TITLE:

FINANCIAL ASSISTANCE

SCOPE

Financial Assistance is available for eligible services rendered at Northern Arizona Healthcare Corporation, including all licensed health care institutions owned by these entities. (Collectively "NAH", see Exhibit A) (See Exhibit B for non-eligible services)

PURPOSE:

At Northern Arizona Healthcare, our mission and vision are, Improving health, healing people and always better care. Every person, every time...together. By showing compassion, doing amazing work, respecting differences, and building community, allows us to be better together.

As a part of our mission, NAH seeks to provide quality care to those we serve regardless of their ability to pay. To that end, NAH has put in place the tools and resources needed for the people we serve who qualify for financial assistance as outlined in this policy. NAH does not base eligibility for financial assistance on a person's age, color, disability or handicap, gender, national origin, race, sex, or sexual orientation.

The Financial Assistance Program policy ensures financial assistance is available for patients unable to meet their financial obligations for care based upon need in accordance with federal and state regulatory guidelines.

POLICY:

ELIGIBILITY CRITERIA

The NAH financial assistance eligibility criteria are based on current gross household income, and current household size, as well as insurance status.

Uninsured or underinsured patients receiving medically necessary care and exhibiting financial need according to the Federal Poverty Guideline (FPL), are eligible to receive financial assistance. To be eligible for consideration, an applicant must be:

- Ineligible for Medicaid;
- Approved for Medicaid postdate of service; or,
- Medicaid eligible but service is not a covered benefit. And,
- Less than 400% of the Federal Poverty Guidelines (See chart below)

EMERGENCY MEDICAL SERVICES:

In compliance with the Emergency Medical Treatment and Labor Act (EMTALA), NAH will provide, without discrimination, emergency medical care to individuals regardless of financial assistance eligibility to the best of our ability. Further, NAH is prohibited from (1) taking actions that would discourage individuals from seeking emergency medical care, (2) requiring patients in the emergency department to pay before receiving treatment for emergency medical conditions, and (3) engaging in debt collection activities that interfere with the provision of emergency medical care.

GROSS INCOME AND HOUSEHOLD SIZE:

At NAH, a reduced price is given to eligible patients or guarantors.

• Full or Partial Financial Assistance is granted to eligible patients with a household income of up to 400% (percent) of Federal Poverty Guidelines per the below schedule. Household members are defined as all dependents and adults residing with the patient.

2024 FINANCIAL ASSISTANCE SCALE			
% of FPL	0% - 200%	200%-300%	300%-400%
DISCOUNT	100%	75%	50%*
No. in Household			
1	$30,120	$45,180	$60,240
2	$40,880	$61,320	$81,760
3	$51,640	$77,460	$103,280
4	$62,400	$93,600	$124,800
5	$73,160	$109,740	$146,320
6	$83,920	$125,880	$167,840
7	$94,680	$142,020	$189,360
8	$105,440	$158,160	$210,880

* For families/households with more than 8 persons, add $5,380 for each additional person.

It is the patient's or the guarantor's responsibility to present the information NAH needs to determine eligibility for financial assistance. Patients who qualify will be asked to re-apply every six months.

ELIGIBLE SERVICES:

Charges for all emergency or other medically necessary services provided by entities covered by this policy are eligible for financial assistance consideration, **except** for the following:

EXCLUSIONS:

Elective Procedures:

- Elective cosmetic care
- Fertility and infertility treatment and procedures (including birth control)
- Hearing aids and hearing tests
- Weight–loss programs (unless diabetes–related)
- Sports physicals
- Bariatric services (unless post-surgical complications)
- Lap Band services
- Executive Physicals
- Genetic testing (Outside of the scope of Cancer treatment)
- Circumcisions

Providers not covered by this policy:

Care provided by physicians not employed by NAH may not eligible for financial assistance consideration under this policy.

Other Excluded Circumstances:

Patients who seek services that are not covered under the patient's benefit agreement, such as a patient who seeks out-of-network service or a patient who refuses to transfer from NAH to an in-network facility. (Whether formally denied, known, or anticipated).

A patient who is insured by a third-party payer who refuses to pay for services because the patient failed to provide information necessary for the third-party to determine payer's liability.

