UPSON REGIONAL MEDICAL CENTER

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Principles/Guidelines

Upson Regional Medical Center ("URMC") seeks to treat all patients equitably, with dignity, respect and compassion. URMC recognizes that some patients are unable to pay their hospital bills due to financial considerations. URMC will assist those individuals who cannot pay for all or part of their care by extending Financial Assistance to qualifying patients. The purpose of this Policy is to describe the financial assistance policy guidelines and application process.

URMC will provide free care and discounted financial assistance in keeping with the Policy described below. In order for URMC to apply this Policy fairly and consistently, patients and their families have a duty to provide appropriate and timely information that will help URMC determine the appropriate level or type of financial assistance given specific individual circumstances.
As further described below, this Financial Assistance Policy (FAP):

- Includes eligibility criteria for receiving financial assistance.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this Policy.
- Limits the amount that URMC will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to no more than the amount generally billed to insured patients by URMC as defined in this Policy.
- Describes the method by which patients may apply for financial assistance.
- Describes the URMC collection Policy.

URMC remains committed to serving the emergency needs of all patients, regardless of ability to pay.

Definitions: As used in this Policy, the following terms have the meanings as set forth below:

1. **Financial Assistance**: Free or discounted health services provided to individuals who meet URMC's criteria for financial assistance and are unable to pay for all or a portion of the medically necessary services provided by the facility. Financial assistance includes:

   - **Free Care** – Free care is available when the household incomes of a patient and/or Guarantor are either equal to or less than 125 percent of the current Federal Poverty Guidelines.

   - **Discounted Financial Assistance** – Financial Assistance discounts are available when the household income of a patient and/or Guarantor is in excess of 125 percent and equal to or less than 300 percent of the current Federal Poverty Guidelines.

2. **Gross Charges** – The total charges at the organization's established rates for the provision of patient care services before deductions from revenue are applied.

3. **Federal Poverty Guidelines (FPG)** - The poverty guidelines issued by the U. S. Department of Health and Human Services at the beginning of each calendar year that are used to determine eligibility for certain assistance programs.

4. **Emergency Medical Conditions** – Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

5. **Medically Necessary** – Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
    a. in accordance with the generally accepted standards of medical practice;
    b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means:
    a. standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
    b. Physician Specialty Society recommendations;
    c. the views of Physicians practicing in the relevant clinical area; and
    d. any other relevant factors.

6. **Eligible Services** – Services eligible under this Policy include: (1) emergency medical services provided in an emergency room setting, (2) non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and (3) other medically necessary services. Eligible services do not include elective, cosmetic or non-medically necessary services.

7. **Family Unit** – The family unit consists of the applicant, spouse and all legal dependents as allowed by the Internal Revenue Service. If the applicant is a minor or legal dependent for income tax purposes, the family unit will include parent(s), legal guardian(s) and/or the taxpayer claiming the patient as a dependent for income tax purposes.

8. **Family Unit Income** – The combined annual gross income of all members within the family unit (as previously defined) which includes the patient or Guarantor. Combined gross income will be calculated by annualizing documented income over the preceding three months. For the purposes of determining financial eligibility for financial assistance, income includes all gross funds or amounts received before taxes or other withholdings from all sources, including, but not limited to any type of employment or self-employment, alimony, sick leave, disability compensation, any pensions or retirement plans including military retirement pay, veteran's payments , rental income, royalty payments, Social Security payments, child support payments, unemployment compensation, regular insurance or annuity payments, interest or dividend income, and workers compensation benefits. The Hospital will require supporting documentation to be submitted with the paper Application to verify income. Income does not include need-based assistance from non-profit organizations, disaster relief assistance, gifts, loans or similar items.

9. **Co-Payments, Coinsurance and Deductibles** – The amount determined by the patient's insurance policy as being due from the patient and/or any Guarantor. This amount is normally a required payment due from the patient or Guarantor by contract.

10. **Guarantor** – Individual other than the patient who is responsible for payment of the patient's bill.

11. **Patient Liability** – Patient Liability is the amount owed by the individual patient and/or Guarantor after first applying any insurance benefits and then applying any financial assistance discounts.

12. **Amounts Generally Billed Percentage** – The percentage determined by dividing the total of claims allowed by Medicare and all private health insurers (including all copayments and deductibles owed by the patient) during the 12-month look-back measurement period by total gross charges for these claims. The measurement period for the AGB percentage will be calculated at the end of each calendar year using the allowed claims from the preceding twelve (12) month period. This AGB percentages calculated will be updated February 1 each year and remain in effect until January 31 of the following calendar year. The AGB percentages for the period February 1, 2026 through January 31, 2027 is twenty-six percent (26%).

