										<u> </u>
Bright Health Plan	Last Updated: 12/14/2021									
									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	_ Estimate Type
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
		DRG		HEART FAILURE SHOCK W MCC	No			\$ 31,074.55	\$10,295.37	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG		Spinal fusion except cervical without major comorbid conditions or complications (MCC)	Yes	\$ 89.541.22	\$ 16,237.64	\$ 58,989.92	\$30,297.06	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%.

I 1									A	
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
, ,										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Service Category	Service Setting	туре	coue	Description	Jervice:	Casir Flice	charge	charge	charge	Estimate Type
										Case Rate-
										Excluding
				Major joint replacement or						Professional
				reattachment of lower extremity						Charges which
				without major comorbid conditions						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	470	or complications (MCC).	Yes	\$ 26,747.32	\$ 8,070.44	\$ 37,721.88	\$15,058.26	CPT/HCPCS
										Case Rate-
										Excluding
				Cervical spinal fusion without						Professional
				comorbid conditions (CC) or major						Charges which
				comorbid conditions or						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	473	complications (MCC).	Yes	\$ 37,083.10	A	\$ 62,430.00	\$19,219.86	CPT/HCPCS

	1							1	A manual Mar	
									Amount We Estimate You	
									Will Owe *	
									will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
										Case Rate-
										Excluding
										Professional
										Charges which
				HIP FEMUR PROCEDURES EXCEPT						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	480	MAJOR JOINT W MCC	No	\$ 58,727.97	\$ 12,375.85	\$ 48,933.51	\$23,091.53	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				HIP FEMUR PROCEDURES EXCEPT						are paid by
Hospital Inpatient Stay H	Hospital Inpatient	DRG	481	MAJOR JOINT W CC	No	\$ 48,507.14	\$ 8,559.98	\$ 38,996.68	\$15,971.67	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				HIP FEMUR PROCEDURES EXCEPT						are paid by
Hospital Inpatient Stay H	Hospital Inpatient	DRG	482	MAJOR JOINT W/O CC/MCC	No	\$ 35,733.50	\$ 6,745.73	\$ 37,731.25	\$12,586.55	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				LOWER EXTREM HUMER PROC						are paid by
										CPT/HCPCS

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> Specific <u>Negotiated</u> <u>Charge</u>	_Estimate Ty
Hospital Inpatient Stay	Hospital Inpatient	DRG	494	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W/O CC/MCC	Νο	\$ 34,304.81	\$ 7,426.74	\$ 43,066.25	\$13,857.21	Case Rate- Excluding Professional Charges whicl 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	\$8,786.03	Case Rate- Excluding Professional Charges whicl are paid by CPT/HCPCS
				RED BLOOD CELL DISORDERS W						Case Rate- Excluding Professional Charges whic are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	811	MCC	No	\$ 23,221.02	\$ 4,255.93	\$ 31,015.82	\$10,253.30	CPT/HCPCS

Image: service Click "CTRL" Service Setting Code Image: service Click "CTRL" Image: service Click "CTRL" </th <th></th>	
Image: service Click "CTRL"	
To Search for a service Click "CTRL" Image: Constraint of the service Click "CTRL" Image: Cons	
+ "F" In the second sec	
+ "F" Image: Code	
+ "F" In the second sec	
CMS De-Identified De-Identified Payer- Code Shoppable Discounted Negotiated Negotiated	
RequiredMequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
RequiredMequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
CodeRequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
CodeShoppableDiscountedNegotiatedNegotiated	
Service Category Service Setting Type Code Description Service? Cash Price Charge Charge Charge Charge Estir	
	imate Type
Case	e Rate-
Exclusion	ding
	essional
	ges which
	aid by
	HCPCS
	TICFCS
	Data
	e Rate-
Exclusion	
	essional
	ges which
	aid by
Hospital Inpatient Stay Hospital Inpatient DRG 928 GRAFT OR INHAL INJ W CC/MCC No \$ 81,430.86 \$ 21,639.28 \$ 150,000.00 \$ 86,925.33 CPT/H	HCPCS
Case	e Rate-
Exclud	uding
	essional
	ges which
	aid by
Hospital Inpatient Stay Hospital Inpatient DRG 929 GRAFT OR INHAL INJ W/O CC/MCC No \$ 38,084.70 \$ 6,540.49 \$ 50,000.00 \$22,502.48 CPT/H	HCPCS
	e Rate-
Exclud	
Profes	essional
	ges which
Charg	ges which aid by

r			1						Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge_	Charge	Charge_	Estimate Type
										Case Rate-
										Excluding
										Professional
				LIMB REATTACHMENT, HIP						Charges which
				FEMUR PROC FOR MULTIPLE						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	956	SIGNIFICANT TRAUMA	No	\$ 105,373.59	\$ 16,085.53	\$ 200,000.00	\$91,188.68	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
				OTHER O.R. PROCEDURES FOR						Charges which
				MULTIPLE SIGNIFICANT TRAUMA						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	957	W MCC	No	\$ 139,128.72	\$ 30,888.17	\$ 200,000.00	\$120,399.85	CPT/HCPCS
										.
										Case Rate-
										Excluding Professional
				OTHER O.R. PROCEDURES FOR						Charges which
				MULTIPLE SIGNIFICANT TRAUMA						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG		wcc	No	\$ 73,933.71	\$ 17,182.69	\$ 125,000.00	\$63,981.09	CPT/HCPCS
-										
										Case Rate-
										Excluding
										Professional
										Charges which
Une and the Line and the state of the state	the surface being at surface			OTHER MULTIPLE SIGNIFICANT	No	é 24.764.97	¢ (122.25	¢ 50,000,00	600 000 0 7	are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	964	TRAUMA W CC	No	\$ 34,/61.85	ə 6,123.35	\$ 50,000.00	\$30,082.37	CPT/HCPCS

		1	1		1	1				
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									· ·	
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
										Case Rate-
										Excluding
										Professional
										Charges which
				VAGINAL DELIVERY W O.R. PROC						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	768	EXCEPT STERIL &/OR D&C	No	\$ 10,335.01	\$ 2,464.00	\$ 27,462.61	\$7,707.38	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W					.	are paid by
Maternity/Delivery	Hospital Inpatient	DRG	783	STERILIZATION W MCC	No	\$ 11,915.22	\$ 3,570.00	\$ 39,605.25	\$4,875.00	CPT/HCPCS
										Corres Data
										Case Rate-
										Excluding Professional
				CESAREAN SECTION W						Charges which are paid by
Matomity/Daliyany	Hernital Innations	DRG	784	STERILIZATION W CC	No	\$ 9,940.40	\$ 3,570.00	\$ 27,865.12	\$4,875.00	CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DKG	704	STERIEIZATION W CC	NU	\$ 5,540.40	\$ 3,370.00	\$ 27,805.12	34,875.00	CF T/HCFC3
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						
Maternity/Delivery	Hospital Inpatient	DRG	785		No	\$ 8,988.27	\$ 3,519.44	\$ 25,870.71	\$4,875.00	
	and the second sec						,		<i>,,,</i>	,
										Case Rate-
										Professional
										Charges which
		1	1		1	1			1	-
				CESAREAN SECTION W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	785	CESAREAN SECTION W STERILIZATION W/O CC/MCC	No	\$ 8,988.27	\$ 3,519.44	\$ 25,870.71	\$4,875.00	are paid by CPT/HCPCS Case Rate- Excluding Professional

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Maternity/Delivery	Hospital Inpatient	DRG	787	CESAREAN SECTION W/O STERILIZATION W CC	No	\$ 11,322.59	\$ 2,835.00	\$ 27,868.32	\$4,875.00	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	\$4,875.00	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	\$1,432.85	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	\$3,250.00	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	C No	\$ 10,897.11	\$ 2,464.00	\$ 25,917.69	\$3,250.00	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	De-Identified Minimum Negotiated <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
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	\$3,250.00	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	\$3,250.00	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	\$3,250.00	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	Νο	N/A	\$ 10,870.00	\$ 10,870.00	N/A	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS

					1	1			Amount We	I
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
· /										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Conto			Shoppable	Discountered	Negotiated	Negotiated	Negotiated	
Constant Containing	Complete Contrine	Code	Conto	Description		Discounted				Telling to Truck
Service Category	Service Setting	<u>Type</u>	<u>Code</u>	Description	Service?	Cash Price	Charge_	Charge_	Charge_	Estimate Type
						52% Charges				
						Estimated at				
Inpatient Rehabilitation Hospital				Inpatient Rehabilitation Hospital		\$2,341.96 Per			\$1,550 Per	Per Diem Per
Stay	Inpatient Rehabilitation Hospital	UB	118	Room & Board	No	Diem			Diem	Day
										Case Rate-
										Excluding
										Professional
				AFTERCARE, MUSCULOSKELETAL						Charges which
				SYSTEM AND CONNECTIVE TISSUE						are paid by
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG		WITH MCC	No	N/A	\$ 18,018,00	\$ 18,018.00	N/A	CPT/HCPCS
	inputient oknicu Huroing	Ditto	555				÷ 10,010.00	<i>ϕ</i> 10,010.00		
										Case Rate-
										Excluding
										Professional
				AFTERCARE, MUSCULOSKELETAL						Charges which
				SYSTEM & CONNECTIVE TISSUE W						are paid by
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	560	CC	No	N/A	\$ 10,435.00	\$ 10,435.00	N/A	CPT/HCPCS

