Frisbie Memorial Hospital - Billing & Collections Policy

I. INTRODUCTION:

This Billing & Collections Policy seeks to balance the preservation of Frisbie Memorial Hospital's ("Hospital") assets and the maintenance of a sound financial basis for its operations with the needs of the Hospital's community and the patients it serves. Patients who have the means are expected to pay for services provided by the Hospital. This policy assumes that patients who have access to affordable insurance will apply for and maintain their coverage. In the event patients are unable to pay, the Hospital assists them in obtaining financial assistance from government programs and other sources for medically necessary services whenever appropriate.

To remain viable as it fulfills its mission, the Hospital must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This Billing & Collections Policy was developed to ensure compliance with applicable laws including but not limited to: (1) New Hampshire's Unfair, Deceptive or Unreasonable Collection Practices Act (RSA 358-C); (2) the federal Fair Debt Collection Practices Act (15 U.S.C §§ 1692-1692p); (3) the Centers for Medicare and Medicaid Services ("CMS") Medicare Bad Debt Requirements (42 C.F.R. § 413.89); and (4) Section 501(r) of the Internal Revenue Code. In undertaking these duties, the Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, gender identity, sexual orientation, age, or disability in providing its services. This applies to both the substance and application of the Hospital's policies concerning the acquisition and verification of financial information, pre-admission or pre-treatment deposits, payment plans, deferred services or admissions, and billing and collection practices.

This policy sets forth the Hospital's general guidelines for acquiring and verifying information, for classifying patients according to their ability to pay, and for collecting payment from third party insurance companies, patients, their guarantors, and others financially responsible for the payment of health care services. The policy applies to services delivered and billed by the Hospital excluding those services delivered and billed by the entities listed in Appendix A (Provider Affiliate List) even in the case where such services may be rendered at the Hospital.

II. DELIVERY OF HEALTH CARE SERVICES:

A. General Principle

All patients presenting for unscheduled treatment will be evaluated according to the classifications included in this section. Emergency or Urgent Services (as defined in Section II(B) below) shall not be denied or delayed based on the Hospital's ability to identify a patient, their insurance coverage, or ability to pay. However, Non-Emergency, Non-Urgent Services (as defined in Section II(C) below) may be indefinitely postponed in those cases where the Hospital is unable to determine a payment source for the services, based on consultation with the patient's treating clinician.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional in accordance with local, state, and national clinical standards of care, and the Hospital's medical staff policies and procedures. It is important to note that classification of patients' medical conditions are for clinical management purposes only, and such classifications are meant to address the order in which the Hospital's clinical staff should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition as reflected in the final diagnosis.

B. Emergency and Urgent Services

"*Emergency Services*" as referred to in this policy include:
Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B). A medical screening examination and any stabilizing treatment for an emergency medical condition, including but not limited to inpatient medical care or any other such service rendered to the extent required under Emergency Medical Treatment and Labor Act (42 U.S.C. § 1395(dd)), qualify as Emergency Services.

"*Urgent Services*" as referred to in this policy include:
Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health.

C. Non-Emergency, Non-Urgent Services

"*Non-Emergency, Non-Urgent Services*" as referred to in this policy include:
Medically necessary services that do not meet the definition of Emergency or Urgent Services set forth in Section II(B) above, or services that a treating clinician has determined are not medically necessary such as nonmedical services (e.g., social, educational, or vocational, cosmetic surgery, research, and other) (the latter category of services may be described in this policy as *Non-Medically Necessary Services*). The patient typically, but not exclusively, schedules these services in advance. The Hospital may decline to provide a patient with Non-Emergency, Non-Urgent Services in those cases when the Hospital is not successful in determining that payment will be made for the services.

III. COLLECTION AND VERIFICATION OF PATIENT INFORMATION:

It is the patient's obligation to provide complete and timely insurance and demographic information to the Hospital and to know what services are covered by their insurance policy. The Hospital will make diligent efforts to positively identify all patients and obtain, record, and verify complete demographic and financial information for every patient seeking care. The information to be obtained includes demographic information (such as patient name, address, telephone number, social security number, gender, date of birth, and other applicable patient information) and health insurance information (including name and address, policy number, group number, subscriber information, and benefit information such as co-payment, deductible and co-insurance amounts) that is sufficient to secure payment for services. The requirement for the Hospital to obtain complete information shall take the patient's condition into account with the patient's immediate health care needs taking priority. For inpatients, verification may occur at any time during the provision of services, at discharge or during the collection process. For outpatients, verification may occur at the time the patient receives Non-Emergency, Non-Urgent Services or during the collection process.