13. **Amounts Generally Billed** – The maximum amount for which all patients meeting the eligibility criteria under this Policy are individually responsible for paying. Amounts Generally Billed (AGB) will be calculated by multiplying gross charges for any eligible service by the appropriate AGB percentage as defined above.

14. **Extraordinary Collections Actions (ECAs)** – Actions that may be taken related to obtaining payment for services rendered include the following:

    a. Selling an individual's debt to another party unless the purchaser is prohibited from engaging in any ECAs to obtain payment, prohibited from charging interest in excess under IRC section 6621(a)(2) at the time the debt is sold, the debt is recallable upon determination the individual is eligible for financial assistance, and the individual does not pay or has no obligation to pay the purchaser and URMC together more than they are personally responsible for paying under this Financial Assistance Policy.
    b. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    c. Deferring, denying, or requiring payment before providing medically necessary care because of nonpayment of one or more bills for previously provided care.
    d. Actions that require a legal or judicial process, including but not limited to:
        i. Placing a lien on an individual's property except for any lien URMC is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which care was provided;
        ii. Foreclosing on an individual's real property;
        iii. Attaching or seizing an individual's bank account or any other personal property;
        iv. Commencing a civil action against an individual;
        v. Causing an individual's arrest;
        vi. Causing arrest or body attachment; and
        vii. Garnishing an individual's wages.

15. Financial Assistance Application - The document made available to the patients of URMC which must be completed with certain required documentation for the hospital representative to determine eligibility for financial assistance.

Eligibility Criteria for Financial Assistance

Free care and discounted financial assistance apply only to eligible services as defined in this Policy. A patient that qualifies for financial assistance under this Policy is eligible for discounts to co-payments, coinsurance and deductibles. Financial assistance discounts do not apply to any amounts received or receivable from an insurance company for eligible services. **Insured patients with out-of-network**

benefits will not be considered for financial assistance under this policy. The maximum amount an FAP-eligible patient will pay is the AGB as defined in this Policy.

Exhausted Insurance Benefits

Insured patients whose benefits for services have been exhausted at this facility and who may otherwise receive such services at another facility, but elect to continue receiving services at this facility, are eligible to apply for financial assistance. This provision applies solely to cases involving exhausted benefits and does not guarantee that financial assistance will be awarded. All applicants must meet the eligibility criteria and requirements set forth within this policy to be considered for assistance.

Financial assistance may also be available for the professional fee portion of hospital services, which includes charges from physicians and other licensed providers who deliver care and consultations within the hospital setting. Eligibility for assistance with these charges will be determined using the same income and documentation criteria applied to facility-based services. Patients approved for financial assistance under this policy may receive proportional support for professional fees associated with their hospital visit, subject to provider participation and applicable program guidelines.

While additional providers may be involved in your care during your visit, only those who participate in URMC's Financial Assistance Policy are eligible under this program. The following providers are currently enrolled and may qualify for financial assistance consideration:

1. Upson Medical Associates – Anesthesiologist and Telemedicine Professional fees
2. Wound Healing - Professional fees
3. URMC Cardiology services - Professional fees
4. URMC Pediatric services - Professional fees
5. Rural Health Services

URMC cannot make any financial arrangements for the charges of any private physician practice, including the following physician practices and ambulance companies offering services at URMC:

1. Guardian Medical (CRNA)
2. Civie Radpod (Radiology)
3. Schumacher (ED and Hospitalist)
4. Ground and Air Ambulance Patient Transport Services
5. Any attending physician

Patients seeking assistance will need to make payment arrangements directly with these physician practices.

URMC will assist the patient in qualifying for any State of Georgia Medicaid or Social Security (SSI) benefits. URMC utilizes the services of outside vendors to assist patients in obtaining these benefits. Amounts billed to patients approved for Financial Assistance pursuant to this Policy shall be based on AGB, as defined in this Policy. Patients shall not be expected to pay Gross Charges. Once a patient has been determined by URMC to be eligible for financial assistance, the patient shall not receive any future bills based on undiscounted Gross Charges for the episode of care in which an Application for Financial Assistance was submitted.

