Hematologics, Inc.
Physical Laboratory: 3161 Elliott Ave., Suite 200, Seattle, WA 98121
Billing Office: PO Box 24712, Seattle, Washington 98124
Billing Office Phone: (206)799-9491, Billing Office Fax: (866) 383-6743

HEMATOLOGICS BILLING POLICIES

To establish guidelines for patient billing and the offering of discounts and write-offs

INSURANCE BILLING

Hematologics will bill insurance companies for services performed in the laboratory. We negotiate in network status with most of the major insurance companies. We have established financial support programs for patients without insurance, and work compassionately with those patients who cannot afford to pay for our services. For many patients with insurance, however, individual insurance plans, including governmental programs, may hold the patients responsible for a portion of Hematologic's charges.

Insured patients are billed deductibles, co-insurance and co-payments as required by their insurance provider. Hematologics will bill patients for any applicable deductible, co-insurance and co-payment amounts, as reflected on explanations of benefits ("EOBs") or similar statements furnished by the insurer. These amounts are determined by the insurer, not by Hematologics.

When Hematologics is not contracted with an insurance plan, we will bill patients for the amount designated by their plan on the EOB as the patient's responsibility for the services provided. Any balance above the allowed amount must also be billed to the patient if the insurer indicates this as a patient responsibility.

An increasing number of insurance companies are requiring pre-authorization and establishment of medical necessity for complex diagnostic laboratory tests most notably Molecular Diagnostic Testing . We recommend that the ordering physician's office contact the insurance company to verify if pre-authorization is required. If we are not contracted with an insurance company this pre-authorization can allow payment at in-network rates. Hematologics is always willing to negotiate rates with any insurance we do not currently hold a contract with.

Uninsured patients will be billed for all charges in full with the following paragraph on the statement.

> ***We performed the above laboratory/pathology services at the request of your physician (named above). The information we received indicated that you have no insurance. If this is incorrect or you desire to set up a payment plan please contact the billing office.***

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PATIENT BILLING

Once a patient's explanation of benefits has been received, payments and insurance assigned discounts will be applied and the remaining balance billed to the patient.

A good faith attempt to collect the amount owed will be made to include no less than two statements in addition to this initial, post EOB statement.

Hematologics does not employ aggressive forms of collection.

PATIENT DISCOUNTS FOR UNINSURED AND UNDERINSURED PATIENTS AND FINANCIAL AID

Hematologics understands that providing quality patient care has a related cost, which in some situations may be burdensome for patients and result in some patients avoiding certain necessary services because they are concerned about the expense. Hematologics is committed to delivering the best patient care to all, and to meet this objective has established guidelines to ensure affordable access to our services.

If the patient contacts Hematologics with requests for discounts, write off's or financial aid, the following guidelines will be applied.

- If the patient is uninsured or their health plan does not cover the test, Hematologics may offer an uninsured/non-covered rate for each test. This amount will be determined for each test as part of our internal price sheet.
- Payment Plans may be entered into for outstanding balances. Monthly amount to be determined individually.
- Patients with special financial needs may be eligible for additional support to help defray some of our testing costs. Hematologics will make assessment of eligibility for financial support based on a submitted financial aid request form and in accordance with federal guidelines. A complete Financial Assistance Policy is attached.
- We will accept and match the financial aid support as determined by another healthcare institution without requiring the patient to complete additional forms. A copy of the financial aid award from the other healthcare provider must be provided by the patient and kept in the patient's records.
- In special cases when patients express extreme anger, emotionally break down, threaten or otherwise exhibit irrational behavior, Hematologics considers it to be a prudent business practice to not exacerbate these exceptional circumstances. The determination to waive the patient's charges or cease collection attempts will be decided on an individual basis by the billing manager and documented in the patients billing record.

A. Notifier: HEMATOLOGICS INCORPORATED

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D._____** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D._____** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D._____** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D._____** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D._____** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D._____** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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Advance Beneficiary Notice (ABN)
Non-Medicare

Patient Name: _____ Insurance ID# _____

Note: You need to make a choice about receiving these health care items or services.

