CONWAY MEDICAL CENTER

POLICY

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TITLE:	Financial Assistance / Uninsured Discount Policies		
ISSUED BY:	Administration	REFERENCE #:	PFS-003-POL
APPROVED BY:	Chief Financial Officer	EFFECTIVE DATE:	10-1-2022

SCOPE: Conway Medical Center organization wide (CMC as used here) including our employed physician practices, surgical centers, and other healthcare entities.

DEFINITIONS: For the purpose of this Policy, the terms below are defined as follows:

Amounts Generally Billed (AGB): The maximum amount CMC will bill to a patient eligible for Financial Assistance under this Policy. CMC determines Amounts Generally Billed on a retrospective basis using the expected reimbursement as compared to total charges for Medicare only to generate the discount percentage for Emergency or other Medically Necessary Care.

Bad Debt: Bad debt results from a patient balance that has remained unpaid following reasonable internal collection efforts consistent with this Policy and CMC Billing and Collections Policy.

Balance After Insurance: The amount owed by a patient or guarantor after the insurance company submits its portion of the bill to the provider. Examples of Balance After Insurance include coinsurance, deductible, and copayments as defined by the insurance company, and amounts resulting from exhausted benefits, length of stay limitations, and lower reimbursement because patient's plan is not contracted with the facility or because the patient is covered under a limited benefit insurance plan.

Conway Medical Center (CMC): A nonprofit corporation headquartered in Conway, SC. For purposes used here this includes all direct and indirect subsidiaries of CMC, together with their respective facilities and operations.

Covered Services: Covered Services include any Emergency and other Medically Necessary Care provided at CMC entities.

Independent Eligibility Assessment (IEA) Charity Care: The use of external publicly available data sources that provide information on a patient's ability to pay and eligibility for full charity care.

Independent Eligibility Assessment (IEA) Screening: A patient account mechanism that uses patient demographic data to estimate the financial status of a patient by accessing numerous publicly available databases to determine whether the patient is electronically eligible for full charity care

under this Policy.

Emergency Care: Care provided by a hospital for emergency medical conditions, which are conditions of sufficient severity such that in the absence of immediate medical attention the condition could result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious jeopardy to the health of the patient (or unborn child if the patient is pregnant). For pregnant women having contractions, Emergency Care includes any care required if there is inadequate time to affect a safe transfer to another hospital before delivery or if transfer may pose a threat to the health of the mother or child.

Episode of Care: The set of services provided to treat one or more procedures related to the same clinical condition.

Excluded Assets: Assets excluded from Financial Assistance eligibility consideration such as a patient's primary residence, primary vehicle, retirement account, or any household affects or personal items used in the patient's primary residence.

Extraordinary Collection Action (ECA): Actions against a patient or guarantor related to obtaining payment for a hospital bill that: (1) require legal or judicial process, (2) report adverse information about the guarantor to consumer credit reporting agencies, (3) sell an individual's debt to another party, or (4) defer, deny, or require payment before providing Medically Necessary Care because the guarantor previously did not pay for care covered under this Policy. Extraordinary Collection Actions do not include transferring a patient account to another party for purposes of collection on behalf of the hospital without the use of Extraordinary Collection. Or asserting a lien on the proceeds of a judgment, settlement or compromise owed to an individual as a result of a personal injury for which medical services were provided.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, adoption, marriage, or domestic partnership.

Federal Poverty Level ("FPL"): The federal poverty level is defined by the federal poverty guidelines updated annually 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 https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Financial Assistance: For purposes of this Policy, Financial Assistance means the income-based discounts described in Section A of this Policy.

Guarantor: The person held accountable for the patient's bill. The Guarantor is always the

patient, unless the patient is a minor or an incapacitated adult.

Medically Necessary Care: Health care services or supplies provided in at CMC and needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

Non-Excluded Assets: An applicant's assets are the combined assets (as follows) of all adult members of the family living in the household. Assets include:

- All funds available in Bank Accounts
- Certificates of Deposit (CD's)
- All Funds, stocks, and other securities in Investment Accounts,
- Real Estate (excluding primary residence)
- Other assets, other than Excluded Assets

Plain Language Summary: A written statement that notifies patients and guarantors that CMC offers financial assistance, summarizes who is eligible for such assistance, and explains how to apply.

Propensity-to-Pay Tool: An IEA analytical tool that predicts the likelihood patients will pay their portion of medical expenses.

