Objective

The AnMed Health Coverage Assistance and Financial Assistance Program (CAFA) policy supports AnMed Health's goal of providing appropriate levels of charity care, commensurate with AnMed's resources and community needs. AnMed Health is committed to assisting patients to obtain coverage from various programs as well as providing financial assistance to patients in need of medically necessary hospital inpatient, outpatient or emergency treatment. AnMed will always provide emergency medically necessary care regardless of the patient's ability to pay.

This policy applies to hospital services received at the following AnMed facilities:

AnMed Health
AnMed Health Oglesby Center
AnMed Health Women & Children's Hospital
AnMed Health Cannon
AnMed Health Cancer Center
AnMed Health PNS Physician Offices

Please note that this financial assistance program does not cover some physician charges such as:
Pathology services
Radiology services
Anesthesia service
Dental services
Vision services
Non-AnMed Health physicians
Ambulance services
Pharmacy services

AnMed Health has the following major objectives for providing Coverage and Financial Assistance to our patients:

• To model at all times AnMed's motto "We're In This Together"
• To ensure patients exhaust coverage opportunities prior to qualifying for AnMed Health financial assistance.
• To ensure AnMed Health complies with applicable Federal or State regulations related to financial assistance.

Definitions

The terms used within this policy are to be interpreted as follows:

1. Elective: Those services that, in the opinion of a physician, are not needed or can be safely postponed.

2. Emergency Care: Immediate care that is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.

3. Financial Assistance Score (FAS Score): A score developed with the assistance of a third party vendor to provide a proactive, consistent and automated mechanism to substantiate a patient's financial profile.
• FAS Score is not a credit score.
• A component of FAS Score is a Household Income Index that is calibrated to Federal Poverty Guidelines.

• Other components include, but are not limited to, a review of census data, consumer transaction history, asset ownership files and utility files.

4. Household Make-up: The residence of a household including any single or legally married adult, and their dependent children under 18 years of age.

5. Household Financial Income: Income derived from any source including but is not limited to:
• Annual household pre-tax job earnings
• Unemployment compensation
• Workers' Compensation
• Social Security and Supplemental Security Income
• Veteran's payments
• Pension or retirement income
• Other applicable income from rents, alimony, child support and any other miscellaneous source

6. Medically Necessary: Healthcare services provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.

7. Other Coverage Options: Options that would yield a third party payment on account(s) under CAFA review including, but not limited to Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, Cobra, etc., or third-party liability payments resulting from automobile or other compensable events.

Policy
AnMed Health follows two different processes based on patient responsibility and coverage when determining eligibility for financial assistance for uninsured and insured patients.
1. Category I – All Inpatient and observation services, as well as outpatient healthcare services with balances greater than or equal to $5,000 gross.

2. Category II – All other healthcare outpatient or emergency services with balances less than $5,000 gross.

A patient will not be charged more than the amounts generally billed for emergency care.

Category I
All uninsured patients with Category I services will be reviewed by the AnMed Health Financial Counselors. Patients with Category I services will be required to complete an AnMed Coverage and Financial Assistance (CAFA) application and provide requested documents prior to being considered for financial assistance. The CAFA application gathers information needed to determine if the patient is eligible for any other coverage options. If the CAFA process indicates a high likelihood of coverage, then the patient, with AnMed Health assistance, will be required to pursue those opportunities before the patient will be considered for AnMed Health financial assistance. AnMed Health representatives are available to help those who are mentally and/or physically disabled in applying for assistance. AnMed Health will keep financial information confidential and will treat patients seeking coverage assistance and financial assistance with dignity. The financial assistance application process will not officially start until the coverage assistance process is completed and the patient is found ineligible for other coverage options. If

the patient fully cooperates when seeking other coverage options, but such coverage is unlikely or properly denied, AnMed Health will determine the patient's eligibility for financial assistance.

A Patient who fails to fully cooperate with this process is deemed ineligible for financial assistance.

Category I Eligibility Criteria
1. Services Eligible:
• All medically necessary (as determined by a physician) inpatient services.
• All medically necessary (as determined by a physician) outpatient services with balances greater than or equal to $5,000.
• All hospital emergency medical services provided in a licensed emergency room with balances greater than or equal to $5,000.
• All non-elective, medically necessary (as determined by a physician) outpatient healthcare services provided in response to life-threatening circumstances in any facility not a licensed emergency room with balances greater than or equal to $5,000.

