




Blue Cross Cover Kids										
	Last Updated: 12/14/2021									
									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	216	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	291	HEART FAILURE SHOCK W MCC	No	\$ 13,710.15	\$ 5,517.78	\$ 31,074.55	\$6,190.90	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	460	Spinal fusion except cervical without major comorbid conditions or complications (MCC)	Yes	\$ 89,541.22	\$ 16,237.64	\$ 58,989.92	\$22,145.30	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	470	Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC).	Yes	\$ 26,747.32	\$ 8,070.44	\$ 37,721.88	\$15,644.30	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	473	Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC).	Yes	\$ 37,083.10	\$ 10,123.74	\$ 62,430.00	\$14,289.80	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	480	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	No	\$ 58,727.97	\$ 12,375.85	\$ 48,933.51	\$16,099.50	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	481	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	No	\$ 48,507.14	\$ 8,559.98	\$ 38,996.68	\$14,313.20	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	482	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	No	\$ 35,733.50	\$ 6,745.73	\$ 37,731.25	\$10,817.25	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	493	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W CC	No	\$ 46,392.83	\$ 9,438.20	\$ 41,283.64	\$12,172.92	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	494	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W/O CC/MCC	No	\$ 34,304.81	\$ 7,426.74	\$ 43,066.25	\$8,309.53	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	743	Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	Yes	\$ 18,033.90	\$ 3,828.29	\$ 28,968.03	\$4,148.33	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	811	RED BLOOD CELL DISORDERS W MCC	No	\$ 23,221.02	\$ 4,255.93	\$ 31,015.82	\$4,611.73	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	812	RED BLOOD CELL DISORDERS W/O MCC	No	\$ 17,544.11	\$ 2,955.18	\$ 26,002.03	\$3,202.23	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	No	\$ 81,430.86	\$ 21,639.28	\$ 150,000.00	\$23,448.31	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	No	\$ 38,084.70	\$ 6,540.49	\$ 50,000.00	\$7,087.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	935	NON-EXTENSIVE BURNS	No	\$ 18,159.73	\$ 3,301.83	\$ 50,000.00	\$3,577.86	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	956	LIMB REATTACHMENT, HIP FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	No	\$ 105,373.59	\$ 16,085.53	\$ 200,000.00	\$49,828.53	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	No	\$ 139,128.72	\$ 30,888.17	\$ 200,000.00	\$37,300.46	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	No	\$ 73,933.71	\$ 17,182.69	\$ 125,000.00	\$25,155.03	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	964	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	No	\$ 34,761.85	\$ 6,123.35	\$ 50,000.00	\$9,957.16	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

										Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>	
Maternity/Delivery	Hospital Inpatient	DRG	768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	No	\$ 10,335.01	\$ 2,464.00	\$ 27,462.61	\$9,288.40	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	783	CESAREAN SECTION W STERILIZATION W MCC	No	\$ 11,915.22	\$ 3,570.00	\$ 39,605.25	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	784	CESAREAN SECTION W STERILIZATION W CC	No	\$ 9,940.40	\$ 3,570.00	\$ 27,865.12	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	785	CESAREAN SECTION W STERILIZATION W/O CC/MCC	No	\$ 8,988.27	\$ 3,519.44	\$ 25,870.71	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	786	CESAREAN SECTION W/O STERILIZATION W MCC	No	\$ 12,696.27	\$ 3,570.00	\$ 35,011.06	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Maternity/Delivery	Hospital Inpatient	DRG	787	CESAREAN SECTION W/O STERILIZATION W CC	No	\$ 11,322.59	\$ 2,835.00	\$ 27,868.32	\$3,501.83	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	No	\$ 9,626.23	\$ 3,242.44	\$ 26,381.06	\$3,501.83	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	795	NORMAL NEWBORN	No	\$ 1,400.10	\$ 626.89	\$ 18,705.56	\$679.30	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	797	VAGINAL DELIVERY W STERILIZATION/D&C W CC	No	\$ 12,785.73	\$ 2,464.00	\$ 25,917.69	\$3,715.26	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	798	VAGINAL DELIVERY W STERILIZATION/D&C W/O CC/MCC	No	\$ 10,897.11	\$ 2,464.00	\$ 25,917.69	\$3,715.26	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Maternity/Delivery	Hospital Inpatient	DRG	805	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	No	\$ 10,518.03	\$ 2,464.00	\$ 27,817.08	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	806	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	No	\$ 8,616.42	\$ 2,464.00	\$ 24,277.74	\$4,562.59	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	No	\$ 7,318.91	\$ 2,464.00	\$ 23,397.98	\$3,501.83	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Inpatient Rehabilitation Hospital Stay	Inpatient Rehabilitation Hospital	DRG	945	REHABILITATION W CC/MCC	No	N/A	\$ 14,553.00	\$ 14,553.00	N/A	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Inpatient Rehabilitation Hospital Stay	Inpatient Rehabilitation Hospital	DRG	946	REHABILITATION W/O CC/MCC	No	N/A	\$ 10,870.00	\$ 10,870.00	N/A	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Inpatient Rehabilitation Hospital Stay	Inpatient Rehabilitation Hospital	UB	118	Inpatient Rehabilitation Hospital Room & Board	No	52% Charges Estimated at \$2,341.96 Per Diem			Non-Par	Per Diem Per Day
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	559	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	No	N/A	\$ 18,018.00	\$ 18,018.00	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	No	N/A	\$ 10,435.00	\$ 10,435.00	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	561	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	No	N/A	\$ 7,474.00	\$ 7,474.00	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	DRG	LTC189	Pulmonary edema respiratory failure	No	N/A	\$ 74,931.49	\$ 74,931.49	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	DRG	LTC207	Respiratory system diagnosis w ventilator support >96 hours	No	N/A	\$ 37,703.24	\$ 37,703.24	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	UB	200	Long Term Care Intensive Care Room & Board	No	70% Charges (Estimated as \$6,047.26 per diem)	\$1,040 Per Diem	\$1,929 Per Diem	Non-Par	Per Diem Per Day