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your health cares costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. **There may be a good reason your doctor recommended it. Right now, in your case, your Insurance Company probably will not pay for**:

Item or Service: **Because**:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your Insurance Company probably will not pay.
- Ask us how much these items or services will cost you *(Estimated Cost:* $_____)

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

☐ **Option 1: Yes, I want to receive these items or services.**
I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

☐ **Option 2: No, I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____
SIGNATURE of patient or person acting on patient's behalf **DATE**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

Hematologics Incorporation
Financial Assistance Policy

Purpose: The purpose of this Policy is to set forth the Hematologics Incorporated (Hematologics) policy of providing free or discounted health care services to patients who meet the Hematologics criteria for Financial Assistance. Specifically, this Policy will describe: (i) eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; and (iii) the method for applying for Financial Assistance from Hematologics.

Scope: This Policy applies to all Hematologics services and all patients regardless of the referral source.

Definitions:

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient needs Financial Assistance for the Laboratory Services provided by Hematologics.

"Family" means pursuant to the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption. For purposes of this Policy, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

"Family Income" means the following income when calculating Federal Poverty Level Guidelines of liquid assets: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources of income. If a person lives with a Family, Family Income includes the income of all Family members.

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services.

"Financial Assistance" means free or discounted Laboratory Services provided to persons who pursuant to the Eligibility Criteria, Hematologics has determined to be unable to pay for all or a portion of their testing.

"Medically Indigent" means persons for whom Hematologics has determined to be unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their Family income or assets even though they have income or assets that otherwise exceed the generally applicable Eligibility Criteria for free or discounted care under the Policy.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for Laboratory Services and is not covered by Medicare, Medicaid or Champus or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

"Underinsured" means the patient has some level of insurance or third-party assistance but still has out-of-pocket expenses such as high deductible plans that exceed his or her level of financial resources.

Hematologics Incorporation
Financial Assistance Policy

Policy: It is Hematologics's policy to provide Financial Assistance to all eligible individuals who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for their laboratory services due to their limited financial resources.

I. Determining Eligibility. In determining eligibility for Financial Assistance, it is important that both the Laboratory and the patient work collaboratively. Specifically, Hematologics will do its best to apply the Eligibility Criteria in a flexible and reasonable manner and the patient will do its best in responding to Hematologics's requests for information in a timely manner.

1. Eligibility for Financial Assistance. Individuals who are Uninsured, Underinsured (ex: high deductible plans), ineligible for any government health care benefit program and unable to pay for their Laboratory Services may be eligible for Financial Assistance pursuant to this Policy.

2. Process for Determining Eligibility for Financial Assistance. In connection with determining eligibility for Financial Assistance, Hematologics (i) will require that the patient complete an application for Financial Assistance along with providing other financial information and documentation relevant to making a determination of financial eligibility; (ii) may rely upon publicly available information and resources to determine the financial resources of the patient or a potential guarantor; (iii) pursue alternative sources of payment from public and private payment benefit programs; (iv) may review the patient's prior payment history; and (v) may accept and match the determined eligibility for financial aid as awarded by another healthcare facility, i.e. a hospital.

3. Processing Requests. During the eligibility determination process, Hematologics will at all times treat the patient or their authorized representative with dignity and respect and in accordance with all State and Federal laws.

4. Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

(a) ***Uninsured Patients:***

(i) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for a 100% discount against Charges for Laboratory Services;

(ii) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against Charges for Laboratory Services;

(iii) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(b) ***Underinsured Patients:***

(i) Payment plans will be extended for any patient liability (including without limitation to amounts due under high deductible plans) identified in a manner consistent with the System's Payment Plan Policy;

(ii) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;

(iii) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;

(iv) Family size is determined based upon the number of dependents living in the household;

(v) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(c) ***Medically Indigent:***

Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the appropriate Hematologics billing manager can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

II. Method for Applying for Financial Assistance. Patients may inquire about initiating the Financial Assistance application process by contacting the Hematologics billing departement. The billing manager will provide the patient with the Financial Assistance application along with a list of the required documents that must be provided to process the application. If the patient or his or her legal representative does not provide the necessary documentation and information required to make a Financial Eligibility determination within fourteen (14) calendar days of Hematologics's request, the Financial Assistance application will be deemed incomplete and rendered void. However, if an application is deemed complete by Hematologics, Hematologics will provide to the patient a written determination of financial eligibility within five (5) business days. Decisions by Hematologics that the patient does not qualify for Financial Assistance may be appealed by the patient within fourteen (14) calendar days of the determination. If the patient appeals the determination, a company Director will review the determination along with any new information and render a final decision within five (5) business days.

