

USA HEALTH SYSTEM

FINANCIAL ASSISTANCE POLICY

Pursuant to 501(r) of the Internal Revenue Code

Policy

USA Health System's goal is to help our patients lead longer, better lives; we are committed to providing quality health care to those we serve. One of the ways USA Health System fulfills this mission is by establishing a policy and procedure to grant financial assistance to uninsured and under-insured members of our community who receive emergency medical care or medically necessary hospital services and who have an established a need for this assistance. USA Health System believes in personal responsibility, and as such, believes that an individual should make every effort to provide for their own health and well-being, as well as the health and well-being of those for whom they are responsible. USA Health System's ability to provide care for free or at a reduced rate is not unlimited and is subject to availability of funds. In addition to the financial assistance offered pursuant to the terms of this Policy, USA Health System may offers other assistance to patients including financial assistance for services that are not provided in a hospital setting.

Purpose

The purpose of this policy is to provide a fair and consistent method for uninsured and/or under-insured patients to apply and be considered for financial assistance for the personally responsible portion of their bill (after insurance payments) related to emergency and other medically necessary hospital care received while being treated at USA Health System's Hospitals and Offsite Hospital Departments. While not all services of the USA Health System are eligible under this Financial Assistance Policy (FAP), this policy is compliant with applicable federal, state and local laws.

Definitions

Amount Generally Billed (AGB): An amount that is not more than the amounts generally billed to individuals who have insurance covering such care as defined by IRS Section 501(r)(5)(A)

Applicant: Patient or other individual responsible for payment of the patient's care who seeks financial assistance.

Application Period: Begins on the date medical care is provided and ends 240 days after the first post-discharge billing statement or 30 days after the hospital or authorized third party provides written notice of extraordinary collection actions the hospital plans to initiate, whichever is later.

Bad Debt: The unpaid charges for care to patients who are able but unwilling to pay all or some portion of the medical bills for which they are responsible.

Charity Committee: A committee appointed by the USA Health System's CFO to review the applications for financial assistance, review the Presumptive Approvals, the recommendations for assistance, Patient Attestations and Affidavits, and Retrospective Charity and/or Indigent Care Approvals. This committee will consider appeals in the event a patient or their representative wishes a reconsideration of a denial of full or partial assistance. The Charity Committee will have final authority for Charity and/or Indigent Care Approvals as well as all appeals to assure that reasonable efforts have been made to determine an individual's eligibility.

USA Hospitals' Collection Policy: The USA Hospital Collection Policy is also known as the "Self-Pay Balance Follow-up and Collection" Policy details the actions that the facility may take in the event of nonpayment and maybe found on the Health System's website along with the FAP and Addendums.

Emergency Care: The care or treatment for an Emergency Medical Condition, as defined by EMTALA.

Emergency Department Credit Policy: The USA Policy that defines the methodology used to assess the patient's medical needs once the patient comes to the Emergency Department and determine charges in the event the patient is determined to have a non-emergent medical condition.

EMTALA: The Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd).

Federal Poverty Level (FPL): The FPL is the set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities, (also known as Federal Poverty Guidelines) and are updated annually. The amount is adjusted for family size and may be regionally adjusted for eligibility in certain programs and benefits. Information on the FPL may be obtained at: <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/> (This website is maintained by the federal government and subject to change at their discretion.)

Financial Assistance: The cost of providing free or discounted care to individuals who cannot afford to pay all or a portion of their hospital medical bills based on the eligibility rules identified in this policy.

Gross Charges: The full established price for medical care provided to patients.

Medically Necessary Care: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration; and
- Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.

Patient: An individual who receives care at a USA Health System Hospital and the person who is financially responsible for the care of the patient.

Self-pay Balance: The amount due to a provider or hospital after services are rendered and all other payment options or reimbursement methods are exhausted.

Self-Pay Balance Follow-Up and Collection Policy: The Policy and Procedure used for collection of Self-Pay balances due after insurance or if there was no insurance at all. This is sometimes referred to as the USA Hospitals' Collection Policy.

Uninsured Patient: A person who is uninsured or does not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:

- Qualifies for charity care as defined in this policy;
- Does not qualify for charity care but does qualify for some discount of his/her charges for hospital services based on a substantive assessment of his/her ability to pay ("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc.; or
- Has some means to pay but qualifies for a discount based on this policy.