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	191	Subacute Care Level 1- Skilled Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 227.70	\$ 850.00	Non-Par	Per Diem Per Day


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	192	Subacute Care Level 2- Comprehensive Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 299.70	\$ 850.00	Non-Par	Per Diem Per Day
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	193	Subacute Care Level 3- Complex Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 370.00	\$ 850.00	Non-Par	Per Diem Per Day
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 530.90	\$ 161.58	\$ 1,803.41	\$88.30	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11104	Biopsy - Punch Biopsy of Skin	No	\$ 584.92	\$ 167.15	\$ 1,829.27	\$111.03	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	17000	Destruction of Lesion (outpatient)	No	\$ 1,131.70	\$ 157.92	\$ 1,634.10	\$44.44	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	19083	Bx breast 1st lesion us imag	No	\$ 3,052.42	\$ 381.25	\$ 2,964.36	\$2,442.41	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	19120	Removal of 1 or more breast growth, open procedure	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Injections	Hospital Outpatient	CPT	20610	Arthrocentesis (outpatient)	No	\$ 370.58	\$ 182.39	\$ 1,461.73	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	27818	Treatment of ankle fracture	No	\$ 1,243.48	\$ 395.00	\$ 2,581.00	\$1,831.64	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	29826	Arthroscopic Shoulder Surgery	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	29881	Arthroscopic Knee Surgery (outpatient)	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	31575	Laryngoscopy - Diagnostic	No	\$ 449.87	\$ 135.86	\$ 1,978.02	\$1,947.09	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	32555	Aspirate pleura w/ imaging	No	\$ 608.39	\$ 288.54	\$ 1,852.06	\$1,985.11	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	42820	Tonsillectomy with Adenoidectomy (outpatient)	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43235	Upper Gastrointestinal Endoscopy - Diagnostic	Yes	\$ 2,027.21	\$ 61.00	\$ 1,867.74	\$0.00	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43239	Upper Gastrointestinal Endoscopy - With Biopsy	Yes	\$ 1,259.34	\$ 372.00	\$ 2,229.48	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45378	Colonoscopy - Diagnostic (outpatient)	Yes	\$ 2,117.86	\$ 335.79	\$ 2,220.88	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45380	Colonoscopy - With Biopsy (outpatient)	Yes	\$ 3,082.66	\$ 343.06	\$ 4,110.45	\$2,216.86	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45385	Colonoscopy - With Polyp Removal (outpatient)	Yes	\$ 3,317.89	\$ 354.50	\$ 4,434.15	\$2,237.03	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45391	Ultrasound examination of lower large bowel using an endoscope	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	47562	Gall Bladder Surgery (outpatient)	Yes	\$ 12,062.52	\$ 504.75	\$ 18,374.88	\$9,692.27	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	49440	Place gastrostomy tube perc	No	\$ 3,111.60	\$ 445.12	\$ 3,166.61	\$2,717.96	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	49505	Repair of groin hernia patient age 5 years or older	Yes	\$ 9,867.85	\$ 470.98	\$ 15,040.03	\$2,991.71	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	51798	Urine Capacity Measurement	No	\$ 97.04	\$ -	\$ 1,579.20	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	52000	Cystoscopy	No	\$ 1,173.22	\$ 282.78	\$ 1,596.52	\$1,524.39	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	55700	Biopsy of prostate gland	Yes	\$ 1,165.04	\$ 284.76	\$ 2,631.84	\$1,987.63	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	55866	Surgical removal of prostate and surrounding lymph nodes using an endoscope	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58100	Biopsy - Endometrial (Uterus)	No	\$ 375.83	\$ 144.00	\$ 1,697.39	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58300	Insert intrauterine device	No	\$ 632.24	\$ 48.93	\$ 1,749.37	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58301	Remove intrauterine device	No	\$ 273.85	\$ 32.34	\$ 1,495.58	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	59025	Fetal Non-Stress Test	No	\$ 260.79	\$ 118.53	\$ 1,596.22	\$1,413.34	Case Rate
Professional Services Associated with Inpatient Stay	Professional Services	CPT	59400	Routine obstetric care for vaginal delivery, including pre-and post-delivery care	Yes	\$ 4,496.21	\$ 242.00	\$ 3,278.48	\$1,417.72	Case Rate
Professional Services Associated with Inpatient Stay	Professional Services	CPT	59410	Obstetrical care	No	\$ 2,230.06	\$ 133.91	\$ 1,625.81	\$852.63	Case Rate
Professional Services Associated with Inpatient Stay	Professional Services	CPT	59510	Routine obstetric care for cesarean delivery, including pre-and post-delivery care	Yes	\$ 4,966.56	\$ 246.05	\$ 3,619.13	\$1,417.72	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Professional Services Associated with Inpatient Stay	Professional Services	CPT	59610	Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care	Yes	\$ 4,706.58	\$ 305.08	\$ 3,429.34	\$1,417.72	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	62322	Injection of substance into spinal canal of lower back or sacrum using imaging guidance	Yes	\$ 1,055.18	\$ 379.33	\$ 1,880.39	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	62323	Injection of substance into spinal canal of lower back or sacrum using imaging guidance	Yes	\$ 1,665.98	\$ 305.01	\$ 1,988.33	\$0.00	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	64483	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	Yes	\$ 1,776.21	\$ 358.46	\$ 1,980.49	\$1,563.97	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	66821	Removal of recurring cataract in lens capsule using laser	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	66984	Removal of cataract with insertion of lens	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	69210	Remove impacted ear wax	No	\$ 168.99	\$ 48.93	\$ 1,604.78	\$0.00	Case Rate
