I. SCOPE:

This policy applies to the Admissions, Billing & Collections departments of HealthBridge Children's Hospital ("Hospital").

II. POLICY:

The Hospital shall provide a discount from standard charges or charity care to financially qualified patients in accordance with the guidelines set forth herein, which are in compliance with California Health & Safety Code Section 127400- 127446 (California's Hospital Fair Pricing Policies Law) and SB 1276.

III. PURPOSE:

The purpose of this policy is to set forth procedures to determine which patients are financially eligible to apply for a discount or charity care in accordance with California's Fair Pricing Law & SB 1276 and to establish the hospital's guidelines and procedures for the handling of such patients' accounts.

IV. DEFINITIONS:

"Charity Care Program" means healthcare services provided at a 100% discount to financially qualified patients who cannot pay and are deemed unable to pay for all hospital services based upon a determination of the patient's financial circumstances, and meeting Hospital's financial assistance criteria.

"Discounted Payment Program" means healthcare services provided at a discount from regular Hospital charges to financially qualified patients based upon a determination of the patient's financial circumstances as set forth in this policy.

"Patient or Responsible Party" means patient, guardian, spouse, parent or legal representative.

"Self-Pay Patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose treatment is not considered as compensable under workers' compensation, automobile insurance or other insurance.

"Patient with High Medical Costs" means an insured patient with high medical costs whose family income does not exceed 350 percent of the federal poverty level. This

shall include those persons who do receive a discounted rate from the hospital as a result of 3rd-party coverage.

"High Medical Costs" means (1) annual out-of-pocket costs incurred by the patient at the Hospital (e.g., medical expenses that were billed to the patient) that exceed ten percent (10%) of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses that exceed ten percent (10%) of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months, and the patient shall provide receipts indicating payment of such medical expenses. The 12 month period shall be the 12 months immediately preceding the date of admission/date of charges. Medical costs shall include, but are not limited to, co-payments, deductibles, coinsurance, expenses incurred after having reached a lifetime limit and non-covered services (including non-medically necessary services).

"Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. This plan will be offered when the Hospital and patient cannot reach a payment agreement during the negotiation process.

"Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

V. PROCEDURE:

A. Notification of Potential Eligibility.

1. As required by California's Fair Pricing Law, signs shall be located within the Hospital in patient admission areas visible to the public, including but not limited to, the admissions department and patient intake areas (both inpatient and outpatient), that inform patients of the availability of discounted payments or charity care for financially qualified patients.

2. Self-Pay and High Medical Cost Patients shall be informed of governmental programs for which the patient may be eligible to apply, including Medicare, Medicaid, Healthy Families, Covered California or other government program and shall be given applications for

appropriate programs preferably upon admission but no later than prior to discharge.

3. Self-Pay and High Medical Cost Patients shall also be informed in writing of the Hospital's Discounted Payment Program and Charity Care Programs (collectively, the "Programs"). Such written notice shall inform the patient that he/she may apply for the Programs and that eligibility for the Programs is based upon a family income level not exceeding 350% of the family Federal Poverty Level ("FPL") and that the patient must be either Self-Pay or have High Medical Costs. In addition, the notice shall inform the patient that he/she can obtain more information and an application for these Programs from the Business Office.

4. The notice provided under paragraph 3 above, as well as any written notices provided pursuant to this policy, shall be provided in English as well as other languages as required under California Insurance Code Section 12693.30.[1]

B. Determination of Eligibility.

1. Assessment for Third-Party Coverage.

The Hospital shall make reasonable efforts to obtain a patient's third party health coverage information, including coverage through Covered California, Medicare, Medicaid, Healthy Families, California Children's Services Program or other public assistance programs designed to provide health coverage, or automobile, workers' compensation, or other insurance is available to cover partially or fully the charges for the care rendered by the Hospital. If Hospital bills a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge, the hospital will notify patient that patient may be eligible for health coverage through Covered California or other State, County-funded health coverage. Hospital to provide the patient with a referral or list of local consumer assistance centers housed at legal offices.

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[1] This Insurance Code provision refers to the "Dymally-Alatorre Bilingual Services Act" which, among other things, requires that material provided in English also be provided in any other language spoken by "a substantial number" of the public served by the agency. A substantial number of non-English-speaking people "are members of a group who either do not speak English, or who are unable to effectively communicate in English because it is not their native language, and who comprise 5 percent or more of the people served by any local office or facility of a state agency." (Government Code §7296.2.)

2. Hospital Financial Assistance Application.

Upon the request of a patient for financial assistance or a reduction to charges, the patient must complete the Hospital's Financial Assistance Application (see Exhibit A) and provide supporting documentation as set forth in this policy. In cases where the patient is unable to complete the written application, verbal provision of information is acceptable, however the patient must sign the application to verify that the information contained therein is accurate. The inability or unwillingness of a patient to provide the requested information can be taken into consideration by the Hospital in determining the patient's eligibility for the Programs.

If a patient applies or has a pending application for another health coverage program at the same time they apply for charity or discounted care, then neither application shall preclude eligibility for the other program.

