MAURY REGIONAL HEALTH

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Financial Assistance (Charitable Care) Policy

MAURY REGIONAL HEALTH FINANCIAL ASSISTANCE (CHARITABLE CARE) AND UNINSURED DISCOUNT POLICY

PURPOSE

The Maury Regional Health (MRH) mission is to serve our region with clinical excellence and compassionate care. We strive to provide care with empathy, understanding and compassion and to improve the health and wellness of the population in our service area.

In service to this mission, Maury Regional Health, which in this policy includes Maury Regional Medical Center (MRMC), Marshall Medical Center (MMC), Wayne Medical Center (WMC) and Maury Regional Medical Group (MRMG), yet excludes certain services at FQHC clinics (see FQHC Charity Policy), is committed to providing medically necessary services to patients regardless of their ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for care provided at applicable Maury Regional Health facilities.

POLICY

MRH is committed to provide high quality patient care for services. This policy provides for treatment of uninsured and/or underinsured patients, who receive emergency and other non-elective, medically necessary healthcare services, regardless of their ability to pay. The MRH policy provides guidelines for assisting patients who do not have the ability to pay medical bills incurred at MRH.

Financial assistance is not considered to be a substitute for personal responsibility. Applicants are expected to cooperate with MRH's procedures for obtaining financial assistance or other forms of payment or assistance, such as possible public benefit or coverage programs available to pay for the cost of care. Applicants are also expected to contribute to the cost of their care based on their ability to pay. MRH will grant financial assistance based on an individualized determination of financial need, and will not discriminate on the basis of age, gender, race, social status, sexual orientation, or religious affiliation.

Patients will be required to assign or pay, to MRH, all insurance payments or liability settlements designated as remuneration for medical expenses. Payments received on an account with a financial assistance adjustment will be applied to the account and the adjustment reversed up to the amount of the financial assistance adjustment.

DEFINITIONS

The following definitions are applicable to this policy.

Amount Generally Billed: The amount generally billed is the expected payment from uninsured patients, or an uninsured patient's guarantor, found eligible for financial assistance. For uninsured patients, this amount will not exceed the rate paid by the most favored commercial insurance payer. No patient found eligible for financial assistance will be billed gross charges for eligible services.

Assets: Certain assets will be considered in making a determination of eligibility for MRH financial assistance.

Catastrophic Care: Financial assistance provided to patients with unreimbursed medical expenses incurred at MRH during a 12 month period that exceed a defined percentage of the annual family income of the patient or responsible party.

Discounted Care: Financial assistance that provides a percentage discount, based on a sliding scale, for eligible uninsured and underinsured patients, or patient guarantors, with annualized family incomes of 250% or less of the Federal Poverty Level.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Family: A group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for the purposes of the provision of financial assistance.

Family Income: An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parents and/or step-parents, or caretaker relatives.

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at http://aspe.hhs.gov/POVERTY/

Financial Assistance: Assistance provided to applicants meeting MRH's established criteria, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for medically necessary or emergency care provided by MRH.

Free Care: A full waiver of patient financial obligation resulting from medical services provided by MRH for eligible uninsured and underinsured patients, or their guarantors, with annualized family incomes at or below 100% of the Federal Poverty Level.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

Gross charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Medically Necessary: As defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Payment Plan: An interest-free, 12 month payment plan that is agreed to by both MRH and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

Qualification Period: Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to unpaid bills incurred for eligible MRH services in the previous 12 months.

Uninsured Discount: This is in accordance with Tennessee law which sets an uninsured discount equal to 175% of the cost for the service for emergency or medically necessary services provided by MRH.

Underinsured Patient: An individual with private or public insurance coverage with expected out-of-pocket expenses for services provided through MRH that exceed his or her financial abilities and whom it would be a financial hardship to fully pay these expenses.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance to assist with meeting a patient's payment obligations.

ELIGIBLE SERVICES:

Services eligible under this financial assistance policy must conform to generally accepted medical practice standards. They include the following.

1. Emergency medical services provided in an emergency room setting
2. Services for a condition, which, if not promptly treated, would lead to an adverse change in the health status of an individual
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting
4. Medically necessary services

Services not eligible for financial support include the following.

