Model Financial Assistance Policy

[Effective date]

POLICY PURPOSE

We are committed to providing financial assistance to people who need quality health care, but are uninsured, underinsured and/or do not qualify for governmental assistance. This includes people who are not eligible for Medicare or Medicaid and lack the income and resources to pay for care that is medically necessary. As an organization, we believe that a person's ability to pay should not influence or prevent them from obtaining quality health care.

This Financial Assistance Policy (FAP) is designed to manage our resources responsibility and to provide financial assistance to the greatest number of patients in need. Based on this principle, we believe patients should financially contribute to the cost of their medical care that is consistent with their ability to pay.

Pursuant to the Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, no patients shall be screened for financial assistance or payment information prior to the rendering of a medical screening examination and to the extent necessary, services needed to treat the patient or stabilize them for transfer as applicable. In addition, we will not consider the patient's age, gender, race, social or immigration status, sexual orientation, gender identity or religious affiliation.

FACILITIES AND PROVIDERS SUBJECT TO THIS POLICY

This policy applies to medical providers and physicians listed in Appendix A

FACILITIES AND PROVIDERS NOT SUBJECT TO THIS POLICY

This policy does NOT apply to medical providers and physicians listed in Appendix B

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

1. **501(r)** means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
2. **Amount Generally Billed (AGB)** means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care. We calculate 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 [entity name], all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on our website [provide link] or by writing to [entity name, department and address]
3. **Community** means following counties [list of covered counties]
4. **Emergency care** means care to treat a medical condition manifesting itself by acute 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.

5. **Federal Poverty Level** means Federal Poverty Guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
6. **Medically Necessary Care** means care that is:
    a. appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a patient's condition; and
    b. the most appropriate supply or level of service for the patient's condition that can be provided safely; and
    c. not provided primarily for the convenience of the patient, the patient's family, physician or caretaker; and
    d. more likely to result in a benefit to the patient rather than harm.
7. **Out-of-network** refers to health care providers not contracted with the insurer to provide health services at a negotiated rate.
8. **Patient** collectively means those persons who received emergency and other medically necessary care at the [name of hospital system] and the person who is financially responsible for the care of the patient.
9. **Underinsured** means the patient has some level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. but still has out-of-pocket expenses that exceed patient's financial ability to pay.
10. **Uninsured** means the patient has no level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. to assist with meeting his/her payment obligations for health care.

ELIGIBILITY – COVERED MEDICAL CARE

Financial assistance is available for eligible patients from the community who receive emergency care and/or necessary medical care from a facility or provider covered by this policy.

The following services are not eligible for financial assistance under this financial assistance policy even if the care meets the definition of medically necessary care. This includes:

[list of excluded procedures and care]

ELIGIBILITY

Financial assistance eligibility will be considered for uninsured and underinsured patients, and those for whom it would be a financial hardship to pay out of pocket expenses for services provided by providers covered by this policy. In addition, this FAP is subject to all applicable federal, state and local laws.

1. FAP Exclusions. Financial assistance does NOT apply to the following:
    a. Patients who live or reside outside the community and would be required to travel in order to receive necessary medical care. This community residency exclusion does NOT apply to non-resident patients seeking emergency care.
    b. Charges an insured patient is responsible for paying like co-pays, co-insurance and deductibles.

c. Non-covered services identified in this FAP.
d. To patients that have a contractual claim or right to reimbursement or indemnification from an insurer or a third-party payor.

2. Waiver of FAP Exclusions. We, at our sole discretion, waive any exclusions after considering all relevant facts and circumstances.

ELIGIBILITY ASSISTANCE CRITERIA

Subject to exclusions above, financial assistance is available to patients on a sliding fee scale based on financial need using the Federal Poverty Level (FPL) guidelines as published by the U.S. Department of Health and Human Services.