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	No	\$ 901.06	\$ 127.22	\$ 1,318.18	\$410.85	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	Yes	\$ 901.06	\$ 127.22	\$ 1,318.18	\$410.85	Per Unit
Radiology Services	Hospital Outpatient	CPT	70482	Ct orbit/ear/fossa w/o&w/dye	No	\$ 2,339.66	\$ 207.79	\$ 2,657.02	\$623.24	Per Unit
Radiology Services	Hospital Outpatient	CPT	70486	Ct maxillofacial w/o dye	No	\$ 1,668.57	\$ 127.52	\$ 2,259.85	\$423.70	Per Unit
Radiology Services	Hospital Outpatient	CPT	70496	Ct angiography head	No	\$ 1,871.05	\$ 223.05	\$ 1,996.31	\$878.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	70498	Ct angiography neck	No	\$ 1,632.72	\$ 223.05	\$ 1,677.63	\$653.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	70551	MRI BRAIN STEM W/O DYE	No	\$ 1,518.19	\$ 252.20	\$ 2,270.30	\$65.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	70553	MRI - Brain (outpatient)	Yes	\$ 2,314.59	\$ 406.50	\$ 3,409.54	\$2,073.98	Per Unit
Radiology Services	Hospital Outpatient	CPT	71045	X-ray exam chest 1 view	No	\$ 138.11	\$ 19.91	\$ 181.37	\$0.00	Per Unit
Radiology Services	Hospital Outpatient	CPT	71046	X-Ray - Chest (outpatient)	No	\$ 148.99	\$ 31.50	\$ 193.55	\$0.00	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	71110	X-ray exam ribs bil 3 views	No	\$ 205.20	\$ 38.07	\$ 271.73	\$74.50	Per Unit
Radiology Services	Hospital Outpatient	CPT	71250	CT THORAX W/O DYE	No	\$ 1,024.52	\$ 141.11	\$ 1,468.48	\$50.86	Per Unit
Radiology Services	Hospital Outpatient	CPT	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$ 1,448.52	\$ 200.76	\$ 2,034.88	\$613.99	Per Unit
Radiology Services	Hospital Outpatient	CPT	71275	Ct angiography chest	No	\$ 1,935.65	\$ 226.19	\$ 2,092.27	\$758.17	Per Unit
Radiology Services	Hospital Outpatient	CPT	72040	X-Ray - Neck, Cervical Spine	No	\$ 154.65	\$ 37.93	\$ 204.42	\$57.79	Per Unit
Radiology Services	Hospital Outpatient	CPT	72070	X-Ray - Middle Back, Thoracic Spine	No	\$ 251.61	\$ 33.93	\$ 338.99	\$61.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	72100	X-Ray - Spine (outpatient)	No	\$ 199.60	\$ 37.93	\$ 265.13	\$63.32	Per Unit
Radiology Services	Hospital Outpatient	CPT	72110	X-Ray, lower back, minimum four views	Yes	\$ 213.64	\$ 52.80	\$ 284.93	\$85.91	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	72125	Ct neck spine w/o dye	No	\$ 1,459.37	\$ 136.86	\$ 1,750.92	\$517.81	Per Unit
Radiology Services	Hospital Outpatient	CPT	72126	Ct neck spine w/dye	No	\$ 1,293.16	\$ 260.86	\$ 1,821.59	\$613.07	Per Unit
Radiology Services	Hospital Outpatient	CPT	72127	Ct neck spine w/o & w/dye	No	\$ 1,815.93	\$ 201.73	\$ 2,118.48	\$755.17	Per Unit
Radiology Services	Hospital Outpatient	CPT	72129	Ct chest spine w/dye	No	\$ 1,520.66	\$ 199.82	\$ 1,805.90	\$613.07	Per Unit
Radiology Services	Hospital Outpatient	CPT	72132	Ct lumbar spine w/dye	No	\$ 1,518.43	\$ 260.86	\$ 1,805.90	\$613.07	Per Unit
Radiology Services	Hospital Outpatient	CPT	72133	Ct lumbar spine w/o & w/dye	No	\$ 1,904.42	\$ 201.90	\$ 2,238.70	\$755.48	Per Unit
Radiology Services	Hospital Outpatient	CPT	72141	MRI NECK SPINE W/O DYE	No	\$ 1,441.84	\$ 252.20	\$ 2,177.11	\$70.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	72148	MRI - Back (outpatient)	Yes	\$ 1,381.13	\$ 252.20	\$ 2,137.12	\$1,050.05	Per Unit
Radiology Services	Hospital Outpatient	CPT	72170	X-Ray - Pelvis	No	\$ 249.04	\$ 28.72	\$ 327.10	\$49.69	Per Unit
Radiology Services	Hospital Outpatient	CPT	72190	X-RAY EXAM OF PELVIS	No	\$ 208.53	\$ 39.60	\$ 264.73	\$9.53	Per Unit
Radiology Services	Hospital Outpatient	CPT	72193	CT scan, pelvis, with contrast	Yes	\$ 1,536.96	\$ 197.29	\$ 2,142.05	\$592.49	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	72197	MRI - Pelvis (outpatient)	No	\$ 2,448.72	\$ 402.71	\$ 3,522.33	\$2,046.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73000	X-ray exam of collar bone	No	\$ 147.59	\$ 22.40	\$ 185.92	\$49.10	Per Unit
Radiology Services	Hospital Outpatient	CPT	73010	X-ray exam of shoulder blade	No	\$ 196.93	\$ 26.01	\$ 251.93	\$49.69	Per Unit
Radiology Services	Hospital Outpatient	CPT	73030	X-Ray - Shoulder (outpatient)	No	\$ 149.50	\$ 28.33	\$ 196.92	\$53.54	Per Unit
Radiology Services	Hospital Outpatient	CPT	73060	X-RAY EXAM OF HUMERUS	No	\$ 147.62	\$ 29.40	\$ 195.82	\$7.65	Per Unit
Radiology Services	Hospital Outpatient	CPT	73070	X-ray exam of elbow	No	\$ 146.83	\$ 25.07	\$ 191.42	\$48.77	Per Unit
Radiology Services	Hospital Outpatient	CPT	73080	X-RAY EXAM OF ELBOW	No	\$ 122.83	\$ 26.72	\$ 154.02	\$7.65	Per Unit
Radiology Services	Hospital Outpatient	CPT	73090	X-RAY EXAM OF FOREARM	No	\$ 117.10	\$ 26.40	\$ 151.82	\$7.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	73110	X-Ray - Wrist (outpatient)	No	\$ 156.52	\$ 30.72	\$ 196.19	\$50.50	Per Unit
Radiology Services	Hospital Outpatient	CPT	73120	X-RAY EXAM OF HAND	No	\$ 192.03	\$ 24.40	\$ 249.73	\$7.35	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	73130	X-Ray - Hand	No	\$ 151.54	\$ 32.72	\$ 198.42	\$50.50	Per Unit
Radiology Services	Hospital Outpatient	CPT	73221	MRI - Shoulder, Elbow, or Wrist	No	\$ 1,211.82	\$ 246.65	\$ 1,702.46	\$948.35	Per Unit
Radiology Services	Hospital Outpatient	CPT	73502	X-Ray - Hip	No	\$ 129.58	\$ 37.77	\$ 197.91	\$70.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	73552	X-RAY EXAM OF FEMUR 2/>	No	\$ 150.51	\$ 29.51	\$ 189.38	\$8.29	Per Unit
Radiology Services	Hospital Outpatient	CPT	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$ 201.92	\$ 32.40	\$ 266.82	\$7.65	Per Unit
Radiology Services	Hospital Outpatient	CPT	73562	X-Ray - Knee (outpatient)	No	\$ 263.50	\$ 36.52	\$ 351.25	\$53.84	Per Unit
Radiology Services	Hospital Outpatient	CPT	73590	X-ray exam of lower leg	No	\$ 239.62	\$ 32.40	\$ 321.48	\$49.69	Per Unit
Radiology Services	Hospital Outpatient	CPT	73600	X-RAY EXAM OF ANKLE	No	\$ 191.55	\$ 31.98	\$ 278.60	\$7.35	Per Unit
