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		DEP'T POLICY:	PFS 4.08
		CATEGORY:	Financial Control
Prepared By:	Director of Compliance, Senior Leadership Team	SUBJECT:	Financial Assistance Policy
Approved By:	Board of Directors	Effective Date:	05/02
Reviewed:	07/05, 10/07, 10/08, 06/09, 03/10, 11/10, 09/11, 01/12, 10/12, 03/13, 01/14, 03/15, 12/15, 3/16, 12/16, 09/17, 5/20	Revised:	10/07, 06/09, 09/11, 03/13, 07/13, 01/14, 03/15, 06/15, 12/15, 3/16, 4/16, 12/16, 9/17, 5/20

Section 1. PURPOSE

Baxter Regional Medical Center ("BRMC") is a not-for-profit healthcare delivery system that recognizes its obligation to provide financial assistance to patients in need. BRMC is committed to using its resources to aid the communities and patients it serves to preserve human dignity and worth as well as general quality of life. At the same time, however, BRMC strives to provide the highest quality care possible, which requires it to use its financial resources wisely to ensure a strong financial position that will allow for the replacement of buildings and equipment, adequate reserves for emergencies, and the potential for future technological developments and medical services. This Policy applies specifically to emergency or other medically necessary care provided by BRMC or its substantially related entities. Due to the COVID-19 public health emergency, BRMC has updated this Policy for 2020 to include a broader range of income levels that qualify for financial assistance. BRMC will review the Policy in one year to assess the qualifying income levels.

Section 2. NON-DISCRIMINATION STATEMENT AND TRANSLATION SERVICES

Baxter Regional Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Baxter Regional does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baxter Regional Medical Center provides (1) free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats, and (2) free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages. If you need these services, call 1-870-508-7770.

If you believe that Baxter Regional has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with either:

Baxter Regional Medical Center
Civil Rights Coordinator
624 Hospital Dr.
Mountain Home, AR 72653
Phone: 1-870-508-7555
Fax: 1-870-508-1998
Email: civilrights@baxterregional.org

U.S. Department of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
Web: https://ocrportal.hhs.gov/ocr/portal/
lobby.jsf

If you need help filing a grievance, the Civil Rights Coordinator is available to help you. For U.S. Department of Health and Human Services complaints, complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TRANSLATION SERVICES

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-870-508-7770.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-1-870-508-7770.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-870-508-7770.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-870-508-7770。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-870-508-7770.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-870-508-7770.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-870-508-7770.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-870-508-7770.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-870-508-7770.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-870-508-7770. 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-870-508-7770.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-870-508-7770 まで、お電話にてご連絡ください。

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-870-508-7770 पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-870-508-7770.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-870-508-7770

Section 3. DEFINITIONS

A. The following terms are used in this policy as defined below:
Amounts Generally Billed (AGB) – the sum of all "allowed" claims for all medical care, as paid by Medicare fee-for-service and all private insurers, during the prior 12-month period and divided by the sum of the associated gross charges for all medical care claims.

B. **Household Income** – the income for all working members of the household as attested either in a federal income tax return or an earnings statement from the patient's employer.

C. **Presumptive eligibility** – program under which a person is presumed to be eligible for financial assistance based on evidence of need.

D. **Qualified Financial Assistance Recipient (QFAR)** - A person who meets the eligibility requirements of Section 3.3 of this policy, completes the application

process for financial assistance, and is determined by BRMC to be qualified for financial assistance under this policy.

E. **Substantially Related Entity** - an entity that is treated as a partnership for federal tax purposes in which a hospital organization owns a capital or profits interest (or a disregarded entity of which the hospital organization is the sole owner or member) and that provides, in a hospital facility operated by the hospital organization, emergency or other medically necessary care that is not an unrelated trade or business with respect to the hospital organization.

Section 4. ELIGIBILITY FOR FINANCIAL ASSISTANCE

Section 4.1. General Eligibility Considerations

In furtherance of this purpose, the Board of Directors of Baxter Regional Medical Center has resolved and is committed to providing financial assistance to patients who are eligible for such assistance according to this Policy and its underlying federal regulations. Patients may be eligible for such assistance if all of the following circumstances exist:

A. The patient needs emergency or other medically necessary care, as identified by a licensed physician or other healthcare provider.

