Cleveland Clinic

PATIENTS FIRST SUPPORT SERVICES

Financial Assistance Policy

CCHS's policy is to provide Emergency Care and Medically Necessary Care on a non-profit basis to patients without regard to race, creed, or ability to pay. Patients who do not have the means to pay for services provided at CCHS facilities may request financial assistance, which will be awarded subject to the terms and conditions set forth below. The eligibility criteria for financial assistance pursuant to this Policy are intended to ensure that CCHS will have the financial resources to provide care to patients who are in the greatest financial need. This Policy applies to all CCHS facilities, including its hospitals and family health centers, as defined below.

I. Background

A. The Cleveland Clinic Foundation and its hospital affiliates are tax-exempt charitable organizations within the meaning of §501(c)(3) of the Internal Revenue Code and charitable institutions under state law.

B. CCHS is committed to providing care on a non-profit basis. "Emergency Care" and "Medically Necessary Care" are provided on a non-profit basis to patients without regard to race, creed, or ability to pay.

C. The principal beneficiaries of the Financial Assistance Policy are intended to be uninsured patients whose Annual Family Income does not exceed 100% of the Federal Poverty Income Guidelines published from time to time by the U.S. Department of Health and Human Services and in effect at the date of service for awards of financial assistance under this Policy (the FPG). Income-based financial assistance may be available for uninsured and certain other patients with Annual Family Incomes *up to* 400% of the FPG. Patients experiencing financial or personal hardship or special medical circumstances also may qualify for assistance. Under no circumstances will a patient eligible for financial assistance under this Policy be charged more than amounts generally billed for such care.

II. Definitions

"Annual Family Income" includes wages and salaries and non-wage income including alimony and child support; social security, unemployment and workers compensation benefits; and pension, interest or rental income of the Family.

"Application" means the process of applying under this Policy, including either (a) by completing the CCHS Financial Assistance Application in person, online, or over the phone with a Patient Financial Advocate or (b) by mailing or delivering a completed paper copy of the CCHS Financial Assistance Application to CCHS.

"CCHS" means The Cleveland Clinic Foundation, its family health centers and its hospital affiliates in the Cleveland Clinic health system, collectively, other than:

(i) Cleveland Clinic Florida,
(ii) Union Hospital,
(iii) Cleveland Clinic Rehabilitation Hospitals,
(iv) Select Cleveland Hospitals and
(v) Ashtabula County Medical Center (including Glenbeigh

each of which has its own Financial Assistance Policy which are available at www.clevelandclinic.org/financialassistance.

"Emergency Care" or "Emergency Treatment" shall mean the care or treatment for an Emergency Medical Condition as defined by EMTALA.

"EMTALA" is the Emergency Medical Treatment and Active Labor Act (42 U.S.C. §1395dd).

"Family" shall mean the patient, patient's spouse (regardless of where the spouse lives) and all of the patient's natural or adoptive children under the age of eighteen who live with the patient. If the patient is under the age of eighteen, the family shall include the patient, the patient's natural or adoptive parent(s) (regardless of where the parents live), and all of the parent(s)' natural or adoptive children under the age of eighteen who live in the home.

"FPG" shall mean the Federal Poverty Income Guidelines that are published from time to time by the U.S. Department of Health and Human Services and in effect at the date of service.

"Guarantor" is a person other than the patient responsible for payment of the patient's medical bills.

"HCAP" is Ohio's Hospital Care Assurance Program. HCAP is Ohio's version of the federally required Disproportionate Share Hospital program. HCAP provides funding for hospitals that provide a disproportionate share of basic medically necessary hospital level services to qualified patients.

"Insured Patients" are individuals who have any governmental or private health insurance.

"Medically Necessary Care" shall mean those services reasonable and necessary to diagnose and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care generally accepted at the time services are provided. Medically necessary care does not include most transplantation services nor does it include supplements or certain outpatient prescription medications. Notwithstanding the foregoing, certain dentistry and certain integrative and functional medicine services are not covered under this policy.

"Policy" shall mean this Financial Assistance Policy as currently in effect.