A. Emergency and Urgent Services

Registration and intake of Emergency and Urgent patients will be performed in accordance with the requirements of EMTALA. Generally, patient demographic and insurance information may be collected in accordance with the Hospital's normal registration process as long as such collection does not delay the

provision of the medical screening examination and/or any stabilizing treatment. Where a patient is unable to provide demographic or insurance information at the time of service and the patient consents, every effort should be made to interview relatives or friends that may accompany or otherwise be identified by the patient. Where practical, insurance information provided by the patient should be confirmed with the payer via electronic means or other available methods. Under no circumstance, however, shall Hospital staff verify a patient's insurance status, obtain pre-approval from third party payers, or give the patient financial responsibility forms prior to the medical screening examination and initiation of any stabilizing treatment.

B. Non-Emergency, Non-Urgent Services

Registration and intake of Non-Emergency, Non-Urgent patients should be performed prior to services being rendered. Returning or established patients will also have the demographic, insurance, and financial information reviewed and updated as needed, including where applicable, verification of their insurance status via electronic or other available methods. Patients have the responsibility to update insurance and demographic information with Registration.

IV. DETERMINATION OF PATIENT FINANCIAL RESPONSIBILITY:

A. General Principles

The Hospital will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care; provided that, screening and the initiation of any stabilizing treatment consistent with EMTALA will be completed for Emergency or Urgent patients prior to activities to determine a patient's financial responsibility. Patients who are members of managed care health plans, or insurance plans with specific access requirements are responsible for understanding and complying with all of their insurance plan requirements, including referrals, authorizations, non-covered benefits, and other 'network' restrictions. The Hospital will request any necessary pre-approval, authorization, or guarantees of payment from the insurer whenever possible. Under some circumstances, including Emergency or Urgent Services, these referrals and authorizations may take place after service delivery. All patients who incur a balance for services will be informed of the availability of a Financial Advocate to assist them in fulfilling their financial responsibility to the Hospital. The Hospital will make its best efforts to advise all patients of any significant financial responsibility prior to any Non-Emergency, Non-Urgent Service delivery to the extent that this information is available to the Hospital.

B. Preparation of Estimates

Upon request by a patient prior to the delivery of a Non-Emergency, Non-Urgent Service, the Hospital shall provide an estimate of the allowed amount or charge for the service including the amount of any facility fees. The estimate information is gathered and then calculated generally by the Hospital using historic average allowed amounts or charges based on the projected medical or surgical service and, if applicable, estimated length of stay. Estimates do not take into account all services delivered and billed by the organizations listed in Appendix A. Final balances may differ from the estimate provided to the patient due to extenuating circumstances which may require more complex procedures, exams, and/or evaluations. Estimates require the participation of the patient and the treating clinician to reasonably identify expected future treatment and clinical care. Once the clinical services necessary to base the estimate upon are identified, the Hospital provides the final estimate to the patient along with payment options.

C. Insured Patients

The Hospital will make diligent efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their health insurance plan. Patients are responsible for obtaining referrals from other providers, when required. Insurance verification will occur in accordance with the principles

previously outlined in Section III above. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-payment, deductibles, and co-insurance. Where feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles, pre-service deposits) associated with a Non-Emergency, Non-Urgent service will be secured from the patient prior to or on the date of service. Where feasible and clinically appropriate, the Hospital may collect co-payments, deductibles, or, in the case of a self-pay patient, a reasonable minimum deposit, at the time of discharge of an Emergency or Urgent patient. In some cases, the patient's insurance plan and type of coverage may not allow for an exact determination of the patient's financial responsibility prior to services being rendered. In those cases, the Hospital may request a deposit equal to its best estimate of the patient's expected financial responsibility. Patients who are unable to provide payment in advance of the receipt of any Non-Emergency, Non-Urgent service or following the receipt of an Emergency or Urgent service may be referred to a Financial Advocate or Customer Service Representative.

