Cedars Sinai **Marina Del Rey Hospital** Attachment A

SUMMARY OF FINANCIAL ASSISTANCE POLICY AND OTHER PROGRAMS

This document is the "in plain language summary" of the Full and Partial Financial Assistance for Financially Qualified Patients Policy (the "Policy) of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (together "Cedars-Sinai"). It is also a description of other financial assistance programs Cedars-Sinai makes available to Patients.

As part of our mission, Cedars-Sinai is committed to providing access to quality health care for the community and treating all of our Patients with dignity, compassion and respect. This includes providing services without charge, or at significantly discounted prices, to eligible Patients who cannot afford to pay for part or all of their care as provided by the Policy. In addition, we offer our Patients a variety of payment plans and options to meet their financial needs even if they do not qualify for assistance under the Policy.

A. Cedars-Sinai program for low-income patients – the Policy.

As provided in detail in the Policy, Cedars-Sinai makes free or discounted care available to Patients whose limited income is within the parameters of the Policy.

1. Eligibility requirements and assistance offered under the Policy.

Full Financial Assistance (no charge to Patient) will be made available to Patients whose income and monetary assets (together "income") are at or below 400 percent of the current year's Federal Poverty Level. Partial Financial Assistance will be made available to Patients whose income is in the range of 401 percent to 600 percent of the current year's Federal Poverty Level. Discounts available to Patients will be on a sliding scale based on family size and income level. Examples: (a) a Patient in a family of four with no insurance and an annual family income of $71,000 could be eligible for a 90 percent discount from amounts generally billed and (b) a Patient in a family of two with insurance that is not sufficient to pay for the services and an annual family income of $55,000 could be eligible for a 70 percent discount from amounts generally billed. Patients who are not able to verify their income status may also be eligible for assistance under the Policy. As the Federal Poverty Level is updated on an annual basis, these examples are subject to change each year.

Patients seeking elective services to be covered by the Policy arrangements will require prior approval for Financial Assistance by the Vice President of Patient Financial Services or his or her designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to Patients who live in the Cedars-Sinai service area or as otherwise approved by an officer of Cedars-Sinai.

If a Patient does not qualify for free services but is eligible for a discount under the Policy, the Patient will not be charged more than "amounts generally billed" by Cedars-Sinai for emergency or other medically necessary care. How we calculate "amounts generally billed" is set out in the Policy, but is an approximate of our Medicare and all private health insurers reimbursement.

Self-pay Patients are assumed not able to afford insurance coverage. Cedars-Sinai presumes

these patients are eligible for financial assistance. There are discounted rates for inpatients, emergency room and outpatients, and these rates are identified in the Policy.

2. Physicians covered by the Policy.

The Policy only applies to services provided by Cedars-Sinai. These services will include physician services if provided at Cedars-Sinai by Cedars-Sinai's emergency department physicians of Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty or physicians employed by Cedars-Sinai Medical Care Foundation or by medical groups which have an exclusive Professional Services Agreement with Cedars-Sinai Medical Care Foundation.

3. How to apply for assistance under the Policy.

Patients seeking free or discounted care under the Policy will need to complete an Application that will be reviewed by Cedars-Sinai. In addition to asking representatives at Cedars-Sinai registration and admission desks, Patients can obtain the Application form and assistance with the Application process by contacting us as provided below.

4. How to obtain copies of the Policy and the Application form including translations.

You may obtain free copies of the Policy and Application in various ways:

- On our website: cedars-sinai.edu type "Financial Assistance Policy" in the search box and follow the instructions. You may also go to the State website oshpd.ca.gov and type "Hospital Fair Pricing Policies" in the search bar and follow the instructions.
- For patients who are currently admitted to the hospital, contact Patient Financial Advocates at 310-423-5071. Their office is in the hospital building on the street level of the South Tower, Room 1740.
- If you are not an inpatient, you may contact Patient Financial Services Customer Service at 323-866-8600. The physical address is 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.
- By telephone: 323-866-8600.
- By Mail: 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.