B. BRMC has been chosen to provide the patient's care, by the patient or an appropriate decision-maker for medical issues.

C. The individual is financially unable to pay for the needed care.

Despite these criteria, BRMC conforms in all cases to applicable requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA") and provides emergency medical care and medically necessary care without regard to the patient's ability to pay.

Section 4.2. Services Generally Eligible for Financial Assistance

Patients seeking financial assistance must satisfy three conditions:

A. The patient is determined to be eligible for financial assistance according to the Eligibility Criteria in Section 4.3 below,

B. The patient successfully completes the application process described in Section 3 below, and

C. BRMC determines that the patient is a Qualified Financial Assistance Recipient.

A patient satisfying these three conditions is known as a Qualified Financial Assistance Recipient. A Qualified Financial Assistance Recipient ("QFAR") may receive financial assistance in the form of a reduction in cost of care between 50-100%.

QFARs will not be charged for emergency or other medical care at rates higher than the amounts generally billed to third parties or patients with health insurance, nor will BRMC bill a QFAR's covered services as "gross charges," meaning full amounts. BRMC uses the "look-back" method to determine AGB by taking the full amount of all medical care allowed during the prior 12-month period and dividing by the sum of the associated gross charges for all medical claims. Amounts generally billed and discount percentages are reviewed annually, and appropriate adjustments are effective upon the approval of an updated version of this Financial Assistance Policy.

AGB% = Sum of Claims Allowed Amount $ / Sum of Gross Charges $ for those claims

AGB for 2020 = 33 %

Section 4.3. Criteria for Financial Assistance Eligibility

Patients may be eligible for financial assistance under this Policy based on their family income. Patients are eligible for financial assistance if they meet these criteria, without regard to who is the actual payer of that patient's bill. BRMC has established levels of eligible financial assistance based on applicants' family income and the national poverty guidelines, as well as other criteria. If the patient-applicant satisfies those criteria and the patient's family income is within a certain range, that patient will be eligible to receive that type of financial assistance.

Each request for financial assistance will be evaluated on its own merit using the income and other criteria in this Section.

In order to establish family income, the patient must provide acceptable income verification. Acceptable sources of income verification include:

A. The most recent federal income tax return applicable to the patient, if the patient applies for financial assistance before March 31 (the first quarter) of the same year,

B. The most recent federal income tax return applicable to the patient, plus an employer's verification of earnings for the current year, if the application is filed after March 31 (the first quarter) of the year, or

C. For self-employed individuals, the most recent federal income tax return and copies of all current quarterly returns.

If the applicant does not have documentation proving household income, he or she may call the financial assistance office and discuss other evidence that may be provided to demonstrate eligibility

BRMC will also need, if applicable, the patient's last two months of bank statements and their two most recent pay stubs. Patients will also need to apply for Medicaid in order to qualify for financial assistance. If BRMC needs more information from an applicant, other eligibility criteria may also include (1) assets and liabilities, (2) most current property tax assessment, (3) the patient's medical condition, (4) the potential need for long-term medical care, (5) the availability of other forms of reimbursement, including insurance, social programs, or other financial resources, and (6) the suitability of the facility for the patient's particular needs and the availability of a more appropriate facility that would offer payment for care. BRMC will also take into account any out-of-pocket medical expenses you have paid over the past 12 months, as demonstrated by statements or documentation from your physician, pharmacy, or other provider. If a patient cannot provide any of the required information, they should contact Patient Financial Services to discuss what other information they may provide to apply.

If a patient (1) states that he or she is homeless at the time care is needed or (2) is physically or mentally incapacitated and has no one to act on his or her behalf, and if BRMC does not find any evidence to the contrary through its own diligence, that patient will be considered a Qualified Financial Assistance Recipient and will not be required to complete the application for such financial assistance. Patients with those circumstances will be eligible for care without cost to the patient.

Under extraordinary circumstances, BRMC's Financial Assistance Committee may consider an applicant for financial assistance even if that individual does not otherwise qualify for financial assistance under this policy. Such discounts will be capped for self-pay individuals as determined by the Financial Assistance Committee.

