
**STANDARD POLICY: FINANCIAL ASSISTANCE POLICY FOR CALIFORNIA-BASED HOSPITALS**

**POLICY SUMMARY/INTENT:**

This policy describes Orchard Hospital's Financial Assistance (Charity Care, FREE CARE, and Discounted Care) policy for its California hospitals. Orchard Hospital provides Financial Assistance to patients and families who are unable to pay all or part of their medical bills, in accordance with the standards below. This policy describes how Orchard Hospital reviews a patient's financial resources to determine if Financial Assistance can be provided. The intent of this policy is to comply with applicable federal, state, and local laws and regulations. Orchard Hospital does not discriminate and is fair in reviewing and assessing eligibility for Financial Assistance for community members in need.

Orchard Hospital is committed to providing Financial Assistance to patients who seek needed healthcare services but have limited or no means to pay for that care. Financial Assistance is comprised of Charity Care (free care) and Discounted Care. Orchard Hospital determines eligibility for Financial Assistance based on: (1) income, (2) type of service requested, (3) availability of other health coverage/insurance, and (4) whether the patient has incurred High Medical Costs compared to income. This policy describes the eligibility criteria and the level of Financial Assistance that will be offered to patients who meet the specified criteria.

Charity Care (free care and Discounted Care are not substitutes for personal responsibility. Patients are expected to work with the facility when seeking Financial Assistance. Persons must help pay for the cost of their care based on their ability to pay. Persons with financial means to purchase health insurance will be encouraged to do so since this helps improve their access to health care services.

All patients will be notified of the Financial Assistance Policy and how to access the Financial Assistance Application. Some patients will be presumptively eligible for Financial Assistance without need for further application. Patients may request Financial Assistance by applying with supporting documentation, as applicable.

Orchard Hospital will apply the standards in this Policy to determine each Financial Assistance Application and shall notify each applicant of its determination. Applicants dissatisfied with the determination may appeal it to Orchard Hospital. The collection of any remaining patient's financial responsibility shall be subject to the Orchard Hospital Self Pay Billing and Collection Policy.

Orchard Hospital provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy, as detailed in Orchard Hospital's Emergency Medical Treatment and Labor Act (EMTALA) policy and Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations (or any successor regulations).

**DEFINITIONS:**

**1.Amount Generally Billed (AGB):**

The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. The AGB percentages for each hospital facility are updated annually.

**2. Application:** Orchard Hospital application form for Financial Assistance.

**3. Charity Care:** Free care provided when the patient is not expected to pay the patient's payment obligation for items and services provided by Orchard Hospital.

**4. Discounted Care:** A reduction from the payment obligations for items and services that are provided for cash, prompt, or advanced payment, or to certain categories of patients, e.g., self-pay patients.

**5. Emergency Medical Care:** Refers to Emergency Services and Care, as defined in the Orchard Hospital Emergency Medical Treatment and Labor Act policy (EMTALA) #AD-06-019-S.

**6. Essential Living Expenses:** Expenses like rent or house payment and maintenance, food, household supplies, laundry and cleaning, utilities and telephone, clothing, medical

and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, repairs and installment payments, and other extraordinary expenses.

**7. Family: Family is defined as:** a. For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and b. For persons under 18 years of age, or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker, relatives, parents, or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

**8. Household Income:** The combined income of the patient seeking Financial Assistance and his/her/their Family as determined under this Policy. Income as used here shall include any sources (as set forth in Appendix D) used to calculate the adjusted gross income, as set forth on line 11 of Form 1040, U.S. Individual Income Tax Return.

**9. Financial Assistance:** Charity Care and Discounted Care.

**10. Federal Income Tax Return:**

The Internal Revenue Service (IRS) form/s used to report taxable income. The IRS form must be a copy of the signed and dated forms sent to the IRS.

**11. Federal Poverty Level (FPL):** The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority. These levels are set forth in Appendix C.

**12. High Medical Costs: Defined as any of the following:**

**A**. Annual Out-of-Pocket Costs, incurred by an individual (10an Orchard hospital, that exceed the lesser of ten percent (10%) of the patient's current Household Income or Household Income in the prior 12 months.