Translations of the Policy, the Application form and this Plain Language Summary are also available by reaching out to us by any of the means listed above. The available Translations are in Farsi, Russian and Spanish.

B. <u>How to contact us with questions, for additional information about the Policy or for assistance with the Application and Application process as well as other assistance programs.</u>

For additional information including questions on how to apply for Financial Assistance or to request copies of the Financial Assistance Policy, you may contact our Patient Financial Services

Customer Service office at 323-866-8600. They are located at 6500 Wilshire Boulevard, Suite 800, Los Angeles, CA 90048.

For patients with questions regarding government insurance (Medi-Cal, Victims of Crime, etc.) you may contact the Patient Financial Advocates office at 310-423-5071. They are located in the hospital building South Tower, Room 1740.

For patients with questions regarding other insurance, please call 800-233-2771 or e-mail insurance@cshs.org.

C. *Governmental programs for low income and certain other patients.*

Cedars-Sinai participates in several government assistance programs that are not part of the arrangements under the Policy. These include Medi-Cal, the California Healthy Families Program and the California Victims of Crime Compensation Program. Patients may be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California). See above for our contact information.

D. *Arrangements with Patients who pay directly (self-pay).*

Patients who do not qualify for free or discounted care under the Policy may find other Cedars-Sinai programs helpful. Patients who lack insurance may receive substantial discounts, similar to the discounts we provide to managed-care insurance plans. Eligible services include outpatient, emergency, and inpatient services. Additionally, Patients who lack insurance or who do not wish to use their commercial insurance are eligible at their request for cash package pricing for selected services. Cash packages generally cover the hospital and anesthesiologist fees for outpatient procedures.

E. *Regulatory notice regarding collection activities.*

We do refer some delinquent accounts to third-party debt collection agencies. State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 877-FTC-HELP (877-382-4357) or online at ftc.gov/os/statutes/fdcpajump.shtm. Additionally, in the event your account is referred to a collection agency and you have problems with that agency, please contact us immediately at 323-866-8600.

Cedars Sinai **Marina Del Rey Hospital** Attachment C

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name:____

Patient Account or Medical Record Number:________________________

Date of Birth:____________ Last 4 Digits of SS#: XXX-XX-__________

Best Daytime Telephone Number: ( )_____-______

Address:____

City:__________________State:________ Zip:____________

Spouse's Name:____________Last 4 Digits of SS#: XXX-XX-__________

Are you a U.S. Citizen? Yes No

If not, a resident alien? Yes No

If not, a non-resident alien? Yes No

Family Status: List all dependents that you support (if more than 4 use separate page)

Name	Age	Relationship

Employment and Occupation

Employer:__________________Position:________________

If self-employed, name of business:__________________________

Employer address:__________________________________

Phone: ( )_____-______ *How long employed:*________________

Spouse's Employer:________________Position:________________

If self-employed, name of business:__________________________

Current Monthly Income	**Patient**	**Spouse**	**Total**
Gross Pay (Salary)	$	$	$
Net Self-Employed Income	$	$	$
Interest and Dividends	$	$	$
Real Estate or Rental Property	$	$	$
Social Security/Retirement/Disability	$	$	$
Alimony, Support Payments	$	$	$
Other	$	$	$
Total Monthly Income	$	$	$

Cedars Sinai **Marina Del Rey Hospital** Attachment C

Essential Living Expenses	Patient	Spouse	Total
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance (Home/Auto)	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

Current Medical Debt	Patient	Spouse	Total
Outstanding Medical Debt (**Cedars-Sinai**)	$	$	$
Other Medical Debt	$	$	$
Total Medical Debt	$	$	$

Assets (Exclude Retirement Accounts)	Patient	Spouse	Total
Stocks and Bonds	$	$	$
Money Market/Brokerage Accounts	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

By signing this application, I agree to allow Cedars-Sinai to check my employment and request a credit history.