Policy for Emergency and Medically Necessary Care

- This policy applies to all Emergency Care and Medically Necessary Care provided in the inpatient or outpatient acute care setting, and applies to all such care provided in the USA Health System's Hospitals or by the USA Health System's Practices as listed in an Addendum to this Policy. This policy does not include or apply to payment arrangements for elective procedures.
- USA Health System's policy is to provide Emergency Care and Medically Necessary Care to patients without regard to race, creed, or ability to pay. Subject to the terms and conditions set forth below, uninsured patients who do not have the means to pay for services provided at USA Health System's Hospitals' facilities may request to be considered for approval of financial assistance under the FAP. The eligibility criteria for financial assistance and the procedures for receiving financial assistance set out in this FAP are intended to ensure that USA Health System will have the financial resources necessary to meet its commitment to providing care to patients who are in the greatest financial need.

- Consistent with EMTALA, USA Health System will provide an appropriate medical screening examination (MSE) to any individual, regardless of race, creed or ability to pay, requesting treatment for a potential emergency medical condition. If, following an appropriate medical screening, USA Health System personnel determine that the individual has an emergency medical condition, USA Health System will provide services, within the capability of its facility, necessary to stabilize the individual's emergency medical condition, or will effect an appropriate transfer as defined by EMTALA.
- USA Hospitals are safety net providers for south Alabama and the surrounding areas and as such their emergency rooms see patients whose medical needs vary from emergency to non-emergent. Each patient entering the facility will have a MSE performed by a licensed professional to determine their medical needs. If the MSE determines that the patient is neither Emergent nor Urgent and that the Non-Emergency Condition is determined to not require immediate medical treatment, the patient will be informed of this determination.
- If the patient's condition is a non-emergent medical condition then immediate treatment is not considered medically necessary. Treatment for care that is not medically necessary is not covered further by this FAP. Once the patient has been informed that their condition does not require immediate treatment, they may choose to delay treatment and leave or they may choose to remain and receive treatment and will be subject to the fees detailed in the Emergency Department Credit Policy (EDCP). Patients will be informed of the fees per the EDCP. Whether the patient chooses to leave or seek further treatment in the Emergency Department the charge for the MSE (Triage) will be written off as covered under the FAP.

Providers Covered Under This Policy

All emergency and other medically necessary hospital care services provided in USA Health University Hospital and USA Health Children's & Women's in Mobile, Alabama as well as in hospital departments located in Mobile and Baldwin Counties.

A list of other USA Health System's Practices that provide emergency or other medically necessary care in the hospital facilities and are covered by this FAP is listed in an Addendum to this Policy. The Addendum indicates the hospital and non-hospital services of these other providers covered by this FAP and the extent to which the services are covered. This Addendum entitled "USA FAP Addendum – Practices that provide emergency or other medically necessary care in the hospital facilities" is available on the Health System's website and also available in writing upon request.

Notifications of the FAP to Patients and the Public

- USA Health System's Hospitals will post a sign in conspicuous places in admission and registration areas (including in the Emergency Department) stating: "You may be eligible for financial assistance, under the terms and conditions of the USA Health System's Financial Assistance Policy, offered to qualified patients. For additional information, contact the financial counselors by calling (251) 434-3505, Monday – Friday, 9 am – 4 pm. All inquiries, as well as all applications and supporting documents are confidential."
- A translation in Spanish and selected Asian languages will be included on the signage and the FAP, the Application and the Plain Language Summary will be translated on the website and made available in paper copies.
- USA Health System will display in a prominent place on its website a notice of the Financial Assistance Policy, a plain language summary of the FAP, and an application along with instructions on applying.
- In addition to appearing on its website, a printed copy of the application and the plain language summary will be available at no charge at the hospital's Patient Access Department and the Emergency Department.
- USA Health System will include a statement on each patient bill that patients meeting certain income criteria may qualify for the financial assistance under the FAP. A telephone number and website with additional information will be included.
- USA Health System's Hospitals will include informational training for employees as well as specific information for referring patient inquiries about the FAP to employees in areas such as:
 - Switchboard,
 - Registration,
 - Scheduling,
 - Business Office,
 - Case Management,
 - Emergency Department Discharge Areas

Limitation on Amounts Generally Billed (AGB)

All patients of a USA Health System Hospital are charged equally for the services provided. Once it is determined that a patient qualifies for financial assistance under this policy, the charges will be reduced by an amount appropriate to the award. If the award is 100%, the patient will be advised and the amount charged for those services will be reduced to zero and no longer billed. Where there is an award of financial assistance that does not cover 100% of the charges for the service, the amounts charged to patients eligible for discounted care will not be more than the amounts generally billed to patients under the Internal Revenue

Service's " look-back method," which is the percentage of charges that USA Hospitals would have received from a combination of Medicare and all private insurers' patients. The look-back percentage will be calculated separately for each hospital. The Amount Generally Billed (AGB) and the calculation methodology for the AGB of each hospital is shown in the "USA FAP Addendum - Amount Generally Billed (AGB)". This Addendum is included on the Health System's website or is also available in writing upon request.