**B**. Annual Out-of-Pocket Costs that are more than ten percent (10%) of the patient's Household Income, if the patient provides documentation of their medical expenses paid by the patient, or the patient's Family Members, in the prior 12 months

**13. Medically Necessary Care:** A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to either (a) protect life, to prevent significant illness or significant disability, (b) to alleviate severe pain, or (c) to prevent, diagnose or treat an illness, injury, condition or disease, the symptoms of an illness, injury, condition or disease, and (d) meets accepted standards of medicine.

**14. Medically Unnecessary Care:** services performed within the hospital for which either

the provider who referred the patient for the hospital services or the supervising health care provider for the hospital services attests that the hospital services were not medically necessary.

**15. Out of Pocket Costs** - any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing

**16. Patient Financial Services (PFS):**

The Orchard Hospital department responsible for billing, collecting, and processing payments

**17. Policy:**

Orchard Hospital Financial Assistance Policy

**18. Self-Pay Patient:**

A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-Pay patients may include Charity Care patients. Self-Pay Patients are considered "Uninsured Patients" herein.

**AFFECTED DEPARTMENTS/SERVICES:**

A. Patient Financial Services (PFS)
B. Patient Access
C. Compliance
D. Finance

Emergency room physicians, who provide emergency medical services at Orchard Hospital and in our critical care facility, are excluded from this policy unless listed as a "Covered Provider" in the documentation from Appendix B. These emergency physicians are also required by California law to provide discounts to Uninsured Patients or patients with High Medical Costs whose Household Incomes are at or below 400 percent of the Federal Poverty Level. Patients who receive a bill from an Emergency Room physician, and are uninsured, underinsured, or have High Medical Costs, should contact that physician's

office and ask about their financial assistance policy.

**Eligible Services:**

The following services are excluded as ineligible for the application of Financial Assistance under this policy, except as required by law: Medically Unnecessary Care with a provider's attestation that hospital services are not medically necessary. • Purchases from a hospital's retail operations, such as gift shops and cafeteria. • Non-hospital services, such as physician services, that are not billed by the hospital, with the exception of services rendered by Covered Providers in the documentation from Appendix B; and • Services that are not licensed hospital services. Orchard Hospital may waive or reduce Medi-Cal or Medicare cost-sharing amounts as part of Charity Care or Discounted Care.

**Applying for Financial Assistance**

Access to Financial Assistance Policy and Application. Orchard Hospital provides information about its Financial Assistance Policy and Application, and its Rural Health Clinic Discount policy and application, available through numerous means in compliance with applicable state and federal laws and regulations. Information about this Policy is available on the website home page and on any website where the patient pays a bill or accesses information about the patient's account, posted in hospital areas that are accessible to the public, such as the emergency department and any rural health clinics waiting areas, included in writing on each billing statement, and by plain language summaries provided in writing to all patients. Hospital personnel shall direct patients, guardians, or family members who request Financial Assistance or information about Financial Assistance, or who the hospital personnel believe may be eligible for Financial Assistance to any hospital registration area or by phone to (530) 846-9011 to receive a paper copy of this Policy and an application form. An explanation of Orchard Hospital's Financial Assistance program, and Orchard Hospital's Rural Health Clinic Discounts program, and the related application forms are available at Orchard Hospital Help Paying Your Bill. Orchard Hospital shall ensure that this Policy is translated into each language spoken by the lesser of 1,000 people or five percent of the population that resides in each hospital's service area and is made accessible by interpretation or alternative formats to ensure access for limited English proficient and disabled individuals.

**Other Forms of Health Coverage**

Orchard Hospital and operated facility shall make all reasonable efforts to obtain from the patient or the patient's representative information about whether private or public health.

insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient. These efforts will include helping the patient find insurance options, including, but not limited to, any of the following:

- Private health insurance, including coverage offered through the California Health Benefit Exchange.
- Medicare
- The Medicaid program, the California Children's Services program, or other state-funded programs designed to provide health coverage.

If a patient applied or has a pending application for another health coverage program while the patient applies for Financial Assistance, neither application will stop eligibility for the other program.

