FROEDTERT SOUTH, INC.

BILLING AND COLLECTION POLICY
February 10, 2026

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 Clinic, Paddock Lake Clinic, Pleasant Prairie Clinic, Prairie Ridge Clinic, and Somers Clinic (the "Organization") to ensure a socially just practice for billing its Patients for the services and care they receive at the Organization's facilities.

PURPOSE

To establish general guidelines for the expected receipt of payment for services provided by the Organization, and Providers, and to establish certain requirements that each hospital and other outpatient facilities must meet prior to taking certain collection actions against individuals that may be eligible for Financial Assistance ("Financial Assistance") under the Organization's Financial Assistance Policy.

POLICY

The Organization will submit claims to Medicare, Medicaid and/or other third-party payors. Any portions not covered by insurance will be the responsibility of the Patient, (for purposes of this Policy references to "Patient" shall include, where applicable, the individual acting as the Guarantor of payment of the Patient's invoice for medical care). The ultimate financial responsibility for payment lies with the Patient.

No individual will be refused treatment for Emergency Care or other Medically Necessary Care at each hospital and other outpatient facilities due to demonstrated financial hardship or inability to pay.

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 Clinic, 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.

GENERAL PROCEDURES

1. A Patient requiring Emergency Care or other Medically Necessary Care will be given appropriate treatment. Promptly after services are provided, the Patient, a family member, or other responsible party will be required to provide all information necessary to properly identify the Patient and to make arrangements for payment for all medical services.

2. Individuals requiring non-Emergency Care or other non-Medically Necessary Care, and individuals seeking elective services will be required to make financial arrangements for the payment of medical care prior to receiving the services.

    a. Each Patient who claims financial hardship or the inability to pay, will be required to complete an application requesting consideration for Financial Assistance in accordance with the Organization's Financial Assistance Policy. Failure to comply with the Financial Assistance Application requirements may result in services, other than Emergency Care or other Medically Necessary Care, being denied, or if services are rendered, the Organization may pursue payment for such services in accordance with the Organization's standard policies and procedures, including this Policy, and in compliance with applicable federal and state laws.

    b. Each Patient with insurance or other form of third-party coverage will be required to provide all information requested to properly identify the Patient/Guarantor and bill the third-party payor. The Organization will make a reasonable effort to verify the Patient plan's coverage for the services, care and treatment the Patient expects to receive at the Organization and the Organization will notify the Patient (or Guarantor, on behalf of the Patient), in advance, of items it knows are not covered benefits. However, should the Patient's plan ultimately deny payment

for the services, care and treatment provided to the Patient, the Patient (or Guarantor, on behalf of the Patient) will be responsible for paying the billed charges for such items, consistent with any applicable, written, contractual discounts and the Organization's Patient Financial Assistance policies.

c. If an assignment of benefits is received, all valid insurance(s) will be accepted and billed by the entity providing the service. Deductibles and coinsurance amount not paid by insurance are expected to be paid by the Patient (or Guarantor, on behalf of the Patient). Patients may be asked to pay amounts towards deductible, co-insurance, or co-pays or non-covered services at the point of scheduling, check in or after services are rendered with receipt of the first invoice, unless alternative acceptable payment arrangements are established.

d. Each Patient seeking non-Emergency Care or other non-Medically Necessary Care services which are not covered by insurance or other third-party payors will be expected to pay estimated charges less any applicable discounts applied in advance. If the actual charges are greater than the collected amount, the Patient will be sent an invoice for the balance. If the actual charges are less than the collected amount, the Patient will be refunded the excess amount.

3. Payments for services provided to Patients are the responsibility of the Patient (or Guarantor, on behalf of the Patient) including those which appear to be covered services by the Patient's third-party payor.

    a. Reasonable efforts will be made to educate the Patient concerning the financial responsibility he/she is accepting prior to the provision of services. An explanation of billing and payment procedures may occur during scheduling or check in. Documents that explain the billing and collection procedures will be provided to the Patient/Guarantor before admission or registration for outpatient surgery, whenever possible.

