## How Amounts Generally Billed (AGB) is Calculated

No individual determined eligible for financial assistance under Kedren financial assistance policies will be charged more for medically necessary hospital care than the amounts generally billed ("AGB") to individuals with insurance covering such care. The AGB for Kedren is calculated as follows:
(1) Every year, Kedren calculates the amount generally billed (AGB) annually based on the prospective method allowed under the IRS Section 501(r)(5). Kedren obtains the annual Medicare Master CPT Fee Schedule from Kedren's Electronic Health Record (EHR) vendor, eClinicalWorks (eCW) and utilizes the eCW's fee schedule engine to calculate Kedren's AGB by applying 150% of the Medicare rates by procedure codes.
(2) As part of Kedren's FAP, following a determination of FAP-eligibility, a FAP-eligible individual will not be charged more for any medical necessary care then the AGB to individuals who have insurance covering for such care. In fact, Kedren is a Federally Qualified Health Center, while the AGB is established by procedure codes, the patients including a FAP-eligible individual is never charged using the rates based on AGB rates since a FAB-eligible patient is only charged based on the Sliding Fee Discount Schedule and in accordance with the Sliding Fee Discount Policy (SFDS Attached). A sample Sliding Fee Discount Schedule is as follows:

**Kedren Community Care Clinic**
**Sliding Fee Discount Program 2020**

Primary Care and Behavioral Health Services under the FQHC (Federally Qualified Health Center) designation:

*The Kedren Community Health Center, Inc sliding fee discount schedule is used to determine the discount a patient will receive on their total charges for services. The scale below is based on annual income.*
*These fees and discounts apply to medical and behavioral health services provided directly by Kedren Community Health Center, Inc.*

| | A | | B | | C | | D | | No Discount |
|---|---|---|---|---|---|---|---|---|---|
| | 0-100% of Federal Poverty Guidelines (FPG) | | 101-140% of Federal Poverty Guidelines (FPG) | | 141-180% of Federal Poverty Guidelines (FPG) | | 181-200% of Federal Poverty Guidelines (FPG) | | Over 200% of Federal Poverty Guidelines (FPG) |
| # of Family Members | If income is between: | | If income is between: | | If income is between: | | If income is between: | | If income is above: |
| 1 | $0 | | $12,761 | $17,864 | $17,865 | $22,968 | $22,969 | $25,520 | $25,521 + |
| 2 | $0 | $17,240 | $17,241 | $24,136 | $24,137 | $31,032 | $31,033 | $34,480 | $34,481 + |
| 3 | $0 | $21,720 | $21,721 | $30,408 | $30,409 | $39,096 | $39,097 | $43,440 | $43,441 + |
| 4 | $0 | $26,200 | $26,201 | $36,680 | $36,681 | $47,160 | $47,161 | $52,400 | $52,401 + |
| 5 | $0 | $30,680 | $30,681 | $42,952 | $42,953 | $55,224 | $55,225 | $61,360 | $61,361 + |
| 6 | $0 | $35,160 | $35,161 | $49,224 | $49,225 | $63,288 | $63,289 | $70,320 | $70,321 + |
| 7 | $0 | $39,640 | $39,641 | $55,496 | $55,497 | $71,352 | $71,353 | $79,280 | $79,281 + |
| 8 | $0 | $44,120 | $44,121 | $61,768 | $61,769 | $79,416 | $79,417 | $88,240 | $88,241 + |
| Nominal Fee | $10 | | $15 | | $20 | | $25 | | FULL PAY |

***"For families/households with more than 8 persons, add $4,480 for each additional person."***
**Discount Schedule based on 2020 Federal Poverty Guidelines, Found at ASPE.hhs.gov**

**No one will be turned away for lack of ability to pay**

For patients with 200% or more FPG, the prospective AGB equals 150% that would be reimbursed by Medicare fee-for-service, plus the amount the patient would be responsible for paying in the form of co-payments, co-insurance, and deductibles. Individuals who have insurance coverage are required to pay the corresponding co-pay, co-insurance, deductible etc. in accordance with the respective insurance coverage.