1) Contracted Insurance Plans

The Hospital contracts with a number of insurance plans. In those cases, the Hospital will seek payment from the insurance plan for all covered services. To assist patients with establishing their out-of-pocket costs, the Hospital shall, upon the request of the patient, provide sufficient information regarding the proposed Non-Emergency, Non-Urgent Service. If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

2) Non-contracted Insurance Plans

The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor (the party responsible for the patient's personal financial obligations). The insurer's failure to respond to the Hospital's bill in a timely manner may result in the patient being billed directly for the services except in those cases where the patient is protected from collection actions (Section IX(B)(6)). Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

D. Uninsured Patients (Self Pay)

Hospital charges to patients who do not have health insurance is limited to the Amount Generally Billed ("AGB") by the Hospital for patients covered by health insurance. *See*, calculation of AGB in the Hospital's Financial Assistance Policy available at https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/. This limitation on Hospital charges applies to both Emergency and Urgent services and Non-Emergency, Non-Urgent services. The Hospital shall provide written notice to uninsured patients of this limitation on its charges in advance of providing a service and at the time the service is billed.

When an estimate of the AGB is not available in advance of the delivery of the Non-Emergency, Non-Urgent service, a pre-determined deposit will be requested. If the patient does not provide the pre-payment or indicates an inability to pay the deposit, then the patient may be referred to a Financial Advocate or Customer Service Representative.

Uninsured patients will be referred to a Financial Advocate or Customer Service Representative to determine their eligibility for available State programs, and if eligible, a Financial Advocate or Customer Service Representative shall assist such patient in applying for such programs. In addition to the potential availability of any government programs, all uninsured patients will be provided information on possible financial assistance programs available under the Hospital Financial Assistance Policy (available at https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/, by calling the Hospital's Patient Accounting and Finance Department at (603) 330-8930, or by visiting a Financial Advocate or Customer Service Representative in person at the Hospital). If there is no immediate need to provide the services as determined by the treating clinician, the Non-Emergency, Non-Urgent service may be indefinitely postponed until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.

V. FINANCIAL COORDINATION SERVICES:

A. Generally

The Hospital will make diligent efforts to identify patients who may be uninsured or underinsured in order to provide counseling and assistance. The Hospital will provide financial counseling to these patients and their families, including screening for eligibility for other sources of coverage, such as State government programs, and providing information regarding all acceptable methods of payment of the Hospital bill. If additional financial assistance is required, Patient Accounting and Finance may extend discounts or other adjustments to patients if they qualify under the Hospital Financial Assistance Policy. The patient has a number of responsibilities in order to qualify for assistance, including the obligation to submit all necessary and accurate documentation.

B. Communication of Financial Coordination Services

The Hospital widely publicizes information about the availability of financial assistance programs, including where to go for assistance. Please reference the Hospital's Financial Assistance Policy for additional details (available at https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/).

C. Residency

Residency is a determinant of available financial assistance eligibility under the available State and Hospital financial assistance programs. Please reference the Hospital's Financial Assistance Policy for additional details (available at https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/).

D. Hospital Financial Assistance, Discounts, Charity Care

Patients are encouraged to first apply for State and/or Federal programs. If the patient is not eligible for these programs, financial assistance may be available under the Hospital Financial Assistance Policy.

E. Special Application Considerations

1) Confidential Applications: Confidential applications for Hospital financial assistance may be considered by the Hospital on a case by case basis.

2) Undocumented Persons: Patients may be concerned about the immigration implications of applying for available State programs. Patients with limited means to pay will be encouraged to apply for New Hampshire Medicaid or other government sponsored programs. If patients continue to express concern, patients may be referred to outside agencies for counsel. Patients refusing to apply for

assistance will continue to be treated as Uninsured and Urgent and Emergency Services will continue to be provided. Non-Urgent, Non-Emergency services may be indefinitely postponed until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

VI. STATE PROGRAMS- NEW HAMPSHIRE RESIDENTS:

In addition to following the general procedures for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients above, the Hospital will encourage patients who are potentially eligible for coverage from New Hampshire Medicaid or other government programs to apply for coverage and may assist the patient in applying for benefits.

A. Application Process – New Hampshire Medicaid

The Hospital assists the patient in completing the application for New Hampshire Medicaid and securing and submitting the necessary documentation required by the Program. Individuals apply for coverage through the appropriate application that is submitted to the State. Necessary documentation may include, but is not limited to proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets. The State will notify the patient of any documentation that needs to be submitted for final verification.

B. Approval for Coverage under New Hampshire Medicaid

The Hospital may assist patients with applying for coverage under New Hampshire Medicaid but has no role in the determination of program eligibility made by New Hampshire Medicaid. New Hampshire Medicaid will issue all notices of eligibility. It is still the patient's responsibility to inform the Hospital of all coverage decisions made to ensure accurate and timely adjudication of all Hospital bills.

C. Effect of a Pending Medicaid Application

Patients for whom the Hospital has submitted a New Hampshire Medicaid application will have bills held until such determination is made.