"Resident" shall mean a person who is a legal resident of the United States and who has been a legal resident of the state in which medical services are sought for at least six (6) months at the time services are provided or who otherwise has the intent to remain in the state in which medical services are sought for at least six (6) months after services are provided.

"Uninsured Patients" are individuals: (i) who do not have governmental or private health insurance; (ii) whose insurance benefits have been exhausted; or (iii) whose insurance benefits do not cover the Medically Necessary Care the patient is seeking.

III. Relationship to Other Policies

A. Policy Relating to Emergency Medical Care

Consistent with EMTALA, all applicable CCHS facilities will provide an appropriate medical screening to any individual, regardless of ability to pay, requesting treatment for a potential emergency medical condition. A facility will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for financial assistance. If, following an appropriate medical screening, CCHS personnel determine that the individual has an emergency medical condition, CCHS will provide services, within the capability of the CCHS facility, necessary to stabilize the individual's emergency medical condition, or will effect an appropriate transfer as defined by EMTALA (see CCHS's EMTALA Policy).

B. CCHS HCAP Policy

CCHS facilities in Ohio are participants in HCAP. All HCAP services are governed by CCHS' HCAP Policy, and nothing in this Policy is intended or should be interpreted to limit an HCAP-eligible person's assistance under HCAP. HCAP covers only basic, medically necessary hospital level services. In some cases, qualified HCAP recipients may be eligible for financial assistance under this Policy for Medically Necessary Care provided by a CCHS employed-physician that is not covered by HCAP.

C. Prescription Drug Coverage

Patients in need of assistance with the costs of their prescription medications not covered under this policy may qualify for one of the patient assistance programs offered by pharmaceutical companies. Please contact the Cleveland Clinic via phone at 866.650.6337 for more information.

IV. Eligibility Criteria for Financial Assistance

Patients who meet the qualifications below are eligible for the assistance described in Section VII under this Policy.

A. **Ohio Facilities**

Patients seeking care at CCHS Ohio facilities are eligible for financial assistance under this Policy under one of the three following categories of financial eligibility:

1. Income Based Financial Assistance:
   a. Patients who are Uninsured Patients and whose Annual Family Income does not exceed 400% of the FPG,
   b. Who are seeking Emergency Care or Medically Necessary Care for inpatient or outpatient hospital or physician services, and
   c. Who are Residents of Ohio
2. Maternity Services Assistance: Pregnant patients with insurance that does not provide maternity benefits will be eligible for financial assistance for maternity services under this category if their Annual Family Income does not exceed 400% of the FPG, they are Ohio residents and they agree to work with CCHS to determine if they may be eligible for coverage under a government program.
3. Catastrophic Balance Financial Assistance: Patients who have excessive medical expenses that have resulted in a balance due to CCHS on charges incurred for an episode of care that are greater than 15% of the patient's Annual Family Income.

Additional Ways to Qualify for Assistance in Ohio. A patient who does not otherwise qualify for financial assistance under this Policy but is unable to pay for the cost of Medically Necessary Care may seek assistance in the following circumstances:

1. Exceptional Circumstances: Patients who relay that they are undergoing an extreme personal or financial hardship (including a terminal illness or other catastrophic medical condition).
2. Special Medical Circumstances: Patients who are seeking treatment that can only be provided by CCHS medical staff or who would benefit from continued medical services from CCHS for continuity of care.

Requests for assistance due to Exceptional Circumstances or Special Medical Circumstances will be evaluated on a case-by-case basis.

B. **Nevada Facilities**

Patients seeking care at CCHS Nevada facilities are eligible for financial assistance under this Policy under the two following categories of financial eligibility:

1. Income Based Financial Assistance:
   (i) Patients who are Uninsured Patients and whose Annual Family Income does not exceed 400% of the FPG,
   (ii) Who are seeking Medically Necessary Care for outpatient services, and
   (iii) Who are Residents of Nevada
2. Catastrophic Balance Financial Assistance: Patients who have excessive medical expenses that have resulted in a balance due to CCHS on charges incurred for an episode of care that are greater than 15% of the patients Annual Family Income.

Additional Ways to Qualify for Assistance in Nevada. A patient who does not otherwise qualify for financial assistance under this Policy but is unable to pay for the cost of Medically Necessary Care may be granted assistance in the following circumstances:

1. Exceptional Circumstances: Patients who relay that they are undergoing an extreme personal or financial hardship (including a terminal illness or other catastrophic medical condition).