Financial assistance is not given for co–payments or for amounts that are due after insurance when the patient fails to get the needed referrals or approvals when insurance requires it. Financial assistance is offered to insured patients only if the insurance contract allows it. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement, or a Flexible Spending Account, will be expected to use these funds prior to being approved for financial assistance

CATASTROPHIC:

In the event an uninsured patient receives medical care at NAH and the amount due from the patient is twice the amount of the household's annual income, they will qualify for partial financial assistance. The patient will receive financial assistance after providing the required documentation, no matter the residency or Federal Poverty Level of the patient.

COBRA PREMIUM ASSISTANCE:

Patients, or guarantors, are expected to apply for programs and other funding sources NAH identifies, including COBRA (the extension of health–care benefits for a limited time once employment ends) coverage. If NAH determines COBRA coverage is possible and the patient does not receive Medicare or Medicaid, the patient or guarantor must provide NAH with the COBRA premium notice.

PRESUMPTIVE ELIGIBILITY:

- If patient is awarded Arizona Health Care Cost Containment System (AHCCCS) coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance;
- Patient had AHCCCS coverage the month preceding and the month post services;
- Patient's services are covered under a grant that has exhausted funding;
- Patient is incarcerated and the care is not the financial responsibility of the local, state, or federal institution;
- AHCCCS covered patients who exceed maximum allowable days;
- Bankruptcy

FINANCIAL ASSISTANCE PROGRAM:

Financial assistance may be given to patients, or their guarantors who meet the guidelines for what is required in terms of income levels under this policy. NAH expects patients or guarantors to cooperate by applying for assistance or other public programs we identify as sources of help to cover the cost of services and care. Patients or guarantors who choose not to cooperate may be denied financial assistance.

Federal Poverty Level guidelines determine if the patient or guarantor is eligible for financial assistance.

Eligible applicants qualify for one of the following:

Full or Partial Financial Assistance: The full or partial amount of charges, for eligible services given at NAH are waived and covered for the patient, or guarantor, if the following guidelines are met;

- The applicant meets eligibility criteria and has a yearly household income that does not exceed 400 percent of Federal Poverty Guidelines, and;
- All other payment sources have been explored and applied for including private coverage, federal, state, and local medical assistance programs, and other forms of financial assistance offered by third parties.

For eligible services provided at NAH clinics, all amounts due from the patient, with the exception of copays, are included if the following guidelines are met.

- The applicant meets eligibility criteria and has a yearly household income that does not exceed 400 percent of the Federal Poverty Guidelines, and
- All other payment sources have been explored and applied for including private coverage, federal, state, and local medical assistance programs, and other forms of assistance provided by third parties.

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COMMUNICATION:

Patients or guarantors must communicate with NAH any time an agreed–upon payment plan cannot be paid on time. Lack of communication may result in the patient's account being sent to a collection agency.

PAYMENT PLANS:

A reasonable, no–interest payment plan may be made between NAH's current payment plan vendor and the patient or guarantor for any amount due that remains once all discounts for financial assistance have been applied.

Eligible patients will have their total charges adjusted according to the Federal Poverty Level Guideline calculation based upon household size and income, according to the scale on page 2 of this document. In the event that the patient receives a tiered discount under this policy, the patient will not be billed more than the

amounts generally billed for care, calculated using the "Amounts Generally Billed" method as described in applicable IRS regulations (See below).

Any prepayment or deposit required by NAH will not exceed the amounts generally billed for that care.

Any amount previously paid over the amounts generally billed for care will be refunded to a patient who becomes qualified for assistance.

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

The basis for calculating amounts generally billed:

Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) individuals with insurance covering the same care for emergency or other medically necessary care.

The AGB is calculated, or determined, using the "look-back method," which is as follows:

NAH reviews all past claims that have been allowed by Medicare fee-for-service and all private health insurers paying claims to NAH for medically necessary care by the hospital in the prior calendar year. The amount is updated in this policy at the beginning of every calendar year. The total amount includes co–payments, deductibles and co–insurance.

The AGB percentages are calculated annually by dividing the sum of claims allowed by Medicare fee-for-service together with all private health insurers to NAH by the sum of the associated gross charges for those claims.

