Financial Arrangements and Assistance: Finance - Prisma Health-Blount Memorial Hospital

Effective Date: 12/1/2024

Policy Statement:

Prisma Health is here to create a better state of health for patients, families, and communities. At the core of everything we do is our purpose: Inspire health. Serve with compassion. Be the difference. This includes our commitment in providing financial assistance topatients who cannot pay for all or a part of their bill.

A further responsibility of Prisma Health requires it to generate sufficient revenues in order to provide high quality patient care and to maintain a sound financial position. In order to provide financial assistance responsive to the population served and keep hospitalization costs at a minimum, Prisma Health has adopted this policy.

All facilities of Prisma Health are available to patients without regard to race, color, religion, age, sex or national origin or any other discriminatory differentiating factor. Emergency services will not be denied because of an inability to pay. Satisfactory financial arrangements are required before elective services are rendered. Elective cases without satisfactory financial arrangements may be deferred with physician consent.

All employed physicians of the Blount Memorial Physicians Group providing medically necessary and/or emergent services at hospital facilities, off -campus hospital departments, and physician offices of Prisma Health participate in this Financial Assistance Policy (FAP). Not all services are eligible for Financial Assistance. Independent providers of the Prisma Health Medical Staff do not participate in the FAP. A complete list of these providers can be found athttps://blountmemorial.org/resources--online_business_office--financial assistance or by writing Prisma Health Blount Memorial Hospital, Attn: Business Office 907 E. Lamar Alexander Pkwy, Maryville, TN 37804.

Definitions:

1. AGB: Amounts Generally Billed for emergency or other medically necessary care to individuals who have insurance coverage. Prisma Health has elected to determine AGB using the Look - back Method as defined below. The AGB percentage can be located on page 4 and 5 of this policy.

2. ECA: Extraordinary Collection Actions- Actions taken to collect a debt, include but are not limited to reporting debts to credit bureaus, selling debt to a third party and pursuing liens, garnishments, and other legal actions.

3. FPG: Federal Poverty Guideline (published by the U.S. Department of Health and Human Services).

Medicare Look-Back Methodology: Calculation based on actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals)

4. Service Catchment Area: A geographic region served by the hospital.

5. Tertiary Care Facility: A hospital that provides specialized care by specialists in a large hospital after a referral from primary care and secondary care. Tertiary centers usually include the following:

   5.1. A major hospital that usually has a full complement of services including pediatrics, obstetrics, general medicine, gynecology, various branches of surgery and psychiatry or

   5.2. A specialty hospital dedicated to specific sub-specialty care (pediatric centers, oncology centers, psychiatric hospitals). Patients will often be referred from smaller hospitals to a tertiary hospital for major operations, consultations with sub- specialists and when sophisticated intensive care facilities are required.

Procedural Steps:

1. Satisfactory Financial Arrangements:

   1.1 All financial arrangements will be made using the following guidelines after the patient's status is determined by the physician:

      1.1.1. Emergency Services- Immediate inpatient, outpatient, or emergency hospital services where the patient is at risk of life or limb that are necessary to prevent death or other serious health risks. Financial arrangements should be made as soon as practical after stabilizing care is rendered.

      1.1.2. Routine/Medically Necessary Services- Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine, no imminent danger. Financial arrangements should be made prior to rendering service.

      1.1.3. Elective Services- Chosen (elected) by the patient or physician and is advantageous to the patient but is not urgent and may or may not be considered medically necessary.
      (e.g., cosmetic surgery). Financial arrangements must be made prior to rendering service.

   1.2. Satisfactory financial arrangements may consist of any one or a combination of the following:

      1.2.1. Payment in full of the patient's obligation made in advance of services being rendered.
      1.2.2. Adequate hospitalization insurance benefits exist which the patient assigned to Prisma Health for the payment of services. Automobile liability coverage alone is not considered adequate hospitalization insurance.

1.2.3. Sponsorship by a third party, such as Medicare, Medicaid or other agencies contracting with Prisma Health for payment of care rendered to patients upon verification of eligibility.

1.2.4. If Prsma Health determines that the patient has no available or inadequate means to pay for services, a patient will then be evaluated for financial assistance.