2. Special Medical Circumstances: Patients who are seeking treatment that can only be provided by CCHS medical staff or who would benefit from continued medical services from CCHS for continuity of care.

Requests for assistance due to Exceptional Circumstances or Special Medical Circumstances will be evaluated on a case-by-case basis.

C. **Medicaid Screening**. Uninsured Patients seeking care at an Ohio facility may be contacted by a representative to determine whether they may qualify for Medicaid. Uninsured Patients must cooperate with the Medicaid eligibility process such that CCHS may make a determination of the patient's qualification for financial assistance under this Policy.

V. Method of Applying

A. **Income-Based Financial Assistance**

1. Presumptive Financial Assistance. Upon scheduling in Ohio and Nevada or prior to admission in Ohio, those Uninsured Patients that CCHS determines through third party verification databases to have Annual Family Income at or under 400% of the FPG will be deemed eligible for financial assistance without further information or documentation. The patient will be notified in writing and, if deemed eligible for less than 100% assistance, will have the opportunity to submit a Financial Assistance Application if the patient believes he or she may qualify for more assistance.

2. Patients seeking Emergency Care will be treated without regard for whether they are eligible for financial assistance. If medically appropriate, a patient who received Emergency Care may receive information in our Emergency Departments from a Patient Financial Advocate about the availability of financial assistance and an Application may be initiated on their behalf.

3. Any other patient seeking income-based financial assistance at any time in the scheduling or billing process may complete the Financial Assistance Application and will be asked to provide information on Annual Family Income for the three-month period immediately preceding the date of eligibility review. Third party income verification services may be used as evidence of Annual Family Income. The Financial Assistance Application may be found in our Emergency Departments and Admissions areas, on the back of your printed statement from Cleveland Clinic, or from a Patient Financial Advocate at our facilities or online at www.clevelandclinic.org/financialassistance, or by calling Patients First Support Services at 866.621.6385.

4. If there is a discrepancy between two sources of information, a CCHS representative may request additional information to support Annual Family Income.

B. **Catastrophic Balance**

Monthly, during the billing process, CCHS may use third party verification databases to determine if a patient balance due on charges incurred for an episode of care exceed 15% of Annual Family Income. If so, CCHS will presume the patient is eligible for financial assistance and notify the patient in writing. If the balance does not exceed 15% of Annual Family Income based on third party verification data, the patient will not be presumed to have a catastrophic balance.

C. **Exceptional Circumstances**

For any patient identified in Ohio or Nevada as having incurred or being at risk to incur a high balance or as reporting an extreme personal or financial hardship CCHS will gather information on financial circumstances and personal hardships from the patient. Determinations are made by Patients First Support Services (PFSS) under the direction of the CFO. The patient will be notified in writing of the final determination.

D. **Special Medical Circumstances**

For any patient identified during the scheduling or admission process as having potential special medical circumstances, a Patient Financial Advocate will solicit a recommendation from CCHS medical staff as to whether the patient needs treatment that can only be provided by CCHS medical staff, or would benefit from continued medical services from CCHS for continuity of care. The patient will be notified in writing if they do not qualify financial assistance due to special medical circumstances. A recommendation must be made by the CCHS physician who is or would be providing the treatment or care which will be transmitted to PFSS. Determinations on special medical circumstances are made by the treating physician and/or Department Chair.

E. **Incomplete or Missing Applications**

Patients will be notified of information missing from the Financial Assistance Application and given a reasonable opportunity to supply it. If missing information is not supplied, CCHS may use third party income verification databases to complete the Financial Assistance Application.

VI. Eligibility Determination Process

A. Financial Interview

A CCHS Patient Financial Advocate will attempt to contact by telephone all Uninsured Patients who are not presumptively eligible for financial assistance at the time of scheduling. The Patient Financial Advocate will ask for information, including family size, sources of family income and any other financial or extenuating circumstances that support eligibility under this Policy and will complete an Application accordingly. At the time of the appointment or upon admission, patients will be asked to visit the Patient Financial Advocate and sign the Financial Assistance Application.