Radiology Services	Hospital Outpatient	CPT	73610	X-Ray - Ankle (outpatient)	No	\$ 239.05	\$ 25.72	\$ 311.14	\$50.50	Per Unit
Radiology Services	Hospital Outpatient	CPT	73620	X-RAY EXAM OF FOOT	No	\$ 196.24	\$ 29.81	\$ 262.21	\$7.35	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	73630	X-Ray - Foot (outpatient)	No	\$ 216.05	\$ 33.95	\$ 289.60	\$50.50	Per Unit
Radiology Services	Hospital Outpatient	CPT	73700	CT LOWER EXTREMITY W/O DYE	No	\$ 1,231.00	\$ 134.01	\$ 1,400.92	\$47.55	Per Unit
Radiology Services	Hospital Outpatient	CPT	73721	MRI - Knee (outpatient)	Yes	\$ 1,224.32	\$ 246.65	\$ 1,828.36	\$948.35	Per Unit
Radiology Services	Hospital Outpatient	CPT	74018	X-Ray - Abdomen	No	\$ 145.61	\$ 28.31	\$ 189.76	\$0.00	Per Unit
Radiology Services	Hospital Outpatient	CPT	74150	Ct abdomen w/o dye	No	\$ 977.64	\$ 142.38	\$ 1,446.99	\$499.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	74170	Ct abdomen w/o & w/dye	No	\$ 1,824.18	\$ 207.86	\$ 2,144.29	\$733.44	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	No	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$620.77	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	Yes	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$620.77	Per Unit
Radiology Services	Hospital Outpatient	CPT	74220	X-ray xm esophagus 1cntrst	No	\$ 394.10	\$ 56.38	\$ 563.71	\$113.49	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	74270	X-ray xm colon 1cntrst std	No	\$ 521.72	\$ 79.34	\$ 578.01	\$165.29	Per Unit
Radiology Services	Hospital Outpatient	CPT	75571	Ct hrt w/o dye w/ca test	No	\$ 306.04	\$ 59.00	\$ 323.39	\$148.17	Per Unit
Radiology Services	Hospital Outpatient	CPT	76536	Ultrasound - Head and Neck	No	\$ 460.62	\$ 78.79	\$ 386.50	\$136.73	Per Unit
Radiology Services	Hospital Outpatient	CPT	76642	Ultrasound - Breast (outpatient)	No	\$ 152.68	\$ 78.52	\$ 249.30	\$141.97	Per Unit
Radiology Services	Hospital Outpatient	CPT	76700	Ultrasound - Abdominal, Complete	Yes	\$ 361.43	\$ 91.69	\$ 433.80	\$191.17	Per Unit
Radiology Services	Hospital Outpatient	CPT	76705	Ultrasound - Abdominal, Limited	No	\$ 327.93	\$ 46.05	\$ 372.20	\$137.98	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76770	US EXAM ABDO BACK WALL COMP	No	\$ 456.58	\$ 76.54	\$ 400.80	\$32.68	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76801	OB US < 14 WKS SINGLE FETUS	No	\$ 391.57	\$ 86.65	\$ 396.27	\$42.95	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	76805	Ultrasound - Pregnancy (outpatient)	Yes	\$ 367.73	\$ 100.36	\$ 437.10	\$210.29	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76811	OB US DETAILED SNGL FETUS	No	\$ 522.04	\$ 198.65	\$ 587.50	\$83.53	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76815	OB US LIMITED FETUS(S)	No	\$ 309.95	\$ 54.75	\$ 384.30	\$29.04	Per Unit
Radiology Services	Hospital Outpatient	CPT	76816	Ultrasound - Pregnancy Follow-Up	No	\$ 406.54	\$ 64.37	\$ 384.30	\$113.25	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76818	FETAL BIOPHYS PROFILE W/NST	No	\$ 476.50	\$ 82.20	\$ 387.27	\$34.51	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 407.39	\$ 97.44	\$ 398.34	\$28.97	Per Unit
Radiology Services	Hospital Outpatient	CPT	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 370.14	\$ 88.69	\$ 391.69	\$31.38	Per Unit
Radiology Services	Hospital Outpatient	CPT	76830	Ultrasound - Transvaginal (non-maternity)	Yes	\$ 475.43	\$ 98.63	\$ 463.90	\$151.54	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	76856	Ultrasound - Pelvic (outpatient)	No	\$ 344.00	\$ 70.34	\$ 408.50	\$151.54	Per Unit
Radiology Services	Hospital Outpatient	CPT	77065	Mammography of one breast	Yes	\$ 546.40	\$ 107.57	\$ 501.03	\$228.27	Per Unit
Radiology Services	Hospital Outpatient	CPT	77066	Mammography of both breasts	Yes	\$ 383.79	\$ 135.81	\$ 629.70	\$290.88	Per Unit
Radiology Services	Hospital Outpatient	CPT	77067	Mammogram (outpatient)	Yes	\$ 406.73	\$ 109.22	\$ 504.02	\$237.48	Per Unit
Radiology Services	Hospital Outpatient	CPT	77080	Bone Density Scan (outpatient)	No	\$ 247.25	\$ 56.29	\$ 393.45	\$207.22	Per Unit
Radiology Services	Hospital Outpatient	CPT	77081	Dxa bone density/peripheral	No	\$ 116.84	\$ 33.80	\$ 171.64	\$66.19	Per Unit
Radiology Services	Hospital Outpatient	CPT	78452	Myocardial Imaging (outpatient)	No	\$ 1,010.04	\$ 336.74	\$ 2,091.45	\$673.73	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 158.03	\$ 11.84	\$ 221.33	\$34.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80053	Blood Test - Comprehensive Metabolic Panel	Yes	\$ 93.73	\$ 14.78	\$ 136.89	\$42.96	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80055	Blood Test - Pregnancy (Obstetric) Panel	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80061	Blood Test - Cholesterol Test, Lipid Panel	Yes	\$ 46.48	\$ 12.05	\$ 101.77	\$101.77	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80069	Blood Test - Renal (Kidney) Function Panel	Yes	\$ 17.24	\$ 8.68	\$ 34.59	\$34.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80076	Blood Test - Hepatic (Liver) Function Panel	Yes	\$ 146.77	\$ 11.44	\$ 205.84	\$34.38	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	80307	Drug test prsmv chem analyzr	No	\$ 128.65	\$ 55.93	\$ 199.53	\$181.23	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81000	Urinalysis nonauto w/scope	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81001	Urine Test - Automated with Microscope Examination	Yes	\$ 23.46	\$ 4.44	\$ 34.47	\$10.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81002	Urine Test - Urinalysis, Manual Test	Yes	\$ 7.24	\$ 2.67	\$ 14.00	\$14.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81003	Urine Test - Automated without Microscope	Yes	\$ 10.40	\$ 3.16	\$ 11.25	\$7.75	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81025	Urine Test - Pregnancy	No	\$ 40.87	\$ 10.45	\$ 58.29	\$26.49	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82247	Bilirubin total	No	\$ 41.02	\$ 4.52	\$ 55.22	\$24.49	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82306	Blood Test - Vitamin D-3 Level	No	\$ 188.74	\$ 26.64	\$ 254.08	\$158.31	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	82330	Assay of calcium	No	\$ 35.11	\$ 12.31	\$ 67.00	\$67.