I		-								· · · · · ·
									Amount We	
									Estimate You	
									Will Owe *	
To Connet for a comico Click "CTD!"										
To Search for a service Click "CTRL" + "F"										
+ "F"										-
					CMS		De-Identified		Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
										Case Rate-
										Excluding
										Professional
				AFTERCARE, MUSCULOSKELETAL						Charges which
				SYSTEM & CONNECTIVE TISSUE						are paid by
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	561	W/O CC/MCC	No	N/A	\$ 7,474.00	\$ 7,474.00	N/A	CPT/HCPCS
		bitto	501				<i>\(\)</i>	<i>v</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
										Case Rate-
										Excluding
										Professional
										Charges which
Long Term Acute Care Inpatient	Inpatient Long-Term Care			Pulmonary edema respiratory						are paid by
Stay	Hospital	DRG	LTC189	failure	No	N/A	\$ 74,931.49	\$ 74,931.49	N/A	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
Long Term Acute Care Inpatient	Inpatient Long-Term Care			Respiratory system diagnosis w						are paid by
Stay	Hospital	DRG	LTC207	ventilator support >96 hours	No	N/A	\$ 37,703.24	\$ 37,703.24	N/A	CPT/HCPCS
						70% Charges				
						(Estimated as				
Long Term Acute Care Inpatient	Inpatient Long-Term Care			Long Term Care Intensive Care		\$6,047.26 per	\$1,040 Per	\$1,929 Per	\$1,750 Per	Per Diem Per
Stay	Hospital	UB	200	Room & Board	No	diem)	Diem	Diem	Diem	Day
						,	-	-		
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &						\$1,109.30 Per			\$850 Per	Per Diem Per
	Innotiont Chilled Numine	UB	101	Subsoute Care Louis 1. Skilled Care	Ne		é 227.70	¢ 050.00		
Board	Inpatient Skilled Nursing	UB	191	Subacute Care Level 1- Skilled Care	No	Diem	\$ 227.70	\$ 850.00	Diem	Day

r						1			Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &				Subacute Care Level 2-		\$1,109.30 Per			\$850 Per	Per Diem Per
Board	Inpatient Skilled Nursing	UB	192	Comprehensive Care	No	Diem	\$ 299.70	\$ 850.00	Diem	Day
						F20/ Channes				
						52% Charges				
Chilled Numing Innetions Doom 9				Subscripts Correctional 2. Complete		Estimated at			COEO Dorr	Der Diem Der
Skilled Nursing Inpatient Room & Board	Innations Skilled Nursing	UB	193	Subacute Care Level 3- Complex Care	No	\$1,109.30 Per Diem	\$ 370.00	¢ 950.00	\$850 Per Diem	Per Diem Per
board	Inpatient Skilled Nursing	UB	193	Care	NO	Diem	\$ 370.00	\$ 850.00	Diem	Day
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 530.90	\$ 161.58	\$ 1,803.41	\$236.36	Case Rate
		_						. ,		
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11104	Biopsy - Punch Biopsy of Skin	No	\$ 584.92	\$ 167.15	\$ 1,829.27	\$236.36	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	17000	Destruction of Lesion (outpatient)	No	\$ 1,131.70	\$ 157.92	\$ 1,634.10	\$236.36	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	10082	Bx breast 1st lesion us imag	No	\$ 3,052.42	\$ 381.25	\$ 2,964.36	\$1,856.71	Case Rate
		CF 1	13003	DA MICASE ESE ICSION US IMAS	NU	÷ 3,032.42	y 301.23	y 2,304.30	,030.71	
						N/A No			N/A No	
				Removal of 1 or more breast		Service			Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	19120	growth, open procedure	Yes	Volume	\$ -	\$ -	Volume	Case Rate

r		1	1			1				
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	-	Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Injections	Hospital Outpatient	СРТ	20610	Arthrocentesis (outpatient)	No	\$ 370.58	\$ 182.39	\$ 1,461.73	\$354.09	Case Rate
							-		-	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	27818	Treatment of ankle fracture	No	\$ 1,243.48	\$ 395.00	\$ 2,581.00	\$1,833.43	Case Rate
						+ -)	+	+ _,	+_,	
						N/A No			N/A No	
						Service			Service	
Upperitel Outpetient Dressdure	Upperitel Outpetient	CDT	20020	Anthropponia Chaulden Currom	Vee		÷	¢		Cose Data
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	29826	Arthroscopic Shoulder Surgery	Yes	Volume	\$-	\$-	Volume	Case Rate
						N/A No			N/A No	
				Arthroscopic Knee Surgery		Service			Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	29881	(outpatient)	Yes	Volume	\$-	\$-	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	31575	Laryngoscopy - Diagnostic	No	\$ 449.87	\$ 135.86	\$ 1,978.02	\$211.76	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	32555	Aspirate pleura w/ imaging	No	\$ 608.39	\$ 288.54	\$ 1,852.06	\$852.89	Case Rate
							-		-	
						N/A No			N/A No	
				Tonsillectomy with Adenoidectomy		Service			Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	42820	(outpatient)	Yes	Volume	ş -	\$-	Volume	Case Rate
			72020	loupdeleng	103	volume	Ÿ -		volume	case nate
				Upper Gastrointestinal Endoscopy -						
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43235	Diagnostic	Yes	\$ 2,027.21	\$ 61.00	\$ 1,867.74	\$1,063.11	Case Rate

												Amount We	
												Estimate You	
To Search for a service Click "CTRL" + "F"												Will Owe *	
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	CMS Required Shoppable Service?		scounted ish Price	<u>Mi</u> Neg	dentified nimum otiated harge	N	<u>-Identified</u> Aaximum egotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	43239	Upper Gastrointestinal Endoscopy - With Biopsy	Yes	s	1,259.34	s	372.00	Ś	2,229.48	\$1,063.11	Case Rate
				Colonoscopy - Diagnostic									
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45378	Colonoscopy - With Biopsy	Yes	\$	2,117.86			\$	2,220.88	\$1,033.30	Case Rate
Hospital Outpatient Procedure Hospital Outpatient Procedure	Hospital Outpatient Hospital Outpatient	СРТ	45380	(outpatient) Colonoscopy - With Polyp Removal (outpatient)	Yes	\$	3,082.66 3,317.89		343.06 354.50	\$	4,110.45 4,434.15	\$1,358.40 \$1,358.40	Case Rate
				Ultrasound examination of lower			N/A No Service			•		N/A No Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45391	large bowel using an endoscope	Yes		/olume	\$	-	\$	-	Volume	Case Rate

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		<u>Code</u>			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	Charge	<u>Charge</u>	Charge_	Estimate Type
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	47562	Gall Bladder Surgery (outpatient)	Yes	\$ 12,062.52	\$ 504.75	\$ 18,374.88	\$6,538.53	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	49440	Place gastrostomy tube perc	No	\$ 3,111.60	\$ 445.12	\$ 3,166.61	\$2,106.69	Case Rate
				Repair of groin hernia patient age 5						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	49505	years or older	Yes	\$ 9,867.85	\$ 470.98	\$ 15,040.03	\$4,205.99	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	51798	Urine Capacity Measurement	No	\$ 97.04	\$-	\$ 1,579.20	\$74.41	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	52000	Cystoscopy	No	\$ 1,173.22	\$ 282.78	\$ 1,596.52	\$752.81	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	55700	Biopsy of prostate gland	Yes	\$ 1,165.04	\$ 284.76	\$ 2,631.84	\$2,396.37	Case Rate
				Surgical removal of prostate and		N/A No	N/A No	N/A No	N/A No	
Userstal Outputs 10	Usersited Octoresting	CDT		surrounding lymph nodes using an	N.	Service	Service	Service	Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	55866	endoscope	Yes	Volume	Volume	Volume	Volume	Case Rate

Service Category Service Setting Code Type Code Code Description Service? Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>	
Image: service Click "CTRL"	
To Search for a service Click "CTRL" Image: Code service Click "CTRL" Image: Code service Click "CTRL" * "F" Code CMS De-Identified Payer- Shoppable Discounted Discounted Negotiated Negotiated	
+ "F" Image: second	
+ "F" Image: second	
+ "F" Image: second	
Code CMS De-Identified De-Identified Payer- Shoppable Discounted Negotiated Negotiated Negotiated	
CodeRequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
CodeRequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
CodeRequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	
Code Shoppable Discounted Negotiated Negotiated	
	te Type
Hospital Outpatient Procedure Hospital Outpatient CPT 58100 Biopsy - Endometrial (Uterus) No \$ 375.83 \$ 144.00 \$ 1,697.39 \$224.61 Case Ra	
	le
Hospital Outpatient ProcedureHospital OutpatientCPT58300Insert intrauterine deviceNo\$ 632.24\$ 48.93\$ 1,749.37\$0.00Case Ratio	te
Hospital Outpatient ProcedureHospital OutpatientCPT58301Remove intrauterine deviceNo\$273.85\$32.34\$1,495.58\$366.20Case Ra	te
Hospital Outpatient Procedure Hospital Outpatient CPT 59025 Fetal Non-Stress Test No \$ 260.79 \$ 118.53 \$ 1,596.22 \$224.61 Case Ra	te
Routine obstetric care for vaginal	
Professional Services Associated delivery, including pre-and post-	
with Inpatient Stay Professional Services CPT 5940 delivery care Yes \$ 4,496.21 \$ 242.00 \$ 3,278.48 \$0.00 Case Ra	te
Professional Services Associated	
with Inpatient Stay Professional Services CPT 59410 Obstetrical care No \$ 2,230.06 \$ 1,33.91 \$ 1,625.81 \$0.00 Case Rail	te
Routine obstetric care for cesarean	
Professional Services Associated delivery, including pre-and post-	
with Inpatient Stay Professional Services CPT 59510 delivery care Yes \$ 4,966.56 \$ 246.05 \$ 3,619.13 \$0.00 Case Ra	I

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Samilas Catagony	Somico Cotting		Code	Description	Service?					Estimate Tune
Service Category	Service Setting	Туре	<u>Code</u>	Description	Servicer	Cash Price	Charge_	Charge	Charge_	Estimate Type
				Routine obstetric care for vaginal						
				delivery after prior cesarean						
Professional Services Associated				delivery including pre-and post-						
						A	÷	÷	<u> </u>	
with Inpatient Stay	Professional Services	СРТ	59610	delivery care	Yes	\$ 4,706.58	\$ 305.08	\$ 3,429.34	\$0.00	Case Rate
				Injection of substance into spinal						
				canal of lower back or sacrum using						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		imaging guidance	Yes	\$ 1,055.18	\$ 379.33	\$ 1,880.39	\$845.50	Case Rate
inospital outpatient Flotedule		CF I	02322	indenie Suldance	103	÷ 1,055.10	÷ 373.33	φ 1,000.33		case nate
				Injection of substance into spinal						
				canal of lower back or sacrum using						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		imaging guidance	Yes	\$ 1,665.98	\$ 305.01	\$ 1,988.33	\$845.50	Case Rate
nospital outpatient Floteutie	nospital outpatient	SF I	02323	indenis suidance	165	φ 1,000.30	- 303.01	ک و،200،35 ک		case nate