______________________________ ________________

(Signature of Patient) (Date)

______________________________ ________________

(Signature of Spouse) (Date)

Cedars Sinai **Marina Del Rey Hospital**

Attachment D

Cedars-Sinai Patient Communication
File 1688
1801 W. Olympic Blvd.
Pasadena, CA 91199-1688

Business Hours:
Mon – Fri; 9am-11:50am and 1pm – 4:50pm
Phone Number: (323) 866-8600
24-hour Access by Fax: (323) 866-3077

In response to your request for financial assistance under the Cedars-Sinai Medical Center Financial Assistance Policy regarding the medical record number identified above, and in order to properly assess your ability to pay all or part of the hospital bill(s), additional documentation is required. Itis possible that the services rendered may be eligible for coverage under the Cedars-Sinai Medical Center Financial Assistance policy. Attached for your review is a policy summary. To assist us in our evaluation, please submit the following documentation no later than (15) days from the date of this letter. You may send your information by mail, Fax, or in an attachment to an E-mail in accordance with the contact information shown at the top of this letter.

(1) Fully completed charity care application (enclosed with this letter).

(2)
- A copy of your most current federal tax return (Form 1040).
- If not available, a copy of your most recent pay stub from all employment during the last six (6) months.
- Please note that this includes public assistance (for example, Unemployment or Disability payments) or your Social Security stub. If you receive your income in cash, please provide us a written statement from your employer stating your monthly income.
- If you currently are not receiving any income that would be reflected in the foregoing documents, please prepare a brief statement stating your current financial situation. Be sure to sign and date the statement. If you are receiving financial assistance or living with someone, please have that person submit an explanation in writing.

(3) Rent or Mortgage verification.

(4) Copy of your prior month's bank statement (All Pages).

(5) Copy of Money market account statements, if applicable.

(6) Copy of Stock and Bond certificates, if applicable.

(7) Copy of Certificate of Deposits, if applicable.

(8) Copy of Brokerage account statements, if applicable.

(9) 40l(K) and 403(B) statements and pension plans are excluded and need not be shared.

We ask that you send copies of the above referenced documents as they will not be returned to you.

Please note that it is imperative to include all requested documents or include a signed statement explaining why any of the above items do not pertain to your situation.

For instance, if you do not pay rent or have a mortgage, please explain why.

Marina Del Rey Hospital

Attachment D

Please also understand that submission of a complete application does not mean that the Services

will qualify under the Medical Center's Financial Assistance Policy. There are a number of considerations involved in our review. We will promptly review your application and let you know its status.

The Medical Center's Financial Assistance Policy provides assistance for patients whose family incomes do not exceed 450% of the federal poverty level. There are a number of other federal, state, local and private sources available to fund care to low-income individuals. We are also available to provide you assistance in identifying sources that would apply to your situation.

Should you have any questions, please contact the Customer Service Representatives at 323 866-8600 for assistance.

Sincerely,

CSMC Department of Patient Financial Services

Dear Patient:

State law requires us to inform you that there are several local assistance centers available in the Los Angeles area. Two are:

- Neighborhood Legal Services of Los Angeles County
  - Telephone: 1-800-896-3202
  - Website: www.nlsla.org

- Health Consumer Alliance
  - Telephone: 1-888-804-3546
  - Website: www.healthconsumer.org

Should you have any questions, please contact Patient Financial Services at 323-866-8860.

Sincerely,

Cedars-Sinai Department of Patient Financial Services

Language for Statement:

Financial Assistance

Cedars-Sinai Medical Center provides some services without charge to eligible patients who cannot afford to pay for part or all of their care. We also offer patients other discounts, payment plans and options. These programs may also apply to physician services if provided by Cedars-Sinai's emergency department physicians, faculty physicians or physicians affiliated with Cedars-Sinai Medical Care Foundation.

Cedars-Sinai also participates in several government assistance programs including Medi-Cal, the California Healthy Families Program and the California Victims of Crime Compensation Program. Patients may also be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California).

You may obtain further information including applications for financial assistance programs in various ways:

- At our Web site address: www.cedars-sinai.edu.
- By Email: Patient. Billing@cshs.org .
- By contacting Patient Financial Services Customer Service at (323) 866-8600 or 6500 Wilshire Blvd, Suite 800, Los Angeles, CA. 90048.
- Having information mailed to you: (323) 866-8600

Translations are also in Spanish.