Limitations of Financial Assistance

As indicated above, the FAP is limited to Emergency or Medically Necessary Treatments. Treatments and procedures that are not deemed and generally considered as emergent or medically necessary, such as elective procedures are not covered by this policy. A non-exhaustive list of items and services that are not covered by the FAP is attached in an Addendum.

Procedure and Who Qualifies

In general, patients are eligible for financial assistance when they receive emergency or medically necessary care at a USA Health System Hospital, (or a practice listed in the Addendum of Participating Non-Hospital Practices), and the patient's family income is at or less than 300% of the Federal Poverty Level (FPL).

The amount of assistance is determined using a sliding scale and may be periodically subject to revision or change.

Approval of financial assistance is made on a case by case and discharge by discharge basis, and as individuals and families financial circumstances can change, the approval for financial assistance for one treatment does not obligate USA Health System to continue to provide care free of charge or at reduced rates. Patients may be required to apply or re-apply for financial assistance at a frequency consistent with the FAP. Each USA site of service reserves the right to require a patient to re-apply at any time.

Once approved for financial assistance the patient's approved application will continue in effect for Emergency and Medically Necessary Hospital Services for a period 180 days, unless notified otherwise by the Hospital's Business Office.

To find out if you qualify for financial assistance, please complete the Application Form and attach the documents required to prove income, assets or other available resources. If you need assistance in completing the application, financial counselors are available by calling (251) 434-3505, Monday – Friday, 9 am – 4 pm.

Eligibility

We will determine financial assistance eligibility based upon income and asset guidelines and the Federal Poverty Limit Guidelines (FPL). Approved applications apply to USA Health System's Hospital accounts only and apply to the patient responsibility amount (amount due after insurance).

USA Health System FAP utilized a written application process to determine eligibility for financial assistance under the FAP. The application allows for the determination of the applicant's qualifying with the family income levels based of the FPL and what level of financial assistance can be allowed.

The levels of financial assistance for Hospital charges available under this policy are:

Family Income Level (of FPL)	Discount
Mobile County	
0 – 150%	100% of Charges
151% - 300%	Charges reduced to AGB
Outside Mobile County (Note)	
0 – 150%	100% of Charges
151% - 250%	Charges reduced to AGB

Notification of Eligibility

Applicants will be notified by letter regarding their financial assistance application status. If a patient is notified that they have been approved for a reduction of charges to AGB, they may still qualify for a greater discount by providing verification that their family income (or in the case where they have assets assumed to be too great to qualify, their assets/liabilities) meet the less than 200% of the FPL. Or in the event that they have been denied approval for financial assistance. They can appeal the decision!

An appeal can be filed within 240 days of the patient's first bill after discharge. To file an appeal the patient (or their representative on file) may contact the USA Health System Business Office and request a review for appeal. They will be expected to explain and detail why they should receive financial assistance or a more generous discount. The Financial Counselor will inform them of what verification is needed to be provided for the appeal, and they may be asked to sign another affidavit.

The appeal and the verification provided will be reviewed by the Business Office and the Charity Committee and a decision to grant or deny the appeal will be communicated by USPS (mail).

Application Process

All inquiries, as well as all applications and supporting documents are confidential.

USA Health System will make every reasonable effort to allow the most generous discount available and maximum financial assistance for which the patient qualifies.

To determine eligibility to the FAP, USA Health System will utilize Presumptive, Attestation and Retrospective methodologies.

- Presumptive Methodology is the utilization of information from sources and vendors other than the patient's application. This would include patient interviews, recommendations from the Hospital's Medicaid and Financial Aid qualifying vendor, and the Hospital's Collection Company.
 - The amount of discount allowed under the presumptive methodology is to discount charges to the AGB unless provable evidence can be obtained.
- Attestation/Affidavit: An attestation/affidavit may be allowed to grant financial assistance to discount the amount due from the patient to in the AGB unless provable evidence can be obtained to qualify the patient for a more generous discount.

