		<u> </u>								1
<u>Centurion</u>	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	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> Specific Negotiated Charge	<u>_Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	216	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	291	HEART FAILURE SHOCK W MCC	No	\$ 13,710.15	\$ 5,517.78	\$ 31,074.55		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	\$58,673.75	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%.

r									A	<b>1</b>
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
т г 										
					CMS		Do Identified	De-Identified	Payer-	
					Required					
		Conto				Discountered	<u>Minimum</u> Negotiated	<u>Maximum</u> Negotiated	Specific	
Convice Cotogony	Comvine Cotting	Code	Code	Description	Shoppable	Discounted			Negotiated	Estimate Turns
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	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		or complications (MCC).	Yes	\$ 26,747.32	\$ 8,070.44	\$ 37,721.88	\$35,151.25	CPT/HCPCS
										Case Rate-
				Compiled an inclusion with cut						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	Ş 10,123.74	\$ 62,430.00	\$62,430.00	CPT/HCPCS

								1	Auto auto 14/-	<b>1</b>
									Amount We Estimate You	
									Will Owe *	
									Villowe	
To Search for a service Click "CTRL"										
+ "F"										
								5 11 VC 1		
					<u>CMS</u>		De-Identified		Payer-	
		Code			Required	Discounted	<u>Minimum</u>	Maximum	Specific	
Service Category	Service Setting	Code Type	Code	Description	Shoppable Service?	Discounted Cash Price	Negotiated Charge	Negotiated Charge	Negotiated Charge	Estimate Type
Service Category	<u>Service Setting</u>	<u>Type</u>	coue	Description	<u>Jervice:</u>	Casir 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	\$28,963.75	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				HIP FEMUR PROCEDURES EXCEPT						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	481	MAJOR JOINT W CC	No	\$ 48,507.14	\$ 8,559.98	\$ 38,996.68	\$22,277.50	CPT/HCPCS
										Core Data
										Case Rate- Excluding
										Professional
										Charges which
				HIP FEMUR PROCEDURES EXCEPT						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG		MAJOR JOINT W/O CC/MCC	No	\$ 35,733.50	\$ 6,745.73	\$ 37,731.25	\$37,731.25	CPT/HCPCS
						,,	,		<i></i>	,
										Case Rate-
										Excluding
										Professional
										Charges which
				LOWER EXTREM HUMER PROC						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	493	EXCEPT HIP, FOOT, FEMUR W CC	No	\$ 46,392.83	\$ 9,438.20	\$ 41,283.64	\$15,737.50	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	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> 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	No	\$ 34,304.81	\$ 7,426.74	\$ 43,066.25	\$43,066.25	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	\$14,356.25	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	¢ 22 221 02	¢ 4 355 03	\$ 31,015.82	\$16,753.75	CPT/HCPCS

<b></b>		1							Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMC		Do Identified	Do Identified	Deview	
					<u>CMS</u>			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
				RED BLOOD CELL DISORDERS W/O						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	812	MCC	No	\$ 17,544.11	\$ 2,955.18	\$ 26,002.03	\$10,883.75	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				FULL THICKNESS BURN W SKIN						are paid 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	\$150,000.00	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				FULL THICKNESS BURN W SKIN						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	929	GRAFT OR INHAL INJ W/O CC/MCC	No	\$ 38,084.70	\$ 6540.49	\$ 50,000.00	\$50,000.00	CPT/HCPCS
nospital inpatient stay		DRG	323		NU		Ş 0,340.49	\$ 50,000.00	\$30,000.00	
										Casa Pata
										Case Rate-
										Excluding
										Professional
										Charges which
										are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	935	NON-EXTENSIVE BURNS	No	ş 18,159. <b>73</b>	\$ 3,301.83	\$ 50,000.00	\$50,000.00	CPT/HCPCS