Financial Assistance does not relieve the patient or the guarantor of the responsibility to ensure payment for health care services. Orchard Hospital encourages patients to cooperate with the Hospital in finding other sources of payment or coverage through public and/or private payment programs.

The patient or guarantor is responsible for meeting the conditions of coverage for their insurance or health plan if they have third-party coverage. The patient is required to pay Orchard Hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for the hospital services received. If the patient receives a legal settlement, judgment or award under a liable third-party action that includes payment for health care services or medical care related to the injury, the patient or guarantor must reimburse Orchard Hospital for the related health care services provided up to the amount reasonably awarded for that purpose.

**C. Application Process**

To be considered for Financial Assistance under this policy, a patient or guarantor must submit a true, accurate, and complete confidential Financial Assistance Application by email, mail or online submission. The Financial Assistance Application must be completed in writing and may be completed by or with the assistance of a staff or management member of the Patient Financial Services Department. The Financial Assistance Application must be signed by the patient or the patient's legal representative and accompanied by the following documentation:

• Recent pay stubs from within the 6 months before or after the patient is first billed (or in preservice when Application is submitted) or

• Copy of Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed

If the patient is seeking a reduction of the Medi-Cal or Medicare Share of Cost, Orchard Hospital may require documentation of the patient's monetary assets to the extent required for Orchard Hospital to be reimbursed under the Medicare program for Medicare bad debt. Orchard Hospital will not consider the patient's monetary assets in determining eligibility for Charity Care or Discounted Care.

A patient, or patient's legal representative, who requests Discounted Care, Charity Care, or other assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. Orchard Hospital may consider the failure to provide this information in making its determination. These documents provided for the Application will only be used in reaching a determination of Financial Assistance and will not be used for collection activities.

An individual is considered to have submitted a complete Financial Assistance Application if he or she provides information and documentation sufficient for the hospital facility to determine eligibility for Financial Assistance. A Financial Assistance Application is incomplete if he or she provides some, but not sufficient, information and documentation to determine eligibility for Financial Assistance.

**D. Notification of Financial Assistance Determination**

Once an Orchard Hospital facility has reviewed the Financial Assistance Application and has made a determination based on the Eligibility requirements stated below, the facility shall notify the individual in writing by mail of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

**E. Effect of Financial Assistance Determination**

If found eligible for Financial Assistance, whether Charity Care or Discounted Care, the facility shall provide the individual with a billing statement that states the amount the individual now owes for the care, how that amount was determined and how the individual can get information regarding the Amounts Generally Billed ("AGB") for the care.

If found eligible for Discounted Care, the patient may enter an extended payment plan to allow payment over time. The hospital and the patient shall negotiate the terms of the payment plan and take into consideration the patient's Household Income, Essential Living Expenses, and the availability of a health savings account of the patient or the patient's family. If the hospital and the patient cannot agree on a payment plan, the hospital shall create a payment plan in which monthly payments will not exceed 10 percent of a patient's Household Income for that month, excluding deductions for Essential Living Expenses.

If appropriate, the facility shall refund the individual any amount he or she has paid for the care (whether to the hospital facility or any other party to whom the hospital facility has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying after Financial Assistance has been applied. The hospital shall make any refunds under this section within 30 days of the determination of eligibility for Financial Assistance. Any interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, Orchard Hospital may choose not to reimburse the patient if Orchard Hospital determines the patient would have qualified for Financial Assistance at the time the patient was first billed and it has either (i) been five years or more since the last payment to the hospital, assignee or debt buyer or (ii) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.

The Financial Assistance approval is valid for 180 days after approval. The adjustment will be applied to all eligible patient account balances, including those received before the application approval date. For bills received 180 days after the Financial Assistance is approved, a new Financial Assistance Application will need to be filled out if the patient is seeking Financial Assistance for those bills.

**F. Appeal of Financial Assistance Determination**

Patients may submit a written request for reconsideration to the Finance Officer of the Orchard Hospital facility at which they received services. Such an appeal should demonstrate that the individual either:

i. Believes their Financial Assistance Application was not approved according to this policy; or

ii. Disagrees with the way the policy was applied to their case

Appeal must be submitted within 30 days of the date of the decision letter. The Financial Officer will be the final level of appeal.