Section 4.4. Presumptive Eligibility for Financial Assistance

In some situations, BRMC may consider a patient presumptively eligible for financial assistance. A patient may be presumptively eligible if BRMC has received information from an appropriate third party, such as a means tested public program, that leads BRMC to believe the patient is eligible, or if the patient has qualified for financial assistance under this Policy in the past.

If a patient is presumptively eligible, BRMC will notify that patient in writing of his or her presumptive eligibility, including the reason why BRMC considers the patient presumptively eligible and how the patient can apply for financial assistance under a more generous financial assistance program (such as this Policy). BRMC will also provide the patient with a reasonable time to apply for financial assistance, and if the patient completes the application within that time period, BRMC will determine whether the patient is a QFAR.

Additionally, if an individual has applied for and received financial assistance within the previous 12 months and the patient's financial situation has not changed, the individual will be deemed eligible for financial assistance without having to submit a new application. All applications are maintained for a period of one year.

Section 4.5. Rate Reduction Schedule for Qualified Financial Assistance Recipients

A patient's cost for care will be based on his or her income in comparison to the national poverty guidelines (discussed below in this Section) and other eligibility criteria. If a patient is a QFAR, the patient's cost of care will first be reduced to an amount equivalent to the amounts generally billed for that care, as described in Section 4.2. After that preliminary reduction, the patient will then be entitled to another 50-100% reduction in cost for emergency or other medically necessary care, depending on the patient's eligibility.

National poverty guidelines are established each year and, for that reason, a patient's rate of financial assistance will change as well. The currently applicable rate reduction schedule for BRMC patients is available on BRMC's website, in the Emergency Room, and at all points of registration in the hospital, and by mail or telephone at the following address/number (all free of charge):

Baxter Regional Medical Center

Attention: Patient Financial Services
624 Hospital Drive
Mountain Home, AR 72653
(800) 508-1080
http://www.baxterregional.org

For example, based on the national poverty guidelines for 2020, a Qualified Financial Assistance Recipient would be eligible for rate reductions on covered medical care at BRMC as shown on the chart below.

2020 Schedule of Rate Reduction and Income Limitations			
Family Size	Income Limits for Each Level of Financial Assistance Based Patient Income as a % of National Poverty Guidelines		
	0-138% of NPG **(100% Reduction)**	139-200% of NPG **(75% Reduction)**	200-300% of NPG **(50% Reduction)**
Individual	$0 - 17,609	$17,610-25,520	$25,521-38,280
Family of 2	$0 - 23,791	$23,792-34,480	$34,481-51,720
Family of 3	$0 - 29,974	$29,975-43,440	$43,441-65,160
Family of 4	$0 - 36,156	$36,157-52,400	$52,401-78,600
Family of 5	$0 - 42,338	$42,339-61,360	$61,361-92,040
Family of 6	$0 - 48,521	$48,522-70,320	$70,321-105,480
Family of 7	$0 - 54,703	$54,704-79,280	$79,281-118,380
Family of 8	$0 - 60,886	$60,887-88,240	$88,241-132,360

The schedule for rate reductions for the current calendar year may be found in Addendum A to this Policy.

Section 4.6. Safe Harbor for Eligible Patients who are Later Qualified for Financial Assistance

In the unusual situation when (1) a patient is charged more than the amount generally billed for medical services, (2) that patient has not yet completed an application for financial assistance, and (3) the patient later completes the application and is determined to be a QFAR, BRMC will reimburse the patient for any amounts paid in excess of that patient's maximum out-of-pocket charge for the service (unless that amount is less than $5.00). However, BRMC will never make the patient's payment of charges in excess of amounts generally billed a precondition to receipt of emergency or other medically necessary care.

Section 4.7. Covered Care and Providers

This Policy applies to emergency provided in a BRMC "hospital facility," including any department or provider-based clinic of the hospital itself, whether located inside the hospital's physical structure on Hospital Drive or elsewhere, if that care is provided by the hospital facility or any entity substantially related to the hospital facility for tax purposes. That is, the applicability of this Policy will depend on two factors, including (1) where the care was provided and (2) which provider provided the care. Elective or non-emergent care is not eligible for financial assistance.

