Patient Financial Assistance Guide

Bassett Healthcare Network

TABLE OF CONTENTS

TOPIC	PAGE
Questions to Consider	2
Were your services the result of an accident?	
What are my health insurance options?	
Do I qualify for Medicaid or Child Health Plus?	
Do I qualify for Medicare A, B, C or D?	
What other financial resources are available?	
Who can assist me in determining my eligibility and enrolling into Medicaid, Child Health Plus, the Marketplace or the Community Services Program?	
Health Insurance and Income Based Medical Assistance Options	
Medicare	5
Medicaid	5
Medicaid Cancer Treatment Program	5
Child Health Plus	6
Employer Sponsored Insurance	6
The Marketplace	6
Elderly Pharmaceutical Insurance Coverage	6
Family Planning Benefit Program	6
HIV Uninsured Care Program	7
Chronic Care/Spousal Medicaid	7
Department of Social Service Offices by County List	7
Office of the Aging Offices by County List	8
Financial Assistance Programs	
Community Services Program	9
Income Assistance Programs	9
Family Assistance	9
Safety Net Assistance	9
Emergency Temporary Assistance	9
Patient Billing	10
Common Terminology	11-15

PATIENT FINANCIAL ASSISTANCE GUIDE

Bassett Healthcare Network is committed to minimizing the financial barriers to health care that exist for members of our community, in particular, those uninsured and those not sufficiently covered by health insurance or governmental payment programs. Financial aid to assist low income and uninsured individuals with their hospital bills is available to all who qualify.

If you do not have health insurance or are concerned that you may not be able to pay for your care in full, we may be able to help. Bassett Healthcare Network provides financial assistance to patients and may be able to help you apply for low-cost health insurance or work with you to arrange a manageable payment plan.

QUESTIONS TO CONSIDER?

Were your services the result of an accident?

If your services are related to an injury/accident, they may be covered by

- Homeowner's insurance (example: dog bites)
- Automobile insurance (example: car accident)
- Worker's Compensation (example: injured at work)

What are my health insurance options?

Employer sponsored, the Marketplace, Medicare, Medicaid, and Child Health Plus. *(Please refer to the Common Terminology section of this guide for more information)*

Do I qualify for Medicaid or Child Health Plus?

These programs have set enrollment guidelines based on income and family size. (*Please refer to the Health Insurance and Income Based Medical Assistance Options section of this guide for more information)*

Do I qualify for Medicare (A, B C or D)?

All of these programs have set enrollment guidelines based on age, disability and/or if you are undergoing dialysis. (*Please refer to the Health Insurance and Income Based Medical Assistance Options section of this guide for more information)*

What other financial resources are available? (*Please refer to the Health Insurance and Income Based Medical Assistance Options section of this guide for more information)*

- Community Services Program
- Income Assistance Programs

Who can assist me in determining my eligibility and enrolling into Medicaid, Child Health Plus, the Marketplace or the Community Services Program?

Bassett's Eligibility Support Unit and Certified Application Counselors:

Cooperstown Clinic	Oneonta/Regional Sites	Inpatients - Bassett
607-547-6642	607-433-4040	Medical Center
	800-348-1477	607-547-7740

Community Services Programs

Applications available online at: www.bassett.org Select "Financial Assistance" and then select the appropriate facility or by contacting the following offices:

Bassett Medical Center (applications for O'Connor, Tri-Town and Bassett)
607-547-3480
800-642-0455
Completed applications with all required documentation should be mailed to:

Community Services Program
Bassett Medical Center
One Atwell Road
Cooperstown, NY 13326

A.O. Fox Memorial Hospital
607-431-5926
607-431-5335
Completed applications with all required documentation should be mailed to:

A.O. Fox Memorial Hospital
Financial Assistance Representative
Business Office
1 Norton Avenue
Oneonta, NY 13820

Little Falls Hospital
315-823-5237
Completed applications with all required documentation should be mailed to:

Community Services Program
Little Falls Hospital Business Office
140 Burwell Street
Little Falls, NY 13365

Cobleskill Regional Hospital
518-254-3338
518-254-3381
Completed applications with all required documentation should be mailed to:

Cobleskill Regional Hospital
Business Office – CSP
178 Grandview Drive
Cobleskill, NY 12043

Health Insurance Navigators *

Bassett Navigator Program
320 N. Prospect Street
Herkimer, NY 13350
Main Voicemail: 315-867-2480
Fax: 315-867-1313

* The Bassett Health Insurance Navigators are trained by the State of New York to provide in person assistance to individuals, families and small businesses applying for health insurance through the Marketplace. You may be eligible for free or low cost health insurance depending upon your income and household size. A full listing of Navigators is also available at: www.nystateofhealth.ny.gov or by calling the New York State of Health Customer Service line at 855-355-5777.

New York State of Health website (www.nystateofhealth.ny.gov)

New York State of Health Customer Service line (855-355-5777)

HEALTH INSURANCE AND INCOME BASED MEDICAL ASSISTANCE OPTIONS

Medicare

Medicare is a U.S. Federal Health Program that covers individuals who are over the age of 65 and have been a U.S. citizen or permanent legal resident for five years; who are disabled and have collected Social Security for a minimum of two years; who are undergoing dialysis for kidney failure or who are in need of a kidney transplant; or who have Amyotrophic Lateral Sclerosis (Lou Gehrig's disease).

There are four different parts of Medicare: Part A – Hospitalization, Part B – Physician, Part D – Prescription and Part C – Medicare Advantage (combines Medicare and supplemental plan) You can verify your eligibility or enrollment by contacting the local Social Security office, visit their web site: www.medicare.gov or by calling 1-800-MEDICARE. You can get additional information and free counseling from your local Office of the Aging office. (*Please refer to the Office of the Aging listing by county list section of this guide for contact information.)*

Medicaid

Coverage under Medicaid is dependent on household income and family size. Other factors can contribute to eligibility like emergent need or disability. You can apply by using the New York State of Health website (www.nystateofhealth.ny.gov), by meeting with one of Bassett's Eligibility Support Unit staff or a Navigator. Some applications can be referred to your county Department of Social Services office for review and approval. Individuals who are over income, but experiencing a chronic illness may still qualify for coverage. A disability determination review must be requested for this type of enrollment consideration. (*Please refer to the Department of Social Services Office list section of this guide for contact information)*

Medicaid Cancer Treatment Program (MCTP)

Provides coverage to any individual needing screening or treatment for breast, cervical, colorectal or prostate cancer. Approval is based on income, age and insurance availability. You may contact the Cancer Services Program at 607-433-3708 for information for this program.

Child Health Plus

Covers children under the age of 19 who are a New York State resident and eligible based on household income. You can apply by using the New York State of Health website (www.nystateofhealth.ny.gov), by meeting with one of Bassett's Eligibility

Support Unit staff, by meeting with a Navigator or by calling the New York State of Health Customer Service line at 855-355-5777.

Employer Sponsored Insurance

If you are currently employed, your employer may offer health insurance. Open enrollments for these plans are usually one time per year. Your employer can provide information on any available options, cost associated with enrollment and when you are allowed to enroll for coverage.

The Marketplace

As part of the Affordable Care Act signed into law March 2010, the individual mandate set up federal and state sponsored web sites to review, compare and purchase health insurance plans. There are limited open enrollment periods and subsidies available for lower income individuals and families to reduce premium and out-of-pocket costs. For more information you can speak to one of Bassett's Certified Application Counselors, meet with a Navigator, or review the New York State of Health website: www.nystateofhealth.ny.gov or call the New York State of Health Customer Service line at 855-355-5777.

EPIC –Elderly Pharmaceutical Insurance Coverage

This program is available for New York State residents age 65 and older who are enrolled or eligible to enroll in Medicare Part D. This program supplements the out-of-pockets costs associated with Medicare Part D. For more information regarding benefits and enrollment you may contact your local Office for the Aging or EPIC at 1-800-332-3742.

Family Planning Benefit Program

Limited coverage for females or males of child bearing age who are New York State residents and qualify based on income. You can apply by meeting with one of Bassett's Certified Application Counselors, a Navigator, by using the New York State Marketplace website: www.nystateofhealth.ny.gov or by calling the New York State of Health Customer Service Line at 855-955-5777.