Physician Services

Your Cedars-Sinai statement may include services provided by physicians who are part of the Cedars-Sinai Emergency Dept., Pathology Dept., Faculty Physicians at Cedars-Sinai and Physicians affiliated with the Cedars-Sinai Medical Care Foundation. For a complete list please visit: www.cedars-sinai.edu. Other physicians will bill you separately. Please be aware that these physicians may or may not be part of your insurance company's network of providers. For your reference, contact information for some of these physician groups appear below.

- **Cedars-Sinai Health Associates**
  Tel (800) 773-2742
- **General Anesthesia Specialists Partnership**
  Tel (213) 637-3700 Fax (213) 639-0790
- **Cedars-Sinai Imaging and MRI**
  Tel (800) 303-3044 Fax (818) 879-8272

Marina Del Rey Hospital

FULL AND PARTIAL FINANCIAL ASSISTANCE DISCOUNT

		Full	Partial	Partial	Partial	Partial
Column A		Column B	Column C	Column D	Column E	Column F
	Uninsured Discount*	100%	95%	90%	85%	85%
	Underinsured Dsicount	100%	90%	80%	70%	60%
Size of Family	**2019 FPL Annual Salary**					
1	$12,490	$49,960	$56,205	$62,450	$68,695	$74,940
2	$16,910	$67,640	$76,095	$84,550	$93,005	$101,460
3	$21,330	$85,320	$95,985	$106,650	$117,315	$127,980
4	$25,750	$103,000	$115,875	$128,750	$141,625	$154,500
5	$30,170	$120,680	$135,765	$150,850	$165,935	$181,020
6	$34,590	$138,360	$155,655	$172,950	$190,245	$207,540
7	$39,010	$156,040	$175,545	$195,050	$214,555	$234,060
8	$43,430	$173,720	$195,435	$217,150	$238,865	$260,580
For each additional person add	$4,420					
		400%	450%	500%	550%	600%

* The difference between the Uninsured and Underinsured Discount rates is based on the following: (1) the Underinsured amount has already been discounted; (2) the Underinsured patient generally has a maximum limit on their annual out of pocket expenses and (3) the amount due from an Underinsured patient is normally less than an amount due by an "Uninsured" patient.

(Note: FPL= Federal Poverty Level)

Column B shows qualifying salaries at the 200 percent of the FPL. Column C at 250 percent of the FPL, Column D at 300 percent, Column E at 350 percent and Column F at 450 percent.

To calculate potential eligibility, select the size of the Family (number of immediate members in the household), then find the annual income in Column B, C, D, E or F. This will identify the potential percent Financial Assistance Discount you may be eligible for once all documentation is verified.

Examples: If the family size is three (3) and the annual income is $45,000, look at the number in Column B. The income of $45,000 is greater than the $42,660 (Column B) and less than $53,325 (Column C), so you would qualify for potential discounts in Column C. Next, look at the Uninsured Discount percent

line in Column C. It is 95 percent. The discount for an Underinsured patient in Column C is 90 percent.

If the family size is one (1) and the annual income is $50,000, look at the Annual Income in Column E. $45,000 is greater than $43,715 (Column E) and less than $56,205 (Column F), so you would qualify for potential discounts in Column F. Next, look at the Uninsured Discount percentage in Column F for the family size of one. It is 85 percent. The potential discount for an Underinsured patient in Column F is 60 percent.

For each additional member, of a unit of eight (8), add $4,420 to each annual salary number.

Uninsured Inpatient Maximum: Patients treated on an inpatient basis and that qualify for a Financial Assistance discount of less than 100 percent will not be financially responsible for more than the amount that would be paid under Medicare Diagnosis Related Group (DRG) payment system.

Underinsured Outpatient Maximum: Patients treated on an outpatient basis and who qualify for a Financial Assistance discount of less than 100 percent will not be financially responsible for more than our average outpatient Medicare reimbursement rate of twelve percent (see note below).