Section 4.7.a. Covered Care Locations

With regard to the ***location*** of care, emergency and other medically necessary care that is provided in a "hospital facility," including hospital itself or in any provider-based clinic or department of the hospital, will be considered for financial assistance. Specifically, that ***includes*** the inpatient hospital floors, the Acute Inpatient Rehabilitation Center, Ahrens Clinic, ARU, the Breast Imaging Center, Fairlamb Senior Health Clinic, the Hensley Behavior Health Center, the Intensive Care Unit, the Women & Newborn Center, the Cline Emergency Center, Cardiac Cath and Rehabilitation, Dialysis, the G.I. Lab, Home Health, Hospice of the Ozarks, Hospice House, Interventional Pain Services, PACU, the Pain Clinic, Physical Therapy, Radiology, Surgery, the Cardiac Diagnostic Testing Center, BRMC Medical Specialists, and the Wound Healing Center. Care provided in clinics or facilities other than the hospital, a department of the hospital, or a provider-based clinic ***is not included*** under this Policy, including the Baxter Regional Home Town Clinics, Baxter Regional Behavioral Health Clinic, Bone & Joint Clinic, BRMC Family Clinic, Comprehensive Women's Clinic, Cardiac, Family Clinic on Market, Gastroenterology and Advanced Imaging, Gynecology Clinic, Internal Medicine and Infectious Disease, Nephrology/Pulmonology Clinic, Neurosurgery and Spine Clinic, Physical Therapy Clinics at Mountain Home and Yellville, Thoracic, Urology Clinic, and Vascular Clinic.

Section 4.7.b. Covered Providers

If the patient receives care that is covered under this Policy, a determination will need to be made as to whether the provider who actually provided the care is a covered provider. Every provider associated with the hospital itself, a department of the hospital, or a provider-based clinic will be a "covered provider" when that provider is providing ***covered care***, including all the clinics and departments included in Section 4.7.a. Likewise, if covered care is provided at the hospital facility by a provider from one of the clinics related to BRMC for tax purposes,

including all of those clinics listed in Section 4.7.a., such as the Ahrens Clinic or the Breast Imaging Center, that provider is covered under this Policy. However, that provider is only covered for care that occurs in the hospital facility or a provider-based clinic or department.

If the patient receives care that is covered under this Policy but that care is not provided by a provider from the hospital facility or any substantially related clinic or other medical facility, that patient's care is not eligible for financial assistance.

Section 4.7.c. Examples

Example 1. Patient X's income makes her eligible for 75% financial assistance under the Financial Assistance Policy for covered care. Patient X is admitted to the BRMC hospital on Monday for an orthopedic surgery that is considered medically necessary. Dr. Moore performs the surgery on Patient X and follows up with her in the hospital on Tuesday and Wednesday. Patient X is discharged on Wednesday and goes to a follow-up appointment in Dr. Moore's office in the Bone & Joint Clinic on Friday. The Financial Assistance Policy would cover Patient X's surgery and the medically necessary follow ups by Dr. Moore in the hospital and the clinic. This means that Patient X would be responsible for only 25% of the charges.

Example 2. Patient Z's income makes him eligible for 50% financial assistance under the Financial Assistance Policy for covered care. Patient Z is admitted to the hospital following a broken hip, which is considered emergency and medically necessary treatment. Patient Z is a patient of Dr. Rauls, who has an independent practice not related to the hospital or any BRMC clinic. Dr. Rauls performs surgery on Patient Z. Patient Z will be responsible for 50% of the charges for care he receives at the hospital by a hospital provider (such as hospital nurses or doctors). However, any cost associated with Dr. Rauls's care would not qualify for financial assistance because he is not a hospital or related provider.

A list of providers with privileges and credentialing at the hospital, and a notation of whether those providers' care is covered or not, is found in Addendum B to this Policy.

Section 5. APPLYING FOR FINANCIAL ASSISTANCE

Section 5.1. Availability of Application for Financial Assistance and Other Information

If any person believes that a patient may qualify for financial assistance under this Policy, BRMC encourages the person to request assistance. Copies of this Policy, a plain language summary of the policy, and the application form may be found in any of these locations, including (1) on the BRMC website, https://www.baxterregional.org/upages.php?id=405, (2) in the BRMC Emergency Room, and (3) at every point of registration into the hospital. Any member of the public or any state or federal governmental entity may also obtain copies of this Policy, the plain language summary of the policy, and the application form by mail or telephone at the following address/number (all free of charge):

Baxter Regional Medical Center
Attention: Patient Financial Services
624 Hospital Drive
Mountain Home, AR 72653
(800) 508-1080

Applicants may also write or call BRMC at this address/telephone number to ask questions about or receive other assistance with the application process and the Financial Assistance Policy. Notices regarding the Financial Assistance Policy are also included on all billing statements and may be found posted in public areas around the hospital, including the Emergency Room and Admissions. Similarly, copies of the plain language summary of this Policy will be included with patients' admission or discharge paperwork, depending on the circumstances.