To obtain the maximum financial assistance available under the FAP, the patient or the patient's representative needs to complete the written application for assistance, attach the requested supporting documents, and mail to the Business Office at the following address:

Mail: USA Health System

Attention: Business Office -Financial Counselor

P.O. Box 40010

Mobile, AL 36640-0010

When completing the application form, be sure to include documents that verify your income and assets both for yourself and for your spouse (if applicable).

Examples of documentation used to verify eligibility include pay subs, tax returns, bank statements and medical bills owed. Additional forms of verification may also be required.

Verification of Income

- If you are currently employed, please provide verification of gross income for the last three (3) months. Verification can be a check stub or a letter from your employer on company letterhead.
- If you are self-employed, please provide a copy of your prior year's Tax Return, including all forms.
- If you are unemployed and drawing unemployment benefits, please provide verification of the amount you receive. Verification can be your notice of approval.
- If you are unemployed and have no income, please provide verification of your circumstances. Verification can be a statement from your physician, your church pastor, or attorney.
- If you are receiving Social Security Benefits, SSI, Social Security Disability, veteran's benefits a Military, Government or Private Pension, please provide verification of that income. Verification can be a copy of your most recent check/stub or deposit verification or a letter from the government or pension authority showing the amount you are receiving. If you have minor children or other members of your household receiving monthly payments, please show proof of those amounts.
- If you are collecting a retirement check, pension, annuity, short/long-term disability or worker's compensation, please provide verification of that income. Verification can be your most recent check/stub or a letter from the income source.
- **If you are collecting governmental assistance, such as rent assistance in a H.U.D. Property, Food Stamps, Medicaid, Alabama All Kids, Alabama Family Assistance, SNAP, WIC, Section 8 Housing, live in an AHEPA apartment, then you will have already had your income and assets verified and as such can use your governmental assistance as verification of income. A copy of your documentation of assistance can be provided as proof of income.**
- If you receive child support or alimony or receive assistance from your child's other parent (not living in your household), please provide verification of that income. Verification can be your child support order or divorce decree.
- If you are separated or going through a divorce, please provide legal proof of your separation or a letter from your lawyer.
- If your expenses exceed your income, please provide verification of how your monthly expenses are being satisfied. Verification can be letters of financial support from your family, friends, church or other organizations. Verification can be letters of financial support from your family, friends, church or other organizations. If you are using credit cards, cash advances or loans to satisfy your monthly expenses, please provide copies of the most recent statement of those items.

- The hospital will deny assistance under the FAP for failure to provide documentation or information only when such information or documentation was requested in the FAP or the FAP Application Form.

Verification of Assets

- Please provide the most recent copy of your complete bank statement (including all pages of all checking, savings or certificates of deposits, 401K investment statements). If your bank account has been closed, please provide a letter from the bank stating that the account has been closed.
- Other assets, such as real estate (other than your primary residence), rental income or investment equity will need to be verified during the approval process.

Charges and Collection Activity

- USA Health System believes in personal responsibility and expects that when notified that USA Hospitals (or other entity) has a FAP to assist the patient, the patient or their representative will cooperate and make reasonable efforts to take advantage of that financial assistance.
- USA Health System's Hospitals will allow a reasonable amount of time for the patient or the patient's representative to provide reasonable evidence and information required to determine if the patient qualifies for financial assistance.
 - The patient or the patient's representative should contact the Hospital Business Office or Patient Financial Counselor as soon as possible if they wish for and intend to apply for financial assistance.
 - The Hospital Business Office will not utilize outside collection efforts (ECA) during the first 120 days after the first bill.
 - During the period of 120 to 240 after the first patient bill, the Business Office will suspend outside collection efforts if an application for financial assistance is received.
 - If an application is received that needs additional information the applicant will be given 30 days to perfect their application, before collection activities resume.
 - If in the event collection activities have proceeded based on a USA Hospitals' Collection Policy. If the collection agency identifies a patient as likely meeting USA Hospitals' financial assistance eligibility under its FAP, the patient's account may be still considered for financial assistance. The Collection Agency will notify the USA Business Office and upon approval from the Business Office, collection activity will be suspended on these accounts until USA Hospitals Financial Counselors have reviewed the patient's account and attempted to make a determination under the FAP. If the entire account

balance is adjusted, the account will be returned to USA Hospitals. If a partial adjustment occurs, the patient fails to cooperate with the financial assistance process, or if the patient is not eligible for financial assistance, collection activity may resume.

Please Note: The financial assistance offered under this program does not apply to physician or other professional fees billed separately from the hospital fees unless otherwise noted in the Addendum.

For questions or assistance with the financial assistance application, please call our office at (251) 434-3505.