1.3. The specific percentage discount for income greater than 200% up to 400% of FPG is updated annually and the sliding scale adjustment is based on Medicare look-back methodology. Standing Board approval permits the specific income limits and percentage discount to be updated annually. The sliding scale adjustment is determined from actual past claims paid to the hospital facility by Medicare fee-for- service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals) for a twelve-month period. AGB is calculated for each hospital facility and the one with the highest adjustment allowance is used for all facilities covered under the same Medicare provider agreement.

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE
Effective 01/12/2024

# Of Persons in Family	Income Level Cap 0-200%	Income Level Cap >200% - Up to 400%
1	$30,120.	$60,240.
2	$40,880.	$81,760.
3	$51,640.	$103,280.
4	$62,400.	$124,800.
5	$73,160.	$146,320.
6	$83,920.	$167,840.
7	$94,680.	$189,360.
8	$105,440.	$210,880.
For each person over 8 add	$10,760.	$21,520.
Allowance to give if uninsured	100%	79% based on AGB*
Allowance to give if insured	100%	See Sliding scale outlined in this document

*See section 1.3 of this policy for details on AGB calculation.

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE Effective 01/17/2025		
# Of Persons in Family	Income Level Cap 0-200%	Income Level Cap >200% - Up to 400%
1	$31,300.	$62,600.
2	$42,300.	$84,600.
3	$53,300.	$106,600.
4	$64,300.	$128,600.
5	$75,300.	$150,600.
6	$86,300.	$172,600.
7	$97,300.	$194,600.
8	$108,300.	$216,600.
For each person over 8 add	$11,000.	$22,000.
Allowance to give if uninsured	100%	79% based on AGB*
Allowance to give if insured	100%	See Sliding Scale outlined in this document

* See section 1.3 of this policy for details on AGB calculation.

1.4. No person eligible for financial assistance under this policy will be charged more for emergency or other medically necessary care than Amounts Generally Billed (AGB) to individuals with insurance covering such care. This applies to all patients if the care is emergency or medically necessary, regardless of county of residency. Financial Assistance is not available for elective care unless approved by Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

1.5. Prisma Health does not extend financial assistance to patients residing in a foreign country. Exception based approvals may be granted on a case- by-case basis in advance of services being rendered and are at the discretion of the Chief Financial Officer CFO) or Vice-President, Acute Revenue Cycle.

1.6. Patients who have a network benefit with an in-network provider other than Prisma Health may choose to receive services as out of network. The out-of-network benefit may pay a small sum, or nothing at all, toward the billed charges. Financial Assistance is not available for charges not covered due to the patient choosing to receive services out of network. However, any out of network patient that receives emergent related care or needs a

level of care only provided by Prisma Health is eligible to apply. Duration for out of network eligibility will be up to 90 days post discharge. Financial Assistance is also not available for patients participating in a shared ministry program that provides financial reimbursement to the patient. Exceptions for extenuating circumstances may be approved by the Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

2. Method for applying for Financial Assistance:

2.1. All patients who believe they may qualify for financial assistance are urged to complete, sign, and submit a Financial Assistance Application. The Financial Assistance Application, Billing and Collections Policy, as well as information about the financial assistance application processes are widely publicized. Information can be obtained by:

2.1.1. Visiting Prisma Health-Blount Memorial Hospital website at https//blountmemorial.org/resources—online_business_office—financial_assistance

2.1.2. Calling Prisma Health-Blount Memorial Hospital Patient Financial Services at 865-977-5599.

2.1.3. Mailing a request to:

Prisma Health-Blount Memorial Hospital, Attn: Financial Assistance
907 E. Lamar Alexander Pkwy. Maryville, TN 37804

2.1.4. Visiting the Prisma Health Blount Memorial Hospital Business Office. Representatives are available to provide a copy of the Financial Assistance Application or assist the patient/guarantor in completing and submitting the application.

2.2. Documentation requested to be submitted with the financial assistance application are:

2.2.1. Two (2) most recent pay stubs

2.2.2. Recent checking/ savings bank statements showing liquid assets

2.2.3. Individuals who are self-employed are required to submit the most recent years' business and personal tax return

2.2.4. Proof of residency:

2.2.4.1. Government issued ID, paystub with home address, rental or mortgage agreement with address listed, bank statement with address listed, utility bill with address, or a written attestation from an individual providing housing (with address) if there is not access to any forms listed.