Section 5.2. Availability of Application for Financial Assistance and Other Information in Languages Other Than English (Limited English Proficiency)

BRMC also makes copies of its Financial Assistance Policy, the plain language summary, and the application form available in certain languages other than English for those with limited English proficiency. Those documents are provided free of charge and are made available for all languages, as required by federal law, that BRMC has determined may be spoken by a significant population of the communities BRMC serves. To determine whether these documents are available in a particular language, and to obtain copies of those documents, an individual may write or call the following address/telephone number:

Baxter Regional Medical Center

Attention: Patient Financial Services
624 Hospital Drive
Mountain Home, AR 72653
(800) 508-1080

Section 5.3. Financial Assistance for Patients with Medicaid Coverage

If a patient has applied for financial assistance under this Policy and has also filed an application for assistance under Medicaid, BRMC may postpone its determination until the Medicaid application has been completed and a decision has been made.

Section 5.4. Application and Eligibility Determination Process

The process for completing an application for financial assistance under this Policy will generally follow these steps:

A. The patient or the patient's representative requests financial assistance. Anyone may request financial assistance on any patient's behalf but only the patient or his or her representative may complete the application.

B. The patient or the patient's representative completes the application form and returns it to BRMC's Patient Financial Services Department ("PFS"). In the event of a patient's death, the patient's family will be given an opportunity to complete an application for financial assistance under this Policy.

C. PFS reviews the application for completeness within 30 days of receipt. If the application is incomplete, PFS contacts the patient or his or her representative to obtain the missing information. If the necessary information is not provided to PFS within 30 days of notice that the application is incomplete, the application will be denied.

D. PFS reviews income verification documentation. If income documentation is missing or the documentation provided does not meet the documentation requirements in this Policy (Section 4.3), PFS contacts the patient or representative to obtain the proper documentation. If the needed documentation is not provided within 30 days, the application will be denied.

E. PFS reviews the services provided to verify that they are services covered under the Financial Assistance Policy. If the service is covered by a third-party payor, such as insurance or government assistance, the patient or representative is contacted and those payment avenues are pursued. If the question of extraordinary circumstances arises, the account will be referred to the appropriate management personnel for determination of eligibility. Following that determination, the account will be either returned to PFS for processing or denied. If denied, PFS will discuss payment options with the patient or representative.

F. If the services in question are covered and there is no alternative payment option, PFS will review family income according to current national poverty guidelines (Section 4.5) and determine whether the patient is eligible discounted care. If so, BRMC will notify the patient or representative of eligibility, explain the details of the discount procedure, apply the appropriate discount, establish a payment plan (if necessary), and update the patient's account record accordingly. Determinations are generally made within 30 days.

G. If the patient does not qualify for financial assistance, the patient or representative will be notified.

H. If an individual has applied for and received financial assistance within the previous 12 months and the patient's financial situation has not changed, the individual will be deemed eligible for financial assistance without having to submit a new application. All applications are maintained for a period of one year.

Section 6. BILLING AND COLLECTION FOR QUALIFIED FINANCIAL ASSISTANCE RECIPIENTS

Section 6.1. Availability of Separate Billing and Collections Policies

BRMC maintains separate policies containing its billing and collections policies as they apply to all patients, not solely to patients seeking financial assistance. Patients may obtain copies of those policies, free of charge, by writing or calling the following address/telephone number:

Baxter Regional Medical Center
Attention: Patient Financial Services

624 Hospital Drive
Mountain Home, AR 72653
(800) 508-1080

Section 6.2. General Billing and Collection Matters

BRMC sends patients account statements on a monthly (30-day) cycle. Generally, if the account is not paid, BRMC will send three statements, with the final statement serving as final notice that the account may be referred to a third-party collection agency if payment is not received within 30 days after the date of the final notice. BRMC requires any collection agency it uses to agree to refrain from abusive collection practices.