Income levels are based upon the published Federal Poverty Guidelines in effect at the time of Marina Del Rey Hospital's receipt of the Financial Assistance Application. Applicants who earn 200 percent of the published minimum level or less may qualify for full assistance. Each level represents the maximum family income to qualify.

Note: The average outpatient Medicare reimbursement rate is calculated by the Executive Director of Revenue Cycle Operations, Marina Del Rey Hospital. The number comes from the monthly contractual adjustment. This is based on a closed account analysis. Accounts are reviewed to determine the total adjustments (the amounts that remain after the Medicare payment and the patient's share of cost, if any). When subtracted from 100 percent, this number yields the outpatient Medicare reimbursement rate.

Cedars Sinai **Marina Del Rey Hospital** Attachment H

January 1, 2020

RE: Application for Financial Assistance
Medical Record #
Total Charges: $

Dear ,

We have received your application for financial assistance under the Cedars-Sinai Medical Center Financial Assistance Policy. In order to complete our review, we need the following information from you:

- ☐ Prior year (1040) Income Tax Return or Current period pay stub
- ☐ Unemployment, Social Security, or Disability stub
- ☐ Prior Month's Bank Statement (All Pages)
- ☐ Rent verification or Mortgage statement

Other: _____

Unless we receive this information within the next (10) days, your Financial Assistance application will be determined ineligible, and you will be fully responsible for the balance owed above.

If you are unable to provide any of the requested items, submit an explanation in writing. If you are receiving financial assistance or living with someone, please have him or her submit an explanation in writing. The document must be signed and dated.

We appreciate your timely attention to this matter. If you have any questions, please call us at (323) 866-8600.

Sincerely,
CSMC Department of Patient Financial Services

(Rev. 11/20/19)

January 1, 2020

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, **your request for Financial Assistance has been determined ineligible because your property/assets exceed Cedars-Sinai Medical Center's guidelines.** However, please note that we have provided a significant discount for your health care services that are similar to what we offer our contracted insurance companies.

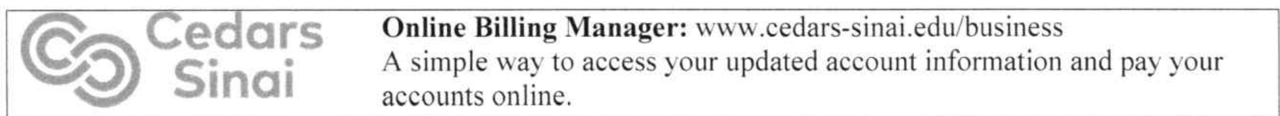
We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500 will be due within 30 days.

Sincerely,

Patient Financial Services

QUESTIONS



Online Billing Manager: www.cedars-sinai.edu/business
A simple way to access your updated account information and pay your accounts online.

To speak to a customer service representative, please call (323) 866-8600
9:00 AM to 11:45 AM and 1:00 PM to 4:45 PM, weekdays.

- **Automated account information?**
  Call (323) 866-8600
  24 hours a day, 7 days a week
- **Itemized bill request?**
  Call (323) 866-8600
- **Written correspondence?**
  Cedars-Sinai Medical Center
  P.O. Box 48954
  Los Angeles, CA 90048-0954

January 1, 2020

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, **your request for Financial Assistance has been determined ineligible because your income level exceeds Cedars-Sinai Medical Center's guidelines.** However, please note that we have provided a significant discount for your health care services that are similar to what we offer our contracted insurance companies.

We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500.00 will be due within 30 days.

Sincerely,

Patient Financial Services

QUESTIONS

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- **Itemized bill request?**
  Call (323) 866-8600
- **Written correspondence?**
  Cedars-Sinai Medical Center
  P.O. Box 48954
  Los Angeles, CA 90048-0954

Attachment I3

January 1, 2020

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, your request for Financial Assistance has been determined ineligible because you have not provided the requested information necessary to determine your eligibility. However, please note that we have provided a significant discount for your health care services that are similar to what we offer our contracted insurance companies.

We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $500.00 will be due within 30 days.

Sincerely,

Patient Financial Services

QUESTIONS

Online Billing Manager: www.cedars-sinai.edu/business
A simple way to access your updated account information and pay your accounts online.