The percentages are applied by the 120th day after the end of the calendar year NAH uses to calculate the AGB percentage(s).

FMC AGB CY23: 44.54%
VVMC AGB CY23: 30.15%

** AGB Calculation discount; Verde Valley patients may not receive less than a 74% discount. Flagstaff patients may not receive less than 49% discount; FMC patients may still receive 75% and above discount if they qualify.*

UNINSURED PATIENT DISCOUNTS:

We will discount NAH's regular billed charges for patients who do not have insurance or a third-party coverage benefit. This includes patients whose financial situation normally would not otherwise qualify them for financial assistance. The discount for all uninsured patients is 50% for hospital and professional services.

THIS POLICY IS COMMUNICATED VIA THE FOLLOWING:

- NAH's website
- Via the guarantor billing statement
- Available throughout the covered facilities and upon request without charge via mail
- Financial Counselors and Customer Service team members

COMMUNICATION OF THE FINANCIAL ASSISTANCE POLICY TO PATIENTS WITHIN THE COMMUNITY:

Notification about Financial Assistance from NAH will include a contact number, will be disseminated by NAH by various means, which may include, but are not limited to; the publication notices in patient bills and by posting notices in emergency rooms, in the Conditions of Admission form, at urgent care centers, admitting and registration departments, hospital business offices, and patient access center offices that are located on facility campuses and at other public places as NAH may elect. NAH also shall publish and widely publicize a

summary of this Financial Assistance Policy on facility websites, in brochures available at patient access sites, and at other places within the community served by the hospital as NAH may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by NAH. Referral of patients for financial assistance may be made by any member of the NAH staff or medical staff including physicians, nurses, benefit advisors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

PROCESSES AND PROCEDURE:

APPLYING FOR FINANCIAL ASSISTANCE:

Patients will be informed of the NAH Financial Assistance Policy and the process for submitting an application to determine if the patient or guarantor is eligible for financial assistance, NAH asks for the necessary information and documents to prove household size, and income. A completed application for financial assistance should be submitted within 240 days from the date of the first post-discharge billing statement, or date of service. Applicants with household income of 400% of FPL or lower may receive financial assistance based upon a tiered discount (see Page 2 table).

NAH will make reasonable efforts to explain the Medicaid benefits, the health insurance exchange and coverage, and other public and private coverage that may apply. NAH will also provide the details of these programs and offer to help patients and guarantors apply for them as well as, private programs and COBRA coverage. Once the patient or guarantor is screened to be potentially eligible for any of these programs, public or private, NAH expects them to apply. If a patient or guarantor chooses not to apply, they may be denied financial assistance.

If the patient or guarantor is potentially eligible for any third-party coverage, they must provide documentation of approval or denial of that third-party coverage before a NAH financial assistance application will be accepted.

Information on the NAH Financial Assistance Policy will be communicated to patients in a culturally appropriate language. Information about the policy will be translated in the most prevalent languages in the NAH primary service area.

Financial Assistance Applications are processed within 15 business days of receipt.

DOCUMENTATION:

All applicants seeking financial assistance must submit required documents to verify income including all sources of income received by the household unit.

Income documentation may include but is not limited to the following;

- Money, wages (including overtime) and salaries before any deductions. Gross receipts from pay received for non-farm or farm self-employment.
- Regular payment from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, and public assistance (including Aid to Families with Dependent Children).
- Supplemental Security Income, General Assistance or General Relief payments, training stipends, alimony and military family allotments or other regular support from an absent family member or someone not living in the household as well as private pensions.

- Government employee pension (including military retirement pay), regular insurance or annuity payments as well as, dividends, interest, net rental income, net royalties, inheritance, and net gambling or lottery winnings, Tax Returns, K-1's, and 1099's.

- Income information will be used to figure, or calculate, an annual gross income on which a decision will be based.

Patients that do not provide the necessary documentation to determine eligibility for AHCCCS will not be considered for financial assistance;

- If the proof of income indicates it is in excess of the limits for AHCCCS eligibility, the financial assistance process may continue without completing the AHCCCS application.

- If the patient has AHCCCS or other insurance coverage, the financial class is changed on the visit/encounter and financial clearance is concluded.

