MERIDIAN HEALTH SYSTEM, INC.
POLICY MANUAL

POLICY ON BILLING AND COLLECTION ACTIONS OF CERTAIN SYSTEM HOSPITALS

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I. PURPOSE

To ensure that Meridian Health System, Inc. ("**Meridian Health**") and certain of the licensed hospital facilities owned by its affiliates (collectively referred to herein as the "**System**" and each affiliate referred to herein as a "**System Entity**") are in compliance with applicable state and federal laws governing hospital billing and collection practices. This Policy shall apply to the following licensed hospital facilities within the System (other System hospital facilities are subject to separate policies):

- Bayshore Community Hospital (Holmdel)
- Jersey Shore University Medical Center (Neptune)
- K. Hovnanian Children's Hospital (Neptune)
- Ocean Medical Center (Brick)
- Raritan Bay Medical Center (Old Bridge and Perth Amboy)
- Riverview Medical Center (Red Bank)
- Southern Ocean Medical Center (Manahawkin)

Actions such as writing off account to bad debt, sending a patient a bill, or calling a patient by telephone to make reasonable inquiries, are not extraordinary collection actions ("**ECAs**"). Actions requiring legal or judicial process or involving adverse reporting information are generally considered ECAs. For purposes of this policy, the term "patient" means the person receiving medical care or his or her guarantor.

Under the System's Policy on Financial Assistance, Emergency Care, and Limitation of Charges, a copy of which is available at http://www.meridianhealth.com/about-meridian/your-bill/index.aspx, the System Entities maintain a Charity Care Program in accordance with guidelines outlined in NJAC 10:52, Subchapters 11, 12, and13 and it is offered to all patients expressing a financial hardship or inability to pay. Any patient who completes a financial assistance application, supplies required documentation, and meets the eligibility criteria is entitled to a reduced rate, determined in accordance with the above noted guidelines. In addition, an Uninsured Discount Program is available for those patients who are not qualified under the NJAC 10:52, Subchapters 11, 12 and 13. This program is extended to all uninsured patients, and amounts due will not exceed Medicare fee-for-service rates.

For unpaid accounts, a "notification period" regarding collection activities, is required by the statute to begin on the date that care is provided and end on the 120th day after the patient is provided the first "post discharge" billing statement. ECAs can begin after the 120-day notification period, provided that the patient has not submitted a Charity Care application, the final 30 day notice has been provided, and or has been denied charity care.

II. PROCEDURE:

A System Entity will make reasonable efforts to determine whether individuals are eligible for Financial Assistance Programs prior to engaging in one or more ECAs. Further, System Entities will not defer or deny medically necessary care as a consequence of nonpayment of one or more bills for previously provided or current care.

III. BILLING/COLLECTION ACTIVITY

Current Accounts Receivable ("**AR**") that reach the end of the self-pay billing cycle (which consists of two statements and two letters over a period of approximately 90 days, without payment or evidence of Charity Care eligibility) are transferred to bad debt as stipulated in Patient Accounts policies and procedures. The System Entities do not engage in ECAs against an individual prior to reasonable efforts being made to determine whether the individual is Financial Assistance Program-eligible.

For these purposes, reasonable efforts include the posting of signage and notices regarding the System's Financial Assistance Program, the provision of a plain-language summary as part of the hospital intake or discharge process, the inclusion of specific information regarding the availability of financial assistance on all billing statements, communicating in person and by telephone regarding the availability of assistance and, in cases where an incomplete application is submitted, informing the patient in writing regarding the additional information/documentation required in order to determine the patient's eligibility.

Under no circumstances will a System Entity (either directly or indirectly, by another person on its behalf) undertake any ECA during the 120-day period following the date of the first post-discharge billing statement issued to the patient. A System Entity may satisfy the notification requirements with respect to an individual's aggregated outstanding bills as long as 120 days have passed since the first post discharge statement for the most recent episode of care included in the aggregated bills. After the expiration of the 120-day period, if a System Entity intends to undertake an ECA, the System Entity (or a third party on its behalf) will provide the patient with a final written notice stating the specific ECAs that will be undertaken if payment is not made or a financial assistance application is not submitted before a stated deadline, which must be at least 30 days after the date of the notice. The 30-day notice must include a plain-language summary of the System's financial assistance policy.

In keeping with the foregoing standards, once a patient account has completed the self-pay billing cycle, the System Entity will forward the account to a primary bad debt collection agency, which will work the account for 180 days. Accounts that remain unpaid at the end of 180 days are automatically reassigned to a secondary agency for an additional 180 days.

Primary and secondary agencies do not pursue legal action on accounts. Secondary agency placement accounts that remain unpaid after 180 days are referred to attorneys. Such attorneys may provide the 30-day notice (described above) on behalf of the System Entity and, after the expiration of the stated deadline, may initiate ECAs on behalf of the System Entity. ECAs will include judgments, liens and garnishments and reporting to credit agencies.

ECAs are suspended during this time if the patient does submit a financial assistance application. The hospital continues to accept and process any completed financial assistance applications for up to 24 months after the original date of service.

If the patient qualifies for Charity Care or the uninsured discount, any amounts previously paid by the patient in excess of their discounted charges will be refunded and any extraordinary collection efforts that have been taken will be reversed.

IV. NOTIFICATION REQUIREMENTS

Notice of availability of the two programs (Charity Care and Uninsured Discount) is included on all statements and collection letters sent to patients during the self-pay billing cycle. Charity Care fact sheets, a Financial Assistance guide, Financial Assistance Policy, the Plain Language summary as well as applications are available on the Meridian Health website and at each campus. The System Entities also participate in Community Outreach Programs in order to make the availability of financial assistance known to those persons most likely to need such assistance.

V. OFFICE OR AUTHORITATIVE BODY TO IMPLEMENT AND CARRY OUT POLICY

The Meridian Health Board of Trustees has granted the V.P. for Finance, Patient Financial Services to act as the authoritative body of the hospital to implement and carry out the policy and procedures. This authority includes responsibility for determining that reasonable efforts have been undertaken to determine eligibility for financial assistance, before undertaking ECAs.