Pershing Health System

Amounts Generally Billed

If you receive assistance under the Pershing Health System (PHS) Financial Assistance Policy (FAP), PHS may not charge you more than the Amounts Generally Billed (AGB) to individuals who have insurance covering emergency and medically necessary care.

A patient eligible for financial assistance is considered to be “charged” only the amount he or she is personally responsible for paying, after all discounts (including discounts available under the FAP) and insurance payments have been applied.

PHS determines AGB by multiplying PHS’s gross charges for that care by one or more percentages of gross charges, called “AGB percentage”. The AGB percentage is calculated annually by dividing the full amount of all of PHS’s claims that have been allowed by health insurers during the prior 12-month period by the sum of the associated gross charges for those claims. For these purposes, the full amount allowed by a health insurer includes both the amount to be reimbursed by the insurer and the amount (if any) the individual is personally responsible for paying in the form of co-payments, coinsurance or deductibles.

The AGB calculation is performed annually for PHS (July - June). This is the approved amount of Medicare, Managed Medicare, Commercial Managed Care and Commercial Insurance payers divided by gross charges. Once eligibility for financial assistance is approved, PHS will apply the applicable financial assistance discount described in the Financial Assistance Income and Discount Table.

Any balance due by you will be reviewed to ensure it is less than the AGB percentage. If the balance due is more than the AGB allowable amount, an additional discount will be applied to the balance to reduce it to the AGB percentage. The AGB amount is subject to change each year.

Effective 07/01/2024 the current discount is 53.40% of the total charges, and the AGB percentage (collectible amount) is 45.86% of the total charges.

Revised: 02/10/2023, 07/01/2024