A patient may qualify for Financial Assistance under this Policy if he or she meets one of the following criteria:

Household Income	Maximum Amount Individual is Responsible for Paying
Less than or equal to 125% of Federal Poverty Guidelines	0% of Gross Charges
In excess of 125% but less than or equal to 300% of Federal Poverty Guidelines	AGB

Qualification for financial assistance based on income will be determined using the following methods:

1. Completion of URMC's Financial Assistance Application as described below. Anyone approved for financial assistance after completion of URMC's Financial Assistance Application will remain approved for any eligible services for subsequent episodes of care rendered within 180 days of the date the application is approved.

2. Bankruptcies, deceased with no estate, Medicaid co-pays and Medicaid in states which URMC does not participate, and any State or Federal programs where funding has been exhausted, accounts will be FAP approved without an application with a 100% discount.

Financial Assistance Application Guidelines:

All requests for Financial Assistance must be submitted using URMC's Financial Assistance Application. The Application must be completed in its entirety and all required supporting documentation must be attached to the Application.

1. URMC makes information readily available to patients in regard to its financial assistance program by:
    a) Posting information in the main lobby, Emergency room lobby, and cashier area of the hospital. (English & Spanish) NOTE –Offering a plain language summary of the FAP to every patient registering for services in the Registration Department, or presenting to the Emergency Department, to Physical Therapy or to the Wound Healing Center.
    b) Making a copy of the FAP and an application for financial assistance is available upon request at the Registration Department, the Business Office and on the hospital website at www.urmc.org. The Policy, plain language summary and the financial assistance application are available in a printable format without requiring additional software or a cost. Paper copies are also available at all primary entrance areas of the hospital.
    c) Including a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance and provides telephone numbers where they may receive more information.

2. URMC makes reasonable efforts to determine whether an individual is FAP eligible prior to engaging in any ECAs. Our collection policies (as approved by the governing board), hold URMC Patient Financial Services Department responsible for this process. ECAs will not be initiated during the 120-day period beginning with the issuance of the first post-discharge billing statement to the patient. If, by the end of this 120-day period the patient has not submitted a Financial Assistance Application, URMC may begin collection actions against the patient, providing the patient has been notified in writing of the specific ECA(s) to be initiated at least 30 days prior to such actions. The application period during which URMC will accept and process a Financial

Assistance Application ends on the 240th day after URMC issues the first post-discharge billing statement to the patient.

3. Applicant shall submit the following supporting documentation, if applicable, with a completed Application:
    a. Proof of income – IRS Form W-2, the most recent federal income tax return, pay stubs covering the last 90 consecutive days as of the date of application, proof of Social Security, unemployment receipts, investment income, alimony, worker's compensation, rental/royalty income, retirement income and any other documentation that supports household income as defined in the Financial Assistance Policy.
    b. Checking and savings account statements for the most recent 3 months. The statements are required to verify an applicant's income.
    c. If the annualized family unit income has decreased since the most recent federal income tax return, the applicant must submit written documentation verifying the decreased amount.
    d. Unemployment denial letter.
    e. Any additional documentation the applicant deems necessary to support their application for Financial Assistance.

4. Falsifying information on the Application will be grounds for denying or revoking financial assistance. Falsifying an Application includes, but is not limited to, failure to disclose all income.

5. Applicant shall identify all known third-party payment sources for services rendered. Applicant shall cooperate with URMC in filing of claims and collection of reimbursement from all third-party payment sources. **Information provided after insurance filing deadline will result in patient remaining as self-pay with no eligibility for financial assistance. Failure to cooperate will be grounds for denying financial assistance.**

6. Applicant shall cooperate in the application process for financial assistance from other sources, such as Medicaid and other programs. Failure to cooperate will be grounds for denying financial assistance.

Financial Assistance Procedures:

1. At the time of registration, which includes registration for Physical Therapy, Upson Clinic and Wound Healing Treatment, each patient will be offered a free written copy of the plain language summary of the Policy. A patient may begin the process for consideration for financial assistance by completing the financial assistance application and providing the necessary documentation to support their income. Granting of financial assistance shall be based on the individualized determination of income, and shall not take into consideration age, gender, race, or immigration status, sexual orientation or religious affiliation.