- If the patient does not have AHCCCS or other insurance coverage, and proof of income indicates possible eligibility, a Financial Counselor engages the patient in the AHCCCS application process. (see MECS AHCCCS eligibility procedure)
- If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance (see Presumed Financial Assistance)

- If the patient is denied coverage, the Financial Counselor will provide the patient with the Financial Assistance Application.

The Financial Assistance Application is completed by the patient/guarantor. The application supporting documents include one of the following:

- Complete copy of the signed prior year federal tax returns;

- Determination letter from AHCCCS (valid denial or acceptance of a completed final application for AHCCCS) or other government-funded program for the patient's individual state, such as Medicaid or Medi-Cal or proof of ineligibility based upon FPL calculator;

The patient/guarantor must prove total household income as defined below;

- **Household income is required for all adults** (18 years or older or full times students under 24);
  - 2 months of personal bank statements for all account types (savings, checking, etc.);
  - Proof of employed patient/guarantor income;

- **Employed applicants**:
  - 2 paycheck stubs or a letter from the applicant's Human Resources Dept.

- **Self-employed applicants**:
  - A copy of the federal tax form schedule C Current tax return

- **Unemployed applicant**:
  - Copies of Unemployment payments or statement for means of support; A copy of the SSA 1099 form if retired and/or on Social Security
  - Copy of any pension benefit letters
  - Other income to include rent, alimony, child support, worker's compensation or other source.

SUBMITTING APPLICATIONS & ACQUIRING INFORMAION:

Online:

Please visit the Financial Assistance Program page to obtain a copy of the Financial Assistance Application, Financial Assistance Policy, and/or Financial Assistance Plain Language Summary form # 0917 and (#5268 - Spanish). Completed Applications cannot be submitted online at this time.

Postal Mail:

To mail your Financial Assistance application, send to;

Northern Arizona Healthcare, Financial Counseling, 1200 N. Beaver St., Flagstaff, AZ 86001

OR

In-Person:

If you need help completing the Financial Assistance Application, please call (928) 773-2025 to make an appointment with one of our Financial Counselors.

Information on Financial Assistance and the notice posted in the Medical Center and Clinic locations will be translated in any language that is the primary language spoken by 1,000, or 5 percent — whichever is fewer — of the residents in the service area.

Telephone Request:

Please call 928-773-2025 to request a copy of the Financial Assistance Application, Financial Assistance Policy, and/or Financial Assistance Plain Language Summary form # 0917 and (#5268 - Spanish). It will be mailed to you at no charge.

INCOMPLETE APPLICATIONS:

Incomplete applications will be returned to the patient/guarantor, along with written notice identifying the missing information or documentation needed to process the application. This notice must describe the collection activities that may occur if the individual does not provide the missing documentation or make arrangements to pay the bill. This will occur in the later of the following scenarios:1) 30 days from the date of notice or (2) 120 days after the first bill to the individual for the most recent episode of care.

- Patient/Guarantor has 30 days to provide missing information or documentation;
- Failure to respond to missing information or documentation request within 30 days may result in denial.

PROCESSES:

Visits for which a third party is liable for care are not eligible for consideration. If the third party does not accept liability for the cost of the services, the applicant may reapply.

The Financial Assistance Applications are not processed if received after the 240th day after the first bill to the individual for the most recent episode of care. If an application is received within that time but after the visit has been sent to bad debt, the account will be recalled to the hospital to review and act on the application in accordance with this policy.

Financial Clearance (FC) can be done prospectively, concurrently, and retrospectively.

Prospective and Concurrent Review:

Patients are reviewed for the ability to pay by Patient Access Services (PAS) after confirmation from clinical staff that the patient has received an appropriate medical screening examination by a qualified medical professional, and either;

No emergency medical condition exists or;

If an emergency medical condition exists, such condition has been stabilized as defined by EMTALA. NAH will provide emergency care in accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations. All patients are seen and given care prior to being screened for financial assistance and/or payment ability in an emergency. NAH will not delay or deny emergency medical care to an individual on the condition that an individual submit information to determine whether the individual qualifies for third-party coverage or financial assistance for the care being delayed or denied.

The financial clearance process will be performed in accordance with the procedural requirements outlined in the job aids indicated in the reference section of this policy.

