PURPOSE

The purpose of this policy is to define the charitable mission of Upland Hills Health Inc. (the "Hospital"), providing financially disadvantaged and other qualified patients with an avenue to apply for and receive free or discounted care consistent with requirements of the Internal Revenue Code and other regulations.

I. ELIGIBILITY CRITERIA

The following classes of individuals and categories of care are eligible for financial assistance under this policy:

A. Financially Indigent

To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or less than 400 % of Federal Poverty Level; however, patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of 25 percent of total outstanding medical bills do not qualify as Financially Indigent. Total net worth of patient/guarantor family may not exceed $175,000.

The following definitions apply to such eligibility criteria:

"Uninsured": A patient who (i) has no health insurance or coverage under governmental health care programs, and (ii) is not eligible for any other third party payment such as worker's compensation or claims against others involving accidents.

"Underinsured": A patient who (i) has limited health insurance coverage that does not provide coverage for hospital services or other medically necessary services provided by the Hospital, (ii) has exceeded the maximum liability under his/her insurance coverage, or (iii) has a copay or deductible assessed under the patient's insurance contract.

"Household Income": The total income of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

Household is defined as: The patient/guarantor, his/her spouse and his/her legal dependents according to the Internal Revenue Service rules. If the patient claims someone as a dependent on his/her income tax return, he/she may be considered a dependent for purposes of Uncompensated Care.

Income is defined as: the total cash receipts from all sources before taxes including, but not limited to, gross wages, salaries, dividends, interest, military allotments, public assistance payments, social security, unemployment compensation, workers compensation, VA benefits, child support, alimony, pension income, insurance and

annuity payments, tax refunds, and income from rents, royalties, estates, and trusts.

Annual income will be determined by using the most recent tax return or the most recent pay information (annualized). This income will be modified by unusual events such as inability to work (e.g. due to accident, illness, job termination) or job change (including both new and improved job and job with reduced compensation).

"Net Worth": Net asset value (assets – liabilities (excluding Hospital liabilities)) of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

B. Medically Indigent

To qualify as Medically Indigent, the patient must have medical bills from the Hospital in excess of 25 percent of the greater of the patient's Household Income or Net Worth.

C. Failure to Apply for Assistance

To be eligible under this policy, patients must cooperate with Upland Hills Health, Inc. to explore alternative means of assistance and if necessary, including application or actions needed to secure coverage by Medicare, Medicaid and the Health Insurance Exchange. Patients will be required to provide necessary information and documentation when applying for a discount through this policy, or for other private or public payment programs.

If an applicant appears likely to qualify for assistance by other private or public programs, but refuses to apply, Upland Hills Health may deny his/her application for Uncompensated Care.

D. Categories of Care Eligible for Financial Assistance

Provided that the patient qualifies as either Financially Indigent or Medically Indigent, the following classes of care are eligible for financial assistance under this policy:

- Emergency medical care
- Medically necessary care

Regardless of a patient's status as Financially Indigent or Medically Indigent, cosmetic procedures or care that is not medically necessary is not eligible for financial assistance under this policy.

Medically necessary is defined as: care that is non-elective and needed in order to prevent death or adverse effects to the patient’s health.

II. COVERED PROVIDERS

Services provided by Upland Hills Health Hospital, Upland Hills Health Center, and Upland Hills Health Clinics in Spring Green, Montfort, Highland, Mount Horeb and Barneveld and Mineral Point Medical Center of Upland Hills Health and Dodgeville Medical Center of Upland Hills Health are covered by this policy. Services provided by Upland Hills Health Nursing and Rehab, Home Health, Hospice and Upland Hills Hometown Medical Equipment, LLC are not covered by this policy.

Care provided by independent community physicians and other independent service providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance.

Patients may obtain a current list of providers who are and are not subject to this policy at no charge by visiting the Patient Benefit Specialists at Upland Hills Health, calling (608)930-7200 ext. 4145 or visiting www.uplandhillshealth.org/patient-visitor/patient-resources/billing-questions.

III. LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED

Patients who are deemed to be eligible for financial assistance under this policy will not be charged for care covered by this policy more than Amounts Generally Billed by the Hospital to individuals who have health insurance covering such care. Discounts granted to eligible patients under this policy will be taken from gross charges.