Responsible Party: A tortfeasor individually; a tortfeasor's insurance company; any underinsured/uninsured automobile insurance coverage that provides benefits to a patient; no fault insurance coverage; any award, settlement or benefit paid under any worker's compensation law, claim or award; any indemnity agreement or contract; and/or any other payment for a patient as compensation for injuries sustained or illness suffered as a result of the negligence or liability of any individual or entity.

Uninsured Balance: The amount owed by an Uninsured Patient.

Uninsured Discount: A discount offered to Uninsured Patients who do not otherwise qualify for Financial Assistance under this Policy.

Uninsured Patient: A patient whose hospital services are not covered by a healthcare savings account, a health insurer, health care service plan, Medicare, or Medicaid; and where applicable, the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or any form of third-party liability as attested by the patient and determined and documented by the CMC entity. A patient whose treatment could be considered a non-covered service by their health insurance plan or who has exhausted benefits under their health insurance plan may be deemed to be an Uninsured Patient. A patient who is fully responsible

for the entire allowable amount, based off a co-payment or deductible outstanding, is not deemed to be an Uninsured Patient. A patient who has insurance that does not have a contractual relationship with the CMC entity may not be deemed an Uninsured Patient. A patient who is covered by and/or has a claim against any Responsible Party for the hospital services provided will not be deemed to be an Uninsured Patient.

POLICY STATEMENT: CMC is committed to minimizing the financial barriers to health care, especially to those who are economically poor and underserved and to those who are not covered by health insurance or governmental health care programs. Consistent with its Mission and Values to improve the overall health of our communities CMC will provide financial assistance to patients who qualify pursuant to this Policy. CMC provides, without discrimination, care for emergency and medically necessary medical conditions to patients regardless of whether the patients are eligible for financial assistance.

POLICY REQUIREMENTS: To describe the CMC Financial Assistance Program, including how CMC will determine patients' eligibility to receive full or discounted Emergency and Medically Necessary Care. This Policy constitutes the Financial Assistance Policy and the Emergency Medical Care Policy (within the meaning of Section 501(r) of the Internal Revenue Code) for CMC. This Policy also contains the Uninsured Discount for Uninsured Patients not eligible for Financial Assistance.

PROCEDURES:

A. Discounts Available Under the Financial Assistance Program

1. **Full Charity Care.** Any patient whose gross family income is at or below 200% of the FPL will be extended a full 100% charity care discount for any Uninsured Balance or Balance After Insurance on patient responsibility for Covered Services.

2. **Charity Care Discount.** Any patient whose gross family income is more than 200% and less than 301% of the FPL will be extended a partial charity care discount for any Uninsured Balance or Balance After Insurance wherein a patient cannot be held responsible for any balance generated as a result of gross charges for the patient's care that exceed the AGB.

3. **Hardship Discount.** Any patient whose balance, which can include Balance After Insurance, exceeds 20% of patient's annual gross family income will be provided a 100% charity care discount for the balance in excess of 20% of the patient's gross family income.

Limitation on Charges. If a patient is eligible for Financial Assistance under this Section A, the patient will not be charged more for Emergency or other Medically Necessary Care than the Amounts Generally Billed as described below in Section H.

B. Covered Services

1. Benefits under this Policy may be applied to any Covered Services.
2. Certain services are not eligible for Financial Assistance under this Policy and are not considered Covered Services under the Financial Assistance Program. These include, but are not limited to, the following:

    a. Elective or lifestyle services that are not considered emergent or medically necessary as determined by a physician at a CMC entity;

    b. Services provided for workers' compensation care;

    c. Services provided to a patient who is covered by and/or has a claim against any Responsible Party; and

    d. Services provided outside of the CMC organization setting, including at other urgent care centers, ambulatory surgery centers, physician office clinics, home health and hospice.

3. CMC will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this Policy. CMC will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that patients pay before receiving treatment for emergency medical conditions. Emergency medical services are provided to all CMC patients in a non-discriminatory manner, pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA) policy.

C. Financial Assistance Program Eligibility

1. In determining a patient's gross family income, CMC will consider the following sources of income for all Family members:

    a. Wages, salaries, tips

    b. Business income

    c. Social Security income

    d. Pension or Retirement Income

    e. Dividends and Interest

f. Rent and Royalties

g. Unemployment compensation

h. Workers' compensation income

i. Alimony and Child support

j. Legal judgments

k. Cash, bank accounts, and money market accounts

l. Matured certificates of deposit, mutual funds, bonds, or other easily convertible investments that can be cashed without penalty

m. Support letters

n. Other Income, such as income from trust funds, charitable foundations, etc.

o. The patient's coverage by or any claim against a Responsible Party.