D. Appeal of Outcome

The patient may take a direct role in appealing or seeking information from New Hampshire Medicaid related to their coverage decision. The request must be sent to New Hampshire Medicaid with supporting documentation.

VII. NON-NEW HAMPSHIRE RESIDENTS:

A. Non-New Hampshire U.S. Residents

In addition to following the procedures stated for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients, the Hospital will encourage non-New Hampshire U.S. resident patients who are potentially eligible for coverage under their own state Medicaid or other government programs (the Non-New Hampshire U.S. Resident State Programs) to apply for coverage.

1) The Hospital has no role in the determination of program eligibility made by Non-New Hampshire U.S. Resident State Programs. Those programs will issue all notices of

eligibility, not the Hospital. It is still the patient's responsibility to inform the Hospital of all coverage decisions made to ensure accurate and timely adjudication of all Hospital bills.

2) The patient may take a direct role in appealing or seeking information from the Non-New Hampshire U.S. Resident State Program related to the coverage decision.

B. International Patients

In addition to following the procedures stated for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients, the Hospital will make every reasonable effort to gather local and permanent address information for residents of foreign countries and take whatever appropriate additional actions are needed in order to secure pre-payment for all Non-Emergency, Non-Urgent services.

VIII. PAYMENT ARRANGEMENTS:

A. Generally

Payments may be made in a variety of settings at the Hospital. Different payment arrangements may be available including deposits (down payments) and payment plans. The patient or guarantor is able to make these arrangements with an the Financial Advocate or Customer Service Representative. All payment arrangements will conform to pre-determined criteria and be recorded appropriately in the Hospital's billing and registration systems.

B. Forms of Payment

Payments may be made by certified/bank check, credit/debit cards or cash. Acceptance of personal checks will be dependent on a range of factors including, but not limited to the amount, the bank the check is drawn on, and the patient's prior relationship with the Hospital. Personal checks may be requested sufficiently in advance of a scheduled service in order to allow time for verification of the check. Patients who have a history of bad debt may be reviewed individually to determine the appropriate mode of payment. The Hospital will maintain a process to track "bad" checks and reverse any payments that may have been applied to the patient's account. Submission of a "bad" check may be grounds for transferring the account to Bad Debt.

C. Currency

Unless otherwise agreed to, payment will be made in U.S. currency.

D. Payment Plans

Self-pay account payment plans will be worked based on the patient request using the below guidelines. These payment plans can be set up by Financial Advocates and Customer Service Representatives.

Up to $99.99– no payment plans available
$100 to $499.99 - over 10 months
$500 to $999.99 - over 12 months
$1,000.00 or more – over 15 months

Patients can request a payment plan from 18 to 24 months. Upon request by a patient, the Hospital may, in its sole discretion, extend a payment plan up to 36 months. These accounts will be reviewed by the Supervisor of Customer Service. The Manager of Patient Accounts will approve and give appropriate action. Blind payment

plans may also be set up for patients who have made 2 monthly payments that fall within the above guidelines to avoid collection activity.

E. Deposits

Hospital reserves the right to request advance payment in full for patients who receive Non-Emergency, Non-Urgent services. If an estimated price is not available, patients will be required to provide a deposit (down payment toward future expected balance). Hospital will not require pre-admission and/or treatment deposits from individuals that require Emergency or Urgent Services or from individuals who are protected from such collection actions under applicable state laws.

IX. PATIENT BILLING AND COLLECTIONS:

A. General Principles

The Hospital will make diligent efforts to collect all charges that are due from insurers according to established industry standards and will seek to apply payments and contractual adjustments on a timely basis to the patient's account. These efforts include billing all available insurance plans according to the payers' requirements and timely follow up of denied claims. Patients or other guarantors will be held responsible for all account balances that remain after application of all insurance payments, contractual adjustments, and agreed upon discount/adjustments in accordance with any remittance advice received from the payer except where the balance may be deemed exempt from collection activity under New Hampshire laws. Collection actions may include patient statements, patient letters, telephone contacts, and certified final collection notices.

It is the patient's obligation to provide complete and timely insurance and demographic information and to know what services are covered by their insurance policy. Patients who have the means are expected to pay for services rendered by the Hospital.