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> Type	Code	Description	CMS Required Shoppable Service?	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
				Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	64483	guidance	Yes	\$ 1,776.21	\$ 358.46	\$ 1,980.49	\$1,098.46	Case Rate
				Removal of recurring cataract in		N/A No Service			N/A No Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	66821	lens capsule using laser	Yes	Volume	\$-	\$-	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		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	СРТ	69210	Remove impacted ear wax	No	\$ 168.99	\$ 48.93	\$ 1,604.78	\$74.41	Case Rate
Radiology Services	Hospital Outpatient	СРТ		CT Scan - Head/Brain, without Contrast	No	\$ 901.06	\$ 127.22	\$ 1,318.18	\$151.61	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	70450	CT Scan - Head/Brain, without Contrast	Yes	\$ 901.06	\$ 127.22	\$ 1,318.18	\$151.61	Per Unit
		СРТ			Νο				\$246.49	Per Unit
Radiology Services	Hospital Outpatient Hospital Outpatient	СРТ		Ct orbit/ear/fossa w/o&w/dye Ct maxillofacial w/o dye	No	\$ 2,339.66 \$ 1,668.57		\$ 2,657.02 \$ 2,259.85	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ		Ct angiography head	No	\$ 1,871.05	\$ 223.05	\$ 1,996.31	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70498	Ct angiography neck	No	\$ 1,632.72	\$ 223.05	\$ 1,677.63	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70551	MRI BRAIN STEM W/O DYE	No	\$ 1,518.19	\$ 252.20	\$ 2,270.30	\$315.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70553	MRI - Brain (outpatient)	Yes	\$ 2,314.59	\$ 406.50	\$ 3,409.54	\$516.53	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71045	X-ray exam chest 1 view	No	\$ 138.11	\$ 19.91	\$ 181.37	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71046	X-Ray - Chest (outpatient)	No	\$ 148.99	\$ 31.50	\$ 193.55	\$107.96	Per Unit

										Amount We	ī
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL" + "F"											
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> Service?	<u>counted</u> sh Price	<u>De-Ide</u> <u>Minir</u> <u>Negot</u> Cha	num iated	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	71110	X-ray exam ribs bil 3 views	No	\$ 205.20	\$	38.07	\$ 271.73	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71250	CT THORAX W/O DYE	No	\$ 1,024.52	\$1	41.11	\$ 1,468.48	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$ 1,448.52	\$ 2	200.76	\$ 2,034.88	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71275	Ct angiography chest	No	\$ 1,935.65	\$ 2	26.19	\$ 2,092.27	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72040	X-Ray - Neck, Cervical Spine	No	\$ 154.65	\$	37.93	\$ 204.42	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72070	X-Ray - Middle Back, Thoracic Spine	No	\$ 251.61	\$	33.93	\$ 338.99	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72100	X-Ray - Spine (outpatient)	No	\$ 199.60	\$	37.93	\$ 265.13	\$151.61	Per Unit
				X-Ray, lower back, minimum four							
Radiology Services	Hospital Outpatient	СРТ	72110	views	Yes	\$ 213.64	\$	52.80	\$ 284.93	\$151.61	Per Unit

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	CMS Required Shoppable Service?	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Typ
Radiology Services	Hospital Outpatient	СРТ	72125	Ct neck spine w/o dye	No	\$ 1,459.37	\$ 136.86	\$ 1,750.92	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72126	Ct neck spine w/dye	No	\$ 1,293.16	\$ 260.86	\$ 1,821.59	\$516.53	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72127	Ct neck spine w/o & w/dye	No	\$ 1,815.93	\$ 201.73	\$ 2,118.48	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72129	Ct chest spine w/dye	No	\$ 1,520.66	\$ 199.82	\$ 1,805.90	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72132	Ct lumbar spine w/dye	No	\$ 1,518.43	\$ 260.86	\$ 1,805.90	\$516.53	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72133	Ct lumbar spine w/o & w/dye	No	\$ 1,904.42	\$ 201.90	\$ 2,238.70	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72141	MRI NECK SPINE W/O DYE	No	\$ 1,441.84	\$ 252.20	\$ 2,177.11	\$315.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72148	MRI - Back (outpatient)	Yes	\$ 1,381.13	\$ 252.20	\$ 2,137.12	\$315.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72170	X-Ray - Pelvis	No	\$ 249.04	\$ 28.72	\$ 327.10	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72190	X-RAY EXAM OF PELVIS	No	\$ 208.53	\$ 39.60	\$ 264.73	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72193	CT scan, pelvis, with contrast	Yes	\$ 1,536.96	\$ 197.29	\$ 2,142.05	\$246.49	Per Unit

											Amount We Estimate You	
To Search for a service Click "CTRL" + "F"											Will Owe *	
Service Category	Service Setting	Code Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>		ounted	De-Identified Minimum Negotiated Charge	<u>Ma</u> Neg	dentified ximum otiated harge	<u>Payer-</u> Specific <u>Negotiated</u> <u>Charge</u>	_Estimate Type
Radiology Services	Hospital Outpatient	СРТ	72197	MRI - Pelvis (outpatient)	No	\$ 2	,448.72	\$ 402.71	\$	3,522.33	\$516.53	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73000	X-ray exam of collar bone	No	\$	147.59	\$ 22.40	\$	185.92	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73010	X-ray exam of shoulder blade	No	\$	196.93	\$ 26.01	\$	251.93	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73030	X-Ray - Shoulder (outpatient)	No	\$	149.50	\$ 28.33	\$	196.92	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73060	X-RAY EXAM OF HUMERUS	No	\$	147.62	\$ 29.40	\$	195.82	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73070	X-ray exam of elbow	No	\$	146.83	\$ 25.07	\$	191.42	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73080	X-RAY EXAM OF ELBOW	No	\$	122.83	\$ 26.72	\$	154.02	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73090	X-RAY EXAM OF FOREARM	No	\$	117.10	\$ 26.40	\$	151.82	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73110	X-Ray - Wrist (outpatient)	No	\$	156.52	\$ 30.72	\$	196.19	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73120	X-RAY EXAM OF HAND	No	\$	19 2.0 3	\$ 24.40	\$	249.73	\$151.61	Per Unit

												Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"													
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>		scounted	<u>Mi</u> Nej	dentified nimum gotiated harge	N	e-Identified Maximum legotiated Charge	<u>Payer-</u> Specific Negotiated Charge	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	СРТ	73130	X-Ray - Hand	No	\$	151.54	\$	32.72	\$	198.42	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73221	MRI - Shoulder, Elbow, or Wrist	No	\$	1,211.82	¢	246.65	¢	1,702.46	\$315.23	Per Unit
	nospital outpatient		73221		110	Ŷ	1,211.02	~	240.05	Ý	1,702.40	<i></i>	
Radiology Services	Hospital Outpatient	СРТ	73502	X-Ray - Hip	No	\$	129.58	\$	37.77	\$	197.91	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73552	X-RAY EXAM OF FEMUR 2/>	No	\$	150.51	\$	29.51	\$	189.38	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$	201.92	\$	32.40	\$	266.82	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73562	X-Ray - Knee (outpatient)	No	\$	263.50	\$	36.52	\$	351.25	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73590	X-ray exam of lower leg	No	\$	239.62	\$	32.40	\$	321.48	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73600	X-RAY EXAM OF ANKLE	No	\$	191.55	\$	31.98	\$	278.60	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73610	X-Ray - Ankle (outpatient)	No	\$	239.05	\$	25.72	\$	311.14	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73620	X-RAY EXAM OF FOOT	No	\$	196.24	\$	29.81	\$	262.21	\$107.96	Per Unit

									Amount We	ľ
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					<u>CMS</u>		De-Identified		Payer-	
		Codo			Required Shoppable	Discounted	Minimum Negotiated	Maximum Negotiated	Specific Negotiated	
Service Category	Service Setting	Code Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
							0.00.80		0110180	
Radiology Services	Hospital Outpatient	СРТ	73630	X-Ray - Foot (outpatient)	No	\$ 216.05	\$ 33.95	\$ 289.60	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73700	CT LOWER EXTREMITY W/O DYE	No	\$ 1,231.00	\$ 134.01	\$ 1,400.92	\$151.61	Per Unit
Padialagy Convices	Hernital Outpatient	СРТ	72721	MPL Knoc (outpotient)	Yes	\$ 1,224.32	\$ 246.65	\$ 1,828.36	\$315.23	Per Unit
Radiology Services	Hospital Outpatient	CPT	/3/21	MRI - Knee (outpatient)	res	\$ 1,224.32	\$ 240.05	\$ 1,828.30	\$315.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74018	X-Ray - Abdomen	No	\$ 145.61	\$ 28.31	\$ 189.76	\$107.96	Per Unit
De die le mi Comitane		COT	74450	Chahdaman uu (a dua	N	¢ 077.04	ć 142.20	¢ 446.00	6454 C4	Devillet
Radiology Services	Hospital Outpatient	СРТ	74150	Ct abdomen w/o dye	No	\$ 977.64	\$ 142.38	\$ 1,446.99	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74170	Ct abdomen w/o & w/dye	No	\$ 1,824.18	\$ 207.86	\$ 2,144.29	\$246.49	Per Unit
				CT Scan - Abdomen and Pelvis, with						
Radiology Services	Hospital Outpatient	СРТ	74177	Contrast	No	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$516.53	Per Unit
				CT Scan - Abdomen and Pelvis, with						
Radiology Services	Hospital Outpatient	СРТ	74177	Contrast	Yes	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$516.53	Per Unit
Radiology Services	Hospital Outpatient	CPT	74220	X-ray xm esophagus 1cntrst	No	\$ 394.10	\$ 56.38	\$ 563.71	\$246.49	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> Service?	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> Charge	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> Charge	Estimate Type
	<u>berrice betting</u>	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	couc	besenption	<u>bervice.</u>	casirrite	charge	enarge	enarge	Lotiniate Type
Radiology Services	Hospital Outpatient	СРТ	74270	X-ray xm colon 1cntrst std	No	\$ 521.72	\$ 79.34	\$ 578.01	\$246.49	Per Unit
Radiology Services	Hospital Outpatient	СРТ	75571	Ct hrt w/o dye w/ca test	No	\$ 306.04	\$ 59.00	\$ 323.39	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76536	Ultrasound - Head and Neck	No	\$ 460.62	\$ 78.79	\$ 386.50	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76642	Ultrasound - Breast (outpatient)	No	\$ 152.68	\$ 78.52	\$ 249.30	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76700	Ultrasound - Abdominal, Complete	Yes	\$ 361.43	\$ 91.69	\$ 433.80	\$151.61	Per Unit
Raubiogy Services	nospital Outpatient		70700	onrasound - Abuoniniai, complete	163	5 501.45	3 <u>31.05</u>	ş 455.60	3131.01	Peronit
Radiology Services	Hospital Outpatient	СРТ	76705	Ultrasound - Abdominal, Limited	No	\$ 327.93	\$ 46.05	\$ 372.20	\$151.61	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76770	US EXAM ABDO BACK WALL COMP	No	\$ 456.58	\$ 76.54	\$ 400.80	\$151.61	Per Unit
							A	A		
Maternity/Delivery	Hospital Outpatient	CPT	10801	OB US < 14 WKS SINGLE FETUS	No	\$ 391.57	\$ 86.65	\$ 396.27	\$151.61	Per Unit