		1	1						Amount Mo	
									Amount We Estimate You	
									Will Owe *	
									Will Owe	
To Search for a service Click "CTRL"										
+ "F"										
									Ť	
					CMS		De-Identified	De-Identified	Payer-	
					<b>Required</b>		<u>Minimum</u>	<u>Maximum</u>	Specific	
		<u>Code</u>			<b>Shoppable</b>	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	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	\$200,000.00	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 мсс	No	\$ 139,128.72	\$ 30,888.17	\$ 200,000.00	\$200,000.00	CPT/HCPCS
										Casa Bata
										Case Rate-
										Excluding Professional
				OTHER O.R. PROCEDURES FOR						Charges which
				MULTIPLE SIGNIFICANT TRAUMA						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	958	W CC	No	\$ 73 933 71	\$ 17 182 69	\$ 125,000.00	\$125,000.00	CPT/HCPCS
noopital inpatient Stay		Dirig	550		110	<i>ų 13,333.</i> /1	÷ 17,102.03	÷ 120,000.00	9123,000.00	
										Case Rate-
										Excluding
										Professional
										Charges which
		1	1		1	1	1	1		
				OTHER MULTIPLE SIGNIFICANT						are paid by

						1	1			
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	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	\$12,593.75	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	\$26,810.00	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG		STERILIZATION W CC	No	\$ 9,940.40	\$ 3,570.00	\$ 27,865.12	\$13,065.00	CPT/HCPCS
	nospital inputient	Dirig	704		110	\$ 5,540.40	\$ 3,570.00	<i>Ş</i> 27,003.12	<i>\$13,003.00</i>	
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG		STERILIZATION W/O CC/MCC	No	\$ 8,988.27	\$ 3,519.44	\$ 25,870.71	\$10,730.00	CPT/HCPCS
	• •									
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W/O						are paid by
				STERILIZATION W MCC	1	1		\$ 35,011.06		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 <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
Maternity/Delivery	Hospital Inpatient	DRG	787	CESAREAN SECTION W/O STERILIZATION W CC	No	\$ 11,322.59	\$ 2,835.00	\$ 27,868.32	\$13,068.75	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	\$11,327.50	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	\$2,341.25	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	\$10,785.00	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	\$10,785.00	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 Charge	<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		VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	No	\$ 10,518.03	\$ 2,464.00	\$ 27,817.08	\$13,008.75	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG		VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	No	\$ 8,616.42	\$ 2,464.00	\$ 24,277.74	\$8,865.00	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery		DRG		VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	No	\$ 7,318.91	\$ 2,464.00	\$ 23,397.98	\$7,835.00	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

		<u> </u>							Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
+ F										
					CMS		De-Identified	<b>De-Identified</b>	Payer-	
					Required		Minimum	Maximum	Specific	
		<u>Code</u>			Shoppable	Discounted	Negotiated	<b>Negotiated</b>	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
						52% Charges				
Inpatient Rehabilitation Hospital				Inpatient Rehabilitation Hospital		Estimated at \$2,341.96 Per				Per Diem Per
	Inpatient Rehabilitation Hospital			Room & Board	No	52,541.96 Per			Non-Par	Day
Stay	inpatient Kenabintation Hospital	OB	110	Room & Board	NU	Diem			Non-Fai	Day
										Case Rate-
										Excluding
										Professional
				AFTERCARE, MUSCULOSKELETAL						Charges which
				SYSTEM AND CONNECTIVE TISSUE						are paid by
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	559	<b>WITH MCC</b>	No	N/A	\$ 18,018.00	\$ 18,018.00	N/A	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
				AFTERCARE, MUSCULOSKELETAL						Charges which
				SYSTEM & CONNECTIVE TISSUE W						are paid by

			1			1				1
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	De-Identified	Payer-	
					<b>Required</b>		Minimum	<u>Maximum</u>	Specific	
		Code			Shoppable	Discounted	<b>Negotiated</b>	<b>Negotiated</b>	<b>Negotiated</b>	
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
										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		No	N/A	\$ 74,931.49	\$ 74,931.49	Non-Par	CPT/HCPCS
Stay	Tiospital	Dirig	LICIOS	lanare	110	17.6	<i>Ş</i> 74,551.45	<i>y</i> 74,551.45	Non-Fui	
										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	Non-Par	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		Per Diem Per
Stay	Hospital	UB	200	Room & Board	No	diem)	Diem	Diem	Non-Par	Day
						E20/ Channes				
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &		1	1		1	\$1,109.30 Per			1	Per Diem Per
Board	Inpatient Skilled Nursing	UB	191	Subacute Care Level 1- Skilled Care	No	Diem	\$ 227.70	\$ 850.00	Non-Par	Day