BRMC will not engage in "extraordinary collection actions" until reasonable efforts have been made to determine whether an individual is eligible for assistance under this Policy. Extraordinary collection actions include selling debt to third parties (except as legally allowed), reporting to consumer credit reporting agencies and credit bureaus, denying future medical care because of nonpayment, filing lawsuits, foreclosing on real estate, attaching or seizing bank accounts or personal property, placing liens on residences, arrests, body attachments, and similar activities.

If a patient account has been referred to a collection agency, that patient may still apply for financial assistance for a period of 120 days. While the application is being completed and while the determination of eligibility for financial assistance is pending, collection efforts will be suspended.

Section 6.3. Notices to be Provided Before Extraordinary Collection Actions are Taken

BRMC may initiate an extraordinary collection action against a QFAR under certain circumstances. First, BRMC may initiate extraordinary collection actions when it provides the patient with at least 30 days' written notice that the action is being initiated and provides a deadline for the patient to bring his or her account current. With that notice, BRMC will provide a plain language summary of this Policy. BRMC will also make reasonable efforts to provide the patient with oral notice that it is initiating an extraordinary collection action.

BRMC recognizes that some patients will receive multiple episodes of care or care on multiple occasions. In that event, BRMC will only initiate an extraordinary collection action on

the aggregate of the patient's outstanding bills after 120 days have passed since BRMC provided the first post-discharge billing statement for the patient's most recent episode of care.

Section 6.4. Limitation on Charges

If a patient has been determined to be a Qualified Financial Assistance Recipient under this Policy and receives care from a provider with the hospital or a substantially related clinic, that provider will limit the charges to the patient. For emergency and other medically necessary care, the patient cannot be charged more than the amounts generally billed for such care (Section 4.2). For all other care, the patient must be charged less than gross charges. "Charges," for purposes of this Section, mean the amount the patient is personally responsible for paying, after all deductions, discounts, insurance reimbursements, or other reductions have been applied. This applies to care provided outside the hospital, a department of the hospital, or a provider-based clinic, and includes all clinics or other medical facilities substantially related to BRMC for tax purposes.

Section 7. MAJOR MEDICAL EXPENSES

Out of pocket patient obligations resulting from medical services provided by Baxter Regional Medical Center will not exceed the following thresholds:

A. If family income is more than 300% but not in excess of 400% of the federal poverty level, the maximum out of pocket is 35% of family income.
B. If family income is more than 400% but not in excess of 600% of the federal poverty level, the maximum out of pocket is 45% of family income.
C. If family income is more than 600% of the federal poverty level, the maximum out of pocket is 55% of family income.

	Family Income Limits Eligible for Stated Maximum Out of Pocket			
Family Size		35%	45%	55%
1		$38,281-51,039	$51,040-76,559	>$76,560
2		$51,721-68,959	$68,960-103,439	>$103,440
3		$65,161-86,879	$86,880-130,319	>$130,320

4		$78,601-104,799	$104,800-157,199	>$157,200
5		$92,041-122,719	$122,720-184,079	>$184,080
6		$105,481-140,639	$140,640-210,959	>$210,960
7		$118,381-158,559	$158,560-247,839	>$247,840
8		$132,361-176,479	$176,480-264,719	>$264,720

ADDENDUM A

PROVIDER LIST

The following is the list of providers who may deliver emergency or other medically necessary care in BRMC's hospital facility with a notation about whether that provider's care would be "covered care" under this Policy. Care provided in the hospital facility, a hospital department, or a provider-based clinic (Section 4.7) by a covered provider is eligible for the rate reductions discussed in this Policy. Care provided b a non-covered provider, no matter where that care is given, is not eligible for the rate reductions discussed in this Policy.

