I. PURPOSE

Horizon has established this Policy to offer financial assistance for prescription drugs to patients with demonstrated financial hardship.

II. POLICY

Horizon shall make a good faith effort to collect the total cost of each prescription that a patient is responsible to pay including any co-pay, deductible, and coinsurance. In accordance with this Policy, Horizon may provide financial assistance to a patient who is financially unable to pay such amounts after making an individualized good faith assessment and determining that financial assistance is warranted based on genuine financial hardship. This Policy sets forth how to apply for financial assistance, eligibility criteria for financial assistance, how such assistance is calculated.

Horizon may adopt a sliding fee schedule based upon a patient's income, and reduce or waive a patient's payment of the applicable charges only if the discount is:

- not offered as part of any advertisement or solicitation.
- made only to patients for whom Horizon has made a good faith determination of financial need by using the Financial Assistance Application form ("Application") attached to this Policy.
- not routinely made; and
- made due to financial need or inability of Horizon to collect payment for the patient's charges after reasonable collection efforts have been made.

Horizon will offer discounts based on financial need in accordance with the Procedures set forth below.

III. PROCEDURES

A. Application Process

1. Application Submission. A patient or a patient's guarantor that indicates an inability to pay may apply for financial assistance by completing the Application attached to this Policy and providing the required supporting documentation. The Application must be submitted to the Reviewer for review in accordance with this Policy.

2. Application Review. Within 30 days after submission of a complete Application, the Reviewer will determine whether the applicant qualifies for financial assistance and will notify the applicant in writing of the decision.

3. Incomplete Application. An incomplete Application will be returned to the applicant with a request to submit the missing information within 15 business days. If additional time is needed to complete the Application or to provide any required documentation, the applicant must contact the Reviewer to request an extension. During the Application review process, a temporary hold will be placed on the account to pause collection activity. If a complete Application is not received within fifteen (15) business days (or by the deadline provided by the Reviewer under an approved extension), collection activity will resume.

4. Notification of Decision. Applicants qualifying for a discount will be notified in writing regarding the amount of the approved discount and any remaining balance due. Any remaining balances will be managed in accordance with the Horizon's *Billing and Collection Policy*. If the Application is denied, the Reviewer will notify the applicant in writing with the reason for the denial.

5. Appeals. Applicants may appeal the financial assistance decision within 30 days of receipt of the denial notification by writing to President and CEO, Jason Dana Costa jcosta@horizonpharmacyri.com .

6. Billing and Collections. If an applicant qualifies for discount but fails to pay the remaining balance due, Horizon may take any of the actions set forth in Horizon's *Billing and Collection Policy*.

B. Determining Financial Need

1. Eligibility. Eligibility for financial assistance will be considered for those patients who are uninsured, underinsured, ineligible for any government health care benefit program, or otherwise unable to pay for their prescriptions, based upon a determination of financial need in accordance with this Policy. The granting of assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

   Patients with gross family income, adjusted for family size, at or below 400% of the Federal Poverty Level (FPL) are eligible for financial assistance, so long as no other financial resources are available, and the patient or guarantor submits information necessary to confirm eligibility. All other funding options

available to the patient must be exhausted or denied prior to any financial assistance being offered. Financial assistance is secondary to other financial resources available to the patient, including but not limited to insurance, government programs, and outside agency programs.

2. Income Review. Applicants will be asked to provide documentation of annual income for all adult household members. Documentation may include the following: the most recently filed tax return(s) including schedules and forms such as W-2 and 1099); paycheck stubs; employer wage verification forms; checking, savings and investment account statements; contracts or court documents evidencing income sources (*e.g.*, rental agreement, divorce decree, annuities). Income includes earnings, unemployment compensation, workers' compensation, Social Security, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, income from estates, trusts, alimony, child support, assistance from outside the household, and other sources.

3. Approval Period. Discounts or waivers are valid for six (6) months from the approval date. Eligible future prescriptions received during the six-month approval period will be discounted on the same basis as the initial approval. If an applicant's financial circumstances materially change during the six-month approval period, the applicant must submit an updated Application.

C. Financial Assistance Discounts

1. Waivers, Discounts. Applicants may receive the following assistance, based on an assessment of income.

   a. *Full Waiver*. The gross (undiscounted) charge amount will be waived for applicants whose total income is at or below 200% of the current federal poverty level, shown on Appendix A.

   b. *Discounts*. Applicants whose total income is greater than 200% but less than or equal to 400% of the current federal poverty level will be provided a sliding scale discount for prescriptions, shown on Appendix A. Uninsured patients will receive discounts applied against the gross charges for prescriptions. Insured patients receive discounts which are applied to the remaining account balance after insurance payment(s).