2. CMC reserves the right to deny Financial Assistance to a patient who meets the gross family income criteria if the patient has sufficient NonExcluded Assets to pay for Covered Services. Patients who disagree with the denial may appeal as described below in Section I.

3. Before finding a patient eligible for Financial Assistance under this Policy, CMC may require the patient to apply for public health coverage programs for which the CMC presumes the patient is eligible, as instructed by CMC financial counselors.

4. CMC may deny eligibility for Financial Assistance under this Policy to a patient who has been screened for a public health coverage program and is presumed to be eligible but is not cooperating with the process to apply for the health coverage program. As a condition to participation in the Financial Assistance Program, CMC may also require a patient to apply for future health care coverage through the federal health care exchange if the individual is eligible for subsidized premiums.

5. A patient is not eligible for Financial Assistance under this Policy if the patient is covered by and/or has a claim against any Responsible Party.

6. CMC in its discretion, may waive or modify eligibility requirements after considering all relevant facts and circumstances in order to provide medical care to patients who lack financial means.

7. Eligibility determinations will be made and full or discounted care will be offered without regard to race, creed, color, religion, gender, orientation, national origin, or physical disability.

D. How to Apply for Financial Assistance

1. Financial counseling is provided free of charge by CMC.

2. The patient or guarantor should complete and submit a Financial Assistance Program application to apply for Financial Assistance.

   a. Patients and Guarantors may request applications by:
      i. Asking a financial counselor or registration/front desk employee within admissions or check in area of any CMC entity;
      ii. Visiting the Collections Department at the hospital's main entrance. Or calling the Collections Dept at 877-818-2963 (toll free), Monday through Thursday, 8 a.m. to 8 p.m. or Friday, 8 a.m. to 4 p.m. Or 843-234-6726, Monday through Friday, 8 a.m. to 4:30 p.m.
      iii. Mailing a written request to the Collections Department, Conway Medical Center, 300 Singleton Ridge Road, Conway, SC 29526; or
      iv. Downloading an application at https://www.conwaymedicalcenter.com/billing-and-insurance/financial-assistance/

   b. The application describes all the personal, financial, and other information or documentation that an individual must submit to be considered eligible for the Financial Assistance Program.

3. The application for the Financial Assistance Program must be submitted to CMC within twelve (12) months of the date of the first post-discharge billing statement that pertains to the care for which the patient or guarantor is seeking Financial Assistance.

4. Completed applications, including all required information and documentation, should be submitted to the CMC for eligibility determination. Completed applications may be:

   a. Submitted by mail using the address on the application; or

   b. Delivered in person to a financial counselor or registration/front desk employee within admissions or check in area of any CMC entity, who will

forward to the Collections Dept; or

c. Visiting the Collections Dept at the hospital's main entrance.

5. Applicants are notified by mail when their application is incomplete and are given an opportunity to provide the missing documentation or information within sixty (60) days of the date of notification. Written notices to persons with incomplete applications will include:

   a. Instructions for how to submit the requested documentation or information;

   b. A Plain Language Summary of this Policy;

   c. Information about Extraordinary Collection Actions that CMC might take if it does not receive the information requested within the 60-day period; and

   d. Contact information for CMC Collections Dept that can provide assistance with the application process.

   In addition to the written notice, applicants may also receive a phone call if their application is incomplete.

6. Despite not completing an application, an Uninsured Patient will still be eligible to receive an Uninsured Discount as described in Section G and may be eligible for full or discounted charity care based on an electronic eligibility determination as described in Section G.

E. <u>Eligibility Procedures</u>

1. For completed applications, CMC will make a determination regarding the applicant's eligibility in a timely manner and consistent with this Policy.

   a. If CMC believes an individual who has submitted a completed application may qualify for Medicaid or other form of assistance, CMC may postpone making a Financial Assistance eligibility determination until after a Medicaid or other application has been submitted and the Medicaid or other eligibility determination has been made.

b. Upon receipt of a completed application, CMC may not initiate or resume any Extraordinary Collection Actions to obtain payment for the care at issue until the eligibility determination has been made.

c. CMC will not deny eligibility for Financial Assistance under this Policy based on an applicant's failure to submit information or documentation that is not specifically required by this Policy or the application.

