2017 FEDERAL POVERTY GUIDELINES CHART[1]

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the "federal poverty level" (FPL). The Health Insurance Marketplace[SM2] will use the 2017 guidelines when making calculations for advance payments of the premium tax credit and income-based cost-sharing reductions starting November 1, 2017.

Note that Medicaid and the Children's Health Insurance Program assessments/determinations are currently based on the 2017 FPL from the HHS 2017 Poverty Guidelines until January or February 2018 when HHS releases the new guidelines for 2018.

The 2018 guidelines have not been released as of the date of publication of this training, but will be available on the HHS Assistant Secretary for Planning and Evaluation (ASPE) website (http://aspe.hhs.gov/poverty/index.cfm).

Household Size	100%	138%[3]**	150%[3]	200%[3]	250%[3]	300%[3]	400%[3]
1	$12,060	$16,643	$18,090	$24,120	$30,150	$36,180	$48,240
2	16,240	22,411	24,360	32,480	40,600	48,720	64,960
3	20,420	28,180	30,630	40,840	51,050	61,260	81,680
4	24,600	33,948	36,900	49,200	61,500	73,800	98,400
5	28,780	39,716	43,170	57,560	71,950	86,340	115,120
6	32,960	45,485	49,440	65,920	82,400	98,880	131,840
7	37,140	51,253	55,710	74,280	92,850	111,420	148,560
8	41,320	57,022	61,980	82,640	103,300	123,960	165,280

[1] Chart is for 48 contiguous states and the District of Columbia; for Hawaii and Alaska, please visit the HHS ASPE website: https://aspe.hhs.gov/poverty-guidelines.
[2] Health Insurance Marketplace [SM] and Marketplace[SM] are service marks of the United States Department of Health & Human Services. When used in this document, the term "Health Insurance Marketplace" or "Marketplace" refers to Federally-facilitated Marketplaces (FFMs), including FFMs where states perform plan management functions and also refers to State-based Marketplaces on the Federal Platform (SBM-FPs).
[3] Dollar amounts are calculated based on 100% column; rounding rules may vary across federal, state, and local programs.

ESSENTIAL HEALTH BENEFITS (EHB)

EHBs must include items and services within at least the following 10 categories:

- Ambulatory patient services, such as doctor visits
- Hospitalization
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Emergency services
- Maternity and newborn care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Pediatric Services (pediatric oral care may be included, or in the Marketplace℠[1], offered as part of a stand-alone dental plan)

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