1. Uninsured Patients with Income LESS THAN 250% of the FPL. The patient will be approved for 100% reduction in the charge for medically necessary care or emergency care provided by the facility or provider covered by this policy. This means the cost for this care will be provided at no cost to the patient.
2. Underinsured Patients with Income LESS THAN 250% of the FPL. Patient's insurance will be billed, and if approved, the patient will be approved for 100% reduction in the remaining charge, but for applicable exclusions like a co-payment.
3. Uninsured and Underinsured Patients with Income BETWEEN 250% and 400% of the FPL. The patient will receive a sliding scale discount on that portion of the charges for services following payment by the insurer. The sliding scale discounts are as follows:
    a. Patients between 251% FPL and 300% FPL will receive 86% discount.
    b. Patients between 301% FPL and 350% FPL will receive 81% discount.
    c. Patients between 351% FPL and 400% FPL will receive 76% discount.
4. Uninsured and Underinsured Patients with Income GREATER THAN 400% of the FPL. A patient may be eligible for a Financial and Medical Hardship. This is a means test for some discount of patient's charges for services from us based on a patient's total medical debt. A patient will be eligible if the patient's total medical debt for emergency and/or medically necessary care is equal to or greater than the patient's household's gross income.
    a. Patients qualifying for Financial and Medical Hardship will receive a 76% discount.
5. Cost of Care. A patient eligible for financial assistance will not be charged more than the calculated Amount Generally Billed.
6. Out-of-Network Insurance Plans. If the providers covered by this FAP are considered "out-of-network", the patient, at our discretion, may receive financial assistance that otherwise would be available to patient based upon a review of patient's insurance information and other pertinent facts and circumstances.

APPLYING FOR FINANCIAL ASSISTANCE

Eligibility determinations will be made based on this policy and an assessment of a patient's financial need. Uninsured and underinsured patients will be informed of the FAP as well as the process for applying. The application process is subject to the following conditions:

1. Ways to Apply. A patient may qualify for financial assistance in one of two ways:

a. Presumptive Eligibility. There may be situations when financial assistance is warranted and the patient qualifies for assistance, despite the lack of formal applications and income analysis described in this policy.
    i. Other Sources of Information. Presumptive eligibility uses other sources of information, such as estimated income and family size provided by a predictive model or information from a recent public health benefits application, to make an individual determination of financial need.
    ii. Use of Third Parties and Presumptive Eligibility Software. We may utilize a third-party to review the patient's information and circumstances to determine financial need. Using healthcare industry-recognized, predictive model that is based on public records, we may be able to estimate a patient's income, resources, and liquidity. This model enables us to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. If a patient does not qualify for the highest level of financial assistance under the presumptive eligibility, the patient may still apply by completing the traditional application process.
b. Traditional Application Process. Patient can apply for financial assistance by submitting a completed application. The FAP Application as well as the FAP Application Instructions are available on the [entity website] or by writing to [entity name and address]
c. Prior Financial Assistance Applications. We will only consider a financial application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care.

2. Public Health Benefits. Applicants for financial assistance are required to apply for public health benefits if we reasonably believe the patient may qualify for coverage.
    a. We will help patients apply for public and private programs.
    b. Applicants also agree to cooperate with our staff to apply for programs that may pay for their care.
    c. Failure to cooperate may result in the patient being denied financial assistance.
3. False Information and Other Grounds for a Denial. A patient may be denied financial assistance if:
    a. the patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process;
    b. 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
    c. 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 for financial assistance. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

APPEALS

The patient may appeal any denial of eligibility for financial assistance by providing additional information to us within thirty (30) calendar days of receipt of the denial. All appeals will be considered

by the [entity name] financial assistance appeals committee. The decision of the committee will be sent in writing to the patient or family that filed the appeal. All committee decisions are final.

Patients can fax explanation for appeal with supporting documentation to [fax number] or by writing to [entity name, department and address]

BILLING & COLLECTIONS

We will not engage in Extraordinary Collection Actions, as defined by applicable federal laws. Patients receiving financial assistance from us, but in good faith are having trouble meeting their obligation under the payment plan, may be able to receive an extension. Payment plan extension request should be directed to [entity department phone number]

The actions that we may take in the event of nonpayment are described in a separate billing and collections policy. This policy may be obtained at no cost by writing [entity department and address] or by calling [phone number].

RECORD KEEPING

We will document all financial assistance applications to maintain proper controls and meet all internal and external compliance requirements as required by law.

QUESTIONS ABOUT THIS POLICY SHOULD BE DIRECTED TO:

[entity department, address and telephone number]

Appendix A

The list below specifies which providers of emergency and other medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). Please note that any care that is not emergency and other medically necessary care is not covered by the FAP for any providers.

[A list of any providers delivering emergency or other medically necessary care in the hospital facility that are subject to this financial assistance policy]

Appendix B

The list below specifies which providers of emergency and other medically necessary care delivered in the hospital facility are NOT covered by the Financial Assistance Policy (FAP).

[A list of any providers delivering emergency or other medically necessary care in the hospital facility that are NOT subject to this financial policy]