Retrospectively:

The Revenue Cycle staff review requests for assistance submitted post discharge.

If the patient is unable to meet his or her financial obligation for care, the Financial Counselor reviews the patient for eligibility for Arizona Medicaid (AHCCCS).

Billing and collection information:

NAH, or a contracted collection agency may take steps to collect unpaid patient balances that remain outstanding after 120 days. These can include sending notices, making telephone calls, and conducting collection actions such as reporting information to credit agencies or requesting foreclosures, attachment/seizures, arrests, liens, wage garnishments or other civil actions. These actions are referred to as Extraordinary Collection Actions, or ECA's.

Before engaging in ECAs, NAH or collection agencies acting on its behalf will make reasonable efforts to determine whether a patient is eligible for financial assistance. These include, but are not limited to:

- Waiting at least 120 days until after the issuance of the first post-discharge billing statement
- Providing a notice at least 30 days before any ECAs occur that:
  - States the ECAs that NAH or the collection agency intends to take.
  - States the date after which ECAs will occur (must be 30 days from the date the notice is provided)
  - States how to obtain information on financial assistance
  - Includes a copy of the plain language summary of the financial assistance policy
- Making reasonable attempts to orally notify individuals about the availability of financial assistance during the collection process
- Processing applications that are submitted within the application period, as defined in Treasury Regulation §1-501(r)-1(b) (3) (B)
- Suspending ECAs while an application is being evaluated and reversing them (to the extent reasonably possible) if a patient is determined to be eligible for financial assistance

COLLECTION ACTIONS TAKEN IN EVENT OF NON-PAYMENT OF ACCOUNTS:

If a statement is sent to a patient or guarantor, and mail is returned as undeliverable, NAH will attempt to find a correct address. If the correct address cannot be found, NAH will attempt to contact the patient or guarantor by telephone at the number listed by the patient or guarantor. If efforts to communicate with the patient or guarantor fail, accounts will be sent to a collection agency.

Reasonable efforts to inform patient of financial assistance: Prior to sending an account to a collection agency, the patient or guarantor will generally receive a minimum of four written statements including the first

post-discharge statement and three subsequent statements. These statements will include a telephone number for information on paying patient balances and a notice about financial assistance.

If an agreement has not been made to resolve the account, the fourth and final statement will be sent to the patient or guarantor. This statement acts as a notice to the account owner of the amount owed to NAH that the account will be placed with a third–party collection agency in 30 days. This statement will include a plain language summary and will outline any collection actions that may be taken if a plan is not put in place to settle the account.

There are other times when accounts may be placed in collections including when:

- The patient or guarantor has not made timely payments according to the agreed–upon payment plan.
- The patient or guarantor has received a financial assistance discount but is no longer working with NAH in good faith to pay off the remaining amount owed

Extraordinary collection activities: Once an account is with the collection agency, the following actions may be taken to make sure debt for services and care is paid. They are ***"Extraordinary Collection Activities" (ECA's).***

- Seizing the patient's or guarantor's bank account
- Civil actions
- Property liens
- Garnishing of wages
- Reporting adverse information to credit bureaus

Before "Extraordinary Collection Activities" can begin, the account must be reviewed, and approval must be given by NAH's Patient Billing Leadership. When one of these actions is to be taken against a patient or guarantor, the patient or guarantor will be given a 30–day written notice of the action to be taken. The patient or guarantor will also be informed of NAH's Financial Assistance Policy and how to apply for it. A plain language summary of the Financial Assistance Policy will be included with the notice.

APPLICATION ACCEPTENCE/DENIAL:

NAH balance adjustment signatory requirement is defined in the "CBO 100-02 NAH Corporate Write-Off Policy". In no event will a determination that an individual is not eligible for assistance under this policy be based on information that there is reason to believe is unreliable, incorrect or obtained from the individual under duress.

The patient/guarantor is notified of approval or denial of application in writing.

- Financial Assistance less than 100% requires an established payment plan to remain in good standing;
- Assistance is applicable to all ELIGIBLE outstanding balances (See excluded services) for 6 months post the date of approval. (*review going backwards 240 days from the date the application for financial assistance is approved.*
- The patient/guarantor is responsible to notify the Revenue Cycle Office of new balances eligible for approved financial assistance adjustment.