1. Elective procedures not medically necessary including, but not limited to, cosmetic services.
2. Other care providers not employed by MRH (for example, independent physician services) Patients must contact these healthcare providers directly to inquire into assistance and negotiate payment arrangements.

ELIGIBILITY

Eligibility for financial assistance will be considered for any US citizen, Amish or Legal Immigrant (in the event citizenship or immigration status cannot be determined based on the application, the applicant will be asked to provide information to prove citizenship, and/or immigrant status) with active accounts at MRH and who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. Active accounts are defined as accounts for which application for assistance is received within one year of the initial patient balance determination.

MRH will consider income, assets and MRH Medical expenses when evaluating an applicant's eligibility for financial assistance. Applicants are required to exhaust all other payment options as a condition of their approval for MRH financial assistance. Applicants choosing not to cooperate in applying for public or private programs identified by MRH as possible sources of payment for care may be denied financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this MRH policy to obtain financial assistance.

Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws.

Financial assistance will be offered to eligible underinsured patients for balances due after insurance has paid claims, providing such assistance is in accordance with insurer's contractual agreement. Financial assistance is not available for patient co-payment or balances after insurance in the event that a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Generally, out of network balances will be reviewed on a case-by-case basis.

MRH reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of MRH.

EMERGENCY MEDICAL SERVICES

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

APPLYING FOR FINANCIAL ASSISTANCE

The determination of eligibility for assistance will be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, MRH may seek additional information.

All of the following income documentation is required from patients or their guarantors in order to determine eligibility.

1. Copy of the tax return, and all attached Schedules, from the most recent tax year
2. Current proof of income (copy of most recent pay stubs, social security payments, unemployment compensation, worker's compensation, pension payments, alimony/child support, or other documentation)
3. Rental income (if applies)

All of the following asset documentation is required from patients, or their guarantors, to determine eligibility.

1. Checking accounts
2. Savings accounts
3. Money market accounts
4. Certificates of deposit
5. Investment accounts, such as bonds and stocks
6. Retirement accounts
7. Real estate other than the primary residence
8. Automobile/Trucks
9. Other assets (ATV's, Boats, Motorcycles, etc.)

Asset information provided by applicants may be considered as a possible source of payment.

Credit reports may be utilized when it is necessary to substantiate data on file and may be considered in the approval process.

The MRH financial assistance application also seeks information on expenses. The information on regularly recurring monthly expenses, including medical expenses, will be considered when making a determination on financial assistance.

A financial assistance application may be submitted at any point in the collection cycle. MRH will process requests for financial assistance promptly and will notify the applicant in writing upon the determination.

Applications must include complete documentation for a determination of eligibility to be made. If an application is incomplete, MRH may use a third party vendor for electronic documentation of the applicant's financial situation. If this provides sufficient information on which to base a decision on assistance, this supplemental information will satisfy documentation requirements under the policy. If electronic documentation does not provide sufficient information on which to base a decision, MRH will send the applicant a letter to notify them of the need for additional information. The applicants will have 20 days to return the required information to MRH; failure to do so will result in a denial of the application.

Patients, or patient guarantors, may also be eligible for an expedited application process, if they are meeting face-to-face or speaking directly with MRH staff regarding financial assistance on accounts with balances due of less than $5,000. Applicants utilizing the expedited application process will be asked to sign a form stating their desire to apply for financial assistance and indicating financial need, household income and size. However, if they are unavailable and unable to sign this form, MRH may use a third party vendor for electronic screening and documentation of the applicant's financial situation. If the information from the electronic screening process indicates financial need, a record of the electronic documentation will be included in the patient file and will serve as adequate documentation under this policy. If the information provided by the patient or through the electronic screening for this expedited application process does not indicate an expedited approval, the patient will be provided with information on the financial assistance policy and encouraged to submit an application through the traditional process.

Financial assistance applications are to be submitted to the following office:

Maury Regional Medical Center
Attn: Financial Counselor
1224 Trotwood Ave
Columbia, TN 38401
931.381.1111

In accordance with state and federal laws, in the case that a paper financial assistance application is subsequently submitted after patient payments have been received and the individual is eligible, any excess collected is refunded unless amount is less than $5.00. Electronic charity adjustments will be reversed if payments are received after the adjustment, in the amount of the payment, up to the original amount of patient responsibility.