r		1	1						A	i
									Amount We Estimate You	
									Will Owe *	
									Viii Owe	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Service Category	<u>Service Setting</u>	туре	coue	Description	<u>Service:</u>	casirrice	charge	charge	charge	Lotinate Type
				Ultrasound - Pregnancy						
Radiology Services	Hospital Outpatient	СРТ	76805	(outpatient)	Yes	\$ 367.73	\$ 100.36	\$ 437.10	\$151.61	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76811	OB US DETAILED SNGL FETUS	No	\$ 522.04	\$ 198.65	\$ 587.50	\$315.23	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76815	OB US LIMITED FETUS(S)	No	\$ 309.95	\$ 54.75	\$ 384.30	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76816	Ultrasound - Pregnancy Follow-Up	No	\$ 406.54	\$ 64.37	\$ 384.30	\$151.61	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76818	FETAL BIOPHYS PROFILE W/NST	No	\$ 476.50	\$ 82.20	\$ 387.27	\$151.61	Per Unit
		-			-					
Maternity/Delivery	Hospital Outpatient	СРТ	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 407.39	\$ 97.44	\$ 398.34	\$151.61	Per Unit
						+			,	
Radiology Services	Hospital Outpatient	СРТ	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 370.14	\$ 88.69	\$ 391.69	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	CFI	10021	INIDDLE CEREDRAL ARTERT ECHU	UVI	÷ 570.14	- 00.09	2 221.03	\$151.0L	rerunit
		1								
				Ultrasound - Transvaginal (non-						
Radiology Services	Hospital Outpatient	CPT	76830	maternity)	Yes	\$ 475.43	\$ 98.63	\$ 463.90	\$151.61	Per Unit

											Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	CMS Required Shoppable Service?	<u>Discour</u> <u>Cash P</u>		<u>Mi</u> Neg	dentified nimum gotiated harge	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Typ
Radiology Services	Hospital Outpatient	СРТ	76856	Ultrasound - Pelvic (outpatient)	No	\$ 34	4.00	\$	70.34	\$ 408.50	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77065	Mammography of one breast	Yes	\$ 54	6.40	\$	107.57	\$ 501.03	\$127.02	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77066	Mammography of both breasts	Yes	\$ 38	3.79	\$	135.81	\$ 629.70	\$161.97	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77067	Mammogram (outpatient)	Yes	\$ 40	6.73	\$	109.22	\$ 504.02	\$134.30	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77080	Bone Density Scan (outpatient)	No	\$ 24	7.25	\$	56.29	\$ 393.45	\$151.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77081	Dxa bone density/peripheral	No	\$ 1:	6.84	\$	33.80	\$ 171.64	\$107.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	78452	Myocardial Imaging (outpatient)	No	\$ 1,01	0.04	\$	336.74	\$ 2,091.45	\$1,720.88	Per Unit

									Amount We	î
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		De-Identified		Payer-	
		Code			Required	Discounted	Minimum	Maximum Negotiated	Specific Negotiated	
Service Category	Service Setting	Code Type	Code	Description	Shoppable Service?	Discounted Cash Price	Negotiated Charge	Charge	Charge	Estimate Type
Service Category	Service Setting	туре	coue	Description	<u>Jervice:</u>	casirrice	charge	charge	charge	Littlate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 158.03	\$ 11.84	\$ 221.33	\$12.69	Per Unit
				Blood Test - Comprehensive						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80053	Metabolic Panel	Yes	\$ 93.73	\$ 14.78	\$ 136.89	\$15.84	Per Unit
, , ,										
						N/A No	N/A No	N/A No	N/A No	
				Blood Test - Pregnancy (Obstetric)		Service	Service	Service	Service	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80055	Panel	Yes	Volume	Volume	Volume	Volume	Per Unit
				Blood Test - Cholesterol Test, Lipid						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80061		Yes	\$ 46.48	\$ 12.05	\$ 101.77	\$20.09	Per Unit
				Blood Test, Benel (Vide se)						
Laboratory & Patholomy Services	Hospital Outpatient	СРТ	90060	Blood Test - Renal (Kidney) Function Panel	Yes	\$ 17.24	\$ 8.68	\$ 34.59	\$13.02	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPI	80069		res	ə 17.24	ο.08 γ	ə 34.59	\$13.UZ	
				Blood Test - Hepatic (Liver)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80076	Function Panel	Yes	\$ 146.77	\$ 11.44	\$ 205.84	\$12.26	Per Unit

r								[Amount We	I
									Estimate You	
									Will Owe *	
									winowe	
To Search for a service Click "CTRL"										
+ "F"										
· · ·										
					CMS		De-Identified	De-Identified	Payer-	
							Minimum	Maximum	Specific	
		Conto			Required	Discountered				
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge_	Charge_	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80307	Drug test prsmv chem anlyzr	No	\$ 128.65			\$93.21	Per Unit
						N/A No	N/A No	N/A No	N/A No	
						Service	Service	Service	Service	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81000	Urinalysis nonauto w/scope	Yes	Volume	Volume	Volume	Volume	Per Unit
				Urine Test - Automated with						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	91001	Microscope Examination	Yes	\$ 23.46	\$ 4.44	\$ 34.47	\$4.76	Per Unit
Laboratory & Pathology Services		CFI	01001		Tes	ş 23.40	Ş 4.44	Ş 34.47	34.70	Peronit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81002	Urine Test - Urinalysis, Manual Test	Yes	\$ 7.24	\$ 2.67	\$ 14.00	\$5.22	Per Unit
				Urine Test - Automated without						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81003	Microscope	Yes	\$ 10.40	\$ 3.16	\$ 11.25	\$3.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81025	Urine Test - Pregnancy	No	\$ 40.87	\$ 10.45	\$ 58.29	\$12.92	Per Unit
,									+	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	822/17	Bilirubin total	No	\$ 41.02	\$ 4.52	\$ 55.22	\$7.53	Per Unit
Laboratory & Pathology Services		CFI	32247		NU	y 41.02	÷ 4.52	y 55.22	<i>ş</i> 7.33	rei Unit
Laboratory 0 Dati 1 - C - 1		CDT	00000	Pland Test Mites 1, D. C. L.		¢			646 FD	Des Halt
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82306	Blood Test - Vitamin D-3 Level	No	\$ 188.74	\$ 26.64	\$ 254.08	\$44.40	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 Amount We Estimate You Will Owe * To Search for a service Click "CTRL" Image: Code TYPE" + "F" Image: Code TYPE" Service Category Service Setting Type Code Type Description Service? Service Category Service Setting Type Code Description Service? Service Category Service Setting Service Category Service Setting Service Setting Type Service Category Service Setting Service Category Service Setting Service Setting	Estimate Type
Image: service Click "CTRL"	Estimate Type
To Search for a service Click "CTRL" Image: Constant of the service Click "CTRL" Image: Constant of the service Click "CTRL" + "F" Code CMS De-Identified De-Identified Locate Code Code Discounted De-Identified Payer- Specific Negotiated Negotiated Negotiated Negotiated Negotiated	Estimate Type
+ "F" Image: second	Estimate Type
+ "F" Image: second	Estimate Type
+ "F" Image: second	Estimate Type
CMS De-Identified De-Identified Payer- Code Code Shoppable Discounted Negotiated Negotiated	Estimate Type
RequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	Estimate Type
RequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	Estimate Type
RequiredMinimumMaximumSpecificCodeShoppableDiscountedNegotiatedNegotiated	Estimate Type
Code Shoppable Discounted Negotiated Negotiated	Estimate Type
	Estimate Type
Service Category Service Setting Type Code Description Service? Cash Price Charge Charge Charge Charge	Estimate Type
Laboratory & Pathology Services Hospital Outpatient CPT 82330 Assay of calcium No \$ 35.11 \$ 12.31 \$ 67.00 \$20.52 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82375 Assay carboxyhb quant No \$ 114.13 \$ 11.09 \$ 153.64 \$18.48 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82465 Assay bld/serum cholesterol No \$ 15.28 \$ 3.92 \$ 23.76 \$6.53 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82550 Assay of ck (cpk) No \$ 12.70 \$ 5.86 \$ 35.53 \$9.77 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82552 Assay of cpk in blood No \$ 26.14 \$ 12.05 \$ 75.41 \$75.41 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82565 Assay of creatinine No \$ 124.50 \$ 7.17 \$ 70.25 \$7.68 P	Per Unit
	cronic
Blood Test - Vitamin B-12	Sea that
Laboratory & Pathology Services Hospital Outpatient CPT 82607 (Cyanocobalamin) Level No \$ 29.40 \$ 13.57 \$ 82.73 \$22.62 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82610 Cystatin c No \$ 140.40 \$ 14.17 \$ 405.00 \$405.00 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82668 Assay of erythropoietin No \$ 36.68 \$ 16.91 \$ 99.20 \$28.19 P	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 82670 Assay of estradiol No \$ 54.51 \$ 25.15 \$ 152.33 \$41.91 P	Per Unit

