under this Policy are effective for Covered Services rendered up to 240 days prior to the application date and for Covered Services 6-months after the final approval date or 12 full months after the final approval date if the applicant's only means of Household Income is from a verifiable fixed-income source such as a pension or Social Security.

Actions Taken in the Event of Non-Payment (Collections/Bad Debt):

The collection process is the same for all Insured Patients regardless of their type of insurance, i.e., Medicare, commercial insurance, managed care, or private health insurance. Patient collection efforts start after all insurances have paid. Any balance remaining after all insurances have paid is considered the patient responsibility amount. Sentara Health attempts to collect the patient responsibility amount from Insured Patients for a minimum of 120 days with at least three balance due notifications before the account/visit becomes bad debt at which time the account/visit may be placed with Sentara's collections department or an outside collection agency.

Uninsured Patients and Self-Pay Patients follow the same collection process as Insured Patients with regards to the patient responsibility amount. Sentara's collections department or the collection agency makes at least three additional attempts over the next 120-day period to collect the amount due from the patient and this also covers the Application Period for a patient to apply for Financial Assistance. Bad debt accounts placed with an outside collection agency remain with the agency until they are paid or returned to Sentara Health. Accounts returned to Sentara Health may receive additional collection efforts or Sentara Health may choose, at its own discretion, to cease all collection efforts based on the patient's individual circumstances.

Sentara Health takes reasonable efforts to determine a patient's eligibility for Financial Assistance under this Policy with respect to Covered Services prior to engaging in collection efforts with respect to such patient. Such efforts include notifying a patient about this Policy, helping a patient remedy an incomplete Application for Financial Assistance, and informing an applicant for Financial Assistance regarding the eligibility determination once a completed application has been received.

If, after reasonable efforts are taken, a patient is found to either not qualify for Financial Assistance under this Policy or is unresponsive to the Covered Entities efforts to obtain the information necessary to determine eligibility for Financial Assistance, the patient's account may be moved to bad debt and the delinquent account turned over to Sentara's collections department or an outside collection agency. ECAs may be taken by a Covered Entity once an account has been turned over to Sentara's collections department or an outside collection agency. ECAs may include the outsourcing of the account to a collection agency that may report the delinquent account to one or more consumer reporting agencies (credit bureaus). In addition, a Covered Entity may file a lawsuit seeking judgment(s), record judgment(s), or deeds of trust, and dock lien(s) on realty.

After a reasonable period and prior to engaging in any ECAs, a Covered Entity will also attempt to qualify a patient and write-off balances related to that patient's Covered Services under this Policy when a patient does not provide financial information or respond to attempts to provide Financial Assistance based on credit reporting data that assists in determining income and credit worthiness. When the credit data suggests that an Insured Patient, Uninsured Patient, or Self-Pay Patient's total Household Income is at or below 300% of the then-current Federal Poverty Guidelines, the account balance for that patient's Covered Services may be written-off to presumptive financial assistance.

A patient is eligible for presumptive financial assistance considerations on Covered Services under this Policy and may also have their account balance written-off if the patient is deemed eligible for or has Medicaid coverage, homeless, deceased with no estate, is receiving healthcare services at a non-Sentara Health free clinic, a Sentara Community Care Clinic, a Federally Qualified Health Center (FQHC), or is participating in the Supplemental Nutrition Assistance Program (SNAP).

Prior to categorizing patient accounts as bad debt, a Covered Entity, as part of its routine collections process, will mail or make available in Sentara Bill Pay (SBP) a series of no less than three balance communications or patient statements, and may also make attempts by phone to contact patients. In the event of non-payment or the absence of any mutually agreed-upon payment arrangement, a Covered Entity will consider an account to be bad debt and may undertake ECAs after 120 days from the provision of a patient's first post-discharge billing statement or first balance due communication in Sentara Bill Pay (SBP). A patient will be mailed an additional series of three patient statements when the account is in bad debt. Any unpaid account(s) remaining at the end of this second series of statements to the patient will be reviewed for legal consideration or placement with an outside collection agency.

Patient balances are eligible for Financial Assistance evaluation during the Application Period. Upon receipt of an Application for Financial Assistance during the Application Period, any ECAs are suspended until a final eligibility determination is made by a Covered Entity. An applicant for Financial Assistance who provides incomplete information during the Application Period is given a reasonable period of time, as determined by Sentara Health, and based upon the particular facts and circumstances, to respond to a Covered Entities written notice describing the additional information and/or documentation required to complete the application. If the applicant does not respond to the request for additional information from a Covered Entity within a reasonable period of time, as determined by Sentara Health and based upon the particular facts and circumstances, then ECAs may resume.

At least 30 days before any ECAs are initiated by a Hospital Facility, a patient is notified, in writing, regarding any ECAs a Hospital Facility intends to initiate to obtain payment, as well as the availability of Financial Assistance for eligible individuals. Along with this notice, the patient is provided a plain language summary of this Policy. A Hospital Facility will also make a reasonable effort to orally notify its patients about this Policy and how they may obtain assistance with the financial assistance application process during the period between mailing the ECA-initiation notice and resuming or initiating ECAs. ECAs may occur no earlier than 120 days from the provision of a patient's first post-discharge billing statement, as outlined in Treas. Reg. Sec. 1.501(r)-6(c)(3)(i).

The Director of Financial Clearance and Collections is responsible for determining that a Covered Entity has made reasonable efforts to determine patient eligibility for Financial Assistance under this Policy before engaging in any ECAs.

Exceptions to this Policy

The Director, Financial Clearance and Collections, Associate General Counsel, Vice President of Revenue Cycle, Senior Vice President of Corporate Finance, and Chief Financial Officer of Sentara are each granted the authority to provide eligibility and determination exceptions to this Policy on a case-by-case basis as appropriate to an individual patient's facts and circumstances. If a Public Health Emergency is declared, Sentara Health leaders authorized on a case-by-case basis to make eligibility and determination exceptions to this Policy may temporarily modify the eligibility and determination requirements of all applicants for the duration of the Public Health Emergency. In no case will a patient be denied Financial Assistance if they meet the stated eligibility and determination requirements for Covered Services set forth in this Policy.