B. Hospital Billing Practices, including Patient Statements, Letters, and Calls

The Hospital will make diligent efforts to ensure the appropriate party is billed and collection is made from the appropriate payer. The Hospital, either directly or through its designated agents, will prepare and mail statements to patients/guarantors on a regular basis to advise them of balances owed to the Hospital. A record of all account actions and communications, including bills, is typically reflected in the billing system. Staff is required to document all contacts with the patient (or guarantor) in the applicable billing system, registration system, or self-pay collection system.

1) Initial Patient Bill: The Hospital will send an initial bill to the patient or the guarantor. The initial bill will have a summary of all charges, payments, and adjustments included with the initial billing for each date of service/admission. The initial bill will provide information about the availability of financial assistance programs that might be able to cover the cost of the Hospital's bill.

2) Subsequent Billing: The Hospital expects to continue billing the patient or guarantor approximately every 30 days for up to 120 days, which is the appropriate period of time representing continuous billing and collection actions.

3) Telephone Calls and other Communication: Telephone calls, billing statements, letters, personal contacts, notices, or any other notification method constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance.

4) Suspension of Billing: In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include, but are not limited to: Bad Address (Section IX(B)(8)), Bankruptcy cases (Section IX(C)(1)), deceased patient (Section IX(C)(2)), patient grievance, small balances (Section IX(B)(9)), pending or approved New Hampshire Medicaid eligibility (Section VI(C) and Section IX(B)(6)), or patients who are in the process of applying for Hospital Financial Assistance.

5) Notification of Availability of Financial Assistance: Patient statements will include notices as required by applicable laws to inform patients of the availability and means to access financial assistance. Notices regarding the availability of financial assistance will also be included in other written and verbal patient communications at intake and discharge.

6) Patients Protected From Collection Action: The Hospital will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action under applicable laws. This may include patients with a pending New Hampshire Medicaid application (Section VI(C)), or with a pending request for financial assistance under the Hospital Financial Assistance Policy. The Hospital may continue to send letters requesting information or action by the patient to resolve coverage and/or eligibility issues with a primary payer, Worker's Compensation Program or to obtain any Third Party Liability or MVA carrier information.

7) Final (Collection) Notice: The Hospital will make reasonable efforts to send each patient a final (collection) notice by certified mail prior to the account being transferred to Bad Debt. Notices for patients who are minors will be sent to the guarantor.

8) Bad Address Returns: The Hospital will make reasonable efforts to track, research, and rebill all patient statements returned by the USPS that are not deliverable. Address information will be verified and corrected using "skip trace" programs that may be available from third parties. Where possible, accounts will be identified as "Bad Address" accounts in the billing and registration systems. Once an account has been flagged as Bad Address, no further statements or letters should be processed unless a new address has been identified. The Hospital will discontinue mailing of statements to incorrect addresses to maintain HIPAA privacy. Accounts whose most recent demographic information contains a Bad Address may be referred to outside agencies as Bad Debt for additional follow up.

9) Small Balance Adjustment: Recognizing the cost of statement processing and collection activities, after the initial statement, the Hospital may suppress statements on accounts below its $5 "small dollar billing" threshold. This policy shall be consistently applied across all payers.

C. Special Collections Situations

1) Patient Bankruptcy: The Hospital will make reasonable efforts to track all Bankruptcy notifications, and maintain them on file to ensure that all approved court procedures are followed, including forgiveness of debt.

2) Deceased Patients: When appropriate and cost effective, the Hospital will perform estate searches, bill estates, and file liens against the estate.

D. Special Account Processing Considerations

Under some circumstances, additional information or procedures may be necessary to properly process a patient's account.

1) Worker's Compensation (WC): Services related to industrial accidents should be appropriately labeled in the registration record. Additional information that is required includes the date and time of accident, employer name and phone number, and employer's worker's compensation carrier and phone number. The Hospital will make reasonable attempts to pursue the WC coverage. Any recoveries that may be received after the submission of a claim will be offset against the original claim and reported to the payer including any required claim voids or returns. If there is no WC coverage, then the claim is managed in the ordinary billing manner.

2) Motor Vehicle Accidents (MVA) and Third Party Liability (TPL): Services related to a motor vehicle accident or other third party liability may be labeled as MVA self-pay.

3) Health Insurance Portability and Accountability Act (HIPAA): Under HIPAA, patients who have paid the Hospital in full for a specific item or service have the right to request that their PHI (Protected Health Information) regarding such item or service not be sent to their health insurance plan for purposes of payment unless such disclosure is otherwise required by applicable law. Such restriction only applies to the specific item or service delivered and billed by the Hospital. Patients that wish to exercise such restriction are expected to pay any outstanding balance in full at the time of service or, if the balance cannot be fully estimated at the time of service, upon receiving statements. If the Hospital is unable to secure payment in full from the patient requesting such restriction after reasonable efforts, the Hospital may notify the patient and bill the patient's health plan. Accounts should be noted per procedure to guard against inappropriate release.