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82375	Assay carboxyhb quant	No	\$ 114.13	\$ 11.09	\$ 153.64	\$64.40	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82465	Assay bld/serum cholesterol	No	\$ 15.28	\$ 3.92	\$ 23.76	\$23.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82550	Assay of ck (cpk)	No	\$ 12.70	\$ 5.86	\$ 35.53	\$35.53	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82552	Assay of cpk in blood	No	\$ 26.14	\$ 12.05	\$ 75.41	\$71.97	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82565	Assay of creatinine	No	\$ 124.50	\$ 7.17	\$ 70.25	\$36.65	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82607	Blood Test - Vitamin B-12 (Cyanocobalamin) Level	No	\$ 29.40	\$ 13.57	\$ 82.73	\$82.73	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82610	Cystatin c	No	\$ 140.40	\$ 14.17	\$ 405.00	\$30.69	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82668	Assay of erythropoietin	No	\$ 36.68	\$ 16.91	\$ 99.20	\$99.20	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82670	Assay of estradiol	No	\$ 54.51	\$ 25.15	\$ 152.33	\$152.33	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	82693	Assay of ethylene glycol	No	\$ 20.29	\$ 13.41	\$ 40.08	\$40.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 33.53	\$ 19.09	\$ 96.63	\$96.79	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82746	Blood Test - Folic Acid Level	No	\$ 37.75	\$ 13.23	\$ 79.52	\$79.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82803	Blood gases any combination	No	\$ 73.40	\$ 20.17	\$ 106.16	\$106.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82947	Assay glucose blood quant	No	\$ 34.04	\$ 5.51	\$ 49.42	\$27.96	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82962	Glucose blood test	No	\$ 45.55	\$ 3.89	\$ 61.82	\$23.61	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83018	Heavy metal quant each nes	No	\$ 172.97	\$ 19.76	\$ 498.96	\$91.90	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83036	Blood Test - Blood Glucose Control (Hemoglobin A1C)	No	\$ 71.27	\$ 8.74	\$ 95.94	\$51.96	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	83088	Assay of histamine	No	\$ 75.84	\$ 26.58	\$ 218.76	\$153.42	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83518	Immunoassay dipstick	No	\$ 147.09	\$ 6.55	\$ 424.29	\$36.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83540	Blood Test - Iron Level	No	\$ 51.90	\$ 9.06	\$ 75.77	\$45.95	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83605	Assay of lactic acid	No	\$ 27.44	\$ 10.41	\$ 58.05	\$58.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83690	Blood Test - Lipase (fat enzyme) Level	No	\$ 69.47	\$ 6.20	\$ 93.51	\$37.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83735	Assay of magnesium	No	\$ 53.82	\$ 9.38	\$ 78.56	\$47.30	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83880	Assay of natriuretic peptide	No	\$ 172.55	\$ 35.33	\$ 232.27	\$103.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84100	Assay of phosphorus	No	\$ 61.73	\$ 6.64	\$ 87.67	\$26.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 43.23	\$ 6.66	\$ 62.65	\$32.30	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 43.23	\$ 6.66	\$ 62.65	\$32.30	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	84144	Assay of progesterone	No	\$ 52.59	\$ 18.77	\$ 96.68	\$96.68	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84153	Blood Test - Prostate Specific Antigen (PSA) Level	Yes	\$ 74.21	\$ 25.75	\$ 116.68	\$59.85	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84154	PSA (prostate specific antigen)	Yes	\$ 106.34	\$ 16.55	\$ 143.15	\$89.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84182	Protein western blot test	No	\$ 382.72	\$ 18.76	\$ 588.80	\$70.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84295	Assay of serum sodium	No	\$ 42.10	\$ 4.33	\$ 56.67	\$26.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84439	Blood Test - Thyroxine (Thyroid Chemical) Level, Free	No	\$ 66.21	\$ 8.12	\$ 89.13	\$41.40	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 64.07	\$ 23.52	\$ 119.09	\$119.29	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	Yes	\$ 64.07	\$ 23.52	\$ 119.09	\$119.29	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84480	Assay triiodothyronine (t3)	No	\$ 96.31	\$ 12.76	\$ 129.65	\$75.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84484	Assay of troponin quant	No	\$ 81.70	\$ 10.26	\$ 121.45	\$121.45	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84702	Chorionic gonadotropin test	No	\$ 125.77	\$ 11.54	\$ 169.31	\$82.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85014	Hematocrit	No	\$ 26.95	\$ 2.13	\$ 36.27	\$12.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85025	Blood Test - Complete Blood Cell Count and Automated WBC	Yes	\$ 77.98	\$ 10.88	\$ 112.06	\$54.75	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85027	Blood Test - Complete Blood Cell Count (Hemoglobin)	Yes	\$ 60.79	\$ 5.82	\$ 81.83	\$35.53	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	85240	Clot factor viii ahg 1 stage	No	\$ 45.97	\$ 16.11	\$ 95.56	\$95.56	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85378	Fibrin degrade semiquant	No	\$ 53.57	\$ 7.44	\$ 72.11	\$58.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85610	Blood Test - Clotting Time	Yes	\$ 44.81	\$ 6.01	\$ 64.27	\$27.96	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85613	Russell viper venom diluted	No	\$ 24.61	\$ 8.24	\$ 70.98	\$55.29	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85660	RBC SICKLE CELL TEST	No	\$ 53.32	\$ 4.96	\$ 71.77	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85730	Blood Test - Coagulation Assessment	Yes	\$ 46.01	\$ 5.41	\$ 61.94	\$32.93	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85732	Thromboplastin time partial	No	\$ 12.63	\$ 5.82	\$ 36.42	\$35.53	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86140	C-reactive protein	No	\$ 48.49	\$ 4.66	\$ 65.28	\$24.07	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86360	T cell absolute count/ratio	No	\$ 65.00	\$ 42.28	\$ 211.59	\$211.59	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86361	T cell absolute count	No	\$ 132.78	\$ 24.10	\$ 383.03	\$206.