HIV Uninsured Care Programs

Four different programs available: AIDS Drug Assistance Program (ADAP), ADSP Plus (Primary Care), HIV Home Care, ADAP plus Insurance Continuation Programs. To apply call 1-800-542-2437 or visit www.health.ny.gov/diseases/aids

Chronic Care Medicaid/Spousal Medicaid (Long Term Care)

Non-income based program solely for long term care. Applicants must be a New York State resident with specific county residence and there are some additional eligibility requirements. You can apply at the county Department of Social Services Office or www.health.ny.gov/health_care/medicaid.

Department of Social Services Offices by County

Broome County	(607) 778-2604
Chenango County	(607) 337-1500
Delaware County	(607) 746-5300
Dutchess County	(845) 486-3000
Erie County	(716) 858-8000
Fulton County	(518) 736-5600
Greene County	(518) 719-3700
Herkimer County	(315) 867-1291
Madison County	(315) 366-2211
Montgomery County	(518) 853-4646
Oneida County	(315) 798-5511 or (315) 798-5632 or (315) 798-5840
Otsego County	(607) 547-1700 or (800) 422-2512
Schenectady County	(518) 388-4470
Schoharie County	(518) 295-8334
Sullivan County	(845) 292-0100
Ulster County	(845) 334-5035

For more information you can visit the New York State Department of Health website: http://www.health.ny.gov/health_care/medicaid/

Offices for the Aging by County

Broome County Office for the Aging	(607)-778-2411
Chenango County Area Agency on Aging	(607)-337-1770
Delaware County Office for the Aging	(607)-746-6333
Dutchess County Office for the Aging	(845)-486-2555
Erie County Department of Senior Services	(716)-858-8526
Fulton County Office for Aging	(518)-736-5650
Greene County Department for the Aging	(518)-719-3555
Herkimer County Office for the Aging	(315)-867-1121
Madison County Office for the Aging, Inc	(315)-697-5700
Montgomery County Office for the Aging, Inc.	(518)-843-2300
Oneida County Office for Aging and Continuing Care	(315)-798-5456
Otsego County Office for the Aging	(607)-547-4232
Schenectady County Dept. of Senior & Long-Term Care Services	(518)-382-8481
Schoharie County Office for the Aging	(518)-295-2001
Sullivan County Office for the Aging	(845)-807-0241
Ulster County Office for the Aging	(845)-340-3456

For additional information you can visit the New York State Office of the Aging website:
http://www.aging.ny.gov/

FINANCIAL ASSISTANCE PROGRAMS

Community Services Program

Bassett Healthcare Network Community Service Program (CSP) provides free care to uninsured individuals and families unable to pay the total cost of their medical care, including emergency medical treatment. Applicants must meet certain eligibility requirements and any Bassett Healthcare Network patient may apply regardless of the location of their residence. (*Please refer to pages 3 -4 of this guide for information regarding how to apply)*

Income Assistance Programs

Numerous state and federal government organizations, charities, and other companies offer a wide variety of low-income assistance programs. You can find programs that can help pay medical bills and expenses. Individuals and families can apply for these income-based programs. Benefits are awarded based on income, resources and needs assessment. Income Assistance Programs are available by application at your county Department of Social Services office as part of Public Assistance. You may need to provide proof of: who you are, age of each household member applying, expenses, Social Security numbers, Citizenship or Immigration status, income, Unemployment benefits and/or interest and dividends. Bassett Medical Center's Social Work and Cast Management staff is available to discuss any assistance options and can be reached at 607-547-3640 or 607-547-3645. *(Please refer to the Department of Social Service Office list section of this guide for contact information)*

Family Assistance (FA)

This program provides money for families with children. Cash benefits are limited to five years in a recipient's lifetime. After five years, a Family Assistance case may continue to receive benefits if an adult is disabled and cannot work or may be required to apply for assistance through Safety Net.

Safety Net Assistance (SNA)

This program provides money for basic living expenses for single adults and childless couples or families who have used up their five year limit of FA. Cash benefits are limited to two years including any cash benefits received through Family Assistance. After two year, the non-cash Safety Net Assistance voucher system provides benefits.