									Amount We	
									Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82693	Assay of ethylene glycol	No	\$ 20.29	\$ 13.41	\$ 40.08	\$22.35	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 33.53	\$ 19.09	\$ 96.63	\$20.45	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82746	Blood Test - Folic Acid Level	No	\$ 37.75	\$ 13.23	\$ 79.52	\$22.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82803	Blood gases any combination	No	\$ 73.40	\$ 20.17	\$ 106.16	\$39.11	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82947	Assay glucose blood quant	No	\$ 34.04	\$ 5.51	\$ 49.42	\$5.90	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82962	Glucose blood test	No	\$ 45.55	\$ 3.89	\$ 61.82	\$4.92	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83018	Heavy metal quant each nes	No	\$ 172.97	\$ 19.76	\$ 498.96	\$498.96	Per Unit
				Blood Test - Blood Glucose Control						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83036	(Hemoglobin A1C)	No	\$ 71.27	\$ 8.74	\$ 95.94	\$14.57	Per Unit

									Amount We	
									Estimate You	
To Search for a service Click "CTRL" + "F"									Will Owe *	
Service Category	Service Setting	<u>Code</u> <u>Type</u>	<u>Code</u>	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83088	Assay of histamine	No	\$ 75.84	\$ 26.58	\$ 218.76	\$218.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83518	Immunoassay dipstick	No	\$ 147.09	\$ 6.55	\$ 424.29	\$424.29	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83540	Blood Test - Iron Level	No	\$ 51.90	\$ 9.06	\$ 75.77	\$9.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83605	Assay of lactic acid	No	\$ 27.44	\$ 10.41	\$ 58.05	\$17.36	Per Unit
				Blood Test - Lipase (fat enzyme)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83690	Level	No	\$ 69.47	\$ 6.20	\$ 93.51	\$10.34	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83735	Assay of magnesium	No	\$ 53.82	\$ 9.38	\$ 78.56	\$ 10.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83880	Assay of natriuretic peptide	No	\$ 172.55	\$ 35.33	\$ 232.27	\$58.89	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84100	Assay of phosphorus	No	\$ 61.73	\$ 6.64	\$ 87.67	\$7.11	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	\$ 43.23	\$ 6.66	\$ 62.65	\$7.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	\$ 43.23	\$ 6.66	\$ 62.65	\$7.14	Per Unit

										Amount We	
										Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	<u>Discounte</u> <u>Cash Price</u>	<u>N</u>	-Identified <u>Ainimum</u> egotiated <u>Charge</u>	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84144	Assay of progesterone	No	\$ 52.	i9 \$	18.77	\$ 96.68	\$31.29	Per Unit
				Blood Test - Prostate Specific							
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84153	Antigen (PSA) Level	Yes	\$ 74.3	1 \$	25.75	\$ 116.68	\$27.59	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84154	PSA (prostate specific antigen)	Yes	\$ 106.	34 \$	16.55	\$ 143.15	\$27.59	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84182	Protein western blot test	No	\$ 382.	/2 \$	18.76	\$ 588.80	\$43.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84295	Assay of serum sodium	No	\$ 42.3	0\$	4.33	\$ 56.67	\$7.22	Per Unit
				Blood Test - Thyroxine (Thyroid							
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84439	Chemical) Level, Free	No	\$ 66.3	1 \$	8.12	\$ 89.13	\$13.53	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 64.	07 \$	23.52	\$ 119.09	\$25.20	Per Unit

r	1	1				1	1			I
									Amount We	
									Estimate You Will Owe *	
									will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Blood Test - Thyroid Stimulating						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84443	Hormone (TSH) Level	Yes	\$ 64.07	\$ 23.52	\$ 119.09	\$25.20	Per Unit
, , ,										
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84480	Assay triiodothyronine (t3)	No	\$ 96.31	\$ 12.76	\$ 129.65	\$21.27	Per Unit
						-		-		
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84484	Assay of troponin quant	No	\$ 81.70	\$ 10.26	\$ 121.45	\$18.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84702	Chorionic gonadotropin test	No	\$ 125.77	\$ 11.54	\$ 169.31	\$22.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85014	Hematocrit	No	\$ 26.95	\$ 2.13	\$ 36.27	\$3.56	Per Unit
				Blood Test - Complete Blood Cell						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85025	Count and Automated WBC	Yes	\$ 77.98	\$ 10.88	\$ 112.06	\$11.66	Per Unit
				Blood Test - Complete Blood Cell						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85027	Count (Hemoglobin)	Yes	\$ 60.79	\$ 5.82	\$ 81.83	\$9.71	Per Unit
aboratory & Pathology Services	Hospital Outpatient	CPI	85027	Count (Hemoglobin)	Yes	Ş 60.79	ə 5.82	> 81.83	\$9.71	Per Unit

	1								Amount We	
									Estimate You	
									Will Owe *	
To Connet for a complete Click #CTPL#										
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		De-Identified	De-Identified	Payer-	
					Required		<u>Minimum</u>	Maximum	Specific .	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Laboratory & Dathalamy Complete	Upperited Outpetient	СРТ	05240	Clat factory iii also 1 store	No	\$ 45.97	¢ 10.11	¢ 05.50	COC OF	Deviluit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85240	Clot factor viii ahg 1 stage	No	\$ 45.97	\$ 16.11	\$ 95.56	\$26.85	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85378	Fibrin degrade semiquant	No	\$ 53.57	\$ 7.44	\$ 72.11	\$14.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85610	Blood Test - Clotting Time	Yes	\$ 44.81	\$ 6.01	\$ 64.27	\$6.44	Per Unit
						+	÷ 0.01	÷ •••••		
		0.07	05640				A A A A	÷ == ==	470.00	D
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85613	Russell viper venom diluted	No	\$ 24.61	\$ 8.24	\$ 70.98	\$70.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85660	RBC SICKLE CELL TEST	No	\$ 53.32	\$ 4.96	\$ 71.77	\$8.27	Per Unit
				Blood Test - Coagulation						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85730	Assessment	Yes	\$ 46.01	\$ 5.41	\$ 61.94	\$9.02	Per Unit
	a second s		50.00			+	+	+ 0104	+	
Laboratory & Dathalams Carri	Upperitel Outpetient	CDT	05722	Theorem is a location at the subscript of	N -	¢ 43.03	¢ 5.00	¢ 20.00	¢20,42	Devilat
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85/32	Thromboplastin time partial	No	\$ 12.63	\$ 5.82	\$ 36.42	\$36.42	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86140	C-reactive protein	No	\$ 48.49	\$ 4.66	\$ 65.28	\$7.77	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86360	T cell absolute count/ratio	No	\$ 65.00	\$ 42.28	\$ 211.59	\$187.50	Per Unit
	and the second sec									

										Amount We	
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL" + "F"											
					<u>CMS</u> <u>Required</u>		1	<u>De-Identified</u> <u>Minimum</u>	Maximum	<u>Payer-</u> Specific	
		<u>Code</u>			Shoppable	Discounte		Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	2	Charge_	Charge_	Charge_	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86361	T cell absolute count	No	\$ 132.	78 9	5 24.10	\$ 383.03	\$383.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86431	Rheumatoid factor quant	No	\$ 52.	70 9	5.10	\$ 70.95	\$8.51	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86592	Syphilis test non-trep qual	No	\$ 37.	81 9	3.84	\$ 50.90	\$6.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86592	Syphilis test non-trep qual	No	\$ 37.	81 9	3.84	\$ 50.90	\$6.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86611	Bartonella antibody	No	\$ 57.	37 9	9.16	\$ 165.50	\$165.50	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86615	Bordetella antibody	No	\$ 25.	74 :	5 11.87	\$ 81.45	\$74.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86651	Encephalitis californ antbdy	No	\$ 25.	74 9	5 11.87	\$ 110.13	\$74.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	<u>8665</u> 2	Encephaltis east eqne anbdy	No	\$ 25.	74 9	5 11.87	\$ 110.13	\$74.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86653	Encephaltis st louis antbody	No	\$ 25.	74 :	5 11.87	\$ 110.13	\$74.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86654	Encephaltis west eqne antbdy	No	\$ 25.	74 :	5 11.87	\$ 110.13	\$74.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86663	Epstein-barr antibody	No	\$ 25.	50 9	5 11.81	\$ 83.21	\$73.85	Per Unit