4) Research Studies: Services related to research studies should be noted at time of registration for that service and labeled to ensure that charges for these services are submitted to the designated research fund.

5) Organ Donors: The Hospital will identify organ donors at the time of service and ensure that claims for these services are applied to the appropriate insurance or other funding source.

X. BAD DEBT PLACEMENT:

A. Transfer of Account to Bad Debt

The Hospital will make a reasonable effort to qualify a patient for financial assistance under State or Hospital programs by notifying the patient in writing about the available assistance programs and assisting such individual with the completion of the applications. Once such reasonable efforts have been made and all internal collection efforts exhausted, accounts may be transferred to Bad Debt. This will typically occur after the account has completed its 120 day patient billing cycle with some exceptions due to Bad Address or other mitigating circumstances. Accounts in Bad Debt will generally receive additional collection efforts through a

number of sources including staff, external collection agencies, or collection attorneys in accordance with applicable laws.

B. Collection Agencies

Any agency seeking to collect patient balances on behalf of the Hospital will be required to conform to this policy, including the obligation to refrain from Extraordinary Collection Actions (ECAs) (as defined below) until such time as the Hospital has made a reasonable effort and followed a reasonable process for determining that a patient is entitled to assistance or exemption from any collection or billing procedures under this policy and the Hospital's Financial Assistance Policy. The Hospital's Patient Accounting and Finance Department has final authority for determining that the Hospital has made reasonable efforts to determine whether a patient is eligible for financial assistance such that the Hospital may engage in ECAs. Any substantive patient complaints will be reported to the Hospital for review and tracking. All agents will fully comply with applicable IRS and Federal Fair Debt Collection laws as well as New Hampshire laws regarding debt collection. All agencies will report any collection or other account actions, including the decision to cease collection efforts, on a timely basis.

XI. CREDIT BALANCES AND REFUNDS:

Generally, the Hospital will refund to patients any credit balances, which may result from excess funds having been collected from the patient. However, if a patient has an existing outstanding balance with the Hospital, the Hospital may seek the patient's consent to apply such credit balance to any outstanding Hospital balances. In cases where efforts to refund a credit balance are unsuccessful, the Hospital will remit credit balances to the New Hampshire Office of the Treasurer in accordance with the state's Abandoned Property regulations.

XII. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

The Hospital also maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

XIII. PATIENT RIGHTS AND RESPONSIBILITIES:

The Hospital shall inform patients of their obligation to:

1) Provide complete and timely insurance and demographic information. Inform the Hospital and the New Hampshire Medicaid program of any changes in status including changes in income.

2) Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance, and deductibles.

3) For patients who have the means, pay for services rendered by Hospital, including co-payments, deductibles, and co-insurance amounts, in a timely manner.

4) Conform with insurance referral, pre-authorization, and other medical management policies. Conform with other insurance requirements including completion of coordination of benefits forms, updating membership information, updating physician information, understanding benefit coverage, and other payer requirements. For non-coverage of select medical services, acknowledge and arrange for alternative payment.

5) For New Hampshire residents, obtain coverage through the New Hampshire Medicaid program, including submission of all required documentation.

6) Notify the Hospital, of any potential Motor Vehicle Accident coverage, Third Party Liability coverage, or Worker's Compensation coverage. For patients covered by New Hampshire Medicaid, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the state public program (e.g. New Hampshire DHHS Division of Family Assistance) within ten days of information related to any lawsuit or insurance claim that will cover the cost of services provided by the Hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the State from the funds received from the third party.

XIV. PUBLICATION OF BILLING & COLLECTIONS POLICY:

The Hospital Billing & Collections policy, Provider Affiliate List, and Hospital Financial Assistance Policy are available at: https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/. The website includes various ways in which patients can apply for assistance from the Hospital, including a list of Financial Coordination locations and contact phone numbers.

APPENDIX A
PROVIDER LIST

1. Anesthesia North American Partners;
2. Salmon Falls Pathology;
3. Seacoast Radiology;
4. Surgical Associates of Rochester;
5. Atlantic Digestive Associates;
6. Seacoast Orthopedics Sports Medicine;
7. Eyesight (Dr. Goldblatt); and
8. Granite State Labs.