    b. Forms of acceptable payment include insurance, cash, check, and credit card. These forms of payment will be explained to the Patient before registration, when reasonably possible. Prompt payment is expected unless there are extenuating circumstances. Except as provided elsewhere in this Policy, Patients are expected to pay the Patient liability amount in full within 120 days of receiving the first billing statement, which are sent within 30 days of the final claims adjudication (or within 30 days from the date of service for Patients without insurance coverage), unless a monthly payment plan is agreed upon. The Organization may agree to monthly payment arrangements depending upon the Patient's account balance. Payments will not be extended beyond 18 months unless there are extenuating circumstances. Payment arrangements beyond 18 months must be approved in advance by the Patient Financial Services Manager or designee. Except as prohibited by this Policy or applicable law, accounts with unpaid balances that are not in a mutually agreed upon payment plan may be referred to a collection agency at any time.

    c. Patients with questions regarding their billing statements can contact a billing representative for assistance with investigating, or initiating a review of, potential billing errors, offing a price adjustment or debt forgiveness based on hospital policy, and establishing a payment plan. All inquiries and requests will be

addressed by a billing representative within 10 business days of being contacted by the Patient, unless otherwise specified.

d. The following Patients will be referred to a Financial Counselor to be screened for potentially available government programs:

    i. Patients scheduled to receive medical care who are without health insurance.
    ii. Patients scheduled to receive elective services such as cosmetic surgery or other services which are not covered by the Patient's health insurance benefits.
    iii. Patients without health insurance who receive Emergency Care or other Medically Necessary Care, or who are admitted to the hospital facility.

In the event that a Patient is unable to pay for services, the Organization will assist the Patient in applying for any available source of financial assistance. Examples include Wisconsin Medicaid Program (Title XIX), Crime Victim Compensation Fund, and enrollment in an insurance plan available through the Federal Health Insurance Marketplace. Refusal of the Patient to cooperate in this effort may result in denial of services except for Emergency Care or other Medically Necessary Care. Financial Assistance may be offered according to the Organization's separate Financial Assistance Policy.

BILLING AND COLLECTION PROCEDURES

In conjunction with its other billing and collection practices, policies, and procedures, the Organization shall follow the following procedures to ensure compliance with Section 501(r) of the Internal Revenue Code of 1986, as amended, and its corresponding regulations ("Section 501(r)"); provided further that, in the event of a conflict between this Policy and any other practice, policy, or procedure of the Organization, this Policy shall control unless the Organization reasonably determines that the Organization may follow the other practice, policy, or procedure without violating Section 501(r).

1. The Organization will not engage in any Extraordinary Collection Action, as defined below, against any individual to collect payment for medical care before the Organization has made reasonable efforts to determine whether the individual is eligible for Financial Assistance under the Organization's Financial Assistance Policy through the use of presumptive scoring and by review of the submitted Financial Assistance Application. This also applies with respect to any other individual who may be responsible for the payment of the Patient's medical bill for such care.

2. "Extraordinary Collection Action" or "ECA" means any action that is defined by Section 501(r) as an extraordinary collection action. Under appropriate circumstances, and in compliance with Section 501(r), the Organization may take any or all of the following ECAs:

    a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;

    b. Deferring or denying, or requiring a payment before providing, Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under the Financial Assistance Policy;

c. Actions that require a legal judicial process (except for the placement of certain liens which a hospital is entitled to assert under state law); and

d. Garnishing an individual's wages.

3. In addition to the above-listed ECAs, the Organization may take its usual and customary steps to obtain payment, including the following (none of which are ECAs):

   a. Sending one or more billing statements or letters;

   b. Making telephone calls;

   c. Conferring personally with Patients/Guarantors, whether at, before, or after the time of service; and

   d. Referring (but not selling) a debt to an outside collection agency.

4. In an effort to determine whether a Patient is eligible for Financial Assistance, at least 30 days prior to initiating an ECA to obtain payment for care (and subject to the 120-day notification period provided in paragraph 5 below), the Organization will:

   a. Notify the Patient/Guarantor about the Financial Assistance Policy, identify the ECA(s) that the Organization intends to take to obtain payment, and states the deadline after which the ECA(s) may be taken (which cannot be less than 30 days following the date that the notice is provided to the Patient/Guarantor):

   b. Provide the Patient/Guarantor with a plain language summary of the Financial Assistance Policy with the written notice described in paragraph 4.a above; and

   c. Make a reasonable effort to orally notify the Patient/Guarantor about the Financial Assistance Policy and about how he or she may apply for such Financial Assistance.

