Financial Arrangements and Assistance: Finance - Prisma Health

Effective Date: 10/1/2025

Policy Statement:

Prisma Health is here to create a better state of health for patients, families, and communities. At the core of everything we do is our purpose: Inspire health. Serve with compassion. Be the difference. This includes our commitment in providing financial assistance topatients who cannot pay for all or a part of their bill.

A further responsibility of Prisma Health requires it to generate sufficient revenues in order to provide high quality patient care and to maintain a sound financial position. In order to provide financial assistance responsive to the population served and keep hospitalization costs at a minimum, Prisma Health has adopted this policy.

All facilities of Prisma Health are available to patients without regard to race, color, religion, age, sex or national origin or any other discriminatory differentiating factor. Emergency services will not be denied because of an inability to pay. Satisfactory financial arrangements are required before elective services are rendered. Elective cases without satisfactory financial arrangements may be deferred with physician consent.

All employed physicians of the Prisma Health Medical Group providing medically necessary and/or emergent services at hospital facilities, off -campus hospital departments, and physician offices of Prisma Health participate in this Financial Assistance Policy (FAP). Not all services are eligible for Financial Assistance. Independent providers of the Prisma Health Medical Staff do not participate in the FAP. A complete list of these providers can be found at https://www.PrismaHealth.org/patients-and- guests/billing-and- insurance/financial- assistance or by writing Prisma Health, Attn: Financial Assistance, P.O. Box 743904, Atlanta, GA, 30374-3904.

Definitions:

1. AGB: Amounts Generally Billed for emergency or other medically necessary care to individuals who have insurance coverage. Prisma Health has elected to determine AGB using the Look - back Method as defined below. The AGB percentage can be located on page 4 and 5 of this policy.

2. ECA: Extraordinary Collection Actions- Actions taken to collect a debt, include but are not limited to reporting debts to credit bureaus, selling debt to a third party and pursuing liens, garnishments, and other legal actions.

3. FPL: Federal Poverty Level- This is a yearly income threshold calculated by the federal government to determine if an individual or family are considered to be in poverty. This is published by the U.S. Department of Health and Human Services annually.

4. Medically Necessary: It is defined as care based upon generally accepted medical practices considering conditions at the time of treatment which is appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition. It is a case that is not cosmetic, experimental or deemed to be non-reimbursable by traditional insurance carriers and governmental payors.

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5. Medicare Look-Back Methodology: Calculation based on actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals).

6. Presumptive Eligibility: The process by which Prisma Health may use analytics from public record sources other than the individual to determine eligibility for financial assistance, and/or the use of previous eligibility determinations.

Procedural Steps:

1. Satisfactory Financial Arrangements:

1.1 All financial arrangements will be made using the following guidelines after the patient's status is determined by the physician:

1.1.1. Emergency Services- Immediate inpatient, outpatient, or emergency hospital services where the patient is at risk of life or limb that are necessary to prevent death or other serious health risks. Financial arrangements should be made as soon as practical after stabilizing care is rendered.

1.1.2. Routine/Medically Necessary Services- Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine, no imminent danger. Financial arrangements should be made prior to rendering service.

1.1.3. Elective Services- Chosen (elected) by the patient or physician and is advantageous to the patient but is not urgent and may or may not be considered medically necessary.
(e.g., cosmetic surgery). Financial arrangements must be made prior to rendering service.

1.2. Satisfactory financial arrangements may consist of any one or a combination of the following:

1.2.1. Payment in full of the patient's obligation made in advance of services being rendered.

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1.2.2. Adequate hospitalization insurance benefits exist which the patient assigned to Prisma Health for the payment of services. Automobile liability coverage alone is not considered adequate hospitalization insurance.

1.2.3. Sponsorship by a third party, such as Medicare, Medicaid or other agencies contracting with Prisma Health for payment of care rendered to patients upon verification of eligibility.