Image: Service Click 'CTRL' Service Click 'CTRL' S												Amount We	I
To Search for a sarvice Cilck "CTRL" To Search for a sarvice Cilck "CTRL" Service Category Service Setting Type Code Code Description Desc													
												Will Owe *	
Service CategoryService SettingCodeCodeDescriptionRequires ServiceNumber ServiceManume SecuricationSecurication Securi	To Search for a service Click "CTRL" + "F"												
Service CategoryService SettingCodeCodeDescriptionRequires ServiceNumber ServiceManume SecuricationSecurication 													
Service CategoryService SettingCodeCodeDescriptionRequires ServiceNumber ServiceManume SecuricationSecurication Securi						CMS			De-Ident	ified	De-Identified	Pavor-	
Service CategoryService SettingTypeCodeDescriptionService?Service?NeutrationNeutrationNeutrationNeutrationService?Service?NeutrationNeutrationService?Se													
Laboratory & Pathology Services Hospital Outpatient CPT 86697 Helicobacter pylori antibody No \$ 30.68 \$ 15.13 \$ 63.03 \$25.28 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86692 Hepatitis delta agent antbdy No \$ 29.16 \$ 15.44 \$ 50.98 \$25.74 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.85 \$ 115.92 \$18.08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B SURFACE ANTIBODY IGM No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit			<u>Code</u>			Shoppable	Disco	ounted	Negotia	ted	Negotiated		
Laboratory & Pathology Services Hospital Outpatient CPT 86692 Hepatitis delta agent antibody No \$ 29,16 \$ 15,44 \$ 50,98 \$ 25,74 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79,65 \$ 12,41 \$ 107,23 \$ 20,69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP 8 CORE ANTIBODY TOTAL No \$ 86,11 \$ 10,85 \$ 115,92 \$ 18,08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 CORE ANTIBODY IGM No \$ 22,98 \$ 10,59 \$ 57,38 \$ 17,66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY IGM No \$ 98,98 \$ 9,67 \$ 133,25 \$ 16,11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY No \$ 98,98 \$ 9,67 \$ 133,25 \$ 16,11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY No \$ 22,56 \$ 10,41 \$ 65,09 \$ \$65,09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit	Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash	n Price	Charg	e	Charge	Charge	Estimate Type
Laboratory & Pathology Services Hospital Outpatient CPT 86692 Hepatitis delta agent antibody No \$ 29,16 \$ 15,44 \$ 50,98 \$ 25,74 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79,65 \$ 12,41 \$ 107,23 \$ 20,69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP 8 CORE ANTIBODY TOTAL No \$ 86,11 \$ 10,85 \$ 115,92 \$ 18,08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 CORE ANTIBODY IGM No \$ 22,98 \$ 10,59 \$ 57,38 \$ 17,66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY IGM No \$ 98,98 \$ 9,67 \$ 133,25 \$ 16,11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY No \$ 98,98 \$ 9,67 \$ 133,25 \$ 16,11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP 8 SURFACE ANTIBODY No \$ 22,56 \$ 10,41 \$ 65,09 \$ \$65,09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86692 Hepatitis delta agent antibody No \$ 29,16 \$ 15,44 \$ 50,98 \$ 25,74 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79,65 \$ 12,41 \$ 107,23 \$ 20,69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP B CORE ANTIBODY TOTAL No \$ 86,11 \$ 10,85 \$ 115,92 \$ 18,08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B CORE ANTIBODY IGM No \$ 22,98 \$ 10,59 \$ 57,38 \$ 17,66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY IGM No \$ 98,98 \$ 9,67 \$ 133,25 \$ 16,11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22,56 \$ 10,41 \$ 65,09 \$ 565,09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22,56 \$ 10,41 \$ 65,09 \$ 565,09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22,71 \$ 11,15 \$ 56,71 \$ 18,59 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86677	Helicobacter pylori antibody	No	Ś	30.68	\$ 19	5.13	\$ 63.03	\$25.28	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 Hepatitis be antibody No \$ 22.56 \$													
Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 Hepatitis be antibody No \$ 22.56 \$													
Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86698 Histoplasma antibody No \$ 79.65 \$ 12.41 \$ 107.23 \$20.69 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 Hepatitis be antibody No \$ 22.56 \$	Laboratory & Bathology Somisor	Hospital Outpatient	CDT	96603	Henetitic delte egent enthdy	No	ć	20.16	ć 11		¢ 50.09	¢25.74	Dor Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.85 \$ 115.92 \$18.08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$	Laboratory & Pathology Services		CPT	00092		INU	>	29.10	\$ 15	.44	Ş 50.56	323.74	Peronit
Laboratory & Pathology Services Hospital Outpatient CPT 86704 HEP B CORE ANTIBODY TOTAL No \$ 86.11 \$ 10.85 \$ 115.92 \$18.08 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$													
Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86698	Histoplasma antibody	No	\$	79.65	\$ 12	2.41	\$ 107.23	\$20.69	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86705 HEP B CORE ANTIBODY IGM No \$ 22.98 \$ 10.59 \$ 57.38 \$17.66 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$ 65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86704	HEP B CORE ANTIBODY TOTAL	No	\$	86.11	\$ 10).85	\$ 115.92	\$18.08	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$ 65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$ 65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86706 HEP B SURFACE ANTIBODY No \$ 98.98 \$ 9.67 \$ 133.25 \$16.11 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86707 Hepatitis be antibody No \$ 22.56 \$ 10.41 \$ 65.09 \$ 65.09 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86705	HEP B CORE ANTIBODY IGM	No	Ś	22.98	\$ 10).59	\$ 57.38	\$17.66	Per Unit
Laboratory & Pathology ServicesHospital OutpatientCPT86707Hepatitis be antibodyNo\$22.56\$10.41\$65.09\$65.09Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86708Hepatitis a antibodyNo\$22.71\$11.15\$56.71\$18.59Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86762Rubella antibodyNo\$78.19\$12.95\$225.56\$225.56Per Unit				00700			Ŷ	22.50	<u> </u>		<i>v</i> 57150		i ci onit
Laboratory & Pathology ServicesHospital OutpatientCPT86707Hepatitis be antibodyNo\$22.56\$10.41\$65.09\$65.09Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86708Hepatitis a antibodyNo\$22.71\$11.15\$56.71\$18.59Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86762Rubella antibodyNo\$78.19\$12.95\$225.56\$225.56Per Unit													
Laboratory & Pathology ServicesHospital OutpatientCPT86707Hepatitis be antibodyNo\$22.56\$10.41\$65.09\$65.09Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86708Hepatitis a antibodyNo\$22.71\$11.15\$56.71\$18.59Per UnitLaboratory & Pathology ServicesHospital OutpatientCPT86762Rubella antibodyNo\$78.19\$12.95\$225.56\$225.56Per Unit							<u>^</u>		<u> </u>		A 400.05		B 11 11
Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86706	HEP B SURFACE ANTIBODY	NO	\$	98.98	\$ 5	9.67	\$ 133.25	\$16.11	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86708 Hepatitis a antibody No \$ 22.71 \$ 11.15 \$ 56.71 \$18.59 Per Unit Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86707	Hepatitis be antibody	No	\$	22.56	\$ 10).41	\$ 65.09	\$65.09	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit													
Laboratory & Pathology Services Hospital Outpatient CPT 86762 Rubella antibody No \$ 78.19 \$ 12.95 \$ 225.56 \$225.56 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86708	Henatitis a antibody	No	s	22.71	\$ 11	1.15	\$ 56.71	\$18.59	Per Unit
	caser and y a ratio of y services			55700			Ÿ		<u> </u>		- 30.71	410.00	
	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86762	Rubella antibody	No	\$	78.19	\$ 12	2.95	\$ 225.56	\$225.56	Per Unit
Laboratory & Pathology Services Hospital Outpatient CPT 86765 Rubeola antibody No \$ 25.14 \$ 11.59 \$ 72.53 \$72.53 Per Unit	Laboratory & Pathology Services	Hospital Outpatient	СРТ	86765	Rubeola antibody	No	\$	25.14	\$ 11	L.59	\$ 72.53	\$72.53	Per Unit

									Amount We	
									Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86769	86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 51.48	\$ -	\$ 112.07	\$63.20	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86790	Virus antibody nos	No	\$ 25.14	\$ 11.59	\$ 76.53	\$19.32	Per Unit
				Blood Test - Hepatitis C Antibody						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86803	Level	No	\$ 67.64	\$ 12.84	\$ 91.06	\$21.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86804	Hep c ab test confirm	No	\$ 23.09	\$ 13.94	\$ 66.62	\$66.62	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86850	Rbc antibody screen	No	\$ 20.32	\$ 5.00	\$ 66.92	\$66.92	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86885	Coombs test indirect qual	No	\$ 244.72	\$ 5.65	\$ 329.43	\$194.11	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$147.48	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$147.48	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$45.2 2	Per Unit

		1	1							
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
									•	
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> Service?	Discounted Cash Price	De-Identified <u>Minimum</u> <u>Negotiated</u> Charge	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
<u>Scrite category</u>	<u>Service Setting</u>	Type	couc	Description	Jervicer	casirritec	charge	charge	charge	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$45.22	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$ 5.82	\$ 4.84	\$ 383.37	\$383.37	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86920	COMPATIBILITY TEST SPIN	No	\$ 244.72	\$ 13.44	\$ 344.22	\$194.11	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87040	Blood culture for bacteria	No	\$ 133.90	\$ 9.29	\$ 180.25	\$15.48	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87070	Bacterial Culture - Swab	No	\$ 138.63	\$ 7.76	\$ 186.61	\$12.93	Per Unit
					-					
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87077	Bacterial Culture - Aerobic Isolates	No	\$ 60.43	\$ 7.27	\$ 81.35	\$12.12	Per Unit
				Test for Disease-Causing (Pathogenic) Organisms, Not						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87081	Limited to a Specific Condition	No	\$ 81.17	\$ 5.97	\$ 109.26	\$9.95	Per Unit

			l						Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Uning Test - Restanial Culture						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87086	Urine Test - Bacterial Culture, Quantitative Colony Count	No	\$ 82.16	\$ 7.26	\$ 110.60	\$12.11	Per Unit
			0/000	Quantitative colony count	110	<i>y</i> 02.10	<i>y</i> 7.20	<i>y</i> 110.00	<i>JIZ.II</i>	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87088	Urine Test - Bacterial Culture	No	\$ 15.80	\$ 7.28	\$ 43.86	\$12.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87110	Chlamydia culture	No	\$ 130.74	\$ 17.64	\$ 175.99	\$29.40	Per Unit
				Evaluation of Antimicrobial Drug						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87186	(antibiotic, antifungal, antiviral)	No	\$ 69.16	\$ 7.79	\$ 93.10	\$12.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87205	Lab Test - Smear for Microorganism	No	\$ 49.93	\$ 3.84	\$ 67.21	\$6.41	Per Unit
	nospital outpatient	CF I	07203	Las rest - Smear for Microorgallistil	NU	y 43.33	y 3.04	÷ 07.21	90.41	
				Lab Test - Detection test for						
	Hospital Outpatient	СРТ	87340	Hepatitis B Surface Antigen	No	\$ 63.55	\$ 9.30	\$ 85.55	\$15.50	Per Unit
Laboratory & Pathology Services				1	1	1	1	1	1	1
Laboratory & Pathology Services										
Laboratory & Pathology Services I										
Laboratory & Pathology Services I				Lab Test - Detection test for HIV-1						

										Amount We	
										Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	ounted Price	De-Identified Minimum Negotiated Charge	<u>Ma</u> Ne	Identified aximum gotiated Charge	<u>Payer-</u> Specific <u>Negotiated</u> <u>Charge</u>	_Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87425	Rotavirus ag ia	No	\$ 37.44	\$ 10.78	\$	108.00	\$108.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87491	Urine Test - Chlamydia	No	\$ 108.43	\$ 31.58	\$	171.03	\$52.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87591	Urine Test - Gonorrhoeae (Neisseria Gonorrhoeae Bacteria)	No	\$ 90.13	\$ 31.58	\$	171.03	\$52.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87635	87635 - SARS-COV-2 COVID-19 AMP PRB	No	\$ 53.36	\$-	\$	136.48	\$76.97	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87798	Detect agent nos dna amp	No	\$ 90.13	\$ 31.58	\$	171.03	\$52.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87804	Lab Test - Detection test for Influenza Virus	No	\$ 37.58	\$ 19.82	\$	70.50	\$24.83	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87880	Strep Test (Streptococcus, group A)	No	\$ 101.56	\$ 19.87	\$	143.48	\$24.80	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	88185	Flowcytometry/tc add-on	No	\$ 68.81	\$ -	\$	120.30	\$30.11	Per Unit