QUALIFICATION PERIOD

If eligibility is approved for MRH assistance, it will be granted for a period of six months. Financial assistance will also be applied to unpaid bills incurred in the previous 12 months for eligible services that are active within MRH accounts receivable. No patient will be denied assistance based on failure to provide information or documentation not required in the application.

MRH also reserves the right to re-evaluate previous financial assistance approvals within the 6-month period if a patient's financial situation appears to, or has been suspected to, have changed. The re-

evaluation will be based on more recent information and such re-evaluations will be handled on a case-by-case basis.

If a patient, or patient's guarantor, is denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

FINANCIAL ASSISTANCE

The type of assistance to be provided will be based on family income, assets, and medical expenses. The federal poverty level will be used to determine an applicant's eligibility for financial assistance. Assistance will be provided after all third party payment options that are available to the applicant have been exhausted or denied and personal financial resources have been reviewed to investigate whether sufficient family assets are available to meet the obligation.

Uninsured Discount: Uninsured patients will be provided an uninsured discount, in accordance with Tennessee Law (TCA-68-11-262), at the time that charges are rendered. This applies to patients with no coverage for payment from health care insurance and/or other third party coverage. Qualifying patients will not be charged more than one hundred seventy-five percent (175%) of the cost for services provided. Periodic internal audits will be conducted within the Finance Departments of MRH to ensure that MRH is in compliance with TCA-68-11-262.

Patients, or patient guarantors, granted the uninsured discount are not precluded from applying and qualifying for additional financial assistance provided herein.

Eligible applicants will receive the following assistance.

Full Free Care: The full amount of MRH charges will be determined covered under this financial assistance policy for any qualifying uninsured or underinsured patients, or patient guarantors, whose gross family income is at or below 100% of the current federal poverty level.

Discounted Care: Financial assistance, based on a sliding scale discount will be provided any qualifying uninsured or underinsured patients, or patient guarantors, whose gross family income is greater than 100% but less than or equal to 250% of the current federal poverty.

Discounts will be provided, according to the following schedule, based on the family income of the patient, or the patient's guarantor.

Family income above 100% FPL but equal to or less than 150% FPL are eligible to receive a 90% discount on the patient balance due.

Family income above 150% FPL but equal to or less than 200% FPL are eligible to receive an 80% discount on the patient balance due.

Family income above 200% FPL but equal to or less than 250% FPL are eligible to receive a 70% discount on the patient balance due.

Catastrophic Care: MRH patients with expenses incurred for eligible services may qualify for catastrophic care assistance if they have incurred out-of-pocket obligations that exceed a certain threshold of family income during any 12 month period.

The level of assistance will also be based on family income, assets, and medical expenses.

Patients, or patient guarantors, with family income equal to or less than 250% FPL, and out-of-pocket obligations resulting from medical services provided by MRH that exceed 20% of FPL, will have their

charges discounted to an amount not exceeding 20% of family income. Patients receiving discounted care under the MRH financial assistance policy but with a balance due that exceeds this threshold will be eligible for catastrophic care assistance and will be expected to pay the lower of the discounted charges.

Patients, or patient guarantors, with family income exceeding 250% FPL but equal to or less than 400% FPL, and out-of-pocket obligations resulting from medical services provided by MRH that exceed 30% of FPL, will have their charges discounted to an amount not exceeding 30% of family income.

Assistance under this policy is not available for elective services that are not medically necessary.

Note: These limitations are applicable to each date of service for each admission or procedure.

Payment Plans: Payment in full is expected for balances due, within 30 days of the initial invoice. If it is not feasible for a patient, or patient's guarantor, to pay in full within this timeframe, a payment plan may be extended for up to 12 months. Arrangements for payment plans must be made with the MRH business office.

Patients are responsible for communicating with MRH anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

Bank Loan Program: MRH will assist patients, or patient guarantors, requiring a repayment term longer than 12 months. They will be offered information on bank loan programs. Payment amounts and terms will be based on the balance and the bank specific criteria.