ELIGIBILITY DETERMINATIONS AND DISPUTE RESOLUTION

Eligibility determinations will be made in accordance with the NAH Financial Assistance Policy. Reasonable efforts will be made to issue a decision timely once a completed application is received. The applicant will be informed in writing of the decision within a reasonable amount of time from the date NAH receives a completed financial assistance application. If financial assistance is denied, NAH will record the reason for the denial in our electronic billing system.

Determination for financial assistance will be made after all efforts to qualify the patient for Medicaid or other public programs have been exhausted. If a decision on such coverage is pending, NAH will not begin extraordinary collection actions.

Applicants denied assistance may reapply if there has been a change of income or status. The original, signed applications will be kept on file.

As noted above, if an application is incomplete, the applicant will be notified by mail that more information is needed to complete the application process. The applicant will be informed of the deadline for providing this information — 30 days from the date the letter was mailed asking for needed information. If the applicant does not respond within the 30–day timeframe, the application will be denied.

Applicants found ineligible for financial assistance may dispute the decision in writing by providing information as to the reason for the dispute and any helpful information to describe the basis for the dispute or appeal. A dispute or appeal letter must be received within 30 days of the date of the determination letter.

Disputes or request for exceptions should be submitted in writing to: NAH – Financial Assistance; 1200 N. Beaver ST., Flagstaff, AZ 86004.

EXCEPTIONS:

Patients/Guarantors requesting exceptions can appeal an outcome by escalation to the Financial Assistance Team;

The Financial Assistance Team is comprised of the System Director of Revenue Cycle Operations, and Clinical Department Director for the affected areas of care.

- Committee findings are documented and mailed to the patient/guarantor.
- Remaining balances after committee findings require an established payment plan to remain in good standing.

REFUNDS:

NAH will refund any amount that the individual has paid for care that exceeds the amount they are determined to be personally responsible for paying as a Financial Assistance Policy eligible individual, unless such amount is less than $24.99, excluding Clinic and Emergency Room copays if those payments occurred within 240 days from the date of the financial assistance application (or such other amount set by notice of other guidance published by the Internal Revenue Bulletin). Outside of discount % range. we will not refund clinic or emergency room co-pays within the 240-day time period.

ENFORCEMENT:

NAH staff are expected to uphold the highest ethical standards. At no time should any staff member use false information or lie in an attempt to collect an account. All business must be conducted in the name of the caller or NAH. By no means should staff lie about being an employee of a credit bureau, collection agency, law firm, etc. Everything a staff member says must be true and correct using a professional approach. NAH staff as well

as, all third–party vendors working on behalf of NAH, will uphold and adhere to the Fair Debt Collection Practices Act.

CONFIDENTIALITY:

NAH will protect the privacy of each patient's financial and personal health information.

REGULATORY REQUIREMENTS:

NAH will comply with all federal, state, and local laws, rules, and regulations, as well as reporting needs that may apply to the work and actions done as a result of our Financial Assistance Policy. Aggregated information on financial assistance given under this policy will be reported once a year on an Internal Revenue Service Form 990, Schedule H.

DEFINITIONS:

Amounts Generally Billed (AGB): Hospital-Specific AGB Percentage means, for each Hospital, a percentage derived by dividing (1) the sum of all claims for Medically Necessary services provided at such Hospital paid during a 12-month period by all private health insurers as primary payers and Medicare fee-for-service, together with any associated portions of these claims paid by insured individuals in the form of co-pays, co-insurance or deductibles divided by the gross charges associated with those claims. The AGB Percentage is calculated by January 31 and is effective until the next annual calculation. The calculation shall comply with the "look-back method" described in Treasury Regulation §1-501(r)-5(b) (1) (B).

Bad Debt: A balance no longer deemed collectable.

Elective: Service deemed by a physician to be non-emergent and safe for delay.

Emergency medical condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd), the term "emergency medical condition" means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in.

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions:
    - There is inadequate time to affect a safe transfer to another hospital before delivery, or
    - Transfer may pose a threat to the health or safety of the woman or the unborn child.