B. Applications

Any Financial Assistance Application, whether completed in person, online, delivered or mailed in, will be forwarded to the Patients First Support Services team (PFSS) for evaluation and processing.

C. Determination of Eligibility

PFSS will evaluate and process all Financial Assistance Applications. The patient will be notified by letter of the eligibility determination. Patients who qualify for less than 100% financial assistance (other than those deemed presumptively eligible) will receive an estimate of the amount due from a Patient Financial Advocate and will be requested to set up payment arrangements or pay a 50% deposit prior to scheduling; provided however, that such payment arrangements are never required as a condition to receiving treatment for Emergency Care.

VII. Basis for Calculating Amounts Charged to Patients, Scope, and Duration of Financial Assistance

Patients eligible for awards of income-based financial assistance under the Policy will receive assistance according to the following income criteria:

1. If your Annual Family Income is up to 250% of the FPG, you will receive free care.
2. If your Annual Family Income is between 251% and 400% of the FPG, you will receive care discounted from gross charges to the "amount generally billed" to Insured Patients for such services.

As used herein, the "amount generally billed" has the meaning set forth in IRC §501(r)(5) and any regulations or other guidance issued by the United States Department of Treasury or the Internal Revenue Service defining that term. See Appendix A for a detailed explanation of how the "amount generally billed" is calculated.

Once CCHS has determined that a patient is eligible for income-based financial assistance, that determination is valid for ninety (90) days from the date of eligibility review. After ninety (90) days, the patient may complete a new Financial Assistance Application to seek additional financial assistance.

For patients who have been approved for assistance with a Catastrophic Balance, those identified charges will be covered.

For patients who have been approved for assistance under Exceptional or Special Medical Circumstances, the patient will be covered under this Policy for 100% of unpaid charges and for charges for all Emergency and Medically Necessary Care provided during the period necessary to complete treatment or care as may be determined by the treating CCHS physician. A patient whose financial situation has changed may request to be re-evaluated at any time.

VIII. Determination of Eligibility for Financial Assistance Prior to Action for Non-Payment

A. Billing and Reasonable Efforts to Determine Eligibility of Financial Assistance

CCHS seeks to determine whether a patient is eligible for assistance under this Policy prior to or at the time of admission or service. If a patient has not been determined eligible for financial assistance prior to discharge or service, CCHS will bill for care. If the patient is insured, CCHS will bill the patient's insurer on record for the charges incurred. Upon adjudication from the patient's insurer, any remaining patient liability will be billed directly to the patient. If the patient is uninsured, CCHS will bill the patient directly for the charges incurred. Patients will receive a series of up to four billing statements over a 120 day period beginning after the patient has been discharged delivered to the address on record for the patient. Only patients with an unpaid balance will receive a billing statement. Billing statements include a Plain Language Summary of this Policy and how to apply for financial assistance. CCHS will also proactively seek to identify patients who are eligible for income-based financial assistance under this Policy through use of third party verification databases. Patients who are identified as presumptively eligible for income-based assistance will be notified and may apply for additional assistance. Reasonable efforts to determine eligibility include: notification to the patient by CCHS of the Policy upon admission and in written and oral communications with the patient regarding the patient's bill, an effort to notify the individual by telephone about the Policy and the process for applying for assistance at least 30 days before taking action to initiate any lawsuit, and a written response to any Financial Assistance Application for assistance under this Policy submitted within 240 days of the first billing statement with respect to the unpaid balance or, if later, the date on which a collection agency working on behalf of the Cleveland Clinic returns the unpaid balance to the Clinic.

B. Collection Actions for Unpaid Balances

If a patient has an outstanding CCHS balance after up to four billing statements have been sent during a 120 day period, the patient's balance will be referred to a collection agency representing CCHS which will pursue payment. CCHS and its collection agencies do not report to credit bureaus nor do they pursue wage garnishments or similar collection actions. Collection agencies representing CCHS have the ability to pursue collection for up to 18 months from the point when the balance was sent to the collection agency. A patient may apply for financial assistance under this Policy even after the patient's unpaid balance has been referred to a collection agency. After at least 120 days have passed from the first post-discharge billing statement showing charges that remain unpaid, and on a case-by-case basis, CCHS may pursue collection through a lawsuit when a patient has an unpaid balance and will not cooperate with requests for information or payment from CCHS or a collection agency working on its behalf.