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86431	Rheumatoid factor quant	No	\$ 52.70	\$ 5.10	\$ 70.95	\$26.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 37.81	\$ 3.84	\$ 50.90	\$18.95	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 37.81	\$ 3.84	\$ 50.90	\$18.95	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86611	Bartonella antibody	No	\$ 57.37	\$ 9.16	\$ 165.50	\$31.92	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86615	Bordetella antibody	No	\$ 25.74	\$ 11.87	\$ 81.45	\$81.45	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86651	Encephalitis californ antbdy	No	\$ 25.74	\$ 11.87	\$ 110.13	\$110.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86652	Encephaltis east eqne anbdy	No	\$ 25.74	\$ 11.87	\$ 110.13	\$110.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86653	Encephaltis st louis antibody	No	\$ 25.74	\$ 11.87	\$ 110.13	\$110.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86654	Encephaltis west eqne antbdy	No	\$ 25.74	\$ 11.87	\$ 110.13	\$110.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86663	Epstein-barr antibody	No	\$ 25.60	\$ 11.81	\$ 83.21	\$83.21	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86677	Helicobacter pylori antibody	No	\$ 30.68	\$ 15.13	\$ 63.03	\$63.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86692	Hepatitis delta agent antbdy	No	\$ 29.16	\$ 15.44	\$ 50.98	\$38.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86698	Histoplasma antibody	No	\$ 79.65	\$ 12.41	\$ 107.23	\$68.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86704	HEP B CORE ANTIBODY TOTAL	No	\$ 86.11	\$ 10.85	\$ 115.92	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86705	HEP B CORE ANTIBODY IGM	No	\$ 22.98	\$ 10.59	\$ 57.38	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86706	HEP B SURFACE ANTIBODY	No	\$ 98.98	\$ 9.67	\$ 133.25	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86707	Hepatitis be antibody	No	\$ 22.56	\$ 10.41	\$ 65.09	\$56.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86708	Hepatitis a antibody	No	\$ 22.71	\$ 11.15	\$ 56.71	\$56.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86762	Rubella antibody	No	\$ 78.19	\$ 12.95	\$ 225.56	\$26.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86765	Rubeola antibody	No	\$ 25.14	\$ 11.59	\$ 72.53	\$46.93	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86769	86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 51.48	\$ -	\$ 112.07	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86790	Virus antibody nos	No	\$ 25.14	\$ 11.59	\$ 76.53	\$76.53	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86803	Blood Test - Hepatitis C Antibody Level	No	\$ 67.64	\$ 12.84	\$ 91.06	\$69.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86804	Hep c ab test confirm	No	\$ 23.09	\$ 13.94	\$ 66.62	\$57.72	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86850	Rbc antibody screen	No	\$ 20.32	\$ 5.00	\$ 66.92	\$54.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86885	Coombs test indirect qual	No	\$ 244.72	\$ 5.65	\$ 329.43	\$24.99	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$21.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$21.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$21.16	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$21.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$ 5.82	\$ 4.84	\$ 383.37	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86920	COMPATIBILITY TEST SPIN	No	\$ 244.72	\$ 13.44	\$ 344.22	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87040	Blood culture for bacteria	No	\$ 133.90	\$ 9.29	\$ 180.25	\$56.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87070	Bacterial Culture - Swab	No	\$ 138.63	\$ 7.76	\$ 186.61	\$47.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87077	Bacterial Culture - Aerobic Isolates	No	\$ 60.43	\$ 7.27	\$ 81.35	\$25.35	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87081	Test for Disease-Causing (Pathogenic) Organisms, Not Limited to a Specific Condition	No	\$ 81.17	\$ 5.97	\$ 109.26	\$35.53	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	87086	Urine Test - Bacterial Culture, Quantitative Colony Count	No	\$ 82.16	\$ 7.26	\$ 110.60	\$42.32	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87088	Urine Test - Bacterial Culture	No	\$ 15.80	\$ 7.28	\$ 43.86	\$43.86	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87110	Chlamydia culture	No	\$ 130.74	\$ 17.64	\$ 175.99	\$107.56	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87186	Evaluation of Antimicrobial Drug (antibiotic, antifungal, antiviral)	No	\$ 69.16	\$ 7.79	\$ 93.10	\$47.43	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87205	Lab Test - Smear for Microorganism	No	\$ 49.93	\$ 3.84	\$ 67.21	\$21.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87340	Lab Test - Detection test for Hepatitis B Surface Antigen	No	\$ 63.55	\$ 9.30	\$ 85.55	\$42.65	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87389	Lab Test - Detection test for HIV-1 and HIV-2	No	\$ 110.43	\$ 21.67	\$ 148.66	\$77.48	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	87425	Rotavirus ag ia	No	\$ 37.44	\$ 10.78	\$ 108.00	\$55.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87491	Urine Test - Chlamydia	No	\$ 108.43	\$ 31.58	\$ 171.03	\$171.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87591	Urine Test - Gonorrhoeae (Neisseria Gonorrhoeae Bacteria)	No	\$ 90.13	\$ 31.58	\$ 171.03	\$171.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87635	87635 - SARS-COV-2 COVID-19 AMP PRB	No	\$ 53.36	\$ -	\$ 136.48	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87798	Detect agent nos dna amp	No	\$ 90.13	\$ 31.58	\$ 171.03	\$171.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87804	Lab Test - Detection test for Influenza Virus	No	\$ 37.58	\$ 19.82	\$ 70.50	\$52.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87880	Strep Test (Streptococcus, group A)	No	\$ 101.56	\$ 19.87	\$ 143.48	\$72.23	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	88185	Flowcytometry/tc add-on	No	\$ 68.81	\$ -	\$ 120.30	\$50.09	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Vaccinations	Physician Office	CPT	90460	Immunization Administration First Component	No	\$ 40.10	\$ 11.68	\$ 75.93	\$22.39	Per Unit