r									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
+ F										
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	Payer-	
					Required		Minimum	Maximum	Specific	
		<u>Code</u>			<b>Shoppable</b>	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	<b>Charge</b>	Charge	Charge	Estimate Type
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &				Subacute Care Level 2-		\$1,109.30 Per				Per Diem Per
Board	Inpatient Skilled Nursing	UB	192	Comprehensive Care	No	Diem	\$ 299.70	\$ 850.00	Non-Par	Day
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &				Subacute Care Level 3- Complex		\$1,109.30 Per				Per Diem Per
Board	Inpatient Skilled Nursing	UB	193	Care	No	Diem	\$ 370.00	\$ 850.00	Non-Par	Day
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 530.90	\$ 161.58	\$ 1,803.41	\$201.95	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11104	Biopsy - Punch Biopsy of Skin	No	\$ 584.92	\$ 167.15	\$ 1,829.27	\$217.25	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	17000	Destruction of Lesion (outpatient)	No	\$ 1,131.70	\$ 157.92	\$ 1,634.10	\$223.35	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	19083	Bx breast 1st lesion us imag	No	\$ 3,052.42	\$ 381.25	\$ 2,964.36	\$1,361.48	Case Rate
						N/A No			N/A No	
				Removal of 1 or more breast		Service			Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	191 <b>20</b>	growth, open procedure	Yes	Volume	\$-	\$-	Volume	Case Rate

r		1	1			1	1			I
									Amount We	
									Estimate You	
									Will Owe *	
To Soarch for a convice Click "CTPI"										
To Search for a service Click "CTRL" + "F"										
+ "+"										
					<u>CMS</u>		De-Identified		Payer-	
					<b>Required</b>		<u>Minimum</u>	<u>Maximum</u>	Specific	
		<u>Code</u>			Shoppable	Discounted	<b>Negotiated</b>	<b>Negotiated</b>	<b>Negotiated</b>	
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	\$282.84	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	27818	Treatment of ankle fracture	No	\$ 1,243.48	\$ 395.00	\$ 2,581.00	\$1,759.00	Case Rate
	· · · · · · · · · · · · · · · · · · ·					<i> </i>	,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,_,	
						N/A No			N/A No	
						Service			Service	
Hospital Outpatient Precedure	Hospital Outpatient	СРТ	20926	Arthroscopic Shouldor Surgery	Voc	Volume	\$ -	ć	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	29020	Arthroscopic Shoulder Surgery	Yes	volume	<b>ə</b> -	\$-	volume	Case hate
						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	\$228.37	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	32555	Aspirate pleura w/ imaging	No	\$ 608.39	\$ 288.54	\$ 1,852.06	\$687.76	Case Rate
							-		-	
						N/A No			N/A No	
				Tonsillectomy with Adenoidectomy		Service			Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	42820	(outpatient)	Yes	Volume	\$ -	\$-	Volume	Case Rate
		GET	72020	loupatient	103	volume	Ý -	Ý -	volume	case nate
				Upper Gastrointestinal Endoscopy -						
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43235	Diagnostic	Yes	\$ 2,027.21	\$ 61.00	\$ 1,867.74	\$827.84	Case Rate

												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?		scounted	Mi Neg	dentified nimum cotiated harge	N	-Identified <u>Iaximum</u> egotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
									<u>~~0*</u>				
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	43239	Upper Gastrointestinal Endoscopy - With Biopsy	Yes	\$	1,259.34	\$	372.00	\$	2,229.48	\$852.48	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45378	Colonoscopy - Diagnostic (outpatient)	Yes	\$	2,117.86	Ś	335.79	\$	2,220.88	\$907.28	Case Rate
		-					,						
				Colonoscopy - With Biopsy									
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45380	(outpatient)	Yes	\$	3,082.66	Ş	343.06	\$	4,110.45	\$1,126.93	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45385	Colonoscopy - With Polyp Removal (outpatient)	Yes	s	3,317.89	s	354.50	Ś	4,434.15	\$1,211.26	Case Rate
							N/A No					N/A No	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	45201	Ultrasound examination of lower	Voc		Service /olume	Ś	_	Ś		Service	Case Pate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	42221	large bowel using an endoscope	Yes		oiume	Ş	-	Ş	-	Volume	Case Rate