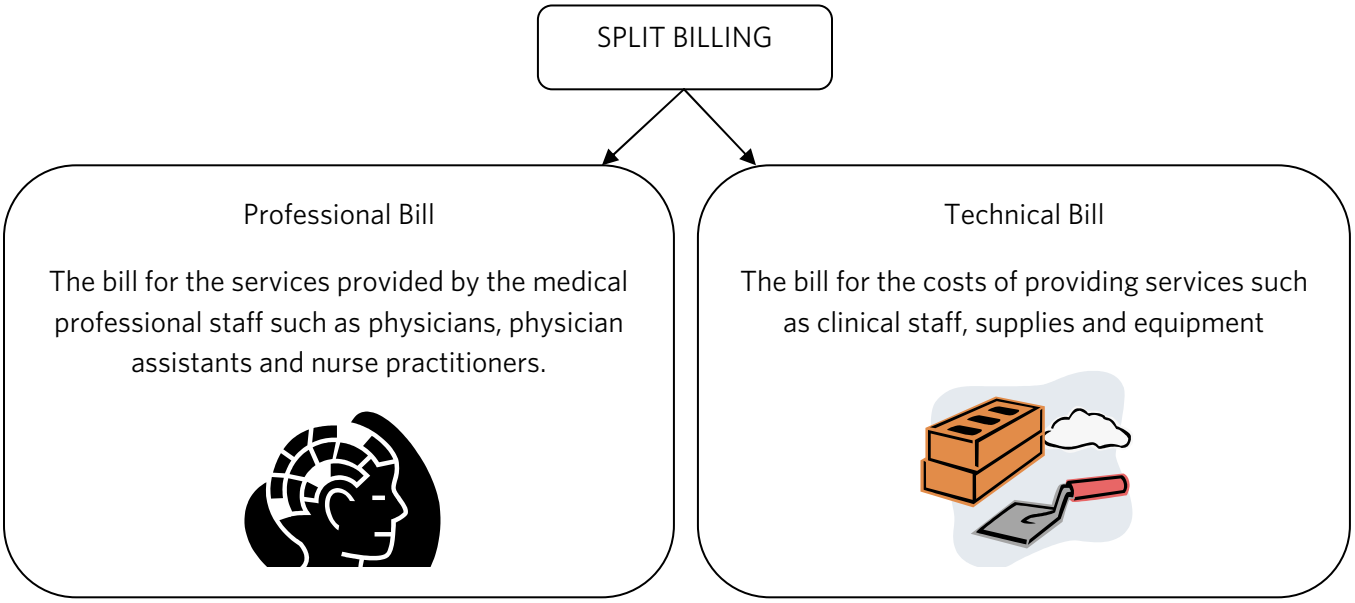
Emergency Temporary Assistance

An emergency is an urgent need or situation that has to be taken care of right away. Emergency Assistance for Families (EAF) and Emergency Safety Net Assistance (ESNA) provide assistance for crisis situations.

PATIENT BILLING

As a patient of a Bassett Network Healthcare provider, you may receive more than one billing statement for a service rendered to you. The billing of services is broken down into two components: Professional and Technical. The professional component is the billable service provided to you by a physician or other medical provider. The technical component is the billable service provided to you by a facility or clinic, which may include x-rays, lab, technical staff, supplies and equipment. This billing is commonly referred to as "Facility Based Billing" or "Split Billing". *(Please refer to the Common Terminology section of this guide for additional information)*

There are also times when your medical care may require the use of an outside agency or provider to provide specific services. In this case, you may also receive a billing statement from that outside agency or provider.



You may incur out-of-pocket expenses (copays, deductible and/or coinsurance for services rendered to you) and you may be responsible multiple copays for services rendered to you on the same day. Please contact your insurance carrier directly if you have any questions regarding your benefits and out-of-pocket costs. Payment plans are available for any balances and can be arranged by contacting MedSPAR at 1-866-295-9819 or 607-729-9885. You can also make payments online by using Bassett's website: www.bassett.org. Under the "Our Network" tab, please select "MedSPAR Online Payment" option.