2. Payment of Remaining Balances. Financial Assistance eligible applicants are expected to comply with Horizon's Billing and Collection Policy and payment

terms on any balances remaining after financial assistance discounts are applied.

D. Good Faith Efforts to Collect

Horizon will make reasonable, bona fide efforts to collect total charges owed by a patient. After the initial request for payment, Horizon will make at least three (3) attempts to collect amounts due by the patient through telephone, email, sending additional invoices/statements, and letters of collection over a 90-day period. If a refill is requested prior to receipt of outstanding balances, Horizon may allow a prescription refill on a case-by-case basis. However, no patient will be permitted to receive a refill or subsequent prescription if the total outstanding amount exceeds $250.00.

Appendix A: Financial Assistance Discounts

Income Guideline: the 2025 federal poverty guidelines based on household size:

2025 Federal Poverty Guidelines (Annual Income) Federal Poverty Levels

Family Size	Poverty Guideline	200%	300%	400%
1	$15,650	$31,300	$46,950	$62,600
2	$21,150	$42,300	$63,450	$84,600
3	$26,650	$53,300	$79,950	$106,600
4	$32,150	$64,300	$96,450	$128,600
5	$37,650	$75,300	$112,950	$150,600
6	$43,150	$86,300	$129,450	$172,600
7	$48,650	$97,300	$145,950	$194,600
8	$54,150	$108,300	$162,450	$216,600
9+	Add $5,500 for each extra person	$11,000	$16,530	$22,000

Note: Federal Poverty Level amounts are higher in Alaska and Hawaii. Link to all HHS poverty guidelines for 2025.

Sliding Fee Scale

Income and assets as a percentage of FPL	Percentage of discount (write-off) from original charges
less than or equal to 100% - 200%	100%
less than or equal to 201% - 300%	75%
less than or equal to 301% - 400%	50%

Appendix B: Financial Assistance Application

Financial Assistance Application

Completing this form will assist Horizon Pharmacy to determine if you are eligible for financial assistance. Provide copies of documentation to support the information in this application (*e.g.*, tax returns, statements, recent pay stub for each employer you worked for in the current year showing year-to-date earnings, child support verification, award letters for disability).

Fill in all blanks on this application to ensure timely processing. Enter "n/a" in any section that is not applicable to you.

Applicant Information			
Applicant's Full Name	Phone	Date of Birth	Patient ID

Are you claimed as a dependent?	If yes, is your primary residence the same at the tax filer:	Marital Status:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Married ☐ Single ☐ Divorced ☐ Single ☐ Widowed ☐ Other _____

Address			
City	State	Zip Code	County

List the names and provide information for all individuals residing in your home below.				
Name	**Date of Birth**	**Relationship**	**Claimed as dependent?**	**Income if 18 years or older?**
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Income Sources – Monthly Gross (Before Taxes)		
Category	**Applicant**	**Spouse**
List all employers for current year		
Start and end dates of employment (mm/dd/yyyy)		
Wages		
Social Security		
Retirement/Pension		
Alimony		
Child Support		
Foster Care		
Disability		
Unemployment		
Workers Compensation		
Veterans Benefits		
Interest and Dividend Income		
Rental Income After Expenses		
Estate or Trust		
Other Income (specify)		

Health Insurance Benefits/Other		
Category	**Applicant**	**Spouse**
Insurance	Company: _____ Effective Date: _____	Company: _____ Effective Date: _____
Do you receive assistance from local, county, state, or federal government agencies? If so, please describe.		

If not, do you qualify for assistance from local, county, state, or federal government agencies? If so, please describe.		
What are your monthly expenses (*e.g.*, rent/housing payment, utilities, food, car payments)?		
Do you have any other extraordinary circumstances which we should consider (*e.g.*, pregnancy, deemed disabled)?		

I attest that the information provided above is true and correct to the best of my knowledge. I understand that I am responsible to report any changes to my application information (*e.g.*, income, employment, marriage) within 30 days. I understand completing this application does not guarantee approval. Horizon Pharmacy reserves the right to bill in full if circumstances change or any information given on this application is found to be fraudulent.

Patient/Guarantor's Signature: _____

Printed Name: _____

Date: _____

FOR PHARMACY USE ONLY

☐ Approved

☐ Denied. If denied, specify reason: _____

Reviewed by _____ on _____, 202__.