									Amount We	[]
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
					<b>C</b> 145		De Identified	De Island fied	Davias	
					<u>CMS</u> Required		De-Identified Minimum	De-Identified Maximum	Payer- 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
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	17562	Gall Bladder Surgery (outpatient)	Yes	\$ 12,062.52	\$ 504.75	\$ 18,374.88	\$4,923.34	Case Rate
nospital outpatient notedure			47502	dan bladder Surgery (Surpatient)	103	<i>y</i> 12,002.52	<i>y 304.73</i>	y 10,374.00	<i>94,523.34</i>	case nate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	49440	Place gastrostomy tube perc	No	\$ 3,111.60	\$ 445.12	\$ 3,166.61	\$1,586.25	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		Repair of groin hernia patient age 5 years or older	Yes	\$ 9,867.85	\$ 470.98	\$ 15,040.03	\$3,314.33	Case Rate
nospital outpatient notedure			45505	years of older	103	<i>y 3,007.03</i>	Ş 470.50	y 13,040.03	<i>93,314.33</i>	case nate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	51798	Urine Capacity Measurement	No	\$ 97.04	\$ -	\$ 1,579.20	\$59.45	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	52000	Custoscomu	No	\$ 1,173.22	\$ 282.78	\$ 1,596.52	\$577.43	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient		52000	Cystoscopy	INU	\$ 1,173.22	y 202.78	\$ 1,596.52	<i>əə11.</i> 43	Case nale
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	55700	Biopsy of prostate gland	Yes	\$ 1,165.04	\$ 284.76	\$ 2,631.84	\$1,641.69	Case Rate
				Surgical removal of prostate and		N/A No	N/A No	N/A No	N/A No	
				surrounding lymph nodes using an		Service	Service	Service	Service	
Hospital Outpatient Procedure	Hospital Outpatient	CPT	55866	endoscope	Yes	Volume	Volume	Volume	Volume	Case Rate

		-											
												Amount We	
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL"													
+ "F"													
, ,													
					CMS			Do-I	dentified	De	-Identified	Payer-	
					Required				nimum		1aximum	Specific	
		Code			Shoppable	Di	scounted		otiated		egotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	_	ash Price		harge		Charge	Charge	Estimate Type
		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									0.10.80	0110180	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	58100	Biopsy - Endometrial (Uterus)	No	\$	375.83	Ś	144.00	Ś	1,697.39	\$234.05	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	58300	Insert intrauterine device	No	\$	632.24	\$	48.93	\$	1,749.37	\$13.52	Case Rate
								-					
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	58301	Remove intrauterine device	No	\$	273.85	\$	32.34	\$	1,495.58	\$324.02	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	59025	Fetal Non-Stress Test	No	\$	260.79	\$	118.53	\$	1,596.22	\$178.96	Case Rate
				Routine obstetric care for vaginal									
Professional Services Associated				delivery, including pre-and post-									
with Inpatient Stay	Professional Services	СРТ	59400	delivery care	Yes	\$	4,496.21	\$	242.00	\$	3,278.48	\$3,196.13	Case Rate
Professional Services Associated						Ι.		Ι.		Ι.			
with Inpatient Stay	Professional Services	СРТ	59410	Obstetrical care	No	\$	2,230.06	\$	133.91	\$	1,625.81	\$1,574.96	Case Rate
				Routine obstetric care for cesarean									
Professional Services Associated	Professional Con 1	COT	FORAC	delivery, including pre-and post-	V.		4.000 50		246.25		2 642 45	63 F33 33	Core Dat
with Inpatient Stay	Professional Services	CPT	59510	delivery care	Yes	\$	4,966.56	\$	246.05	<u>ې</u>	3,619.13	\$3,528.30	Case Rate

	1							-		
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	Payer-	
					Required		Minimum	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
<u>Scrite category</u>	<u>Service Setting</u>	турс	couc	Description	Scruce.	casirritec	charge	charge	charge	Estimate Type
				Routine obstetric care for vaginal						
				delivery after prior cesarean						
Professional Services Associated				delivery including pre-and post-						
with Inpatient Stay	Professional Services	СРТ	59610	delivery care	Yes	\$ 4,706.58	\$ 305.08	\$ 3,429.34	\$3,344.99	Case Rate
				Injection of substance into spinal						
				canal of lower back or sacrum using						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	62322	imaging guidance	Yes	\$ 1,055.18	\$ 379.33	\$ 1,880.39	\$639 <b>.0</b> 3	Case Rate
				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	\$662.12	Case Rate
			02020	0.1.0 0.1.001100	103	,000.00	+ 505.01	- 1,000.33	4002.12	case mate