A. Calculation of Amounts Generally Billed

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Hospital determines its AGB utilizing the method detailed below.

The Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is the Hospital's gross charges multiplied by the AGB Percentage. Patients may obtain the Hospital's most current AGB Percentage and a description of the calculation in writing free of charge by visiting the Hospital's patient financial services office, the emergency room front desk or the admissions desk, by calling (608)930-7200 ext. 4145 or by visiting www.uplandhillshealth.org/patient-visitor/patient -resources/billing-questions.

The Hospital calculates its AGB Percentage on an annual basis. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.

B. Amount of Financial Assistance/Discount

Patients who qualify for financial assistance as **Financially Indigent** are eligible for financial assistance based upon the following sliding fee scale:

FPL	0-200%	201-250%	251-300%	301-400%
Discount	100%	80% discount or AGB percentage, whichever results in the greater discount	65% discount or AGB percentage, whichever results in the greater discount	AGB Percentage Discount

Patients who qualify for financial assistance as **Medically Indigent** will be responsible for their medical bills up to 25% of the greater of their Household Income or Net Worth. Any remaining amount will be considered financial assistance under this policy.

If financial assistance provided to the patient results in a charge of greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

IV. APPLICATION PROCESS & DETERMINATION

Patients who believe they may qualify for financial assistance under this policy are required to submit an application on the Hospital's financial assistance application form during the Application Period. Completed applications must be returned to Upland Hills Health, ATTN: Patient Benefit Specialist, 800 Compassion Way, Dodgeville WI 53533.

For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 240th day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date the Hospital provides the patient the requisite final notice to commence Extraordinary Collection Actions ("ECAs").

Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial assistance application free of charge (i) by mail by calling (608)930-7200 ext. 4145, (ii) by download from www.uplandhillshealth.org/patient-visitor/patient-resources/billing-questions, or (iii) in person at (a) the emergency room, (b) any admission areas, or (c) Patient Benefit Specialist Department .

An application approved for financial assistance will be effective for a period of up to six (6) months from the date the application was approved. A new application will not need to be submitted. A change in financial situation or the addition of third party payor eligibility may alter the approval period and require further review.

A. Completed Applications

Upon receipt, the Hospital will suspend any ECAs taken against the patient and process, review and make a determination on completed financial assistance applications submitted during the Application Period as set forth below. The Hospital may, in its own discretion, accept complete financial assistance applications submitted after the Application Period.

Determination of eligibility for financial assistance shall be made by the Patient Benefit Specialist, Revenue Cycle Director and the Chief Financial Officer.

Unless otherwise delayed as set forth herein, such determination shall be made within 30 days of submission of a timely completed application.

To be considered "complete", a financial assistance application must provide all information requested on the form and in the instructions to the form.

The Hospital will not consider an application incomplete or deny financial assistance based upon the failure to provide any information that was not requested in the application or accompanying instructions. The Hospital may take into account in its determination (and in determining whether the patient's application is complete) information provided by the patient other than in the application.

For questions and/or assistance with filling out a financial assistance application, the patient may contact Upland Hills Health Patient Benefit Specialist by phone or in person. Individuals needing assistance should contact (608)930-7200 ext. 4145 to obtain assistance or make an appointment.

If a patient submits a completed financial assistance application during the Application Period and the Hospital determines that the patient may be eligible for assistance through a private or public program (including participation in Medicaid), the Hospital will notify the patient in writing of such potential eligibility and request that the patient take steps necessary to enroll in such program. In such circumstances the Hospital will delay the processing of the patient's financial assistance application until the patient's application for these private or public programs (e.g., Medicaid) is completed, submitted to the requisite governmental authority, and a determination has been made. If the patient fails to submit an application within thirty (30) days of the Hospital's request, the Hospital will process the completed financial assistance application and financial assistance will be denied due to the failure to meet the eligibility criteria set forth herein.

B. Incomplete Applications

Incomplete applications will not be processed by the Hospital. If a patient submits an incomplete application, the Hospital will suspend ECAs and provide the patient with written notice setting forth the additional information or documentation required to complete the application. The written notice will include the contact information (telephone number, and physical location of the office) of patient financial assistance. The notice will provide the patient with at least 30 days to provide the required information; provided, however, that if the patient submits a completed application prior to the end of the Application Period, the Hospital will accept and process the application as complete.