III. Relationship to Hematologics's Collection Practices. In the event a patient fails to qualify for Financial Assistance or fails to pay their portion of discounted charges pursuant to this Policy, and the patient does not pay timely their obligations to Hematologics, Hematologics reserves the right to turn the patients account over to a collection agency. For those patients that qualify for Financial Assistance and who are cooperating in good faith to resolve Hematologics's outstanding accounts, Hematologics may offer extended payment plans to eligible patients, will not send unpaid bills to outside collection agencies and will cease collection efforts.

IV. Regulatory Compliance. Hematologics will comply with all state and federal laws, rules and regulations applicable to the conduct described in this Policy.

V. Uninsured patients. Patients that are uninsured and do not qualify for the full or partial discounted Financial Assistance program, will receive an uninsured/non-covered rate for each test. This discounted amount is determined by Hematologics and is part of Hematologics test menu and pricing.

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2019 FINANCIAL HARDSHIP APPLICATION
FOR WAIVER OF COPAY/DEDUCTIBLE

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof of patients income in relation to the current federal poverty guidelines, see chart on page 3. This can include documents such as:

   a. W-2 withholding statements
   b. Pay check stubs
   c. Income tax return
   d. Forms from Medicaid or other State-funded medical assistance
   e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

   a. proof of bankruptcy settlement
   b. catastrophic situations (death or disability in family, divorce)
   c. documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

Completion of this application does not mean your request will be granted or that you will be relieved of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

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Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

Uninsured Patients:

1) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for a 100% discount against Charges for Laboratory Services;
2) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against Charges for Laboratory Services;
3) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

Underinsured Patients:

1) Payment plans will be extended for any patient liability (including without limitation to amounts due under high deductible plans) identified in a manner consistent with the System's Payment Plan Policy;
2) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;
3) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;
4) Family size is determined based upon the number of dependents living in the household;
5) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

Medically Indigent:

Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the appropriate Hematologics billing manager can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

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FINANCIAL DISCLOSURE FORM

Federal Poverty Guidelines are used to determine financial hardship based on annual income.

2019 Federal Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$12,490	$15,600	$14,380
2	16,910	21,130	19,460
3	21,330	26,660	24,540
4	25,750	32,190	29,620
5	30,170	37,720	34,700
6	34,590	43,250	39,780
7	39,010	48,780	44,860
8	43,4430	54,310	49,940
each add person add	$4,420	$5,530	$5,080

Please provide following information as appropriate so we may complete your application:

- ☐ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- ☐ Check stubs for the past 30 days for all persons employed in the home
- ☐ Unemployment check stubs for the past 30 days
- ☐ Proof of all other income received in the past 30 days
- ☐ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- ☐ Medicaid Denial letter
- ☐ Attached financial statement (completely filled out and signed)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed. Please return all items (as applicable) on this checklist (by fax, email or paper mail).

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Financial Statement and Financial Aid Application.

PATIENT NAME: _____

DATE(S) OF SERVICE: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

NUMBER OF FAMILY MEMBERS LIVING IN HOUSEHOLD: _____

EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

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MONTHLY FAMILY INCOME AND SOURCE

_____ Patient _____ Spouse _____ Parent or other Responsible Party

Monthly Salary (Gross) $_____

Public Assistance Benefits $ _____

Unemployment Benefits $ _____

Social Security Benefits $ _____

Workman's Compensation $ _____

Child Support $ _____

Other (Alimony, Etc.) $ _____

TOTAL FAMILY INCOME $_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE (YOUR COMPANY] TO VERIFY ANY INFORMATION
CONTAINED IN OR ATTACHED TO THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of Person Making Request Date

_____ _____
Signature of Spouse/Other Date

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____
Date

By _____
Name and Title

Approved by _____
Signature of billing manager or laboratory director