									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
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	Yes	\$ 1,776.21	\$ 358.46	\$ 1,980.49	\$832.61	Case Rate
			04405	Buttance	103	<i>y</i> 1,770.21	÷ 330.40	÷ 1,500.45	<u> </u>	
				Removal of recurring cataract in		N/A No Service			N/A No Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ		lens capsule using laser	Yes	Volume	\$ -	\$-	Volume	Case Rate
						N/A No			N/A No	
	Usersited Output	CDT		Removal of cataract with insertion	Χ.	Service	<u>,</u>	<u>,</u>	Service	Care Dat
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	66984	of lens	Yes	Volume	\$-	\$-	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	69210	Remove impacted ear wax	No	\$ 168.99	\$ 48.93	\$ 1,604.78	\$95.98	Case Rate
				CT Scan - Head/Brain, without						
Radiology Services	Hospital Outpatient	СРТ		Contrast	No	\$ 901.06	\$ 127.22	\$ 1,318.18	\$157.58	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	<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
Radiology Services	Hospital Outpatient	СРТ	70450	CT Scan - Head/Brain, without Contrast	Yes	\$ 901.06	\$ 127.22	\$ 1,318.18	\$157.58	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70482	Ct orbit/ear/fossa w/o&w/dye	No	\$ 2,339.66	\$ 207.79	\$ 2,657.02	\$246.82	Per Unit
Radiology Services	Hospital Outpatient	СРТ		Ct maxillofacial w/o dye	No	\$ 1,668.57	\$ 127.52	\$ 2,259.85	\$158.09	Per Unit
hadology services			70400		110	÷ 1,000.57	<i>y</i> 127.52	\$ 2,235.05	\$150.05	T CT Offic
Radiology Services	Hospital Outpatient	СРТ	70496	Ct angiography head	No	\$ 1,871.05	\$ 223.05	\$ 1,996.31	\$284.74	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70498	Ct angiography neck	No	\$ 1,632.72	\$ 223.05	\$ 1,677.63	\$284.74	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70551	MRI BRAIN STEM W/O DYE	No	\$ 1,518.19	\$ 252.20	\$ 2,270.30	\$305.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70553	MRI - Brain (outpatient)	Yes	\$ 2,314.59	\$ 406.50	\$ 3,409.54	\$489.41	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71045	X-ray exam chest 1 view	No	\$ 138.11	\$ 19.91	\$ 181.37	\$79.10	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71046	X-Ray - Chest (outpatient)	Νο	\$ 148.99	\$ 31.50	\$ 193.55	\$81.92	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> Neg	dentified inimum gotiated charge	N	e-Identified Maximum legotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	71110	X-ray exam ribs bil 3 views	No	\$	205.20	\$	38.07	\$	271.73	\$114.22	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71250	CT THORAX W/O DYE	No	\$	1,024.52	\$	141.11	\$	1,468.48	\$181.69	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$	1,448.52	\$	200.76	\$	2,034.88	\$245.60	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71275	Ct angiography chest	No	\$	1,935.65	\$	226.19	\$	2,092.27	\$290.34	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72040	X-Ray - Neck, Cervical Spine	No	\$	154.65	Ş	37.93	\$	204.42	\$82.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72070	X-Ray - Middle Back, Thoracic Spine	No	\$	251.61	\$	33.93	\$	338.99	\$106.95	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72100	X-Ray - Spine (outpatient)	No	\$	199.60	\$	37.93	\$	265.13	\$108.63	Per Unit
				X-Ray, lower back, minimum four									
Radiology Services	Hospital Outpatient	СРТ	72110		Yes	\$	213.64	\$	52.80	\$	284.93	\$111.45	Per Unit