1.2.4. If Prisma Health determines that the patient has no available or inadequate means to pay for services, a patient will then be evaluated for financial assistance.

1.3. The specific percentage discount for income greater than 250% up to 400% of FPL is updated annually and the sliding scale adjustment is based on Medicare look-back methodology. Standing Board approval permits the specific income limits and percentage discount to be updated annually. The sliding scale adjustment is determined from actual past claims paid to the hospital facility by Medicare fee-for- service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals) for a twelve-month period. AGB is calculated for each hospital facility and the one with the highest adjustment allowance is used for all facilities.

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TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE Effective 10/1/2025 – 1/13/2026		
# Of Persons in Family	Income Level Cap 0-250%	Income Level Cap >250% - Up to 400%
1	$39,125.	$62,600.
2	$52,875.	$84,600.
3	$66,625.	$106,600.
4	$80,375.	$128,600.
5	$94,125.	$150,600.
6	$107,875.	$172,600.
7	$121,625.	$194,600.
8	$135,375.	$216,600.
For each person over 8 add	$13,750.	$22,000.
Allowance to give if uninsured	100%	77% based on AGB*

*AGB is determined from actual past claims paid to the hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals) for a twelve-month period. AGB is calculated for each Prisma hospital facility and the one with the highest adjustment allowance is used for all facilities.

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TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE Effective 01/14/2026 – 9/30/2026		
# Of Persons in Family	Income Level Cap 0-250%	Income Level Cap >250% - Up to 400%
1	$39,900.	$63,840.
2	$54,100.	$86,560.
3	$68,300.	$109,280.
4	$82,500.	$132,000.
5	$96,700.	$154,720.
6	$110,900.	$177,440.
7	$125,100.	$200,160.
8	$139,300.	$222,880.
For each person over 8 add	$14,200.	$22,720.
Allowance to give if uninsured	100%	77% based on AGB*

*AGB is determined from actual past claims paid to the hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals) for a twelve-month period. AGB is calculated for each Prisma hospital facility and the one with the highest adjustment allowance is used for all facilities.

1.4. No person eligible for financial assistance under this policy will be charged more for emergency or other medically necessary care than Amounts Generally Billed (AGB) to individuals with insurance covering such care. This applies to all patients if the care is emergency or medically necessary, regardless of county of residency. Financial Assistance is not available for elective care unless approved by Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

1.5. Prisma Health does not extend financial assistance to patients residing in a foreign country. Exception based approvals may be granted on a case- by-case basis in advance of services being rendered and are at the discretion of the Chief Financial Officer CFO) or Vice-President, Acute Revenue Cycle.

1.6. Patients who have a network benefit with an in-network provider other than Prisma Health may choose to receive services as out of network. The out-of-network benefit may pay a small sum, or nothing at all, toward the billed charges. Financial Assistance is not available for charges not covered due to the patient choosing to receive services out of network.

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However, any out of network patient that receives emergent related care or needs a level of care only provided by Prisma Health is eligible to apply. Duration for out of network eligibility will be up to 90 days post discharge. Financial Assistance is also not available for patients participating in a shared ministry program that provides financial reimbursement to the patient. Exceptions for extenuating circumstances may be approved by the Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

2. Method for applying for Financial Assistance:

2.1. All patients who believe they may qualify for financial assistance are urged to complete, sign, and submit a Financial Assistance Application. The Financial Assistance Application, Billing and Collections Policy, as well as information about the financial assistance application processes are widely publicized. Information can be obtained by:

2.1.1. Visiting Prisma Health website at https://prismahealth.org/patients-and-guests/billing-and-insurance/financial-assistance

2.1.2. Visiting Mychart to review balances and apply if applicable.

2.1.3. Calling Prisma Health Patient Financial Services at 833-425-0404.

2.1.4. Mailing a request to:

Prisma Health, Attn: Financial Assistance
P.O. Box 743904
Atlanta, GA 30374-3904

2.1.5. Visiting a Prisma Health facility. Representatives are available to provide a copy of the Financial Assistance Application or assist the patient/guarantor in completing and submitting the application.