To speak to a customer service representative, please call (323) 866-8600
9:00 AM to 11:45 AM and 1:00 PM to 4:45 PM, weekdays.

- **Automated account information?**
  Call (323) 866-8600
  24 hours a day, 7 days a week
- **Itemized bill request?**
  Call (323) 866-8600
- **Written correspondence?**
  Cedars-Sinai Medical Center
  P.O. Box 48954
  Los Angeles, CA 90048-0954

Cedars Sinai Marina Del Rey Hospital

Attachment J

Financial Assistance Worksheet

Patient Name:

Medical Record Number:

Recommendation/Comment:

Monthly Income: **$**

Yearly Income: **$**

Family Size:

Total Patient Balances **$**

Determination Based on Financial Assistance Guidelines

100 % ___________ 95 %___________ 90% ___________ 85% ___________

80 % ___________ 70 % ___________ 60% ___________ Ineligible ___________

Approvals:

Financial Specialist: ______________________ Date: ___________

Supervisor: ______________________ Date: ___________

Manager: ______________________ Date: ___________

Director: ______________________ Date: ___________

Vice President: ______________________ Date: ___________

Financial Assistance 2019 Federal Poverty Guidelines

Uninsured Discount	100%	95%	90%	85%	85%
Underinsured Discount	100%	90%	80%	70%	60%

Size of Family Unit	2019 FPL Annual Salary					
1	$12,490	$49,960	$56,205	$62,450	$68,695	$74,940
2	$16,910	$67,640	$76,095	$84,550	$93,005	$101,460
3	$21,330	$85,320	$95,985	$106,650	$117,315	$127,980
4	$25,750	$103,000	$115,875	$128,750	$141,625	$154,500
5	$30,170	$120,680	$135,765	$150,850	$165,935	$181,020
6	$34,590	$138,360	$155,655	$172,950	$190,245	$207,540
7	$39,010	$156,040	$175,545	$195,050	$214,555	$234,060
8	$43,430	$173,720	$195,435	$217,150	$238,865	$260,580
For each additional						
per person, add	$4,420					
		400%	450%	500%	550%	600%

Cedars Sinai Marina Del Rey Hospital

Attachment K

January 1, 2020

Name
Address
City, State, Zip

RE: Application for Financial Assistance
Patient Name: Name
Medical Record No: 123456789

Dear Name,

We have reviewed and approved your request for financial assistance under the Cedars-Sinai Medical Center Financial Assistance Policy. We want you to know that we value you as a patient and appreciate the opportunity to provide services to you. There are various accounting rules and laws that direct the Medical Center to run its financial assistance program in a relatively formal manner. Please understand that it remains your responsibility to secure a treating physician.

This approval has several limitations attached to it. They are as follow:

(a) Based upon the information you submitted, you are eligible for a discount of 100%. Accordingly, you will owe a balance of $0.00 to the Medical Center for outstanding account balances with service dates prior to the date of this letter. The same percentage discount will apply to outstanding faculty physician accounts with service dates prior to the date of this letter.

(b) Services rendered by other private, attending physicians (who are not providing Services to you as a member of the Medical Center's faculty) must be paid by you, unless other arrangements have been made with them.

(c) If you need additional services for this specific injury or illness, the Medical Center, in its sole discretion, may determine to provide such services and will, at that time, determine the appropriate discount. Any future discount will need to be agreed to by the Medical Center in writing and may require that you re-confirm your family's financial condition or complete a new financial assistance application if required.

(d) If you access additional services approved in (c) above at the Medical Center, please bring this letter with you and show it to the registration representative.

(e) Because the Medical Center may be entitled to reimbursement for the services it provides to you from other sources, we will require that you continue to cooperate in the

application for funding from such sources. Funding sources may include Victim of Crime, Queens Care, Medi-Cal, Proposition 99, etc.

(f) Established patients of the Medical Center's Primary Adult Care Center (ACC) are eligible for a discounted pharmacy price for their prescriptions. To qualify for this discount, please bring this letter with you.