2. Services Ineligible:
• Elective and cosmetic services
• Procedures not deemed medically necessary

3. Patients Eligible:
• Household income is between 0% and 400% of the Federal Poverty Level (FPL)
• Uninsured and ineligible for other coverage options for the account(s) under CAFA review
• South Carolina and Georgia residents ONLY
• Exhausted other coverage options

4. Patients Ineligible:
• Household income is greater than 400% of the Federal Poverty Level (FPL)
• Have current insurance coverage
• Have other coverage options available for the account(s) under review
• Do not reside in South Carolina or Georgia
• Fail to exhaust other coverage options

Determination of Category I FA Discount:
The discounts stated below are applied to patient-responsible balances after a 50% self-payer discount has been applied. This results in a discount that is less than the amounts generally billed.

• Completion of the CAFA application, including requested documents, will be used to determine if other coverage options are available for medically necessary and non-elective services.

• Eligibility for a financial assistance discount is based on a patient's total Household Financial Income for the 30 days prior to the evaluation completion date.

• Financial need will be determined by comparing total Household Financial Income to Federal Poverty Level (FPL) in effect at the time of determination.

• Patients who can demonstrate that their total Household Financial Income is at or below 200% of FPL is eligible for a 100% discount for a period of 360 days (180 retro, 180 forward).

• Patients who can demonstrate that their total Household Financial Income is between 201%-300% FPL is eligible for a 75% discount for a period of 360 days (180 retro, 180 forward).

• Patients who can demonstrate that their total Household Financial Income is at or below 301%-400% of FPL is eligible for a 65% discount for a period of 360 days (180 retro, 180 forward).

• Qualifying patient payments received prior to any financial assistance adjustment will not be refunded.

Category I Verification of Household Financial Resources and Eligibility Period:
Typically, CAFA applications are completed at or after the time that services are rendered. AnMed Health financial counselors will attempt to interview all uninsured inpatients unable to pay for services. AnMed Health will utilize, where appropriate, any available external third party data to validate information provided by the patient on the CAFA application.

• Verification Period - Total Household Financial Income will be based on a look back period of 30 days prior to the application date. If there is a discrepancy found, the patient may be asked to provide further documentation of income.

• Eligibility Period - Once approved, the eligibility period for Financial Assistance is 180 days from the date of application, as well as 180 retro from date of application for medically necessary and non-elective services. Any changes occurring within the eligibility period that would result in a high likelihood that the patient would be newly eligible for other coverage options must be pursued by the patient to retain financial assistance eligibility.

• Documentation - Patients may be asked to provide documentation from employers and banking institutions to further verify income. Financial statements and verification of income and third party vendor documentation will be retained by AnMed Health for the greater of 10 years or any period required by law. Falsification of financial information including withholding information will result in denial of financial assistance.

• Fraud – AnMed Health reserves the right to reverse financial assistance adjustments provided by this policy if the relied upon information provided by the patient is false or if AnMed Health obtains proof that the patient has received coverage or compensation for the medical services from other sources not disclosed to AnMed Health.

Category II
AnMed Health will use a presumptive process to determine financial assistance eligibility for Category II services. All uninsured patients with Category II services will be evaluated Automatically at final bill for a financial assistance discount based on a financial assistance score (FAS.) The patient is not required to complete a CAFA application for assistance. The FAS score is assigned once the bill has finalized. The FAS will be assigned based on proprietary scoring algorithms from experienced third party experts selected by AnMed Health. AnMed Health will periodically test the algorithms to ensure they are consistently applied and will adjust the FAS thresholds as needed. Patients found eligible will receive a 100% financial assistance discount on eligible services with gross charges equal to or less than $5,000 and will not receive a bill.