COMMON TERMINOLOGY

Affordable Care Act (ACA) – Health Care Law that was signed into effect March 2010 that focused on health insurance coverage expansion and insurance market reform. Some provisions were effective immediately and others become effective in the following years.

Allowed Amount – Maximum amount allowed to be paid for a covered health service by a health insurance company. This may be also called "eligible expenses", "payment allowance" or "negotiated rate". If a provider charges more than the allowed amount, the individual may have to pay the difference which is known as Balance Billing.

Balance Billing – When a provider bills an individual for the difference between the provider's charge and the amount allowed by the health plan. Providers may not bill the individual for covered services if the provider has a contract with the individual's health insurance plan.

Catastrophic Plan – A type of coverage that is designed to provide emergency services coverage and to protect individuals from unexpected medical costs, but has limits on regular doctor visits. The premium amount an individual pays each month for health care is generally lower than other types of plans, but the out-of-pocket costs for deductibles, copayment and coinsurance are generally higher.

Certified Application Counselors (CAC) – Persons who will provide outreach, education, referral and enrollment activities to individuals requesting such assistance. These persons will conduct public education activities to raise awareness of available Qualified Health Plans within the Marketplace and assist individuals with enrollment via the Marketplace web site.

Child Health Insurance Program (CHIP) – Program which offers full medical care including vision and dental coverage for individuals under age 19 and premiums are either free or pro-rated based on household income and family size.

Coinsurance – An individual's share of the cost of a covered health service, calculated as a percent of the amount allowed by the health plan for that service. An individual pays coinsurance plus any deductibles that are owed.

Coordination of Benefits (COB) - Coordination of benefits is the practice of ensuring that insurance claims are not paid multiple times, when an individual is covered by two health plans at the same time. The idea behind coordination of benefits is to ensure that the payments of both plans do not exceed 100% of the allowed amount. The two health plans coordinate the health care benefits in the order in which the health plans must pay benefits. COB rules determine which plan is primary and which is secondary. The primary plan will pay the claims first and the unpaid balance will be billed to the secondary plan. Benefits are coordinated between the two health plans to ensure that policyholder receives full coverage.

Copayment – A fixed amount individuals pay for a covered health care service, usually at the time of service. The amount can vary by the type of covered service, such as seeing a doctor, filing a prescription or going to the emergency room. Copays are generally lower for services rendered by primary care providers than by specialists and for in-network providers than out-of-network providers.

Deductible – The amount an individual owes for health care services before his or her health insurance plan begins to pay. Some health care services may be covered by the health plan even if the individual has not met the deductible. Premiums do not count towards meeting the deductible amount.

Flexible Spending Account (FSA) - A type of savings account available that provides the account holder with specific tax advantages. Set up by an employer for an employee, the account allows employees to contribute a portion of their regular earnings to pay for qualified expenses, such as medical expenses or dependent care expenses.

Health Savings Account (HSA) - An account created for individuals who are covered under high-deductible health plans (HDHPs) to save for medical expenses that HDHPs do not cover. Contributions are made into the account by the individual or the individual's employer and are limited to a maximum amount each year. The contributions are invested over time and can be used to pay for qualified medical expenses, which include most medical care such as office visits, dental and vision.

Health Insurance –contract between an individual and a health insurance vendor that requires the vendor to pay or reimburse some or all of an enrollee's health care costs when he or she gets sick or needs medical care.

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from in-network doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require individuals to live or work in its service area to be eligible for coverage. In exchange for limited access to providers, premiums are usually lower than in other types of insurance plans.

Health Reimbursement Account (HRA) - Employer-funded plans that reimburse employees for incurred medical expenses that are not covered by the company's standard insurance plan. Because the employer funds the plan, any contributions are considered tax deductible (to the employer). Reimbursement dollars received by the employee are generally tax free.

