FROEDTERT SOUTH, INC.

FINANCIAL ASSISTANCE POLICY
March 1, 2024

POLICY/PRINCIPLES

It is the policy of Froedtert South, Inc., its related hospital and outpatient facilities including, but not limited to, Froedtert Pleasant Prairie Hospital, Froedtert Kenosha Center, Paddock Lake Clinic, Prairie Ridge Clinic, Pleasant Prairie Clinic, and Somers Clinic (the "Organization") to ensure a socially just practice for providing Emergency Care or other Medically Necessary Care at the Organization's facilities. This Policy is specifically designed to address the Financial Assistance eligibility for Patients who are in need of Financial Assistance and receive care from the Organization.

1. All Financial Assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This Policy applies to all Emergency Care and other Medically Necessary Care services provided by the Organization, including employed physician services. This Policy does not apply to payment arrangements for care that is not Emergency Care or otherwise Medically Necessary Care.

3. The List of Providers Covered by the Financial Assistance Policy is maintained separately from this Financial Assistance Policy and provides a list of providers delivering care within the Organization facilities that are covered by the Financial Assistance Policy. The List of Providers Covered by the Financial Assistance Policy applies only as of the date on which it was created or last updated.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- ***"501(r)"*** means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

- ***"Amount Generally Billed"*** or **"AGB"** means, with respect to Emergency Care or other Medically Necessary Care, the amount generally billed to individuals who have insurance covering such care.

- ***"Emergency Care"*** means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious

dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.

- ***"Medically Necessary Care"*** means care is determined to be medically necessary, non-elective and is needed or necessary to prevent death or adverse effects to a patient's health and is a determination of clinical merit by the admitting physician or other licensed physician. Services not considered medically necessary include, but are not limited to, cosmetic procedures, bariatric surgery, complementary medicine, Occupational Health and retail services.

- ***"Guarantor"*** means the person who is financially responsible for the care of the patient. In most cases, the guarantor and the Patient are the same person.

- ***"Organization"*** means Froedtert South, Inc., its related hospital and outpatient facilities including, but not limited to, Froedtert Pleasant Prairie Hospital, Froedtert Kenosha Center, Paddock Lake Clinic, Pleasant Prairie Clinic, Prairie Ridge Clinic, and Somers Clinic.

- ***"Patient"*** means those persons who receive Emergency Care or Medically Necessary Care at the Organization.

FINANCIAL ASSISTANCE PROVIDED

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.

2. At a minimum, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale is as follows:

Family Size		1	2	3	4	5	6	7	8	Each additional person
2024 Guidelines		$ 15,060	$ 20,440	$ 25,820	$ 31,200	$ 36,580	$ 41,960	$ 47,340	$ 52,720	$ 5,380
000% - 250% FPL (100% Discount)	**UP TO**	$ 37,650	$ 51,100	$ 64,550	$ 78,000	$ 91,450	$ 104,900	$ 118,350	$ 131,800	$ 13,450
251% - 300% FPL (90% Discount)	**UP TO**	$ 45,180	$ 61,320	$ 77,460	$ 93,600	$ 109,740	$ 125,880	$ 142,020	$ 158,160	$ 16,140
301% - 350% FPL (80% Discount)	**UP TO**	$ 52,710	$ 71,540	$ 90,370	$ 109,200	$ 128,030	$ 146,860	$ 165,690	$ 184,520	$ 18,830
351% - 400% FPL (70% Discount)	**UP TO**	$ 60,240	$ 81,760	$ 103,280	$ 124,800	$ 146,320	$ 167,840	$ 189,360	$ 210,880	$ 21,520

3. Eligibility for Financial Assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility – including in situations where a Patient (or Guarantor, on behalf of the Patient) has not completed a Financial Assistance Application ("FAP Application"). More specifically, the Organization may utilize a third-party to assess a Patient's financial need by conducting an electronic review of information from public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each Patient to the same standards and is calibrated against historical approvals for Organization Financial Assistance under the traditional application process. Patient accounts granted presumptive eligibility will be reclassified

under the Financial Assistance Policy and will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the hospital's bad debt expense.

4. Eligibility for Financial Assistance must be determined for any balance for which the Patient with financial need is responsible.