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> Type	<u>Code</u>	Description	CMS Required Shoppable Service?	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Vaccinations	Physician Office	СРТ		Immunization Administration First Component	No	\$ 40.10	\$ 11.68	\$ 75.93	\$0.00	Per Unit
Vaccinations	Physician Office	СРТ		Immunization Administration Each Additional Component	No	\$ 25.13	\$ 10.49	\$ 38.51	\$0.00	Per Unit
Vaccinations	Hospital Outpatient	СРТ	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 81.80	\$81.80	Per Unit
Vaccinations	Hospital Outpatient	СРТ		Immunization Administration Each Additional Component	No	\$ 12.56	\$-	\$ 38.51	\$18.11	Per Unit
Vaccinations	Hospital Outpatient	СРТ	90651	9V HPV Vaccine 2/3 Dose	No	\$ 142.32	\$ 9.56	\$ 227.93	\$0.00	Per Unit
Vaccination	Hospital Outpatient	СРТ		Vaccine - Pneumococcal Conjugate for Injection into Muscle	No	\$ 285.59	\$ 9.56	\$ 345.21	\$345.21	Per Unit

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Type</u>	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	_Estimate Type
				Vaccine - Tetanus, Diptheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection						
Vaccination	Hospital Outpatient	СРТ	90715	into Muscle	No	\$ 57.74	\$ -	\$ 77.73	\$ 51.42	Per Unit
Evaluation & Management Services	Professional Services	СРТ	90791	Psychiatric Diagnostic Evaluation	No	\$ 308.81	\$ 118.93	\$ 198.74	\$186.32	Per Unit
Evaluation & Management Services	Professional Services	СРТ	90832	Psychotherapy - 30 Minutes	Yes	\$ 88.03	\$ 57.92	\$ 99.25	\$93.05	Per Unit
Evaluation & Management Services	Professional Services	СРТ	90834	Psychotherapy - 45 Minutes	Yes	\$ 116.77	\$ 77.37	\$ 132.34	\$124.07	Per Unit
Evaluation & Management Services	Professional Services	СРТ	90837	Psychotherapy - 60 Minutes	Yes	\$ 174.90 N/A No	\$ 116.00	\$ 198.22 N/A No	\$185.84 N/A No	Per Unit
Evaluation & Management Services	Professional Services	СРТ	90846	Family psytx w/o pt 50 min	Yes	Service Volume	\$-	Service Volume	Service Volume	Per Unit
Evaluation & Management Services	Desfessional Comisso	СРТ	00847	Psychotherapy - Family Session	Yes	\$ 146.15	\$ 97.13	\$ 166.18	\$155.79	Per Unit

[Amount We Estimate You	
											Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>		scounted sh Price	<u>Mi</u> Neg	dentified nimum otiated harge	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
							N/A No Service			N/A No Service	N/A No Service	
Evaluation & Management Services	Professional Services	СРТ	90853	Psychotherapy - Group Session	Yes		/olume	\$	-	Volume	Volume	Per Unit
Medicine Speech Therapy	Hospital Outpatient	СРТ	92507	SPEECH/HEARING THERAPY	No	\$	52.00	\$	17.40	\$ 251.43	\$115.46	Per Unit
Medicine Cardiovascular	Duefersional Comisso	CDT	02000	Electrocardiogram, routine, with	Vec	Ś	26.27	¢	28.12	Ś 95.52	622.84	Per Unit
	Professional Services	СРТ	93000	interpretation and report	Yes	\$	36.27	Ş	20.12	ş 55.52	\$23.84	Per Unit
Medicine Other	Hospital Outpatient	СРТ	93005	Electrocardiogram (ECG or EKG)	No	\$	142.29	\$	-	\$ 295.26	\$74.41	Per Unit
Medicine Cardiac Stress Test	Hospital Outpatient	СРТ	93017	CARDIOVASCULAR STRESS TEST	No	\$	471.40	\$	61.00	\$ 634.57	\$342.37	Per Unit
Medicine Other	Hospital Outpatient	СРТ	93306	Tte w/doppler complete	No	\$	1,404.83	\$	322.26	\$ 1,593.05	\$651.43	Per Unit
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	93452	Insertion of catheter into left heart for diagnosis	Yes	\$	8,847.45	\$	579.93	\$ 12,920.92	\$3,855.11	Case Rate
Medicine Other	Hospital Outpatient	СРТ	93971	Extremity study	No	\$	240.64	\$	92.64	\$ 400.67	\$151.61	Per Unit

		1			1		1			
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"									$\overline{}$	
+ F										
									-	
					<u>CMS</u>		De-Identified		Payer-	
					Required		Minimum	Maximum	Specific	
		<u>Code</u>			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	Charge_	Charge	Charge_	Estimate Type
Medicine Other	Hospital Outpatient	CPT	95044	Allergy patch tests	No	\$ 189.82		\$ 1,229.53	\$1,229.53	Per Unit
						N/A No	N/A No	N/A No	N/A No	
Medicine Neurology and						Service	Service	Service	Service	
Neuromuscular	Hospital Outpatient	СРТ	95810	Sleep study	Yes	Volume	Volume	Volume	Volume	Per Unit
Injections	Hospital Outpatient	СРТ	96402	Chemo hormon antineopl sq/im	No	\$ 110.26	\$ 66.86	\$ 196.20	\$81.80	Case Rate
						-	-	-		
				Dhurical Theremy Manual						
Restation Disector Lagradiation and				Physical Therapy - Manual						
Medicine Physical Medicine and				Electrical Stimulation Therapy, 15		A A A A A	÷	÷	404 F0	
Rehabilitation	Hospital Outpatient	СРТ	97032	minutes	No	\$ 31.26	\$ 12.56	\$ 59.90	\$21.59	Per Unit
Medicine Physical Medicine and				Physical Therapy - Ultrasound						
Rehabilitation	Hospital Outpatient	CPT	97035	Therapy	No	\$ 26.92	\$ 11.95	\$ 40.29	\$20.87	Per Unit
Medicine Physical Medicine and				Physical Therapy - Therapeutic						
Rehabilitation	Hospital Outpatient	СРТ	97110	Exercises	Yes	\$ 88.74	\$ 17.40	\$ 119.46	\$44.34	Per Unit
Medicine Physical Medicine and				Physical Therapy - Neuromuscular						
Rehabilitation	Hospital Outpatient	СРТ	97112	Reeducation	No	\$ 69.93	\$ 26.14	\$ 104.78	\$50.93	Per Unit
			5.112			÷ 05.55	+ 20.14	+ 104.70		. cr onit
Medicine Physical Medicine and										
Rehabilitation	Hospital Outpatient	СРТ	97116	GAIT TRAINING THERAPY	No	\$ 77.61	\$ 22.90	\$ 104.48	\$43.85	Per Unit
Renabilitation	nospital outpatient	GF I	21110	GALL TRAINING THERAPT	INU	y 77.01	y 22.30	Y 104.40	2-3-03	i ci unit

		1		1			-		1	A	
										Amount	
										Estimate Will Ow	
							+			VIIIOW	
To Search for a service Click "CTRL"											-
+ "F"											
										· · · ·	
					CMS		De	e-Identified	De-Ident	tified Payer	:
					Required		Ν	<u> Vinimum</u>	Maxim	um Specifi	<u>c</u>
		Code			Shoppable	Discounted	N	egotiated	Negotia	ted <u>Negotiat</u>	<u>ed</u>
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price		Charge	Charg	<u>e</u> Charge	Estimate Type
Medicine Physical Medicine and											
Rehabilitation	Hospital Outpatient	СРТ	97140	Physical Therapy - Manual Therapy	No	\$ 56.2	0\$	23.73	\$ 9	93.92 \$40.83	Per Unit
Medicine Physical Medicine and				Physical Therapy - Low Complexity							
Rehabilitation	Hospital Outpatient	СРТ	97161	Evaluation	No	\$ 168.0	6 Ş	71.97	Ş 25	52.78 \$123.6	5 Per Unit
Restation Disector Lagradiation and				Discolution Theorem . Bits down to							
Medicine Physical Medicine and Rehabilitation	Upperitel Outpetient	СРТ	97162	Physical Therapy - Moderate Complexity Evaluation	Ne	\$ 62.4		71.97	\$ 25	52.78 \$123.6	5 Per Unit
Reliabilitation	Hospital Outpatient	CPT	97102		No	\$ 02.4	U Ş	/1.9/	ş 2:	52.76 3123.0	5 Per Unit
Medicine Physical Medicine and				Physical Therapy - High Complexity							
Rehabilitation	Hospital Outpatient	СРТ	97163	Evaluation	No	\$ 168.0	6 4	71.97	\$ 21	52.78 \$123.6	5 Per Unit
Rendomitation		GET	57103		NU	ý 100.0	v v	/1.5/	φ Z:	, <u>2.70</u> 3123.0	
Medicine Physical Medicine and											
Rehabilitation	Hospital Outpatient	СРТ	97164	Physical Therapy - Re-Evaluation	No	\$ 113.3	4 5	48.67	Ś 13	70.97 \$84.65	Per Unit
							- F	10107			
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$ 180.8	8 Ś	77.05	\$ 24	\$130.9	2 Per Unit
			5						- -	4-3013	

												Amount We	
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL" + "F"													
					CMS			De-Ide	ntified	De	-Identified	Payer-	
					Required			Minir			laximum	Specific	
		Code			Shoppable	Disc	counted	Negot	iated	Ne	egotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cas	h Price	Cha	rge		Charge	Charge	Estimate Type
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97166	OT EVAL MOD COMPLEX 45 MIN	No	\$	62.40	\$	72.00	\$	245.32	\$130.44	Per Unit
Medicine Dhysical Medicine and				Dhusical Theremy, Theremoutic									
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	СРТ	97530	Physical Therapy - Therapeutic Activities	No	Ś	92.45	Ś	17.40	Ś	124.45	\$56.42	Per Unit
						+		¥		Ŧ			
Medicine Physical Medicine and				Physical Therapy - Self-care or									
Rehabilitation	Hospital Outpatient	СРТ	97535	Home Management Training	No	\$	68.89	\$	-	\$	109.03	\$49.19	Per Unit
Evolution & Management Complete	Drofossional Comisso	СРТ	00034	Dester fellow we visit	Ne	Ś		~		Ś	14.27	\$0.00	Deviluit
Evaluation & Management Services	Professional Services	CPT	99024	Postop follow-up visit	No	>	-	\$	-	Ş	14.27	\$0.00	Per Unit
												Ame	
Evaluation & Management Services	Protessional Services	СРТ	99202	Office Visit - New Patient, Minor	No	\$	167.93	Ş	90.34	Ş	200.08	\$72.74	Per Unit
Fundantian & Management Commission	Drofossional Convisos	CDT	00202	Office Visit - New Patient, Low	Vec	~	192.00		22.54		272.00	¢100.10	Deviluit
Evaluation & Management Services	Protessional Services	СРТ	99203	Complexity	Yes	\$	182.06	> 1	132.54	Ş -	273.99	\$109.10	Per Unit