2.2. Documentation that may be required to be submitted with the financial assistance application are:

2.2.1. Two (2) most recent pay stubs

2.2.1.1. If currently unemployed, a no income attestation may be required

2.2.2. Recent checking/ savings bank statements

2.2.3. Individuals who are self-employed are required to submit the most recent years' business and personal tax return

2.2.4. Proof of residency:

2.2.4.1. SC or TN ID, paystub with home address, rental or mortgage agreement with address listed, bank statement with address listed, utility bill with address, or a written attestation from an individual providing housing (with address) if there is not access to any forms listed.

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2.3 Failure to submit requested documentation may result in denial of the financial assistance application.

3. Extraordinary Collection Actions (ECAs):

3.1. Prisma Health will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for financial assistance under this Financial Arrangements and Assistance Policy. Prisma Health Revenue Cycle Administration has final responsibility for outlining processes ensuring the hospital facility has made reasonable efforts to determine whether an individual is financial assistance eligible before engaging in ECAs.

3.1.1. Prisma Health offers hospital patients and physician practice patients two options for payment when financial assistance is not available:

3.1.1.1. In-house interest free payments.

3.1.1.2. If an extended payment is needed, reasonable payment arrangements with reasonable interest are available with an outside agency.

3.1.1.3. Patients may contact customer service for details.

3.2. Patient balances that do not qualify for financial assistance and are unpaid may be placed with a collection agency. These actions are further described in the Billing and Collections Policy. Members of the public may obtain a free copy of this separate policy from Prisma Health as indicated in the contact list in this policy or by going to https://prismahealth. org/patients -and- guests/billing-and-insurance/financial-assistance.

4. Financial Assistance Eligibility Criteria:

4.1. We offer screening for Medicaid, Prisma Health's Financial Assistance Program, and discounted fees for uninsured patients who do not qualify for the Financial Assistance Program. Payment plans are also available. Cooperation in the Medicaid screening process is required for the Financial Assistance application to be reviewed and processed. Applicants should complete and sign the Financial Assistance Application. This requirement may be waived in the event that the totality of circumstances indicates the patient would qualify for financial assistance but circumstances such as patient is deceased, homeless, transient, or as a result of physical or mental incapacity is unable to provide the required information, to name a few

4.2. Criteria for eligibility is outlined in section one through six below. If a person does not meet criteria based on requirements outlined in section one through six, the person may qualify under section seven, which is an alternative means of qualifying based a significant financial hardship.

4.2.1. Applicants must meet the following criteria:

4.2.1.1. South Carolina or Tennessee resident, or a person domiciled in South Carolina or Tennessee.

4.2.1.2. Uninsured individuals and in-network insured individuals meeting all criteria for financial assistance with an income level at or below 250% of the Federal Poverty Guideline (FPL) receive 100% adjustment on covered services.

4.2.1.3. Uninsured individuals and in-network insured individuals meeting all criteria for financial assistance with an income level at or above 250% FPL up to 400% FPL will receive a sliding scale adjustment as set forth in this policy on covered services.

4.2.2. Household composition is used to calculate the level of financial assistance and is based on income and the number of dependents in the family that the guarantor is financially responsible for. These are person(s) claimed on an individual's tax return. Household composition is defined as follows:

4.2.2.1. The patient, the patient's spouse/partner, patient's parents or guardians (in the case of a minor patient), and any dependent claimed on the patient's or parent's income tax returns and living in the patient's or his/her parent's/guardian's household.

4.2.2.2. Family income is defined as the amount of money that a family earns or receives. Family income includes: wages, salaries, unemployment compensation, workers compensation, social security income, supplemental security income, public assistance, veteran payments, survivor benefits, pension/retirement income, rents from property, profits and fees from their own business, interest, dividends, royalties, income from estates, trusts, alimony, child support and other misc. sources.