(g) The Medical Center reserves the right to retroactively cancel this determination of financial assistance eligibility in the event the Medical Center discovers your application was not truthful or materially misleading.

(h) Should your financial situation change, you must notify the Medical Center of those changes. Changes may be of a material, financial and/or family size change that could impact your financial assistance status with the Medical Center.

Sincerely,

CSMC Department of Patient Financial Services
(323) 866-8600

Cedars Sinai **Marina Del Rey Hospital**

Attachment K1

January 1, 2020

Name
Address
City, State, Zip

RE: Application for Financial Assistance
Patient Name: Name
Medical Record No: 123456789

Dear Name,

In accordance with Treasury Regulation 501(r), Cedars-Sinai Medical Center has presumptively determined your eligibility for assistance under its Financial Assistance Policy. What this means is that we have approved a discount of XX percent off of the bills noted below based on information provided to us from an outside vendor.

When you do not apply for Financial Assistance or when you submit an application that is not complete, we use a third-party vendor to help us figure out if you are eligible for assistance. This vendor determines your eligibility based on public and private data sources in combination with predictive models and algorithms.

Presumptive eligibility is only good for the medical expenses noted below. It does not apply towards any future services. If your discount is less than 100 percent, you are eligible to apply for additional assistance under the Cedars-Sinai Financial Assistance Program. To obtain a more generous discount you will need to submit a complete Cedars-Sinai Financial Assistance Application. For an account to be considered, the application needs to be submitted no later than 240 days from the first post-discharge bill for each account listed. Please let us know if you have any questions about these dates or if you need any help completing your application.

Approved accounts for past expenses are identified below:

Account No.	Date of Service	Amount	Amount Due after Discount
________	__________	$______	$________
________	__________	$______	$________
________	__________	$______	$________

We value you as a patient and appreciate the opportunity to provide services to you.

Sincerely,

CSMC Department of Patient Financial Services
(323) 866-8600

Attachment L

January 1, 2020

Name
Address
City, State, Zip

Re: Application for Financial Assistance
Medical Record Number: #123456789

RE: Financial Assistance Ineligibility Determination After Appeal
Patient Name: Name
Medical Record No: 123456789
Account Number(s): 00001, 00002, 00003
Patient Liability: $500.00

Dear Name,

We have received your appeal to our initial ineligibility determination for financial assistance. After review of your appeal submission, we have upheld our original ineligibility determination based on the following reason(s):

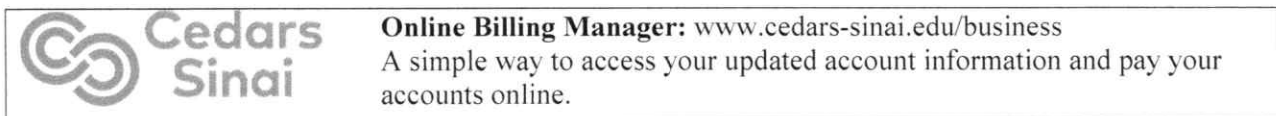
____

____.

You are responsible to pay the remaining amount of $500.00 within 30 days of the date of this letter. If you are unable to pay this amount, we encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a interest free monthly payment schedule.

Sincerely,

CSMC Department of Patient Financial Services



Online Billing Manager: www.cedars-sinai.edu/business
A simple way to access your updated account information and pay your accounts online.

To speak to a customer service representative, please call (323) 866-8600
9:00 AM to 11:45 AM and 1:00 PM to 4:45 PM, weekdays.

- Automated account information?
  Call (323) 866-8600
  24 hours a day, 7 days a week
- Itemized bill request?
  Call (323) 866-8600
- Written correspondence?
  Patient Communication
  File 1688
  1801 W. Olympic Blvd
  Pasadena, CA. 91199-1688

(Rev. 11/20/19)

AMOUNTS GENERALLY BILLED ("AGB")

Per IRS regulations §501(r)-5(b), Cedars-Sinai's current AGB is shown below:

Patient Classification	Amounts Generally Billed
Inpatient	23%
Emergency Room	28%
Outpatient	20%

These percentages are updated annually.