3. Criteria for Eligibility for the Programs.

a) The Hospital Designee will apply FPL guidelines by using the FPL table which is updated periodically in the Federal Register by the US Department of Health and Human Services subsection (2) of Section 9902 of Title 42 of the United States Code. The patient's family size is used to determine whether family monthly or annual income falls at, below, or exceeds 350% of the FPL.

b) To be eligible for the Discounted Payment Program, the patient must have a family income that is equal to or less than 350% and more than 100% of the FPL and must be either (i) a Self-Pay Patient, or (ii) a Patient with High Medical Costs.

c) To be eligible for the Charity Care Program, all of the above requirements under the Discounted Payment Program apply except that the patient's family income must be equal to or less than 100% of the FPL.

4. Determination of Family Members and Family Resources.

As used in this policy, the term "dependent children" means children eligible as dependents in accordance with Internal Revenue Code

guidelines (i.e., the child could be claimed as a dependent on the tax return). Absent a tax return, dependency can be determined based upon the obligation of the patient, patient's spouse or domestic partner to be financially responsible for at least fifty percent of the dependents annual living expenses.

a) Family Members — the number of family members in a patient's household shall be determined as follows:

(i) For patients 18 years and older — To calculate the number of family members include the patient, the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.

(ii) For patients under 18 years old — To calculate the number of family members include the patient, the patient's mother/father and/or legal guardian or caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

b) Income — the family's yearly gross income shall be determined as follows:

(i) For patients 18 years and older —Yearly family income includes the sum of the total yearly gross income of the patient and the patient's spouse or domestic partner, and dependent children under 21 years of age, whether living at home or not.

(ii) For patient's under 18 years old — Yearly family income includes the income from the patient, the patient's mother/father and/or legal guardian or caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(iii) In assessing a patient's eligibility for the Discounted Payment Program, the patient shall submit either tax returns or paycheck stub or equivalent, such as a Wage and Earnings Statement, telephone verification by employer of the patient's income, or a signed attestation of income along with supporting information. However, if a patient is unable to provide tax returns or a paycheck stub or equivalent, the Hospital should document that such forms were unavailable,

and the Hospital may accept other forms of income documentation from the patient.

(iv) In assessing a patient's eligibility for the Charity Care Program, the Hospital may consider the same income documentation as considered in paragraph (iii) above for the Discounted Payment Program. In addition, the Hospital may consider other forms of income documentation.

c) Monetary Assets.

(i) As required by the California Fair Pricing Law, no monetary assets may be considered in making a determination of eligibility for the Discounted Payment Program.

(ii) In making a determination of eligibility for the Charity Care Program, the Hospital may consider all monetary assets of the patient, except retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans. Furthermore, the first $10,000 of a patient's monetary assets shall not be counted to determine eligibility, nor shall 50% of a patient's monetary assets over the first $10,000 be counted. The Hospital will obtain waivers or releases from the patient or the patient's family, as necessary, which authorize the Hospital to obtain account information from financial or commercial institutions or other entities that hold or maintain the monetary assets.

(iii) Information obtained regarding monetary assets shall not be used for collections activities and the Hospital shall set up guidelines to ensure that collection personnel and/or agencies do not have access to the monetary asset information gathered for the purpose of determination of eligibility for the Charity Care Program.

5. Information Submission and Falsification.

a) It is the patient's responsibility to submit evidence of family income, and for the Charity Care Program, evidence of monetary assets. Such information should be submitted with the completed Financial Assistance Application, but in any event no later than within 30 days

of the submission of the Financial Assistance Application or within 30 days of discharge, whichever is earlier. The lack of such information can be taken into consideration by the Hospital in making a determination of eligibility for the Programs. However, if additional information is submitted after the initial determination, the Hospital may take into account the additional supporting documentation.

b) The Hospital shall deny a patient's eligibility for the Programs in the event that falsified information is submitted. If, after a patient is granted financial assistance, the Hospital finds material provision(s) of the documentation submitted to be untrue, eligibility for the Programs may be revoked.

C. Amount of Reduction to Charges.

1. After a determination that the patient is financially eligible for the Programs, the Hospital will provide a reduction from its normal charges as follows:

a) For patient eligible for Discounted Payment Program, the Hospital's charges shall be limited to the greater of the amount of payment for the same services from Medicare, Medicaid, Healthy Families, or any other government-sponsored health program in which the Hospital participates. In addition, the patient shall be allowed to pay this discounted price over time under a payment plan with terms to be developed by the patient and the Hospital and which shall bear no interest. (Note: discounted charges shall be considered as "partial charity" for purposes of state reporting requirements to the Office of Statewide Health Planning and Development.)

b) For patient eligible for the Charity Care Program, the Hospital shall provide care free of charge (i.e., at a 100% discount from charges).

2. To the extent the Hospital receives payment in excess of the amount due under the Program, the Hospital shall reimburse the patient any amount paid in excess of the amount due under the Programs. The amount to be repaid shall include interest at a rate of 7% per annum. Such interest shall start to accrue upon the latter of the date the Hospital receives the payment or the date the patient qualifies for the Programs.

