Request to View Hospital Standard Charges

- These charges represent the standard charges for diagnosis-related groups. The charge is for care without complications. Actual charges may be different for specific patients due to medical condition, length of time spent in surgery or recovery, necessary specific equipment, supplies or medication, complications requiring unanticipated procedures or other treatment ordered by the physician.
- If a patient has contracted in-network health insurance, significant discounts may have already been obtained by the insurance company and the patient will only pay the applicable deductible, copay and/or coinsurance and any non-covered services or elective services. Patients should contact their health plan directly for their specific financial obligations that aren't reimbursed by insurance.
- If a patient does not have health insurance, significant discounts may be available that could result in either the care being free or at a greatly reduced price if the patient meets the required qualifications.
- Contact the Financial Counselor, at (618)253-0251 to help determine any discounts a patient may qualify for.
- This information is not a quote or a guarantee of what the charges will be for a specific patient's care.
- This charge information does not include the professional services provided by a physician, surgeon, hospitalist, radiologist, anesthesiologist, pathologist, advanced practice nurse or other independent practitioners.
- Patients will likely receive separate bills for the physicians and other professionals who provided treatment. These physicians may not be participating providers in the same insurance plans and networks as the hospital. As such, there may be greater patient financial responsibility for these services which are not under contract with the health plan.
- An important component for choosing a health care provider is determining quality of care. Information pertaining to the hospital's quality metrics can be obtained at Hospital Compare www.medicare.gov/hospitalcompare. Your doctor can be a helpful resource in choosing where to obtain care.
- A helpful document for further information regarding hospital prices is the Healthcare Financial Management Association's Understanding Healthcare Prices: A Consumer Guide www.hfma.org
- To compare hospital median charges for nearly 50 major diagnoses, quality and patient satisfaction metrics in Illinois, go to the Illinois Hospital Report Card website www.healthcarereportcard.illinois.gov/

Frequently Asked Questions:

1. How much will I actually have to pay out of my pocket?

Patient pays:

- A patient with health insurance will pay the applicable deductible, copay and/or coinsurance and non-covered amounts or elective services set by their health plan.

  The financial obligations could differ depending on whether the hospital or physicians are "out-of-network," meaning the health plan does not have a contract with them. Contact your insurance company to understand what your financial obligations will be.
- A patient without health insurance will discuss financial assistance options available that could include either a complete write-off or a substantial reduction of the charges in accordance with the Illinois Hospital Uninsured Patient Discount Act and the hospital's Financial Assistance Program.

  Please contact Financial Counselor, at (618)253-0251 to obtain further information about the discounts available.

Health insurance plan pays: Health plans such as Medicare, Medicaid, workers' compensation, contracted in-network commercial health insurance, etc., do not pay charges. Instead, they pay a set price that has been predetermined or negotiated in advance. The patient only pays the out-of-pocket amounts set by the health plan.

If you need help understanding your health care bill, please contact Patient Accounts at (618)253-0251 or (618)253-0498.

2. What do the following health insurance terms mean?

Deductible means the amount the patient needs to pay for health care services before the health plan begins to pay. The deductible may not apply to all services.

Copay means a fixed amount (for example, $20) the patient pays for a covered health care service, such as a physician office visit or prescription.

Coinsurance means the percentage the patient pays for a covered health service (for example, 20% of the bill). This is based on the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

A patient's specific health care plan coverage, including the deductible, copay and coinsurance, varies depending on what plan the patient has. Health plans also have differing networks of hospitals, physicians and other providers that the plan has contracted with. Patients need to contact their health plan for this specific information.

3. What is the difference between charges, cost and price?

Total Charge is the amount set before any discounts. Hospitals are required by the federal government to utilize uniform charges as the starting point for all bills.

The charges are based on what type of care was provided and can differ from patient to patient for similar services, depending on any complications or different treatment provided due to the patient's health.

Cost - For a hospital, it is the total expense incurred to provide the health care. Hospitals have higher costs to provide care than freestanding or retail providers, even for the same type of service. This is because a hospital is open 24 hours a day, 7 days a week and needs to have everything necessary available to cover any and all emergencies. Non-hospital health care providers can choose when to be available and typically would not provide services that would result in losses. A hospital's cost of services can vary depending on additional factors such as:

- Types of services it provides since many vital services are provided at a loss such as trauma, burn, neonatal, psychiatric, and others;
- Providing medical education programs to train physicians, nurses and other health care professionals, again provided at a loss;
- More patients with significantly higher levels of illness, yet payment doesn't cover;
- A disproportionately high number of patients who are on public assistance or uninsured and unable to pay much if anything toward the cost of their care.

Total Price is the amount actually paid to a hospital. Hospitals are paid by health plans and/or patients, but the total amount paid is significantly less than the starting charges.

- On average in 2013, Medicare paid Illinois hospitals only 91% of a hospital's cost to provide that care and Medicaid even less.
- Medicare and Medicaid pay hospitals according to a set fee schedule depending on the service provided, much less than the hospital charge and actually less than their costs.
- Commercial insurers negotiate discounts with hospitals on behalf of their enrollees and pay hospitals at varying discount levels, but less than starting charges.
- Illinois hospitals provide free care to uninsured patients with incomes up to 200% ($47,700 for family of 4 in 2014) of the federal poverty level (FPL) in urban areas and 125% ($29,813 for family of 4 in 2014) in rural areas.
- Illinois hospitals provide discounts to 135% of the hospital's costs to patients with incomes up to 600% ($143,100 family of 4 in 2014) FPL in urban areas and 300% FPL ($71,550 family of 4 in 2014) in rural areas.
- Illinois hospitals provided $1.07 billion in free and discounted care measured at cost in 2012. In addition, they wrote off about $780 million in bad debt cost.

4. How can I use this hospital charge information for comparing prices?

Charge information is not necessarily useful for consumers who are "comparison shopping" between hospitals because the descriptions for a particular service could vary from hospital to hospital and what is included in that description. It is difficult to try to independently compare the charges for a procedure at one facility versus another. An actual procedure is comprised of numerous components from several different departments - room and board, laboratory, other diagnostics, pharmaceuticals, therapies, etc.

A patient who has the specific insurance codes for services requested, available from their physician, can better gauge charge estimates across hospitals. Ask your physician to provide

the technical name of the procedure that has been recommended as well as the specific ICD and CPT codes for service.

5. How can I get an estimate for a specific procedure?

If you need an estimate for a specific procedure or operation, please contact Financial Counselor, at (618)253-0251 in the Patient Accounts department.

Such estimate will be an average charge for the procedure without complications. A physician or physicians make the determination regarding specific care needed based on considerations using the patient's diagnosis, general health condition and many other factors. For example, one individual may require only a one-day hospital stay for a particular procedure, while another may require a two-day stay for the exact same procedure.

Remember, few patients will pay charges. Rather, the patient with contracted in-network health insurance will only pay the specified deductible, copay and coinsurance amounts and any non-covered services or elective services established by their health plan. A patient without health insurance or sufficient financial resources may be eligible for significant discounts from charges if they meet the required qualifications. Please contact Financial Counselor, at (618)253-0251 in the Patient Accounts department for further information.