

Department: Administration	
Procedure Title: Financial Assistance Policy Attachment	Procedure #: 9110-05A

Attachment A

Family Size (Total Number of Members)

	0%-250%	251%-300%	301%-350%	351%-400%
Base FPL	Plan 1	Plan 2	Plan 3	Plan 4
\$12,060	\$ 30,150.00	\$ 36,180.00	\$ 42,210.00	\$ 48,240.00
\$16,240	\$ 40,600.00	\$ 48,720.00	\$ 56,840.00	\$ 64,960.00
\$20,420	\$ 51,050.00	\$ 61,260.00	\$ 71,470.00	\$ 81,680.00
\$24,600	\$ 61,500.00	\$ 73,800.00	\$ 86,100.00	\$ 98,400.00
\$28,780	\$ 71,950.00	\$ 86,340.00	\$ 100,730.00	\$ 115,120.00
\$32,960	\$ 82,400.00	\$ 98,880.00	\$ 115,360.00	\$ 131,840.00
\$37,140	\$ 92,850.00	\$ 111,420.00	\$ 129,990.00	\$ 148,560.00
\$41,320	\$ 103,300.00	\$ 123,960.00	\$ 144,620.00	\$ 165,280.00

Note: Add \$4,180 for each additional household member over 8

These yearly income amounts are computed using the 2017 Federal Poverty Guidelines as published by the U.S. Department of Health and Human Services (HHS) and are subject to change when HHS modifies their poverty guidelines.

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How Southwest Health System, Inc. Calculates Amounts Generally Billed

In the case of emergency or other medically necessary care, a patient who is eligible for assistance under this Policy will not be charged more for emergency or other medically necessary care than the Amounts Generally Billed (AGB).

Southwest Health System, Inc. calculates AGB using the look-back method consistent with the 501(r) requirements. AGB is determined by multiplying the gross charges for any emergency or other medically necessary care it provides by AGB percentages, which are based on claims allowed under Medicaid, in combination with Medicare fee-for-service and all private health insurers.

The AGB rate through September 30, 2017 is 26 percent system-wide for both inpatient and outpatient care.

This percentage was based on all claims allowed for emergency or other medically necessary inpatient and outpatient care under Medicaid, in combination with Medicare fee-for-service and all private health insurers from 1/1/2016 – 12/31/2016, divided by the associated gross charges for those claims.

Only those amounts to be paid by the patient themselves are discounted, not amounts covered by a third party.

The AGB percentage will be reviewed and updated by the 120th day after June 30th of each year.