2. Applicants must fully cooperate and comply with verification of income to the best of their ability.

3. A Financial Assistance Representative (FAR) is available to discuss the Financial Assistance program offered by URMC with the patient or the patient's designated representative. A free written copy of the Financial Assistance Policy and Financial Assistance Application may be obtained from the Financial Assistance Representative. At the request of the patient or the patient's designated representative, the Financial Assistance Representative will assist the patient with

initiation of the Financial Assistance Application. A Financial Assistance Representative is available in the Business Office Monday through Thursday; from 8:30 a.m. until 4:30 p.m. and Friday; from 8:30am to 3:00pm

4. Applications may also be mailed to URMC for processing to Upson Regional Medical Center 801 West Gordon Street Thomaston, Ga. 30286.

5. URMC will assist patients in becoming covered under available state, local, federal, or community-based assistance programs as requested.

6. When an Application is received, the Financial Assistance Representative will review the Application for completeness, which shall include all supporting documentation. If it is determined that the Application is incomplete, URMC will take the following actions:
    a. Suspend any collection actions against the patient/Guarantor.
    b. Provide the patient with a written notice that describes the additional information or documentation the patient must submit to complete his or her Application.
    c. Provide the patient with at least one written notice that informs the patient/Guarantor about the extraordinary collection actions that the hospital intends to initiate or resumed if the Application is not completed or if the amount due is not paid within 30 days from the date of the notice.
    d. If all supporting documentation is not submitted or the amount due is not paid within 30 days of the written notice as described in the preceding paragraph, the request for Financial Assistance will be denied and the account will remain in the billing cycle. A new Application may be submitted if the date of the Application is within 240 days after URMC issues the first post-discharge billing statement to the patient.

7. Once a completed Application has been received and reviewed, the Financial Assistance Representative will make a recommendation for approval or denial on the Application. URMC will render a decision in no more than five (5) working days from the receipt of a completed Financial Assistance Application.

8. Approval authority for Financial Assistance is as follows: All accounts involved resulting in a financial write off will be routed to the Director of Patient Financial Services, or her designee, for approval.

9. The patient will be notified in writing of URMC's decision to provide or deny Financial Assistance.

Collection Practices and Policies

In the event of non-payment by the patient for their portion of their account, statements indicating the process for applying for financial assistance will be mailed to the patient every 21 days.
If the account is not paid after 150 days from the first post discharged bill date, the hospital will refer the account to its primary collection agency for future collection efforts. The collection agency will provide the same disclosure on its statements as the hospital does to advise the individual of the Financial Assistance Policy and how to obtain a copy of the Policy, the plain language summary and application to apply for assistance.

The collection agencies must notify the patient in writing at least 30 days prior to initiating any ECAs and provide a copy of URMC's plain language summary of the FAP with the 30-day written notice.

ECAs will not be initiated by either URMC or any of its agents (including any collection agencies) until at least 120 days from the date the first post-discharge bill was issued. In addition, either URMC or the collection agency will make reasonable attempts to notify all patients orally about the hospital's FAP and how they can apply

URMC has the right to provide notification simultaneously for multiple episodes of care; however, ECAs cannot begin until 120 days after the first post-discharge billing for the most recent episode of care.

If an individual applies for financial assistance after the ECAs have begun, the hospital will suspend all ECAs, notify the individual in writing of the determination, and take all reasonable measures to reverse any ECA actions taken such as: report to the credit bureau to delete, cancel a judgment, and/or cancel any garnishment action, etc.

Appeal Process for Financial Assistance Denials:
An applicant may appeal a denial of financial assistance determination. An appeal may be submitted in writing, either by letter or email, and sent to the Financial Assistance Representative at Upson Regional Medical Center. The FAR will respond to the appeal within 10 business days. Written appeals should be sent to:
Upson Regional Medical Center
Attention: Financial Assistance Representative
P.O. Box 1059
Thomaston, GA 30286

Email appeals should be sent to alisha.wilson@urmc.org
Individuals may present to the Business Office Monday through Thursday, 8:30 a.m. through 4:30 p.m. Friday, 8:30a to 2:30 pm to appeal the decision in person.
URMC operates under an Emergency Care Policy which is available upon request through the Compliance Department at the hospital. Calls may be directed to 706-647-8111 Ext. 1240.
For more information contact:

Financial Assistance Representative: 706-647-8111 Ext. 1473
Lead Patient Accounts Specialist: 706-647-8111 Ext. 1161
Information may also be obtained on the hospital website at www.urmc.org.

The original FAP was approved by the Board of Trustees as the authorized body for Upson Regional Medical Center. Annual updates to the AGB determination are approved by the Controller and CFO/COO.