								1	1	
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CNAS		De Identified	Do Identified	Devier	
					<u>CMS</u>		De-Identified		Payer-	
					Required		<u>Minimum</u>	Maximum	Specific	
		<u>Code</u>			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Office Visit - New Patient,						
Evaluation & Management Services	Professional Services	СРТ	99204	Moderate Complexity	Yes	\$ 250.6	9 \$ 177.01	\$ 432.49	\$186.66	Per Unit
				New patient office of other						
Evaluation & Management Services	Professional Services	СРТ	99205	outpatient visit, typically 60 min	Yes	\$ 448.0	4 \$ 156.38	\$ 553.76	\$243.90	Per Unit
Erandation & management berries			33203	outputtent visit, typicany oo min	105	Ç	· · ·	<i>v</i> 333.70	<i>Q</i> 240100	
Evaluation & Management Services	Professional Services	СРТ	99212	Office Visit - Basic	No	\$ 58.7	4 \$ 46.41	\$ 133.24	\$37.08	Per Unit
				Office Visit - Established Patient,				1.		
Evaluation & Management Services	Professional Services	СРТ	99213	Low Complexity	No	\$ 99.6	7 \$ 81.71	\$ 201.59	\$74.15	Per Unit
				Office Visit - Established Patient,						
Evaluation & Management Services	Professional Services	СРТ	99214	Moderate Complexity	No	\$ 151.1	9 \$ 140.90	\$ 279.47	\$114.35	Per Unit

			1			1				Amount We	
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL"											
+ "F"											
+ r											
					<u>CMS</u>			De-Identified			
					Required			<u>Minimum</u>	<u>Maximum</u>	Specific	
		Code			Shoppable		ounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cas	h Price	Charge	Charge	Charge	Estimate Type
				Office Visit - Established Patient,							
Evaluation & Management Services	Professional Services	СРТ	00215	High Complexity	No	Ś	315.87	\$ 192.33	\$ 385.34	\$161.58	Per Unit
Evaluation & Management Services	Professional Services	CFT	33213	nigh complexity	NO	\$	515.07	\$ 152.55	ə 565.54	\$101.56	Per Unit
Professional Services Associated											
with Inpatient Stay	Professional Services	СРТ	99232	Subsequent hospital care	No	\$	159.88	\$ 50.60	\$ 111.92	\$104.93	Per Unit
				Patient office consultation,							
Evaluation & Management Services	Professional Services	СРТ	99243	typically 40 min	Yes	Ś	212.43	\$-	\$ 142.18		Per Unit
						· ·		· ·	•	-	
				Patient office consultation,							
Evaluation & Management Services	Professional Services	СРТ	99244	typically 60 min	Yes	\$	338.80	Ş-	\$ 226.38	8	Per Unit
				Emergency Department Visit -							
Emergency Room Visit	Hospital Outpatient	СРТ	99281	Minor (outpatient)	No	Ś	230.81	\$ 74.98	\$ 689.88	\$95.66	Case Rate
Entergency noon visit	noopital outputient	<u>.</u>	55201	minor (outputient)	itto	Y	200.01	y 17.30	y 000.00		case nate

	1					1				
									Amount We Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					C1 4C		De Island Gest	De Island Gerd	Deven	
					<u>CMS</u> Required		De-Identified Minimum	De-Identified Maximum	Payer- Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
	_									
Freezen av De erre Misit	Upperited Outpetient	CDT		Emergency Department Visit - Low	No	\$ 430.38	ć 02.52	ć 1 114 22	6228 70	Core Data
Emergency Room Visit	Hospital Outpatient	СРТ	99282	Complexity (outpatient)	No	\$ 430.38	\$ 93.52	\$ 1,114.22	\$238.70	Case Rate
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	СРТ	99283	Moderate Complexity (outpatient)	No	\$ 932.99	\$ 182.62	\$ 2,714.83	\$338.87	Case Rate
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	СРТ		Higher Complexity (outpatient)	No	\$ 2,400.69	\$ 270.43	\$ 4,475.48	\$475.86	Case Rate
	• • •				-					
				Emergency Department Visit - High						
Emergency Room Visit	Hospital Outpatient	СРТ	99285	Complexity (outpatient)	No	\$ 3,149.91	\$ 458.20	\$ 5,806.95	\$1,667.37	Case Rate

i		1								1
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	СРТ	99291	Critical Care (outpatient)	No	\$ 17,860.61	\$ 425.50	\$ 6,308.07	\$2,262.95	Case Rate
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient,						
Evaluation & Management Services	Professional Services	СРТ		Younger than 1 Year Old	No	\$ 156.75	s -	\$ 225.38	\$0.00	Per Unit
						- 100.75	Ŧ	- 220.00	+0.00	
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 1-						
Evaluation & Management Convices	Professional Convises	CDT		4 Years Old	No	\$ 163.82	é	\$ 236.91	¢0.00	Per Unit
Evaluation & Management Services	Professional Services	CPT	33397	4 Tears UID	No	\$ 163.82	\$ -	\$ 236.91	\$0.00	PerUnit

							Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"								
Service Category Service Se	Code tting Type	Description	CMS Required Shoppable Service?	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> Charge	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	_Estimate Type
Evaluation & Management Services Professional Service	25 CPT	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 5- 11 Years Old	Νο	\$ 170.96	Ś-	\$ 413.46	\$0.00	Per Unit
				+	•	·		
		Office Visit - Comprehensive						
Evaluation & Management Services Professional Service	es CPT	Preventive Medicine Evaluation and Management, New Patient, 12- 17 Years Old	Νο	\$ 193.58	\$-	\$ 280.75	\$0.00	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		De-Identified		Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	<u>Type</u>	<u>Code</u>	Description	Service?	Cash Price	Charge_	Charge_	Charge_	Estimate Type
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 18-						
Evaluation & Management Services	Protessional Services	СРТ	99385	39 Years Old	Yes	\$ 187.80	\$ 59.23	\$ 347.60	\$102.98	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 40-						
Evaluation & Management Services	Professional Services	СРТ	99386	64 Years Old	Yes	\$ 217.32	\$ 91.72	\$ 1,293.56	\$137.58	Per Unit

					-				Amount We	I
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified		Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	Specific	
		<u>Code</u>			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	<u>Type</u>	<u>Code</u>	Description	Service?	Cash Price	Charge	Charge_	Charge_	Estimate Type
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
				and Management, Younger than 1						
Evaluation & Management Services	Professional Services	СРТ	99391	Year Old	No	\$ 141.19	ş -	\$ 267.83	\$0.00	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
Evaluation & Management Services	Professional Services	CPT	99392	and Management, 1-4 Years Old	No	\$ 150.93	\$ -	\$ 305.91	\$0.00	Per Unit

		1								
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		<u>Minimum</u>	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
Evaluation & Management Services	Professional Services	СРТ	99393	and Management, 5-11 Years Old	No	\$ 150.44	\$ -	\$ 305.91	\$0.00	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
Evaluation & Management Services	Professional Services	СРТ	99394	and Management, 12-17 Years Old	No	\$ 165.14	\$ -	\$ 398.57	\$0.00	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
Evaluation & Management Services	Professional Services	СРТ	99395	and Management, 18-39 Years Old	No	\$ 168.81	\$ 37.07	\$ 304.60	\$55.61	Per Unit
					-				1.2.2.2	

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"	,									
Service Category	Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> <u>Service?</u>	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> <u>Charge</u>	<u>De-Identified</u> <u>Maximum</u> <u>Negotiated</u> <u>Charge</u>	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	_Estimate Type
Evaluation & Management Service	s Professional Services	СРТ	99396	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 40-64 Years Old	Νο	\$ 180.12	\$ 64.57	\$ 429.79	\$96.86	Per Unit
			55550			Ş 100.12	, 04.37	÷ 425.75	<i>\$</i> 30.80	
Exablate	Hospital Outpatient	СРТ	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	\$ 11,272.90	\$16,909.35	Case Rate
Vaccinations	Hospital Outpatient	СРТ	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$-	\$ 126.95	\$51.56	Per Unit
Vaccinations	Hospital Outpatient	СРТ	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$-	\$ -	\$51.56	Per Unit
Medicine Hyberbaric	Hospital Outpatient	СРТ	G0277	Hbot, full body chamber, 30m	No	\$ 773.99	\$ 46.24	\$ 1,424.46	\$185.57	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	СРТ	G0378	Hospital observation per hr	No	\$ 15,685.71	\$ 605.00	\$ 24,131.86	\$3,250.88	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Evaluation & Management Services	Hospital Outpatient	СРТ	G0463	Hospital outpt clinic visit	No	\$ 130.00	\$ 74.02	\$ 200.00	\$156.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	G0480	Drug test def 1-7 classes	No	\$ 476.03	\$-	\$ 732.35	\$171.65	Per Unit
Injections	Hospital Outpatient	HCPCS	J1071	Inj testosterone cypionate	No	\$ 0.22	\$ 0.03	\$ 0.34	\$0.05	Per Unit
						A A A	A A TA	A A A A	<u> </u>	
Injections	Hospital Outpatient	HCPCS	J1815	Insulin injection	No	\$ 2.13	\$ 0.78	\$ 3.27	\$1.31	Per Unit
Injections	Hospital Outpatient	HCPCS	J7325	Synvisc or synvisc-one	Νο	\$ 26.95	s -	\$ 89.11	\$15.33	Per Unit
injections		IICF C3	37323	Synvise of Synvise-one	NU	÷ 20.95		<i>Ş</i> 03.11	313.33	rei Ullit
Injections	Hospital Outpatient	СРТ	J9217	Eligard	No	\$ 2,818.54	\$-	\$ 4,336.21	\$336.68	Per Unit