2. If CMC finds an applicant is eligible for a full charity care discount as the result of a completed application, CMC will:

a. Provide the applicant with a written notice that indicates the individual was determined to be eligible for full care;

b. Refund to the individual any amount that he or she has previously paid for the care, unless that amount is less than $10; and

c. Take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual, including removing any adverse information from a credit report that arose as a result of a CMC credit disclosure made for the relevant Episode of Care.

3. If CMC finds an applicant is eligible for a full charity care discount as the result of an IEA screening the patient's account will be reclassified as Financial Assistance and any remaining balance due will be forgiven.

4. If CMC finds an applicant is eligible for a partial charity care discount as the result of a completed application, CMC will:

a. Provide the applicant with a billing statement and written notice that indicates the amount the individual owes based on the Financial Assistance given, how that amount was determined, and how the individual may obtain information regarding the Amounts Generally Billed for the care;

b. Refund to the individual any amount that he or she has previously paid for the care that exceeds the amount he or she is personally responsible for as a person eligible for Financial Assistance under this Policy, unless that amount is less than $10; and

c. Take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual, including removing any adverse information from a credit report that arose as a result of a CMC credit disclosure made for the relevant Episode of Care.

5. If CMC finds an applicant is eligible for a partial charity care discount as the result of an IEA screening, CMC will notify the patient of the partial discount, provide information on what information was accessed to reach that decision, provide the patient and/or guarantor with information on how to apply for full charity care discount, and provide the patient with time to apply as required by law.

6. If CMC finds an applicant not eligible for Financial Assistance as the result of an IEA screening, the patient may still provide requisite information and be considered under the application process.

7. If CMC finds an applicant is not eligible for Financial Assistance under this Policy, CMC will provide the applicant with a billing statement and written notice that indicates the amount the applicant owes and the basis for the determination that the applicant was ineligible for Financial Assistance. The denial letter will also include information on how the applicant may appeal the decision, as described in Section I below. Uninsured Patients determined to be ineligible for Financial Assistance will not be held responsible for more than 40% of the total charges, pursuant to CMC's Uninsured Discount as discussed in Section O.

8. Under the following circumstances, CMC may revoke, rescind, or amend the Financial Assistance provided:
   a. Fraud, identity theft, or misrepresentation by the patient or guarantor, or other circumstances that undermine the integrity of the Financial Assistance Program; or

   b. Identification of a third-party payor, including a public or private health coverage program, workers' compensation, or any Responsible Party.

9. If a denied applicant believes that his or her application was not properly considered, he or she may submit a written request for reconsideration within forty-five (45) days of the date of determination. The request should include information that was not submitted with the original application that supports the applicant's reason for appealing. The denial letter provides additional information

about the appeal process. Appeals are reviewed by designated hospital staff, and appeal decisions are final.

10. Eligibility determinations will not be based on information which CMC has reason to believe is unreliable or incorrect or on information obtained from the applicant under duress or through the use of coercive practices. Coercive practices include delaying or denying emergency medical care to an individual until the individual has provided information requested to determine whether the individual is eligible for assistance under this Policy.

11. Recognizing that circumstances relating to a patient's or guarantor's ability to pay may change subsequent to an initial eligibility determination, CMC may make subsequent eligibility determinations at any time during the collection cycle. Upon approval of an application, balances associated with dates of service prior to the episode of care for which the application was submitted may be considered for Financial Assistance.

F. Length of Eligibility Determination

At the discretion of CMC eligibility for Financial Assistance for patients who submit an application for Financial Assistance under this Program will apply:

a. To a particular Episode of Care or dates of service; or

b. For up to a 12-month period from the initial eligibility determination.

If the eligibility determination is expected to last for a period of time following the date of the eligibility determination, CMC at their discretion, may ask for an updated application or adjust the Financial Assistance for future episodes of care based on changes to the patient's or guarantor's demonstrated financial need.

G. Presumptive Eligibility and Screening

1. CMC will evaluate a patient to determine if the patient is presumptively eligible for Financial Assistance under this Policy without the patient completing an application. An Uninsured Patient is ordinarily presumed to be eligible for full charity care (100% discount) in the following circumstances:

a. Homelessness;

b. Deceased without evidence of an estate;

c. Mentally incapacitated with no one to act on the patient's behalf;

d. Eligible for Medicaid or indigent programs but not on date of service or for non-covered services; Medicaid or indigent program benefits have been exhausted or exceeded the length of stay for Medicaid or indigent program; or when the patient is enrolled in a Medicaid or indigent program but not in the state or county where the services were rendered;

e. Personal bankruptcy within the past 7 years;

f. Incarceration in a penal institution where services are not covered by the Department of Corrections;

g. Recipient of any local, state, or federal needs based program such as WIC, food stamps, etc.;

h. Affiliation with a religious order with a vow of poverty;

i. Recipient is a Victim of Crime where funding has been exhausted;

j. Recipient is a beneficiary of a county or state program for reimbursement and the program funding has expired or otherwise been exhausted;

k. Not required to file a Federal tax return for the most recently concluded calendar year; or

l. In the custody of any state or federal agency where services are not covered by said agency.