Provider Name	*Provider Type*	*Is the Provider's Care Covered*
Adkins, Kevin	MD	No
Adkins, Michael	MD	No
Alexander, Christine	RN/APRN	No
Allen, Jana "Michelle"	RN/CRNA	Yes
Anderson, Brandi	RN/APRN	Yes
Babcock, James	MD	No
Badejo, Abodunrin	MD	Yes
Baker, Alex	PA	No
Baker, Deborah	Audiologist	No
Barker, Monty	MD	No
Barrow, Harley	MD	No
Baugh, Brett	RN/CRNA	Yes
Bean, Casey	RN/CRNA	Yes
Beau, Scott	MD	No
Bennett, Paula	RN/CRNA	Yes
Benz, Allen	RN/ANP	No
Bibb, Bradley	MD	Yes
Bisswanger, Billy	MD	No
Bogle, Shawn	MD	Yes
Bollinger-Fisher, Tracy	RN/APRN	No
Booth, Allison	MD	No
Bounds, Andrea	MD	No
Bradley, Lucas	MD	Yes
Brambett, Marcella	RN/APRN	Yes
Brantley, Mildred "Gale"	RN/CRNA	Yes
Brewer, Terry	RN/CRNA	Yes
Brooks, Robert	RN/APRN/CRNA	Yes
Brown, Cindy	RN/APRN	Yes
Brown, Timothy	MD	No
Bruton, Ronald	MD	No
Bryant, Kevin	RN/APRN	Yes

Bufford, Phillip	MD	No
Burr, Mary	RN/ANP	Yes
Butler, Chastity	PA	Yes
Camp, Kelli	RN/APRN	No
Camp, Michael	MD	No
Carson, Amanda	RN/APRN	No
Caststeel, Hannah	RN/APRN	No
Chapa, Meredith	RN/APRN	No
Chatman, Ira D.	MD	No
Cheney, Lori	MD	No
Clary, Cathy	MD	No
Clifton-Jones, Denise	RN/APRN	No
Combs, Katie	RN/CNP	Yes
Conaway, Cindy	RN/CRNA	Yes
Connelley, Jon	MD	Yes
Cotterman, Karen	RN/CRNA	Yes
Cureington, James	RN/CNP	No
Decker, Daniel	MD	Yes
Dickinson, Jacob	MD	No
Dirst-Roberts, Melissa	MD	No
Distin, Dahlia	RN/APRN	No
Douglas, Steve	MD	No
Dyer, William	MD	Yes
Eaton, Sarah	RN/APRN	No
Elders, J. Greg	MD	No
Eldridge, Jordan	RN/CRNA	Yes
Elkins, Louis	MD	Yes
Flowers, Maureen	MD	Yes
Foster, Jennifer	MD	No
Foster, Thomas	MD	Yes
Fountain, Leah	RN/APRN	No
Frisby, Brittany	MD	Yes
Fulghum, David	RN/ANP	Yes
Garner, W Russ	RN/CRNA	Yes
Gaston, Issac	RN/APRN	No
Gocio, Allan	MD	Yes
Godfrey, Lincoln	MD	No
Godfrey, Michelle	MD	No
Goodwin, Candice	RN/CRNA	Yes
Goodwin, Daniel	MD	No
Graves, Daniel	RN/APRN	Yes
Gray, Adam	MD	No
Griffin, Dylan	RN/CRNA	Yes
Hacker, Shandle	RN/APRN	No
Hagaman, Michael	MD	No
Hale, Jamie	RN/APRN	No
Hammon, Lee	RN/CRNA	Yes
Hammonds, Mark	MD	No

