Financial Assistance Summary

Avita is committed to providing access to health care for everyone regardless of their ability to pay. We commit to do so in a professional and compassionate manner that respects our patients' dignity and privacy.

The Avita Financial Assistance Program is designed to provide fair and consistent access for all patients through use of a formalized application process. Standardized eligibility criteria are based on total gross family income, the number of dependents in the family unit, and the family's liquid assets.

The income guidelines are a sliding scale with a maximum income amount of 400% of Federal Poverty Level guidelines. Full (100%) assistance is given to families with income less than 200% of Federal Poverty Level.

The value of liquid assets that exceeds the family's total gross income for the previous (3) months is included in the calculation of the family's income.

Medical hardship adjustments will be considered on a case-by-case basis for families if their Avita medical expenses within a twelve (12) month time frame exceed $10,000 in patient responsibility and more than 20% of the family's income once the initial hospital assistance has been applied or if the patient would not otherwise qualify for charity care but have experienced dramatic changes in their financial circumstances post-service. The percentage of hardship awarded will not exceed 90%.

Presumptive charity will be given to families identified by external data analysis to not have the ability to pay.

CHARGES WILL NOT EXCEED AMOUNTS GENERALLY BILLED (AGB)

- If you receive financial assistance under our Policy, you will not be charged more for emergency or other medically necessary care than the amount we generally bill patients having commercial insurance or Medicare coverage.
- Avita utilizes the "look-back" method to determine the "amounts generally billed" to individuals who have insurance covering Emergency or other Medically Necessary Care.
- The percentage is calculated using all claims allowed by both private pay insures and Medicare (Traditional) for both inpatient and outpatient services. Total expected payment from allowed claims is divided by total billed charges for such claims to calculate the AGB.

To be eligible, patients/guarantors must:

- Exhaust available private and public resources, including but not limited to health insurance, liability insurance, pharmacy assistance programs, and grant programs. With the exception of Medicare eligible patients and patients over 18 years of age with no dependents under 18 years of age, families must complete the Medicaid application process to be considered for the Avita Financial Assistance Program.
- Be a U.S. citizen or a non-U.S. citizen living in Ohio voluntarily. Non-U.S. citizens who are on vacation in Ohio or any patient who comes to Ohio solely to receive medical care are excluded from assistance.
- Be unable to access other programs that would cover medical expenses.
- Not have declined health insurance through an employer within the last 12 months or a family member who could have covered the patient must not have declined coverage in the previous 12 months.
- Agree to enroll for coverage through the Marketplace during the next open enrollment*. If patient fails to enroll and maintain monthly premiums, he/she will not be eligible for additional assistance unless patient submits verification that the lowest monthly premium for which family members are eligible exceeds the family's gross monthly income by more than 15%.
  **Exclusion – if enrolled in an employer-sponsored, ACA-compliant health plan.*
- Authorize the release of any information needed to determine the family's eligibility, not to exclude address verification, a credit check through a national credit bureau, asset check through County Tax Assessor, and verification of all income and benefits received.
- Apply for assistance within 240 days after the first post-discharge statement

Electronic Signatures:

- May be used to authorize the release of information and/or sign a completed Financial Assistance Application except when restricted by applicable law, regulation, or Avita Health System policy or

process specifically requiring a handwritten signature. To the fullest extent allowed by law, Avita Health System accepts Electronic Signatures as legally binding, unless the individual does not have the Signature Authority to sign the Financial Assistance Application.

No Contract Plans:

- Financial Assistance will only be granted on amounts left to patient responsibility (deductible, coinsurance, etc).

Out-of-Network Plans:

- Financial Assistance will not be given on out-of-network plans with the exception of Emergency Room visits.

Family income:

- Is calculated based on the gross income for the three months prior to the service date multiplied by four or the twelve months prior to the service date, whichever is lower
- Includes, but is not limited to:
    - Wages, salaries, earnings
    - Unemployment and Workers Compensation benefits
    - Social Security and SSI benefits for all family members
    - VA benefits
    - Pension and retirement income
    - Interest, dividends, royalties, trust funds, income from estates
    - Child support and alimony
    - Food stamps
- Must be verified with documentation or patient attestation if no documentation available (e.g., written statement of support from friends or relatives)
- Income from self-employment will be calculated by reviewing a copy of the applicable federal tax Schedule C Profit or Loss Statement. For service dates within the first three months of the calendar year, the previous year's tax statement can be used. For service dates within the last nine months of the year, an updated, interim Schedule C must be prepared by the family and provided with the application. If a Schedule C was not filed for the previous tax year, an interim Schedule C must be prepared by the family and provided with the application. Excluded deductions include but are not limited to:
    - Home office
    - Furniture
    - Mileage, travel, parking, tolls, meals, entertainment, and gifts
    - Depreciation
    - Education/training
    - Charity deductions made for business purpose
    - Utilities for home based business
    - Internet hosting/services for home based business
    - Moving
    - Safe or safety deposit box

Medical hardship assistance:

- Is awarded to families who, within a specific time frame, incur medically necessary Avita expenses:
    - In excess of $10,000
    - Not covered by insurance or other private or government programs, and
    - That exceed 20% the family's gross income for that specific time frame. The time frame for comparison of expenses to income must be at least three (3) months but not more than twelve (12) months.
    - Percentage of hardship awarded will not exceed 90%
- Is calculated on the patient responsibility amount after all available third party insurance have paid or been exhausted, available government and private programs have paid, and charity adjustments based on income and liquid assets have been applied.