2. **Independent Eligibility Assessment Screening.** For a patient or guarantor who has not applied for Financial Assistance or been determined to be presumptively eligible for Financial Assistance as set forth in the section above, an independent eligibility assessment (IEA) using other sources of information may be used to determine whether a patient is eligible for Financial Assistance under this Policy. Such Independent Eligibility Assessments may be done through a third party engaged by CMC to perform an electronic financial need screening process to review a patient's or guarantor's information to assess financial need.

This review utilizes a healthcare industry-recognized, predictive model that could include public record databases, algorithms that incorporate data from credit bureaus, demographic databases, and hospital specific data to infer and classify individuals into respective economic means categories. The model's rule set is designed to assess each patient based upon the same standards. When the model is utilized, it will be deployed prior to Bad Debt assignment or after all other

eligibility and payment sources have been exhausted. This allows CMC to screen all patients for eligibility for Financial Assistance prior to pursuing any Extraordinary Collection Actions.

Financial Assistance determined under the IEA Screening process may result in a determination to apply a full charity care discount for Covered Services for retrospective dates of service only. This decision will not constitute Financial Assistance for a full Episode of Care as available through the traditional application process. These accounts will be treated as eligible for Financial Assistance under this Policy. They will not be sent to collection, will not be subject to further collection action, and will not be included in CMC's bad debt expense. Patients will not be notified of such decision when the patient qualifies for the most generous level of free care, nor will the individual be eligible for a refund of payments already made. A patient will only be eligible to receive written notice or a refund if the patient subsequently completes and is approved through the application process.

H. Amounts Generally Billed Calculation (AGB)

The maximum amount CMC will bill a patient eligible for Financial Assistance under this Policy is the Amounts Generally Billed. CMC determines Amount General Billed using the look-back method by multiplying the hospital's gross charges for that care by the percentages of gross charges for Medicare for any emergency or other medically necessary care provided. There may be circumstances in which CMC billed a patient more than the Amounts Generally Billed before the patient had submitted a completed application or before CMC found the patient eligible for Financial Assistance under this Policy. If a patient eligible for Financial Assistance under this Policy has paid charges in excess of the Amounts Generally Billed, then CMC will refund any amount the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as an individual eligible for Financial Assistance under this Policy, unless such excess payment is less than $10. Questions concerning Amounts Generally Billed should be directed to CMC Collections Dept at 877-818-2963 (toll free), Monday through Thursday, 8 a.m. to 8 p.m. or Friday, 8 a.m. to 4 p.m. Or 843-234-6726, Monday through Friday, 8 a.m. to 4:30 p.m.

I. Appeals and Disputes

Patients may seek a review from CMC in the event of a dispute over the application of this Policy. Patients denied Financial Assistance may also appeal their eligibility determination. Disputes and appeals may be filed by contacting the Collections Supervisor at 300 Singleton Ridge Road, Conway, SC 29526.

The basis for the dispute or appeal should be in writing and submitted within forty five (45) days of the patient's experience giving rise to the dispute or notification of the decision on Financial Assistance eligibility (see also E9 above).

J. Actions in the Event of Non-Payment

1. CMC does not conduct, or permit collection agencies to conduct on their behalf, Extraordinary Collection Actions, as defined under Internal Revenue Code Section 501(r), against individuals before reasonable efforts have been made to determine whether the patient is eligible for the Financial Assistance Program. Reasonable efforts include the hospital making a determination that any portion covered by Medicare or commercial insurance is ineligible for the Financial Assistance Program. Collection agencies may access consumer credit reports as part of their collection process and determine account qualification or collectability.

2. CMC's Director of Patient Accounts maintains oversight and responsibility for determining if CMC has made reasonable efforts and whether an Extraordinary Collection Action is appropriate. If a patient believes an Extraordinary Collection Action was initiated improperly, the patient should contact CMC Customer Service – Patient Concerns at 843-347-8248 and provide his/her contact information for follow up.