3. Regardless of qualification for the Programs, Medicaid patients must incur and pay their "share of cost" as required under the Medicaid program.

D. Collection of Deposit.

The Hospital may collect a deposit from any patient eligible or potentially eligible under the Programs. To the extent any deposit exceeds the actual allowed charges, the excess amount shall be refunded to the patient with interest at the rate of 7% per annum.

E. Appeal Process.

In the event the Hospital denies a patient's application for the Programs, the Business Office/Admissions Office shall document the reason for the rejection and shall make a notation regarding the method of notification to the patient (i.e., verbal or written) and the date of the notification. A patient may appeal a denial of eligibility for the Programs. The patient's appeal must be filed with the Hospital's Chief Financial Officer ("CFO") or Designee within 15 business days of the date of the notice of denial. Such appeal shall be in writing and shall be accompanied by any documentation supporting the patient's eligibility for a discount under this policy. The initial determination denying eligibility shall be affirmed or reversed by the Hospital Designee within 15 business days of receipt of the patient's appeal.

F. Billing Procedures.

1. When the Hospital bills a patient that has not provided proof of coverage by a third-party, the bill shall include a clear and conspicuous notice that contains the following:

   a) A statement of charges for services rendered by the Hospital.

   b) A statement indicating that the patient may be eligible for coverage offered through California Health Benefit Exchange and other State or County-sponsored health care, as well as Medicare, Medicaid, Healthy Families, California Children's Services Program, coverage under workers' compensation, automobile or other insurance, or any other coverage for health care costs.

c) A statement indicating that if the patient does not have health insurance, or lacks adequate insurance, he/she may be eligible for charity care or a reduction from the Hospital's regular charges if the patient meets specific financial requirements and provides the required financial documentation.

d) The bill shall include a statement indicating that the patient may obtain more information regarding the programs listed above, including the Hospital's Programs, by contacting the Hospital's Admissions/Designee (714) 464-1860.

2. The bill to patients potentially eligible for the Programs shall contain the same information concerning services and charges as that provided to all other patients.

G. Collection Procedures.

1. A patient account to is eligible or potentially eligible for the Programs may be advanced for collection if payment is not received with 30 days of the initial bill and upon the authorization of the Billing Office Manager. This time period may, however, be extended by the Billing Office Manager. The debt may be advanced for collection based upon a lack of payment, a lack of adequate payment, a patient's unwillingness to apply for applicable indigency programs (including the Hospital's Programs), and a patient's lack of communication with the Billing Office or other factors that the Billing Office Manager deems relevant. Debt advanced for collection activities shall be sent to the Hospital's Collection Department or an outside collection agency consistent with Hospital protocols at the time.

2. If the Hospital utilizes the services of an outside collection agency, the Hospital shall obtain a written agreement from that agency that it will adhere to the Hospital's collection standards and all applicable laws, including California's Fair Pricing Law.

3. Prior to commencing collection activities for Self-Pay Patient accounts or High Medical Cost Patient accounts, the Hospital shall provide the patient with a written notice. This notice shall also accompany any document indicating that the commencement of collection activities may occur. However, if the Hospital has assigned the dept to a collection agency or any other assignee, the Hospital shall ensure that such

assignee comply with these notice requirements. The written notice shall be clear and conspicuous and shall include the following statements:

a) "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 circumstance, debt collectors may not contact you before 8:00 a.m. or after 9:00 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 1-877-FTC-HELP (!-877-382-4357) or online at www.ftc.gov."

b) "Nonprofit credit counseling services may be available in the area."

4. For Self-Pay Patients and High Medical Cost Patients, the Hospital and its outside collection agency, if one is used, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after the initial billing. This period shall be extended if the patient has a pending appeal for coverage of the services.

   a) A pending appeal includes (i) a grievance against a contracting healthcare service plan or insurer, (ii) an independent medical review in accordance with California's Insurance law, (iii) a fair hearing for review of a Medi-Cal claim, or (iv) an appeal regarding Medicare coverage.

5. The Hospital shall not use, nor shall it permit an assignee of the debt to use, information regarding the patient's monetary assets that was collected for the purpose of determining eligibility for Charity Care during the collection process.

6. The Hospital, or an assignee which is an affiliate or subsidiary of the Hospital, shall not, in dealing with patients eligible under the Programs, use wage garnishments or liens on primary residences as a means of collecting unpaid Hospital bills. Furthermore, if the Hospital utilizes an

unaffiliated collection agency, the Hospital shall ensure that such agency pursues collection activities in accordance with all applicable laws, including the California Fair Pricing Law.

7. Nothing in this policy prohibits a Hospital, collection agency, or other assignee from pursuing payment and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible parties.

VI. REFERENCES:

California Health & Safety § 127400, et. seq.

HEALTHBRIDGE CHILDREN'S HOSPITAL

EXHIBIT A

HOSPITAL FINANCIAL ASSISTANCE APPLICATION