Vaccinations	Physician Office	CPT	90461	Immunization Administration Each Additional Component	No	\$ 25.13	\$ 10.49	\$ 38.51	\$11.26	Per Unit
Vaccinations	Hospital Outpatient	CPT	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 81.80	\$3.40	Per Unit
Vaccinations	Hospital Outpatient	CPT	90472	Immunization Administration Each Additional Component	No	\$ 12.56	\$ -	\$ 38.51	\$3.40	Per Unit
Vaccinations	Hospital Outpatient	CPT	90651	9V HPV Vaccine 2/3 Dose	No	\$ 142.32	\$ 9.56	\$ 227.93	\$0.00	Per Unit
Vaccination	Hospital Outpatient	CPT	90670	Vaccine - Pneumococcal Conjugate for Injection into Muscle	No	\$ 285.59	\$ 9.56	\$ 345.21	\$0.00	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Vaccination	Hospital Outpatient	CPT	90715	Vaccine - Tetanus, Diphtheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection into Muscle	No	\$ 57.74	\$ -	\$ 77.73	\$0.00	Per Unit
Evaluation & Management Services	Professional Services	CPT	90791	Psychiatric Diagnostic Evaluation	No	\$ 308.81	\$ 118.93	\$ 198.74	\$145.95	Per Unit
Evaluation & Management Services	Professional Services	CPT	90832	Psychotherapy - 30 Minutes	Yes	\$ 88.03	\$ 57.92	\$ 99.25	\$60.88	Per Unit
Evaluation & Management Services	Professional Services	CPT	90834	Psychotherapy - 45 Minutes	Yes	\$ 116.77	\$ 77.37	\$ 132.34	\$79.33	Per Unit
Evaluation & Management Services	Professional Services	CPT	90837	Psychotherapy - 60 Minutes	Yes	\$ 174.90	\$ 116.00	\$ 198.22	\$116.28	Per Unit
Evaluation & Management Services	Professional Services	CPT	90846	Family psytx w/o pt 50 min	Yes	N/A No Service Volume	\$ -	N/A No Service Volume	N/A No Service Volume	Per Unit
Evaluation & Management Services	Professional Services	CPT	90847	Psychotherapy - Family Session	Yes	\$ 146.15	\$ 97.13	\$ 166.18	\$100.09	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	90853	Psychotherapy - Group Session	Yes	N/A No Service Volume	\$ -	N/A No Service Volume	N/A No Service Volume	Per Unit
Medicine Speech Therapy	Hospital Outpatient	CPT	92507	SPEECH/HEARING THERAPY	No	\$ 52.00	\$ 17.40	\$ 251.43	\$0.00	Per Unit
Medicine Cardiovascular	Professional Services	CPT	93000	Electrocardiogram, routine, with interpretation and report	Yes	\$ 36.27	\$ 28.12	\$ 95.52	\$91.92	Per Unit
Medicine Other	Hospital Outpatient	CPT	93005	Electrocardiogram (ECG or EKG)	No	\$ 142.29	\$ -	\$ 295.26	\$53.52	Per Unit
Medicine Cardiac Stress Test	Hospital Outpatient	CPT	93017	CARDIOVASCULAR STRESS TEST	No	\$ 471.40	\$ 61.00	\$ 634.57	\$0.00	Per Unit
Medicine Other	Hospital Outpatient	CPT	93306	Tte w/doppler complete	No	\$ 1,404.83	\$ 322.26	\$ 1,593.05	\$481.57	Per Unit
Hospital Outpatient Procedure	Hospital Outpatient	CPT	93452	Insertion of catheter into left heart for diagnosis	Yes	\$ 8,847.45	\$ 579.93	\$ 12,920.92	\$1,512.88	Case Rate
Medicine Other	Hospital Outpatient	CPT	93971	Extremity study	No	\$ 240.64	\$ 92.64	\$ 400.67	\$325.76	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Medicine Other	Hospital Outpatient	CPT	95044	Allergy patch tests	No	\$ 189.82	\$ -	\$ 1,229.53	\$16.46	Per Unit
Medicine Neurology and Neuromuscular	Hospital Outpatient	CPT	95810	Sleep study	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Per Unit
Injections	Hospital Outpatient	CPT	96402	Chemo hormon antineopl sq/im	No	\$ 110.26	\$ 66.86	\$ 196.20	\$137.51	Case Rate
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97032	Physical Therapy - Manual Electrical Stimulation Therapy, 15 minutes	No	\$ 31.26	\$ 12.56	\$ 59.90	\$35.25	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97035	Physical Therapy - Ultrasound Therapy	No	\$ 26.92	\$ 11.95	\$ 40.29	\$36.14	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97110	Physical Therapy - Therapeutic Exercises	Yes	\$ 88.74	\$ 17.40	\$ 119.46	\$56.74	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97112	Physical Therapy - Neuromuscular Reeducation	No	\$ 69.93	\$ 26.14	\$ 104.78	\$42.23	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97116	GAIT TRAINING THERAPY	No	\$ 77.61	\$ 22.90	\$ 104.48	\$0.00	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97140	Physical Therapy - Manual Therapy	No	\$ 56.20	\$ 23.73	\$ 93.92	\$79.79	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97161	Physical Therapy - Low Complexity Evaluation	No	\$ 168.06	\$ 71.97	\$ 252.78	\$186.54	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97162	Physical Therapy - Moderate Complexity Evaluation	No	\$ 62.40	\$ 71.97	\$ 252.78	\$186.54	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97163	Physical Therapy - High Complexity Evaluation	No	\$ 168.06	\$ 71.97	\$ 252.78	\$186.54	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97164	Physical Therapy - Re-Evaluation	No	\$ 113.34	\$ 48.67	\$ 170.97	\$126.17	Per Unit
Medicine Occupational Therapy	Hospital Outpatient	CPT	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$ 180.88	\$ 77.05	\$ 245.32	\$0.00	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Medicine Occupational Therapy	Hospital Outpatient	CPT	97166	OT EVAL MOD COMPLEX 45 MIN	No	\$ 62.40	\$ 72.00	\$ 245.32	\$0.00	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97530	Physical Therapy - Therapeutic Activities	No	\$ 92.45	\$ 17.40	\$ 124.45	\$61.52	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97535	Physical Therapy - Self-care or Home Management Training	No	\$ 68.89	\$ -	\$ 109.03	\$68.24	Per Unit
Evaluation & Management Services	Professional Services	CPT	99024	Postop follow-up visit	No	\$ -	\$ -	\$ 14.27	\$0.00	Per Unit
Evaluation & Management Services	Professional Services	CPT	99202	Office Visit - New Patient, Minor	No	\$ 167.93	\$ 90.34	\$ 200.08	\$171.13	Per Unit
Evaluation & Management Services	Professional Services	CPT	99203	Office Visit - New Patient, Low Complexity	Yes	\$ 182.06	\$ 132.54	\$ 273.99	\$236.99	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99204	Office Visit - New Patient, Moderate Complexity	Yes	\$ 250.69	\$ 177.01	\$ 432.49	\$348.34	Per Unit
Evaluation & Management Services	Professional Services	CPT	99205	New patient office of other outpatient visit, typically 60 min	Yes	\$ 448.04	\$ 156.38	\$ 553.76	\$436.90	Per Unit