5. The Organization will not initiate any ECA for at least 120 days from the date the Organization delivers the first post-discharge billing statement for care.

6. If an individual submits an incomplete Financial Assistance Application during the Application Period (as defined in paragraph 12.) the Organization will notify the individual about how to complete the application. The individual will be given a reasonable opportunity to complete and submit the application. During this time, the Organization will suspend any ECA it has initiated with respect to the individual and it will provide the individual with a written notice that describes the additional information that must be submitted and includes the contact information at the Organization at which the individual can obtain information about the Financial Assistance Policy, and the department of the hospital which can provide assistance with the Financial Assistance Application.

   a. ECAs will be suspended until either the Organization has determined whether an individual is eligible for Financial Assistance based upon a complete Financial Assistance, or the individual has failed to respond to requests for additional information within a reasonable period of time given by the Organization to respond to such requests.

b. If an individual subsequently submits a complete application during the Application Period (or, if later, such other reasonable timeframe allowed by the Organization), then the Organization will take the actions set forth in paragraphs 7.a to 7.e. below.

7. If an individual subsequently submits a complete application during the Application Period (or, if later, such other reasonable timeframe allowed by the Organization), the Organization will take the following actions in a timely manner:

    a. Suspend any ECAs that have been initiated with respect to the Patient/Guarantor;

    b. Determine whether the individual is eligible for Financial Assistance and notify the individual of the determination and the basis for such determination;

    c. If the individual is eligible for Financial Assistance other than free care, then provide the individual with a billing statement that specifies the amount the individual owes for the medical care, how that amount was determined and states how the individual may obtain information regarding the Amounts Generally Billed (AGB) for such medical care;

    d. Refund any excess amount which the individual has paid over that amount for which the individual is determined to be responsible for considering the Financial Assistance eligibility (unless such excess is less than $5); and

    e. Take all reasonable measures to reverse any ECAs taken against the individual.

8. Upon submission of a complete Financial Assistance Application during the Application Period, the Organization will:

    a. Make a determination as to whether the individual qualifies for Financial Assistance within a reasonable timeframe; and

    b. Take the actions set forth in paragraphs 7.a to 7.e above.

9. In those circumstances where the Organization reasonably believes that the individual may qualify for Medicaid, the Organization may postpone determining whether the individual is eligible for Financial Assistance under the Financial Assistance Policy until such a time that a Medicaid Application has been submitted and a determination as to such individual’s Medicaid eligibility has been made.

10. In a situation where the Organization intends to defer or deny, or require payment before providing, Medically Necessary Care, as defined in the Financial Assistance Policy, because of a Patient's nonpayment of one or more bills for previously provided care covered under the Financial Assistance Policy, the Patient will be provided an application form and a written notice indicating that Financial Assistance is available for eligible Patients and stating the deadline, if any, after which the Organization will no longer accept and process an application submitted (or, if applicable, completed) by the Patient for the previously-provided care at issue. This deadline shall be no earlier than the later of thirty (30) days after the date that the written notice is provided or two hundred forty (240) days after the date that the first post-discharge billing statement was provided for the previously provided care.

11. If the Organization refers a Patient's debt to a third party, the Organization will take appropriate measures pursuant to Section 501(r) to safeguard against such third party taking ECAs against the Patient to obtain payment for medical care until reasonable efforts have been made to determine if the Patient is eligible for Financial Assistance in accordance with the process outlined in this Policy and the Financial Assistance Policy. Such safeguards will include entering into a written agreement with the third party designed to ensure the third party's compliance with this Policy and applicable federal statutes and regulations.

12. For purposes of this Policy, the "Application Period" is the period during which an individual must submit a Financial Assistance Application pursuant to the Organization's Financial Assistance Policy. Except as otherwise provided in this Policy, this period begins on the date on which Emergency Care or other Medically Necessary Care is provided and ends on the later of the 240th day after the post-discharge billing statement for such care is provided or the date specified in a written notice from the Organization regarding its intention to initiate ECAs.

13. The Patient Financial Services department shall have final authority and responsibility for determining that the Organization has made reasonable efforts to determine whether an individual is eligible for Financial Assistance and deciding that the Organization therefore may engage in ECAs against the individual. More information about this Policy and the Patient Financial Services department may be found:

    a. Online at www.froedtertsouth.com

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

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

    d. 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.