Application forms are available free of charge:

- Apply online via MyChart
- Apply online at avitahealth.org
- Download Application
- At Avita registration desks or Avita physician office front desks
- By contacting Avita's Customer Service Team at 419-468-0512
- On the back of Avita first statements sent to families with a patient responsibility amount

The Vice President of Finance/Chief Financial Officer (CFO), Director of Patient Financial Service (PFS), and Patient Receivables Manager have the authority to approve charity care.

An approved financial assistance application is good for 90 days, unless otherwise stated.

Definitions

Covered Services: Medically necessary services as defined by Medicare and Ohio Medicaid programs for the following organizations and provider groups:

- Galion Hospital
- Bucyrus Hospital
- Avita Ontario
- Avita Ontario ASC
- Avita Physicians (GCH Health Services, BCH Health Services, NCOFCC)

Excluded services include but are not limited to:

- Scheduled elective procedures cleared through Avita's Financial Clearance Program
- Cosmetic procedures
- Cataract surgery that does not meet Medicare medical necessity guidelines
- Upgraded lens used in medically necessary cataract surgery
- Vascular and endovascular surgery that does not meet Medicare medical necessity guidelines
- Hearing aids
- Fertility procedures
- Experimental drugs and procedures
- Hip and knee replacement surgeries that do not meet Medicare medical necessity guidelines
- Avita retail pharmacy
- Avita DME
- Physicals related to school/work/sports
- Service of physicians who are not employed by Avita Health System (e.g., Riverside Radiology, Emergency Room professional fees and independent physicians)
- Bariatric services

Elective Procedures: Covered services scheduled in advance because no medical emergency is involved.

Non-Elective Procedure: A procedure that must be performed immediately for lifesaving or damage-preventing reasons.

Financial Clearance: A process that helps patients understand their financial responsibility and assists in helping patients find appropriate funding sources for medical bills through payment arrangements, eligibility for insurance (e.g. Employer, Marketplace, Medicaid), or likelihood to qualify for financial assistance.

Out-of-Network: When healthcare providers and hospitals do not participate in an insurer's provider network. This means the provider or hospital has not signed a contract agreeing to accept the insurer's negotiated prices.

No Contract Plan: No Contract Plans are programs offered by companies that are not participating in an Avita managed care plan (even though a plan name may appear on the card) or have only agreed to network terms for physician clinic services. No Contract Plans include but are not limited to:

- Limited Benefit Plan
- No PPO Network
- Practitioner or Ancillary Only
- Assignment of Benefits (AOB)

Family of patient 18 years of age or older:

- Patient
- Patient's spouse, regardless of whether or not he/she lives in the home
- Patient's children under 18, natural or adoptive who live in the home
- Any person who is providing more than 50% of funding required for the patient's living expenses, regardless of whether or not he/she lives in the home with the patient
- Any person living in the home with the patient who is dependent on the patient's family income for over 50% of their support

Family of non-married, un-emancipated patient 17 years of age or younger

- Patient
- Patient's natural or adoptive parent(s), regardless of whether they live in the home
- The parent(s)' children, natural or adoptive under the age of 18 who live in the home
- Any person who is providing more than 50% of funding required for the patient's living expenses, regardless of whether or not he/she lives in the home with the patient
- Any person living in the home with the patient who is dependent on the patient's family income for over 50% of their support

Liquid assets included in income calculation

- Cash
- Checking account funds
- Savings
- Money market funds
- Certificates of deposit
- Stocks and bonds
- Available money held in a trust fund for the patient
- Lottery winnings within twelve months of service date

Family Size	100% Assistance Annual Income (200%)		90% Assistance Annual Income (250%)		75% Assistance Annual Income (300%)		40% Assistance Annual Income (400%)	
			From	To	From	To	From	To
1	Under	$30,120	$30,121	$37,650	$37,651	$45,180	$45,181	$60,240
2	Under	$40,400	$40,401	$50,500	$50,501	$60,600	$60,601	$80,800
3	Under	$50,680	$50,681	$63,350	$63,351	$76,020	$76,021	$101,360
4	Under	$60,960	$60,961	$76,200	$76,201	$91,440	$91,441	$121,920
5	Under	$71,240	$71,241	$89,050	$89,051	$106,860	$106,861	$142,480

Medical Hardship Guidelines

Patient's Responsibility Amount After All Available Payment and Charity Resources are Exhausted	Medical Hardship Adjustment
20-24.9% of total gross family income	50%
25-34.9% or more of total gross family income	75%
35% or more of total gross family income	90%