**G. Change in Circumstances**

If at any time information relevant to the eligibility of the patient changes, the patient may update the documentation related to income and provide the relevant Orchard Hospital owned and operated facility with the updated information

**How to Ask for Help**

More information about Financial Assistance and paper copies of this Policy and Application are available from any hospital registration area or by phone at (530) 846-9011.

**5. Eligibility**

**A**. Presumptive Eligibility Orchard Hospital reserves the discretion to grant presumptive Financial Assistance for individuals if it determines that the individual is eligible for Financial Assistance for the care based on information other than that provided by the individual or based on a prior Financial Assistance determination.

If the patient does not or cannot respond to the application process, Orchard Hospital will screen the patient for certain socioeconomic or financial factors described below and use an independent credit-based financial assessment tool to estimate the patient's income and financial capacity. The third-party vendor's electronic eligibility review uses a healthcare-industry-recognized model based on public records databases. The electronic eligibility review data that supports Financial Assistance for an estimated Household Income of 200% FPL or less will only be applied to past patient balances. The above information helps Orchard Hospital make an informed, good-faith decision about a patient's financial need by using the best available estimates when the patient does not or cannot provide the requested information.

Examples of the socio-economic or financial factors Orchard Hospital considers for presumptive eligibility for Financial Assistance include but are not limited to:

i. The patient was granted Financial Assistance within the last 180 days.

ii. The patient's medical record that documents he/she is homeless;
iii. The patient expired with no known estate or spouse;
iv. The patient is currently incarcerated;
v. The patient qualifies for a public benefit program, including Social Security Disability Insurance, Unemployment Insurance Benefits, Medicaid, County Indigent Health, TANF, Food Stamps, WIC, etc.; or
vi. The patient meets the requirements of another public benefit program that are similar to the eligibility standards in this Policy. Orchard will apply a presumptive Charity Care determination of 100% assistance in the following situations:
i. Patient has an active Medicaid plan.
ii. Patient is eligible for Medicaid; or iii. Patients with current active Medicaid coverage, even if they did not have Medicaid coverage on the date of service If Orchard Hospital determines the patient is presumptively eligible for Charity Care, the patient will not be required to take further action, and assistance will be applied to the patient's past bills.

If Orchard Hospital determines that the patient is eligible for Discounted Care, Orchard Hospital will notify the individual regarding the basis for the presumptive Financial Assistance determination and the way to apply for more generous assistance available under this Financial Assistance Policy. Orchard Hospital will provide the patient with a reasonable period of time to apply for more generous Financial Assistance before initiating extraordinary collection actions to obtain the discounted amount owed for the care.

**B. Standard Eligibility**

The level of Financial Assistance, such as Charity Care (no charge to the patient) or Discounted Care (a discount to the patient), is based on several factors: Household Income, the patient's insurance plan, and whether the patient has High Medical Costs. Different discount policies apply based on the Household Income level, insurance status of the patient, and whether the services are rendered by a rural health clinic.

Orchard Hospital authorizes Financial Assistance as set forth in this Policy. Hospital discounts are based on the AGB thresholds set forth in Appendix E. Orchard Hospital will limit charges to a patient eligible for Financial Assistance to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare or Medi-Cal, whichever is greater, if this amount is lower than the discounted amounts set forth in the tables below.

Non-covered and denied services and related services provided to Medicaid-eligible

beneficiaries are considered a form of Charity Care. Medicaid beneficiaries are not responsible for any patient financial liability other than the Share of Cost, unless waived or reduced. Examples of this include but are not limited to services provided to Medicaid beneficiaries with restricted Medicaid, Medicaid pending accounts, Medicaid of other indigent care program denials, charges related to days exceeding length-of-stay limits, Medicaid claims (including out-of-state Medicaid claims) with "no payments," and any service provided to a Medicaid-eligible patient with no coverage and no payment

Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts and other liabilities for medically necessary hospital services. Orchard Hospital may waive or reduce Medi-Cal or Medicare Share of Cost amounts as part of Charity Care of Discounted Care.

| | |
|---|---|
| **Subject** | Community Care Financial Assistance and Discount Payment Program |
| **Department(s)** | Business Office and Compliance |
| **Reference #** | 4632 |

**Scope of Policy (Identifies the entities that are covered under the policy)**

| | | | | | |
|---|---|---|---|---|---|
| X | All Orchard Hospital entities | | Medical Specialty Center | | |
| | Orchard Hospital | | Medical Specialty Center (Oroville) | | |

## 2026 HHS POVERTY GUIDELINES - 400% FPL

| Household Size | 400% US Poverty Level |
|---|---|
| 1 | $63,840.00 |
| 2 | $86,560.00 |
| 3 | $109,280.00 |
| 4 | $132,000.00 |
| 5 | $154,720.00 |
| 6 | $177,440.00 |
| 7 | $200,160.00 |
| 8 | $222,880.00 |
| 9 | $245,600.00 |
| 10 | $268,320.00 |

**To determine Medically Indigent eligibility according to income level:**

Count the number of people in your family/household.

- For persons 18 years of age and older, include spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not
- For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Calculate the household income (annual).

Orchard Hospital

| | |
|---|---|
| **Subject** | Financial Assistance Free Care and Discount Payment Program |
| **Department(s)** | Business Office and Compliance |
| **Reference #** | 4632 |

**Scope of Policy (Identifies the entities that are covered under the policy)**

| | | | | | |
|---|---|---|---|---|---|
| X | All Orchard Hospital entities | | Medical Specialty Center | | Community Care Center |
| | Orchard Hospital | | Medical Specialty Center (Oroville) | | |

Calculate the household income (annual).

Sliding across the row corresponding to the number of persons in your family/household above, stop in the first bucket that has an amount greater than the household income.

At the top of that column, the % discount is displayed.

**REPAYMENT SCHEDULE**

| Total Patient Responsibility | Maximum Repayment Term | Minimum Monthly Payment |
|---|---|---|
| $50 or less | In Full | In Full |
| $51 - $100 | 2 Months | $40 |
| $101- $300 | 3 Months | $55 |
| $301- 4600 | 6 Months | $75 |
| $601 - $1,000 | 9 Months | $100 |
| $1,001- $3,000 | 12 Months | $150 |
| $3,001- $6,000 | 15 Months | $250 |
| $6,000 And over | 18 Months | $350 |

**To determine repayment schedule parameters:**

Establish estimated or calculated total patient charges prior to discount.

| | |
|---|---|
| **Subject** | Financial Assistance Free Care and Discount Payment Program |
| **Department(s)** | Business Office and Compliance |
| **Revised** | 01/2026 |

| **Scope of Policy (Identifies the entities that are covered under the policy)** | | | | | |
|---|---|---|---|---|---|
| x | **All Orchard Hospital entities** | | **Medical Specialty Center** | | |
| | **Orchard Hospital** | | **Medical Specialty Center (Oroville)** | | |

## 2026 HHS POVERTY GUIDELINES

| Household Size | 100% US Poverty Level | 150% US Poverty Level | 200% US Poverty Level |
|---|---|---|---|
| | 80% Discount | 60% Discount | 40% Discount |
| 1 | $15,960.00 | $23,940.00 | $31,920.00 |
| 2 | $21,640.00 | $32,460.00 | $43,280.00 |
| 3 | $27,320.00 | $40,980.00 | $54,640.00, |
| 4 | $33,000.00 | $49,500.00 | $66,000.00 |
| 5 | $38,680.00 | $58,020.00 | $77,000.00 |
| 6 | $44,360.00 | $66,540.00 | $88,720.00 |
| 7 | $50,040.00 | $75.060.00 | $100,080.00 |
| 8 | $55,720.00 | $83,580.00 | $111,440.00 |
| 9 | $61,400.00 | $92,570.00 | $122,800.00 |
| 10 | $67,080.00 | $100,620.00 | $134,160.00 |

**To determine discount eligibility:**

Count the number of people in your family/household.