High Deductible Health Plan (HDHP) – A plan that features higher deductibles than traditional insurance plans in exchange for lower monthly premiums. HDPHs can be combined with a health savings account or flexible spending account. These health reimbursement arrangements allow an individual to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Indemnity- The concept of indemnity is based on a written agreement made between two parties. One party (the insurer/insurance company) agrees to compensate the other (the insured or patient) for any damages or losses (medical care), in return for premiums paid by the insured to the insurer. Payments can be directed to the medical provider who provided the care if that person or facility is a participating provider. *(Please refer to the Participating Provider definition for more information)*

Managed Care - A system of health care (HMO or PPO) that controls costs by placing limits on physicians' fees and by restricting the patient's choice of physicians. The intention is to eliminate redundant facilities and services and to reduce costs. Health education and

preventive medicine are encouraged. Patients may pay a flat fee or copay for basic family care but may be charged additional fees for specialty care services. *(Please refer to the HMO and PPO definitions for more information)*

Marketplace – a resource available on line and by telephone where individuals, families, small business owners and their employees can learn about health coverage options, compare health insurance plans based on costs and benefits, choose a plan, and enroll in health coverage. It can also direct individuals who qualify to Medicaid and Child Health plus coverage options.

Medicaid - A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care provided they qualify. Although largely funded by the federal government, Medicaid is run by the state where coverage may vary.

Medicare - A U.S. federal health program that subsidizes people who meet one of the following criteria: (1) An individual over the age of 65 who has been a U.S. citizen or permanent legal resident for five years (2) An individual who is disabled and has collected Social Security for a minimum of two years (3) An individual who is undergoing dialysis for kidney failure or who is in need of a kidney transplant (4) An individual who has Amyotrophic Lateral Sclerosis (Lou Gehrig's disease).

Navigators – An individual who assists others in reviewing the qualified health plans offered through the Marketplace; provides information concerning enrollment in qualified health plans, and reviews the availability of premium tax credits and cost-sharing reductions; assists in enrollment in qualified health plans; and provides referrals to any applicable health insurance assistance programs as necessary.

Non-participating Provider – a doctor, hospital, or other health care office that is not part of an insurance plan's network. The patient would be responsible for payment of the charges and would be required to submit any billing(s) to their insurance carrier for reimbursement. Some insurance plans require a patient to see a participating provider in order for services to be covered.

Participating Provider - a doctor, hospital, or other health care office that is part of an insurance plan's network who agrees to accept insurance allowances for covered medical services. Patient can be billed their out-of-pocket costs such as deductibles, coinsurances and/or copays.

Point of Service (POS) - A type of plan in which individuals pay less if they use doctors, hospitals and other health care providers that belong to the plan's network. With this type of plan, an individual may go out-of-network at a higher cost. POS plan may also require individuals to get a referral from their primary care doctor in order to see a specialist.

Preferred Provider Organization (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Individuals pay less if they use providers that belong to the plan's network. Individuals can visit doctors, hospitals and providers outside of the network at an additional cost.

Premium – The amount that must be paid to a health insurance company for a health insurance plan. Individuals and/or their employers usually pay it monthly, quarterly or yearly.

Primary Health Insurance- An insurance policy that covers health care costs up to the policy's limit, after deductibles, coinsurance or copays. Coverage is limited to the covered benefits outlined in the policy and subject to the limits of that policy.

Professional Component Billing – Billable services provided by medical providers. These include consultation, interpretation of an x-ray, CT scan, or MRI or interpretation of a laboratory test, often in the form of a written report.

Qualified Health Plan (QHP) – Health plans that are certified by the Health Insurance Marketplace under the Affordable Care Act. These plans provide essential benefits and follow established limits on cost sharing (deductible, co-insurance, and copays). Some examples of QHPs include: Medicare, Medicaid, Child Health Plus, Employer-sponsored coverage or a marketplace product.

Secondary Insurance Coverage - Insurance coverage that is available in addition to any primary policy that an insured may carry. It is often used to supplement existing policies or to cover any gaps in insurance coverage. It may also be present when two spouses have coverage through different employers. When coverage overlaps, there are methods available to determine how it will apply. (*Please refer to the Coordination of Benefits definition for more information)*

Self-Funded - A health plan that is employer-based and the employer pays the claims with its own funds for its employees.

Split Billing (Facility Based) Reimbursement – A structure under which two separate bills, for professional and technical reimbursements, are generated for a service. Professional reimbursements go to the physician and technical reimbursements to the hospital.

Technical Component Billing – Billable service provided to you by a facility or clinic setting which may include lab, x-rays, technical staff, supplies and equipment.