3. CMC will not pursue an Extraordinary Collection Actions until 120 days after the date of the first post-discharge billing statement for the care at issue.

4. At least 30 days before initiating an Extraordinary Collection Actions, CMC will:

    a. Provide the individual with a written notice that: indicates Financial Assistance is available for eligible individuals, identifies the ECAs that the hospital intends to initiate to obtain payment for the care, and states that ECAs will be initiated 30 days after the date of the written notice;

    b. Provide the individual with a Plain Language Summary of this Policy; and

    c. Make a reasonable effort to orally notify the individual about this Policy and about how the individual may obtain assistance with the

application process.

The patient's collection cycle will vary based upon the guarantor's Propensity-to-Pay, which affects the allotted timeline for payment.

5. Electronic eligibility screening occurs prior to the bad debt placement; therefore, reasonable efforts are made to determine Financial Assistance eligibility by the Collections Department. This department is also responsible for evaluating that reasonable efforts were made to determine eligibility.

6. As authorized by state and federal law, CMC may file a hospital lien on the proceeds of a judgment, settlement, or compromise owed to a patient (or his or her representative) as a result of personal injuries for which CMC provided care. This type of lien is not considered an ECA and does not require advance notice be given to the patient. CMC will notify the patient of such a lien in accordance with state law.

7. For information on CMC's billing and collections practices for amounts owed by patients or guarantors, please see CMC's Billing and Collections Policy, which is available free of charge at CMC, or at https://www.conwaymedicalcenter.com/billing-insurance/

K. Providers Participating in the Financial Assistance Program

CMC entities may contract with other physician groups and independent contractors that provide Emergency Care and other Medically Necessary Care but do not participate in the CMC Financial Assistance Program. Therefore, a patient who is eligible for the Financial Assistance Program will not necessarily receive Financial Assistance from those non-participating providers. Attachment B lists these contracted providers and indicates whether or not they participate in the Financial Assistance Program. Patients who receive care from one of the non-participating providers are advised to contact the provider directly to determine whether the provider has its own financial assistance program.

L. Distribution of this Policy

1. Each CMC entity will offer a Plain Language Summary of this Policy to patients as part of the intake or discharge process. CMC financial counselors will also distribute the summary of this Policy to patients as appropriate during counseling sessions.

2. Each billing statement from CMC will include a conspicuous written notice informing patients about the availability of Financial Assistance, including

both a telephone number and website address where the patient may obtain additional information and copies of the Plain Language Summary of this Policy.

3. Each CMC entity will have public displays in the emergency department and registration areas notifying patients of the Financial Assistance Program.

4. This Policy, the Plain Language Summary, and the Financial Assistance Program Application will be available at https://www.conwaymedicalcenter.com/billing-and-insurance/financial-assistance/and are also available upon request and without charge in each CMC emergency department and registration area.

5. This Policy, the Plain Language Summary, and the Financial Assistance Program application will be translated into the language spoken by each limited English proficiency group that constitutes the lesser of 1,000 individuals or 5% of the community served by CMC.

M. Regulatory Requirements

CMC will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this Policy. CMC Policy will comply with applicable state laws and may be revised as necessary to comply with state law. This Policy requires that CMC track Financial Assistance provided to ensure accurate reporting. Information on Financial Assistance provided under this Policy will be reported annually on the IRS Form 990 Schedule H.

N. Record Keeping

CMC will document all Financial Assistance in order to maintain proper controls and meet all internal and external compliance requirements.

O. Other Assistance for Uninsured Patients Not Eligible for Financial Assistance

Uninsured Patients who are not eligible for Financial Assistance under this Policy will be treated fairly and with respect at all times regardless of their ability to pay. CMC will offer a standard discount in the amount of 60% of total charges to Uninsured Patients who do not otherwise qualify for Financial Assistance under this Policy for Emergency and Medically Necessary Care. The Uninsured Discount will be automatically applied to the account upon initial billing to the Uninsured Patients. In the interest of completeness for CMC the Uninsured Discount is included in this Policy but is not need-based and is not intended to be subject to Internal Revenue Code

Section 501(r).

ASSOCIATED DOCUMENTS:

RECORDS: Cerner Revenue Cycle

REFERENCE STANDARDS:

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
Effective 10/1/22	New Document	Replaces PFS-001-POL (aka PFS-CS01-POL) and PFS-HAP01-PRO