2.3 Failure to submit required documentation may result in denial of the financial assistance application.

3. Extraordinary Collection Actions (ECAs):

3.1. Prisma Health will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for financial assistance under this Financial Arrangements and Assistance Policy. Prisma Health Revenue Cycle Administration has final responsibility for outlining processes ensuring the hospital facility has made reasonable efforts to determine whether an individual is financial assistance eligible before engaging in ECAs.

3.1.1. Prisma Health-Blount Memorial Hospital offers patients options for payment when insurance or financial assistance is not available:

3.1.1.1. In-house interest free payments.

3.1.1.2. Patients may contact customer service for details.

3.2. Patient balances that do not qualify for financial assistance and are unpaid may be placed with a collection agency. These actions are further described in the Billing and Collections Policy. Members of the public may obtain a free copy of this separate policy from Prisma Health as indicated in the contact list in this policy or by going to https://blountmemorial.org/resources--online_business_office--financial_assistance.

4. Financial Assistance Eligibility Criteria:

4.1. We offer screening for Medicaid, Prisma Health's Financial Assistance Program, and discounted fees for uninsured patients who do not qualify for the Financial Assistance Program. Payment plans are also available. Cooperation in the Medicaid screening process is required for the Financial Assistance application to be reviewed and processed. Applicants should complete and sign the Financial Assistance Application. This requirement may be waived in the event that the totality of circumstances indicates the patient would qualify for financial assistance but circumstances such as patient is deceased, homeless, transient, or as a result of physical or mental incapacity is unable to provide the required information, to name a few. Patients with an active balance or those that have a scheduled visit with Prisma Health are eligible to apply unless patient is participating with the in-house Medicaid screening process. Exceptions for extenuating circumstances may be approved by the Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

4.2. Criteria for eligibility is outlined in section one through six below. If a person does not meet criteria based on requirements outlined in section one through six, the person may qualify under section seven, which is an alternative means of qualifying based a significant financial hardship.

4.2.1. Applicants must meet the following criteria:

4.2.1.1. Resident of service catchment area, admitted alien for permanent residence, or a person domiciled in service catchment area.

4.2.1.2. Uninsured individuals and in-network insured individuals meeting all criteria for financial assistance with an

income level at or below 200% of the Federal Poverty Guideline (FPG) receive 100% adjustment on covered services.

4.2.1.3. Uninsured individuals with an income level of > 200% FPG up to 400% FPG receive discounted care based on a sliding scale as set forth in this policy.

4.2.1.4. In-network insured individuals meeting all criteria for financial assistance with an income level > 200% up to 400% of the FPG will receive an encounter balance adjustment after insurance on covered services.

Encounter Balance after Insurance	Discount Provided
$2,000 - $5,000	35%
>$5,000 - $10,000	45%
> $10,000	55%

4.2.2. Resource Limits:

4.2.2.1. Liquid assets convertible to cash and unnecessary for the patient's daily living; not to exceed a combined total value of ten thousand dollars ($10,000).

4.2.3. Household composition is used to calculate the level of financial assistance and is based on income and the number of dependents in the family that the guarantor is financially responsible for. These are person(s) claimed on an individual's tax return. Household composition is defined as follows:

4.2.3.1. Adult- a person at least eighteen (18) years of age or a younger person who is or has been married or has had the disabilities of minority removed for general purposes, i.e., emancipated minor.

4.2.3.2. Unmarried couples- Those that live together as a married/unified couple that support joint property and/or children together.

4.2.3.3. Managing conservator - a person designated by a court to have legal responsibility for a minor.

4.2.3.4. Minor child- a person up to and including the month of the nineteenth (19th) birthday and is claimed as a dependent on an adult's Federal tax return. This person counts in the household composition but not in the income. A person over the age of eighteen (18) years old is considered his/her own guarantor and is allowed to apply for him/herself and the parents' income is not considered when determining financial assistance for that individual.