4.2.3. Filing timeline:

4.2.3.1. An applicant has 240 days from the date of the first post discharge billing statement to apply.

4.2.4. Duration of Eligibility:

4.2.4.1. Duration of eligibility will be twelve (12) months from date of application.

4.2.5. Prisma Health has the right to revoke or deny your financial assistance if at any time during your eligibility period you no longer meet eligibility criteria. Patient must wait six (6) months before reapplying whether eligibility is denied or revoked unless there are extenuating circumstances that have impacted your financial situation.

4.2.6. Catastrophic Event:

4.2.6.1. Patients who have applied for financial assistance and

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determined to not be eligible may qualify under the catastrophic clause. A catastrophic event is defined as an unplanned episode of care where the uninsured patient's obligation to Prisma Health exceeds 25% of the household annual gross income. For insured patients, the patient obligation after insurance, for a covered service, must exceed 25% of the household annual gross income. Catastrophic is not applicable for services non-covered by patient's insurance.

4.2.6.2. Catastrophic Financial Assistance will not be added to the patient's record for future dates of service. The individual may reapply when additional services are received. Exceptions for extenuating circumstances may be approved by the Chief Financial Officer (CFO) or Vice-President, Acute Revenue Cycle.

4.2.7. Patients may also be eligible for other forms of assistance not covered by this policy, such as drug replacement discounts or other programs as available.

4.3. Income, residency information, etc., provided by the patient will be verified through an electronic vendor inquiry. Income discrepancies between information provided by the patient/patient representative and the electronic inquiry may require additional information/documentation from the patient/patient representative. In the event additional information/documentation is requested but not received (examples include but are not limited to bank statements, most recent years' tax return or other financial documents), the account will be dispositioned twenty-eight (28) days after the request and may be denied for failure to submit requested information/documentation.

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5. Presumptive Eligibility

5.1. There are certain scenarios where a patient may be considered as having met criteria for financial assistance on a presumptive basis. A financial assistance application will not be required in these instances.

5.1.1. Patients who are dual eligible for Medicare and Medicaid or eligible for Medicaid. In the event the co-payment has not been satisfied.

5.1.2. Patients eligible for a Medicaid program will be eligible for assistance associated with emergency or medically necessary services not covered by a Medicaid program.

5.1.3. Patients who eligible for retro Medicaid and the claim is not paid by Medicaid.

5.1.4. Patients who are affiliated with the AccessHealth program or referred by the Community Free Clinics who support the regions served by Prisma Health Hospitals.

5.1.5. Patients who are homeless.

5.1.6. Patients who are deceased with no estate found.

5.1.7. Patients with a recent personal bankruptcy.

5.1.8. Patients incarcerated in a penal institution.

5.1.9. Evidence from an independent third-party agency, indicating that the family income is less than or equal to 250% FPL.

5.2. Prisma Health Vice President of Acute Revenue Cycle will determine the percentage guidelines utilized for financial assistance on an annual basis. Prisma Health reserves the right to define maximum charitable expenditures, prevailing charges, excluded services, fee reduction schedules, patient responsibilities and other business practice parameters consistent with the prudent management of Prisma Health.

5.3. Prisma Health accommodates all significant populations served who have limited proficiency in English by translating copies of our Financial Arrangements and Assistance Policy, Financial Assistance Application Form, and this summary in the primary languages spoken by those populations.

6. Uninsured Discount

6.1 Uninsured patients will receive an uninsured discount. This discount will show on the first statement. The discount does not apply to package prices. The discount will not apply to any accounts related to an accident until it is confirmed that there is no liability or insurance coverage. The discount is

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calculated based on our Commercial/ Managed Care weighted average percentage. The current uninsured discount rates are: South Carolina and Tennessee physician practices will receive a 35% discount, South Carolina Hospital facilities will also receive a 35% discount, and Tennessee facilities will follow the state mandate and receive a 69% discount.

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