Hatch, Kala	RN/APRN	Yes
Heath, Tara	RN/CRNA	Yes
Hill, Mark	RN/CRNA	Yes
Hill, William	MD	No
Hiser, Corinne	RN/ANP	No
Hlass, Lacey	RN/CRNA	Yes
Hodges, Michael	MD	No
Horne, Amanda	RN/CRNA	Yes
Hudson, Hilton	MD	Yes
Hutchens, Julie “K”	RN/APRN/CNP	Yes
Jackson, Allen	MD	No
Johnson, Arlene	MD	No
Keller, William	RN/APRN/CNP	Yes
Kelly, Rhonda	RN/CRNA	Yes
Kilgore, Kenneth	MD	No
King, Mark	MD	No
King, William	MD	Yes
Kinney, Dana	MD	No
Knox, Thomas	MD	No
Krafft, Ryan	MD	No
Kruse, Carmel	RN/APRN/CNP	Yes
Lawrence, George	MD	No
Ledden, Matthew	RN/CRNA	Yes
Leslie, Tom	MD	Yes
Lie, Kam	MD	Yes
Lincoln, Candy	MD	No
Lincoln, Lance	MD	No
Lindsay, Jason	MD	Yes
Littlefield, Rachel	MD	No
Malte, Brian	MD	Yes
Martin, Rebecca	MD	Yes
Marx, Douglas	MD	No
Mathews, Grant	MD	Yes
McAlister, Kyle	MD	No
McConnell, Jason	MD	No
McCurdy, Malachi	MD	No
McNamara, Timothy	MD	No
McNelley, Matthew	MD	No
Meier, Brian	RN/CRNA	Yes
Milam, Terry	RN/CRNA	Yes
Morgan, Cheyenne	PA	Yes
Morris, Jennifer	RN/CRNA	Yes
Nachtigal, Kent	MD	No
Nachtigal, Tom	MD	No
Neis, John	MD	No
Neis, Paul	MD	No
Newman, Adam	MD	No
Norris (McCoy), Julie	RN/CNP	No
Norris, W Chip	RN/ANP	No

Paden, Timothy	MD	No
Pena, Mary Leigh	RN/APRN	Yes
Peterson, Kirsten	RN/APRN	Yes
Pevril, Daniel	RN/APRN	Yes
Pierson, Janet	RN/CRNA	Yes
Pingel, Caleb	MD	No
Pollard, Jesse	RN/CRNA	Yes
Potter, Hillary-Paige	PA	No
Prinner, Kathleen	RN/APRN	Yes
Pritchard, Jamie	MD	No
Quevillon, Melissa	MD	No
Rauls, Russ	MD	No
Redic, Jonathan	RN/CRNA	Yes
Reed, Whitney	RN/APRN	Yes
Reese, Jerrad	RN/ANP	No
Riley, Diana	PA	No
Robinson, Lonnie	MD	No
Roddey, April	RN/APRN/CRNA	Yes
Rodriguez, Miguel	RN/ANP	Yes
Sarie, Tiffany	RN	No
Schmidt, Richard	MD	No
Schulte, Debra	RN/CNP	Yes
Schulz, Brad	MD	No
Scribner, John	MD	Yes
Shackleford, Lisa	RN/CRNA	Yes
Shahan, Jamie	RN/CRNA	Yes
Shealy, Brenda	RN/CRNA	Yes
Sheppard, Richard	RN/CRNA	Yes
Silber, William	MD	Yes
Silvey, Chad	RN/CRNA	Yes
Smart, William	RN/CRNA	Yes
Smith, Asa	RN/APRN	No
Smith, Corey	MD	Yes
Smithhart, Elizabeth	RN/CRNA	Yes
Spann, Eric	MD	No
Spore, John	MD	No
Stevens, Benjamin	MD	Yes
Stewart, Josh	RN/CRNA	Yes
Stills, David	MD	No
Stowers, Marion	MD	No
Tate, Jeffrey	PA	Yes
Teague, Jeremy	RN/CRNA	Yes
Terry, Megan	RN/ANP	No
Thitoff, Meagan	RN/APRN	No
Thompson, Marie	RN/RNP/ANP	No
Thorton, Amanda	RN/ANP	No
Tobbia, Patrick	MD	No
Tullis, Joe	MD	No
Valach, Daniel	MD	No

Vargas, Leslie	RN/APRN	No
Waddell, David	MD	No
Walter, Gail	RN/CRNA	Yes
Wagner, Maegan	RN/APRN	No
Walter, Gail	RN/CRNA	Yes
Warr, James	MD	No
Warr, Otis	MD	No
Warr, Shelley	MD	No
Watlington, Amanda	MD	No
Webb, Christopher	MD	No
West, Mark	MD	No
White, Bruce	MD	Yes
White, Edward	MD	No
Whitlock, Michael	MD	No
Wilhite, Debra	RN/CNP	Yes
Wilson, Matt	MD	No
Woodard, Jessica	RN	No
Woodward, Wynne	RN/CNS	Yes
Wright, Ethan	MD	No
Wyatt, Robert	RN/CRNA	Yes
Yancey, Chris	RN/CRNA	Yes
Zehm, Charles	MD	Yes
Zak, Dmitriy	MD	Yes
Zak, Veronica	MD	Yes