4.2.4. Filing timeline:

4.2.4.1. An applicant has 240 days from the date of the first post discharge billing statement to apply.

4.2.5. Duration of Eligibility:

4.2.5.1. Duration of eligibility will be twelve (12) months from date of application.

4.2.6. Prisma Health has the right to revoke or deny your financial assistance if at any time during your eligibility period you no longer meet eligibility criteria. Patient must wait six (6) months before reapplying whether eligibility is denied or revoked unless there are extenuating circumstances that have impacted your financial situation.

4.2.7. Catastrophic Event:

4.2.7.1. Patients who have applied for financial assistance and determined to not be eligible may qualify under the catastrophic clause. A catastrophic event is defined as an episode of care where the uninsured patient's obligation to Prisma Health exceeds 25% of the household annual gross income. For insured patients, the patient obligation after insurance, for a covered service, must exceed 25% of the household annual gross income. Catastrophic is not applicable for services non-covered by patient's insurance.

4.2.7.2. Financial Assistance will not be added to the patient's record for future dates of service. The individual may reapply when additional services are received. Exceptions for extenuating circumstances may be approved by the Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

4.2.8. Patients may also be eligible for other forms of assistance not covered by this policy, such as drug replacement discounts or other programs as available.

4.3 In the event additional information/documentation is requested but not received (examples include but are not limited to bank statements, most recent years' tax return or other financial documents), the account will be dispositioned fourteen (14) days after the request and may be denied for failure to submit requested information/documentation.

5. Presumptive Eligibility

5.1. There are certain scenarios where a patient may be considered as having met criteria for financial assistance on a presumptive basis. A financial assistance application will not be required in these instances.

5.1.1. Patients who are dual eligible for Medicare and Medicaid or eligible for Medicaid. In the event the co-payment has not been satisfied after the mailing of one billing statement.

5.1.2. Patients who applied and were determined to be non-covered by Medicaid may be deemed eligible for financial assistance.

5.1.3. Patients who are covered by Family Planning Only Medicaid for services not covered by Family Planning Only Medicaid.

5.1.4. Patients who are covered by Emergency Services Medicaid may be deemed eligible for financial assistance for services not covered by Emergency Services Medicaid.

5.1.5. Patients who are eligible for retro Medicaid and the claim is not paid by Medicaid.

5.1.6. Patients who are eligible for Out of State Medicaid and the claim is not paid by the State Medicaid Plan.

5.1.7. Patients who are affiliated with the AccessHealth program or referred by the Community Free Clinics who support regions served by Prisma Health Hospitals.

5.1.8. Patients who are homeless or have receipt of low income/subsidized housing (verified by a valid address) or medical record documentation.

5.1.9. Patients who have a verified admission to a long-term care facility for behavioral health.

5.1.10. Patients who are eligible for Women, Infants, and Children (WIC) programs, food stamps, subsidized school lunch program, or other state or local assistance programs.

5.1.11. Patients who are verified long-term (at least 6 months served and/or more than 6 months remaining incarceration (if unmarried) and/or facility assignment.

5.1.12. Guarantor is deceased for a period of 11 months with no known estate (verified by probate court or, as a last resort, a written statement from family member) or with an insolvent estate.

5.2. Prisma Health Vice President of Acute Revenue Cycle will determine the percentage guidelines utilized for financial assistance on an annual basis. Prisma Health reserves the right to define maximum charitable expenditures, service catchment areas, prevailing charges, excluded services, fee reduction schedules, patient responsibilities and other business practice parameters consistent with the prudent management of Prisma Health.

5.3. Prisma Health accommodates all significant populations served who have limited proficiency in English by translating copies of our Financial Arrangements and Assistance Policy, Financial Assistance Application Form, and this summary in the primary languages spoken by those populations.

6. Uninsured Discount

6.1 Uninsured patients will receive an uninsured discount. This discount will show on the first statement. The discount does not apply to package prices. The discount will not apply to any accounts related to an accident until it is confirmed that there is no liability or insurance coverage. Uninsured patients eligible for financial assistance under this policy will receive an uninsured discount plus any additional discount required to equal the AGB.

The discount is calculated based on our Commercial/ Managed Care weighted average percentage or applicable state requirements. The current uninsured discount for hospital balances is 69% of gross charges, and the current uninsured discount for physician balances is 30% of gross charges.