5. The process for Patients and families to appeal an Organization's decision regarding eligibility for Financial Assistance is as follows:

    a. If financial assistance is denied, an appeal can be filed within fourteen (14) calendar days of receipt of notification of the denial. Send a letter to the Office of the Vice President of Finance, Attn: Financial Assistance Appeals Committee, Froedtert Kenosha Center, 6308 Eighth Avenue, Kenosha, WI 53143, outlining why the application should be reconsidered and providing any additional supporting information.

    b. All appeals will be considered by Froedtert South, Inc.'s Financial Assistance Appeals Committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal within 2 weeks of submission.

LIMITATIONS ON CHARGES FOR PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

Patients eligible for Financial Assistance under this Policy will not be charged individually more for Emergency Care or other Medically Necessary Care than the Amount Generally Billed ("AGB") to individuals who have insurance coverage for such care. Furthermore, charges for any Emergency Care or other Medically Necessary Care provided to individuals who are eligible for financial assistance under this Policy will be less than the gross charges for such services. The Organization calculates one or more AGB percentages using the "look-back method" and including Medicare Fee-For-Service and all private health insurers that pay claims to the Organization, all in accordance with 501(r) and set forth in Exhibit A.

APPLYING FOR FINANCIAL ASSISTANCE AND OTHER ASSISTANCE

A Patient may qualify for Financial Assistance through presumptive scoring eligibility or by applying for Financial Assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available:

1. Online at www.froedtertsouth.com

2. By Mail: Send Request to Financial Counselors, Froedtert Kenosha Center, 6308 Eighth Avenue, Kenosha, WI 53143.

3. In person: Visit Registration desks at all Organization locations, cashiers or financial counselors located within the Business Office at Froedtert Kenosha Center.

4. By Phone: Call Customer Service at 855-241-9952 or 262-652-8259.

For questions or assistance with the application, please call Customer Service at 855-241-9952 or 262-652-8259.

BILLING AND COLLECTIONS

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of this billing and collections policy may be obtained:

1. Online at www.froedtertsouth.com

2. By Mail: Send Request to Financial Counselors, Froedtert Kenosha Center, 6308 Eighth Avenue, Kenosha, WI 53143.

3. In person: Visit Registration desks at all Organization locations, cashiers or financial counselors located within the Business Office at Froedtert Kenosha Center.

4. By Phone: Call Customer Service at 855-241-9952 or 262-652-8259.

INTERPRETATION

This Policy is intended to comply with 501(r), except where specifically indicated. This Policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

EXHIBIT A
AMOUNT GENERALLY BILLED CALCULATION
March 1, 2024

Patients eligible for Financial Assistance under this Policy will not be charged individually more for Emergency Care or other Medically Necessary Care than the Amount Generally Billed to individuals who have insurance coverage for such care ("AGB"). Furthermore, charges for any Emergency Care or other Medically Necessary Care provided to individuals who are eligible for Financial Assistance under this Policy will be less than the gross charges for such services. The Organization calculates one or more AGB percentages using the "look-back method" and including Medicare Fee-For-Service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). These calculations are made as follows:

1. The Organization determines AGB by multiplying the gross charges for the applicable medical care by the AGB Percentage, which is determined annually by dividing (a) the sum of the amounts for all of its claims for Emergency Care and other Medically Necessary Care that have been allowed during the AGB Period by Medicare fee-for-service and all private health insurers as primary payors, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-pays, co-insurance or deductibles by (b) the sum of the associated gross charges for those claims.

   The AGB percentage is 33.3%.

2. "Gross Charges" means the Organization's full, established price for medical care that the Organization consistently and uniformly charges Patients before applying any contractual allowances, discounts, or deductions.

3. The "AGB Period" means each prior 12-month period ending on December 31st.

4. The Organization will begin to apply the annually determined AGB Percentage within 120 days following the end of the AGB Period that was used in calculation the AGB Percentage.

5. Any capitalized terms not defined in this document will have the meaning assigned to such term in the Organization's Financial Assistance Policy.

These limitations on charges for medical services shall not apply if an individual has not submitted a complete Financial Assistance Application as of the time the charges are billed to such individual; provided, however, that adjustments will be made if amounts are charged in excess of these limitations and the individual is subsequently determined to be eligible for Financial Assistance.