1. **Services Eligible:**
• All medically necessary (as determined by a physician) outpatient services with balances less than $5,000 gross
• All hospital emergency room services with balances less than $5,000 gross

2. **Services Ineligible:**
• Elective and cosmetic services
• Procedures not deemed medically necessary

3. **Patients Eligible:**
• FAS Score calibrated to Federal Poverty Guidelines
• Do not have current health insurance coverage

4. **Patient Ineligible:**
• Have current insurance coverage
• Eligible for other coverage options

Determination of Category II FA Discount
• Eligibility for FA for Category II services is based on the AnMed Health FAS Score that is obtained from a third party vendor at final bill.
• Each patient with Category II services that has an eligible FAS Score will receive a 100% discount with gross charges equal to or less than $5,000 for an eligibility period of 180 days.
• Qualifying patient payments received prior to any financial assistance adjustment will not be refunded.
• Each billable encounter of care for Category II service as determined by Medicare billing rules will be evaluated separately for FA eligibility.

Applying for Coverage Assistance and Financial Assistance:

Category I:
CAFA applications are for patients who have received Category I services. As stated above, AnMed Health teammates will strive to interview all uninsured Category I patients and assist them in the completion of a CAFA application. AnMed Health will determine eligibility for financial assistance once the coverage assistance process is completed. In those situations, where the patient cooperates with the CAFA application, AnMed Health will automatically determine financial assistance eligibility at the completion of the coverage assistance process. If AnMed Health teammates are unable to interview a patient with Category I services, the patient may download a paper Financial Assistance Application online and mail the application to AnMed Health. A patient may also request a paper application by calling 864-512-3435 and an application will be sent to the patient via mail. Patients with Category I services can also apply in person at the time of service.

Category II:
Patients who have received Category II services are not required to complete an application for financial assistance. Patients with Category II services will be automatically screened for financial assistance eligibility at final billing. A patient found eligible will receive a 100% discount. If the patient believes that they should be eligible for financial assistance, even though the FAS Score deemed the patient ineligible, they can apply for CAFA by downloading an application online and mailing it to AnMed Health. A patient may also request a paper CAFA application by calling 864-512-3435 and an application will be sent to the patient via mail. Only fully completed CAFA applications will be reviewed. Patients who choose to apply for CAFA will

be required to pursue other coverage options before being considered for a financial assistance discount.

Amounts Generally Billed Calculation
AnMed Health provides financial assistance to medically indigent patients meeting the eligibility criteria outlined in the Financial Assistance Policy. Patients shall be charged no more than amounts generally billed (AGB) to individuals who have Medicare fee for service and private health insurers for emergency and other medically necessary care. The Look Back Method is used to determine AGB. Patients or members of the public may obtain this summary document at no charge by contacting the hospital billing office.

Amounts Generally Billed is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charges for those claims.

AGB % = Sum of Claims Allowed Amount $ / Sum of Gross Charges $ for those claims

Allowed Amount = Total charges less Contractual Adjustments
If no contractual adjustment is posted then total charges equals the allowed amount.
Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

On an annual basis the AGB is calculated for each AnMed Health.

- •Look Back Method is used. A twelve (12) month period is used.
- •Includes Medicare Fee for Service and Commercial payers
- •Excludes Payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, motor vehicle and liability, and worker's compensation.

Hospital: AnMed Health
Amounts Generally Billed: 21.7 %
Effective: January 1, 2022

All paper applications should be mailed to:
AnMed Health Business Office
ATTN: Financial Counselors
800 North Fant Street
Anderson, SC 29621

Once an application is received, an AnMed Health Financial Counselor will contact the patient if necessary.

Communication of Policy:
AnMed Health communicates the availability of its CAFA process to all patients through the following:

- AnMed Health's website
- On all billing statements
- Information posted in the Emergency Department and at Admissions/Outpatient Registrations
- Onsite Coverage Assistance Services interviews with patient and families
- Patient Accounting Customer Service Department
- AnMed Health Physician's Offices

Hardships
In the event of undue hardships AnMed may offer discounts that fall outside of this financial assistance policy. If the patient does not qualify for assistance under this policy please contact your patient financial assistance counselor to determine if other discounts are available.

Actions In the Event of Non-Payment
The actions AnMed Health may take in the event of non-payment for services are described in a separate billing and collections policy which can be obtained by asking for a free copy from the Patient Accounting Service Department at 864-512-1450.

Quality Assurance and Other Provisions:
AnMed Health teammates are prohibited from making recommendations and/or process CAFA applications for family members, friends and co-workers. The PAS Quality Assurance Department will conduct periodic audits of accounts processed for FA discounts for Category I patients to ensure the appropriate documentation is on file. The PAS Quality Assurance Department will also test the Category II process to ensure appropriate adjustments are being made.