In no case will Emergency Care be delayed or denied to a patient because of an unpaid balance. In no case will Medically Necessary Care be delayed or denied to a patient before reasonable efforts have been made to determine whether the patient may qualify for financial assistance. In Ohio and Nevada, an uninsured patient who seeks to schedule new services and has not been presumed eligible for financial assistance will be contacted by a Patient Financial Advocate who will notify the patient of the Policy and help the patient initiate an Application for financial assistance if requested.

C. Review and Approval

CCHS's Patients First Support Services (PFSS) has the authority to review and determine whether reasonable efforts have been made to evaluate whether a Patient is eligible for assistance under the Policy such that extraordinary collection actions may begin for an unpaid balance.

IX. Physicians not Covered under the CCHS Financial Assistance Policy

Most services provided by physicians at Cleveland Clinic facilities are covered by the CCHS FAP, as described below.

Physicians working at each facility who are not covered under the FAP are identified in the attached Appendix B, Provider List, by name and the hospital facility where they practice. The list is updated quarterly and is also available online at www.clevelandclinic.org/financialassistance, in all our Emergency Departments and admissions areas, and upon request by calling Patients First Support Services (PFSS) or asking a Cleveland Clinic Patient Financial Advocate.

Ohio Main Campus Facility. All services by physicians, whether in the hospital or in a physician office, are covered under the FAP because the physicians are Cleveland Clinic employees with one exception. This is also true in all our Ohio Family Health and Surgery Centers, with very limited exceptions as listed under the heading "Ohio Main Campus, FHCs and Ohio ASCs".

Ohio Regional Hospitals. Most physicians performing services in our regional hospitals are in private practice. Their services are not covered under our FAP. You would receive a bill from us for the hospital services and a separate bill from them for their physician services. The names of the physicians whose services are not covered by the FAP are listed under the name of each regional hospital where they practice.

Ashtabula County Medical Center (ACMC) has its own separate Financial Assistance Policy (FAP) which covers ACMC and Glenbeigh. For the ACMC FAP see www.clevelandclinic.org/financialassistance.

Cleveland Clinic Rehabilitation Hospital has its own FAP. For the Cleveland Clinic Rehabilitation Hospital FAP, see www.clevelandclinic.org/financialassistance.

Select Cleveland Hospitals has its own FAP. For the Select Cleveland Hospital FAP, see www.clevelandclinic.org/financialassistance.

Union Hospital has its own FAP. For the Union Hospital FAP, see www.clevelandclinic.org/financial.

Florida. Cleveland Clinic Florida has its own FAP covering hospital and medical facilities in Southeastern and East Central Florida. For the Cleveland Clinic Florida FAP see www.clevelandclinic.org/financialassistance.

Nevada. All services by physicians in Nevada are covered under the FAP because the physicians practicing there are Cleveland Clinic employees.

X. Measures to Publicize CCHS's Financial Assistance Policy

CCHS is committed to publicizing this Policy widely within the communities served by CCHS facilities. To that end, CCHS will take the following steps to ensure that members of the communities to be served by its facilities are aware of the Policy and have access to the Policy.

A. CCHS will make a copy of its current Policy available to the community by posting a plain language summary of the Policy on its webpage along with a downloadable copy of the Policy and Financial Assistance Application with instructions for downloading copies. There is no fee for downloading a copy of the Policy, the Plain Language Summary or Financial Assistance Application.

B. CCHS will provide a plain language summary of the Policy in locations throughout its facilities where the summary will be available to patients and their families, including a plain language summary of the Policy to be provided with any invoices covering amounts charged for services.

C. Patient Financial Advocates will make a plain language summary of the Policy available to all patients with whom they meet and will provide to any person who requests it a copy of the Policy.

D. CCHS will include a description of how to obtain a copy of or information about the Policy in community benefit reporting done to the community at large.

E. CCHS will make information regarding its Policy available to appropriate governmental agencies and nonprofit organizations dealing with public health in CCHS's service areas.