Evaluation & Management Services	Professional Services	CPT	99212	Office Visit - Basic	No	\$ 58.74	\$ 46.41	\$ 133.24	\$121.37	Per Unit
Evaluation & Management Services	Professional Services	CPT	99213	Office Visit - Established Patient, Low Complexity	No	\$ 99.67	\$ 81.71	\$ 201.59	\$148.11	Per Unit
Evaluation & Management Services	Professional Services	CPT	99214	Office Visit - Established Patient, Moderate Complexity	No	\$ 151.19	\$ 140.90	\$ 279.47	\$201.15	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99215	Office Visit - Established Patient, High Complexity	No	\$ 315.87	\$ 192.33	\$ 385.34	\$310.54	Per Unit
Professional Services Associated with Inpatient Stay	Professional Services	CPT	99232	Subsequent hospital care	No	\$ 159.88	\$ 50.60	\$ 111.92	\$50.59	Per Unit
Evaluation & Management Services	Professional Services	CPT	99243	Patient office consultation, typically 40 min	Yes	\$ 212.43	\$-	\$ 142.18	\$104.10	Per Unit
Evaluation & Management Services	Professional Services	CPT	99244	Patient office consultation, typically 60 min	Yes	\$ 338.80	\$-	\$ 226.38	\$144.95	Per Unit
Emergency Room Visit	Hospital Outpatient	CPT	99281	Emergency Department Visit - Minor (outpatient)	No	\$ 230.81	\$ 74.98	\$ 689.88	\$125.42	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Emergency Room Visit	Hospital Outpatient	CPT	99282	Emergency Department Visit - Low Complexity (outpatient)	No	\$ 430.38	\$ 93.52	\$ 1,114.22	\$171.86	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99283	Emergency Department Visit - Moderate Complexity (outpatient)	No	\$ 932.99	\$ 182.62	\$ 2,714.83	\$340.54	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99284	Emergency Department Visit - Higher Complexity (outpatient)	No	\$ 2,400.69	\$ 270.43	\$ 4,475.48	\$973.73	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99285	Emergency Department Visit - High Complexity (outpatient)	No	\$ 3,149.91	\$ 458.20	\$ 5,806.95	\$1,392.52	Case Rate


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Emergency Room Visit	Hospital Outpatient	CPT	99291	Emergency Department Visit - Critical Care (outpatient)	No	\$ 17,860.61	\$ 425.50	\$ 6,308.07	\$3,811.95	Case Rate
Evaluation & Management Services	Professional Services	CPT	99381	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, Younger than 1 Year Old	No	\$ 156.75	\$ -	\$ 225.38	\$180.33	Per Unit
Evaluation & Management Services	Professional Services	CPT	99382	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-4 Years Old	No	\$ 163.82	\$ -	\$ 236.91	\$195.25	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99383	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 5-11 Years Old	No	\$ 170.96	\$ -	\$ 413.46	\$198.79	Per Unit
Evaluation & Management Services	Professional Services	CPT	99384	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 12-17 Years Old	No	\$ 193.58	\$ -	\$ 280.75	\$231.39	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
<p>To Search for a service Click "CTRL" + "F"</p> <p style="text-align: right;">Amount We Estimate You Will Owe * </p>										
Evaluation & Management Services	Professional Services	CPT	99385	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18-39 Years Old	Yes	\$ 187.80	\$ 59.23	\$ 347.60	\$227.75	Per Unit
Evaluation & Management Services	Professional Services	CPT	99386	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 40-64 Years Old	Yes	\$ 217.32	\$ 91.72	\$ 1,293.56	\$276.34	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99391	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, Younger than 1 Year Old	No	\$ 141.19	\$ -	\$ 267.83	\$183.74	Per Unit
Evaluation & Management Services	Professional Services	CPT	99392	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 1-4 Years Old	No	\$ 150.93	\$ -	\$ 305.91	\$199.10	Per Unit


*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99393	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 5-11 Years Old	No	\$ 150.44	\$ -	\$ 305.91	\$206.32	Per Unit
Evaluation & Management Services	Professional Services	CPT	99394	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 12-17 Years Old	No	\$ 165.14	\$ -	\$ 398.57	\$194.51	Per Unit
Evaluation & Management Services	Professional Services	CPT	99395	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 18-39 Years Old	No	\$ 168.81	\$ 37.07	\$ 304.60	\$203.01	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Professional Services	CPT	99396	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 40-64 Years Old	No	\$ 180.12	\$ 64.57	\$ 429.79	\$260.06	Per Unit
Exablate	Hospital Outpatient	CPT	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	\$ 11,272.90	Service Not Covered by Payer	Case Rate
Vaccinations	Hospital Outpatient	CPT	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$ -	\$ 126.95	\$3.40	Per Unit
Vaccinations	Hospital Outpatient	CPT	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$ -	\$ -	\$3.40	Per Unit
Medicine Hyberbaric	Hospital Outpatient	CPT	G0277	Hbot, full body chamber, 30m	No	\$ 773.99	\$ 46.24	\$ 1,424.46	\$40.71	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	CPT	G0378	Hospital observation per hr	No	\$ 15,685.71	\$ 605.00	\$ 24,131.86	\$1,132.92	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Evaluation & Management Services	Hospital Outpatient	CPT	G0463	Hospital outpt clinic visit	No	\$ 130.00	\$ 74.02	\$ 200.00	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	G0480	Drug test def 1-7 classes	No	\$ 476.03	\$ -	\$ 732.35	\$0.00	Per Unit
Injections	Hospital Outpatient	HCPCS	J1071	Inj testosterone cypionate	No	\$ 0.22	\$ 0.03	\$ 0.34	\$0.00	Per Unit
Injections	Hospital Outpatient	HCPCS	J1815	Insulin injection	No	\$ 2.13	\$ 0.78	\$ 3.27	\$0.00	Per Unit
Injections	Hospital Outpatient	HCPCS	J7325	Synvisc or synvisc-one	No	\$ 26.95	\$ -	\$ 89.11	\$89.11	Per Unit
Injections	Hospital Outpatient	CPT	J9217	Eligard	No	\$ 2,818.54	\$ -	\$ 4,336.21	\$2,036.62	Per Unit

*Estimates have been normalized to provide a quote based on the amount we anticipate you your insurance to owe. For example, if the rate is 45% of charges the median charge has been multiplied by 45%.