PURPOSE:

This policy sets forth expectations related to identifying, asking for and collecting all insurance co-payments, coinsurance, deductibles and minimum required payments on services when copay may not apply.

SCOPE:

This policy applies to pre-service and time of service processes for clinic and hospital team members. The policy excludes any visit for emergency services that are covered under EMTALA. This also excludes Aurora at Home and ACL Laboratories.

DEFINITIONS:

A. **Co-payment or co-pay** is a capped contribution defined in the patient’s insurance policy and paid by an insured person each time a medical service is assessed. It must be paid before any policy benefit is payable by an insurance company. Co-pays are to be paid in full prior to the service being rendered.

B. **Co-insurance** is a fixed percentage; an insured must pay against a claim after the deductible is satisfied.

C. **Deductible** is a specified amount the insured must pay before an insurance company will pay a claim.

D. **Outstanding balance** is defined as a self-pay balance that is over 60 days old.

E. **Balances due** include deductibles and coinsurance, as well as amounts for non-covered and elective services.

F. **Minimum required payment** is the amount that has been determined to be collected from a patient based on the service scheduled.

POLICY:

At Aurora, we are committed to educating our patients about the cost of their health care. We expect payment prior to the service being rendered for the following:
• Co-payments
• Deductibles/Coinsurances
• Outstanding balances Due (which are the patient responsibility)
• Third-Party Liability claims

Non-Covered/Elective Services. We will exert every effort to work with our patients on their account resolution and will offer payment arrangements and financial aid when necessary. It is important to inform our patients that while we are willing to work with them in paying their bills, we will pursue outside collection remedies and, as a last resort, may result in dismissal from care after all other possible collection efforts have been pursued. All team members have the responsibility to understand and effectively communicate Aurora Health Care’s financial payment policy to our patients. Routine, preventative, screening or elective care may be delayed or deferred based on criteria established and agreed upon by the Clinical and Executive Business Office Leadership teams until an appropriate financial plan is in place.

PROCESS:

A. Pre-Service: (Scheduling, or Pre-Registration or Financial Clearance Processes)
   a. Team members will notify patients that payment will be expected at the time of service or can be paid.
   b. Team members will contact patients according to the appropriate workflow to educate the patient on any payment amount required before services are rendered.

B. Check-In for Scheduled Service
   a. Team members will collect any payments due prior to the patient receiving their scheduled service.
   b. Team members will refer to appropriate workflow to inform patient of next steps if payment is not made.

C. Check-In for Unscheduled or STAT Service
   a. Team members will collect amounts due pertaining to the service being rendered. Outstanding balances will not be considered in deferral of care for unscheduled or stat services.
   b. Team members will refer to appropriate workflow to inform patient of next steps if payment is not made.

RESPONSIBILITY:

Questions regarding this policy should be directed to the Financial Counselor at (715) 735-8012 or toll-free at 1(888)788-2070 ext. 8012.

Attachments:

Approval Signatures

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<th>Approver</th>
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<tr>
<td>Finance Director</td>
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<td>Single Business Office Mgr [Finance Director]</td>
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**Applicability**

Bay Area Medical Center