Federal Poverty Guidelines: The Federal Poverty Guidelines/Levels (FPG, FPL) use income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPG can be referenced at http://aspe.hhs.gov/POVERTY/.

Financial assistance: Assistance given to eligible patients or guarantors, who might otherwise have financial hardship, to dismiss all or part of their financial requirements for medically necessary care provided by NAH.

Full or Partial Assistance: All patient amounts due that are a result of having received eligible services given at NAH to eligible patients, or their guarantors, with yearly household incomes at or below 400 percent of the Federal Poverty Level.

Guarantor: A person, other than the patient, who is responsible to pay the patient's account. The guarantor and the patient may be one and the same.

Gross charges: Total charges at the full established rate for patient care services before deductions from revenue are applied.

Household:

Adults: In calculating the Household Size, include the patient, the patient's spouse, and any dependents. (As defined by the Internal Revenue Service's Internal Revenue Code)

Income: Adults: If the patient is an adult, "Yearly Household Income" means the sum of the total yearly gross income or estimated yearly income of the patient and patient's spouse, and any adult claimed on the income tax return.

Medically Necessary Services: Medical care required to ensure the well-being of the patient as defined by generally accepted medical practice.

Minors: In calculating the Household Size, include the patient, the patient's mother, the patient's father, dependents of the patient's mother and dependents of the patient's father. (As defined by the Internal Revenue Service's Internal Revenue Code). If the patient is a minor, "Yearly Household Income" means the sum of the total yearly gross income or estimated yearly income of the adult claiming the minor child on income taxes as a dependent

NAH Flat Rate: NAH provides flat rate self-pay fees for specific services to uninsured patients.

Payment plan: A financial arrangement that includes a payment plan that NAH and the patient or guarantor agrees to for out-of-pocket amounts due. The plan considers the patient's financial issues, the amount owed, and any prior payments.

Qualification period: Applicants who are eligible for financial assistance will be given this assistance for (6) Six Months. Assistance will also be applied to eligible past unpaid accounts for eligible services.

Uninsured patient: A patient with no third-party coverage such as commercial third-party insurance, an ERISA plan, a Federal Health Care Program (including without limit Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation or other third–party assistance, to assist with meeting a patient's payment obligations.

AVAILABILITY OF TRANSLATIONS:

Spanish (Español)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-928-773-2025.

Navajo

EXHIBIT A – SERVICES ELIGIBLE FOR FINANCIAL ASSISTANCE

Flagstaff Medical Center
Verde Valley Medical Center
Verde Valley Medical Center – Sedona Campus
Northern Arizona Healthcare Outpatient Surgery Center
EntireCare Rehabilitation & Sports Medicine
Northern Arizona Healthcare Medical Group Clinics including the following:
NAHMG – Anesthesiology
NAHMG – Cardiovascular Institute
NAHMG – Center for women
NAHMG – Endocrinology
NAHMG – General Surgery
NAHMG – Hospitalists
NAHMG – Immediate Care
NAHMG – Infectious Disease
NAHMG – Internal Medicine
NAHMG – Medical Oncology
NAHMG – Neonatal
NAHMG – Neurology
NAHMG – Orthopedic and Spine Institute
NAHMG – Palliative Care
NAHMG – Primary Care
NAHMG – Breast Surgery Services
NAHMG – Emergency Services
NAHMG – Bariatric Clinic (as deemed medically necessary)
NAHMG – Behavioral Health
NAHMG – Sleep Medicine
NAHMG – Urology
NAHMG – Wound Care
NAHMG – Children's Health Care
NAHMG - Pulmonology

EXHIBIT B: SERVICES NOT ELIGIBLE FOR FINANCIAL ASSISTANCE

Northern Arizona Plastic Surgeons
NAHMG – Bariatric Clinic (services not deemed medically necessary)

INCLUDED DOCUMENTS	Financial Assistance Scale
RELATED DOCUMENTS	Financial Assistance Application
REFERENCES	Treasury Regulation §1-501(r)-5(b) (1) (B) Federal Poverty Guideline (FPL) CBO 100-02 NAH Corporate Write-Off Policy Emergency Medical Treatment and Active Labor Act IRS regulations Arizona Medicaid–Arizona Health Care Cost Containment System (AHCCCS)

Reviewed:

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