C. Presumptive Eligibility

Upland Hills Health Inc. may refer to or rely on external sources and/or other program enrollment resources in the case of patients lacking documentation that supports eligibility or individual circumstance. At its sole discretion, when a patient is unable to provide necessary documentation to support an eligibility determination, Upland Hills Health, Inc. may provide free or discounted services under this Program when:

1. Patient is homeless.
2. Patient is referred from the Community Connections Free Clinic – Dodgeville WI for x-ray and lab tests. Patients referred for scheduled procedures will need to complete the Uncompensated Care application to be reviewed for the program.
3. Patient is eligible for other state or local assistance programs that are unfunded.
4. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act.
5. Patient is deceased, without a spouse, and no estate has been filed with the court system within 12 months or expiration or at the time it can be determined patient does not have assets requiring the filing of an estate.
6. Patient receives a bankruptcy determination within the six months immediately preceding the application date if applicant is looking for consideration on any active account not discharged as a part of the bankruptcy determination.
7. Patient's valid address is considered low income or subsidized housing and patient authorizes the applicable housing authority to validate income and/or net worth directly to the Hospital.
8. If it is determined that a patient has been approved for Medicaid, all accounts currently in the A/R with UHH will be written off to Uncompensated Care after payment is received from the insurance.

Patient will be informed of the criteria used to determine eligibility for discounted or free care. If patient is approved for less than the most generous discount through presumptive eligibility, patient will be provided with information on how to apply for free care through the application process.

V. COLLECTION ACTIONS

Patients will be offered a plain language summary of the financial assistance policy upon registration or prior to discharge from the Hospital. Furthermore, all billing statements will include a conspicuous written notice regarding the availability of assistance, including the contact information identifying where the patient may obtain further information and financial assistance-related documents and the website where such documents may be found.

The Hospital or its authorized representatives may refer a patient's bill to a third party collection agency or take any or all of the following Extraordinary Collection Actions ("ECAs") in the event of non-payment of outstanding bills:

- Reporting to credit bureaus
- Legal suit
- Selling the account to a third party
- Garnishment of wages

The Hospital may refer a patient's bill to a collection agency 120 days from the date the first bill for care was provided to the patient. The Hospital will not take ECAs against a patient or any other individual who has accepted or is required to accept financial responsibility for a patient unless and until the Hospital has made "reasonable efforts" to determine whether the patient is eligible for financial assistance under this policy. Patient Benefit Specialist, Revenue Cycle Director and Chief Financial Officer are responsible to determine whether the Hospital has engaged in reasonable efforts to determine whether a patient is eligible for financial assistance.

A. No Application Submitted

If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and

2. Provides at least thirty (30) days' notice to the patient that:

    - Notifies the patient of the availability of financial assistance;

    - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and

    - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;

3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and

4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

5. If the patient has been granted financial assistance based on a presumptive eligibility determination, the Hospital has provided the patient with the notice required in the financial assistance policy.

B. Incomplete Applications

If a patient submits an incomplete financial assistance application during the Application Period, "reasonable efforts" will have been satisfied if the Hospital:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information (telephone number, and physical location of the office) of the Hospital department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 30 days to provide the required information; and

2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, the Hospital must suspend ECAs and make a determination on the application.

C. Completed Applications

If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if the Hospital does the following:

1. Suspends all ECAs taken against the individual, if any;

2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and

3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If the Hospital has requested that the patient apply for assistance through a public or private program, such as Medicaid, the Hospital will suspend any ECAs it has taken against the patient until the patient's application (e.g., Medicaid application) has been processed or the patient's application is denied due to the failure to timely apply for coverage (e.g., Medicaid coverage).

If a patient is eligible for financial assistance other than free care, the Hospital will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the ABG for the care provided;

2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to the Hospital (unless such amount is less than $5); and

3. Take reasonable measures to reverse any ECAs taken against the patient.

VI. EMERGENCY MEDICAL CARE

Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under the financial assistance policy. The Hospital will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with Hospital policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

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