APPEALS PROCEDURE

If an applicant is denied eligibility for financial assistance, an appeal of the denial may be submitted, in writing, within 30 days of the denial date. Once a written appeal is received, the application will be re-evaluated by a financial counselor and their direct supervisor. A written response to the denial will be provided to the patient and will indicate either approval or the upholding of the denial.

PRESUMPTIVE ELIGIBILITY

MRH understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. In these cases, other information may be utilized by MRH to determine whether a patient's account may qualify for assistance and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their qualifying for other programs or life circumstances such as:

1. Homelessness, or receipt of care from a homeless clinic;
2. SNAP benefits (Supplemental Nutritional Assistance Program, (formerly known as Food Stamps) as proof of need;
3. Patients, or guarantors, who are deceased with no estate in probate: If MRH finds that a patient is deceased, all applicable laws will be followed for the handling of the deceased patient's account. If MRH research finds that the patient has no estate, or that the time to file on the estate has passed, MRH will adjust the account as an indigent estate and documentation will be maintained (hard copy if available, or notes in system if hard copy is not available) to verify the adjustment(s) made.

4. TennCare beneficiary, for and out-of-pocket or costs associated with eligible services under this policy that are not covered by the program, or for costs associated with eligible services received prior to being enrolled in program but incurred during the qualification period.

MRH understands that certain patients may be non-responsive to MRH application process. Under these circumstances, MRH may utilize other sources of information to make an individual assessment of financial need. This information will enable MRH to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

MRH may utilize a third-party to conduct an electronic screening of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for MRH financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This enables MRH to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic review will constitute adequate documentation of financial need under this policy.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their presumptive eligibility qualification, and will not be included in the hospital's bad debt expense.

AMOUNT GENERALLY BILLED TO FAP-ELIGIBLE PATIENTS

Financial Assistance Policy eligible individuals may not be charged more than Average Generally Billed (AGB) for medically necessary care.

For patients who are determined to be eligible for a financial assistance program, MRH will not hold the patient responsible for more than the AGB. The AGB percentage is calculated using the “Look-Back” method, as defined in federal regulations. Each MRH entity calculates its AGB percentage based on all claims allowed by Medicare and private health insurers over a 12 month period, divided by the applicable hospital’s associated gross charges for those claims.

MRH adjusts charges annually at the beginning of the fiscal year based on a variety of factors including costs, market conditions, government regulations, and insurance contract requirements. Once the charges are determined for the year, the current year AGB is calculated utilizing the aforementioned methodology.

The actual discount rate may be higher than the aforementioned formula prescribes, but never less than what the formula prescribes. This calculation is updated annually. Members of the public may obtain a written copy of the MRH AGB percentage free of charge if requested.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on financial assistance will be available to patients and the community served by MRH. The financial assistance policy, non-covered provider list, application and a plain language summary of the policy will be available on the hospital's website.

Financial assistance information will also be provided in the patient admission information package. Information on the MRH financial assistance policy and instructions on how to contact MRH for assistance and further information will be posted in areas that include, but are not limited to, emergency rooms, urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as MRH may elect. Patient statements will include information on the MRH financial assistance policy and on how an application may be obtained.

MRH will respond to oral or written requests for more information on the financial assistance policy made by a patient or any interested party. A request for financial assistance may be made by the patient or a family member, a patient's guarantor, close friend, or associate of the patient, subject to applicable privacy laws. Referral of patients for financial assistance may be made by any member of the MRH staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, etc.

REGULATORY REQUIREMENTS

MRH will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant this policy. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

NON-PAYMENT ACTIONS

In the event of non-payment of services (discounted or full-rate) MRH may take extraordinary actions to pursue collections, including but not limited to: referring the account to outside collections agencies, adverse credit reporting, and/or legal action, pursuant to MRH’s Billing and Collections Policy. A free copy of the Billing and Collections Policy is available by request from Patient Services, by calling 931.381.1111. Hours of operation are 8am-4:30pm M-F; location is Maury Regional Medical Center, Patient Services, 1223 Trotwood Ave Annex Building Columbia, TN 38401.

RECORD KEEPING

MRH will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

POLICY APPROVAL

MRH's Chief Financial Officer has authority to approve the financial assistance policy. This policy has been approved by the MRH CFO. The policy is subject to periodic review and MRH reserves the right to amend and/or update this policy.