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	<u>Code</u> <u>Туре</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 Typ
Radiology Services	Hospital Outpatient	СРТ	72125	Ct neck spine w/o dye	No	\$ 1,459.37	\$ 136.86	\$ 1,750.92	\$169.35	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72126	Ct neck spine w/dye	No	\$ 1,293.16	\$ 260.86	\$ 1,821.59	\$405.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72127	Ct neck spine w/o & w/dye	No	\$ 1,815.93	\$ 201.73	\$ 2,118.48	\$247.33	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72129	Ct chest spine w/dye	No	\$ 1,520.66	\$ 199.82	\$ 1,805.90	\$243.41	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72132	Ct lumbar spine w/dye	No	\$ 1,518.43	\$ 260.86	\$ 1,805.90	\$405.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72133	Ct lumbar spine w/o & w/dye	No	\$ 1,904.42	\$ 201.90	\$ 2,238.70	\$246.82	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72141	MRI NECK SPINE W/O DYE	No	\$ 1,441.84	\$ 252.20	\$ 2,177.11	\$305.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72148	MRI - Back (outpatient)	Yes	\$ 1,381.13	\$ 252.20	\$ 2,137.12	\$305.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72170	X-Ray - Pelvis	No	\$ 249.04	\$ 28.72	\$ 327.10	\$104.70	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72190	X-RAY EXAM OF PELVIS	No	\$ 208.53	\$ 39.60	\$ 264.73	\$110.87	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72193	CT scan, pelvis, with contrast	Yes	\$ 1,536.96	\$ 197.29	\$ 2,142.05	\$238.61	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 ash Price	<u>Mi</u> Neg	dentified nimum gotiated harge	<u>M</u> Ne	-Identified aximum egotiated Charge	<u>Payer-</u> <u>Specific</u> <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	\$481.55	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73000	X-ray exam of collar bone	No	\$ 147.59	\$	22.40	\$	185.92	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73010	X-ray exam of shoulder blade	No	\$ 196.93	\$	26.01	\$	251.93	\$105.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73030	X-Ray - Shoulder (outpatient)	No	\$ 149.50	\$	28.33	\$	196.92	\$79.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73060	X-RAY EXAM OF HUMERUS	No	\$ 147.62	\$	29.40	\$	195.82	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73070	X-ray exam of elbow	No	\$ 146.83	\$	25.07	\$	191.42	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73080	X-RAY EXAM OF ELBOW	No	\$ 122.83	\$	26.72	\$	154.02	\$78.51	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73090	X-RAY EXAM OF FOREARM	No	\$ 117.10	\$	26.40	\$	151.82	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73110	X-Ray - Wrist (outpatient)	No	\$ 156.52	\$	30.72	\$	196.19	\$78.51	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73120	X-RAY EXAM OF HAND	No	\$ 192.03	\$	24.40	\$	249.73	\$104.12	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> Neg	dentified nimum gotiated harge	N	e-Identified <u>Maximum</u> egotiated <u>Charge</u>	<u>Payer-</u> Specific <u>Negotiated</u> <u>Charge</u>	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	73130	X-Ray - Hand	No	\$ 151.54	\$	32.72	\$	198.42	\$78.51	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73221	MRI - Shoulder, Elbow, or Wrist	No	\$ 1,211.82	\$	246.65	\$	1,702.46	\$296.37	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73502	X-Ray - Hip	No	\$ 129.58	\$	37.77	\$	197.91	\$82.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73552	X-RAY EXAM OF FEMUR 2/>	No	\$ 150.51	\$	29.51	\$	189.38	\$79.10	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$ 201.92	\$	32.40	\$	266.82	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73562	X-Ray - Knee (outpatient)	No	\$ 263.50	\$	36.52	\$	351.25	\$79.61	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73590	X-ray exam of lower leg	No	\$ 239.62	\$	32.40	\$	321.48	\$77.42	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73600	X-RAY EXAM OF ANKLE	No	\$ 191.55	\$	31.98	\$	278.60	\$77.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73610	X-Ray - Ankle (outpatient)	No	\$ 239.05	\$	25.72	\$	311.14	\$78.51	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73620	X-RAY EXAM OF FOOT	No	\$ 196.24	\$	29.81	\$	262.21	\$76.91	Per Unit

									Amount We	l I
									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	<b>Negotiated</b>	<b>Negotiated</b>	
Service Category	Service Setting	<u>Type</u>	<u>Code</u>	Description	Service?	Cash Price	Charge_	Charge_	Charge_	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	73630	X-Ray - Foot (outpatient)	No	\$ 216.05	\$ 33.95	\$ 289.60	\$78.00	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73700	CT LOWER EXTREMITY W/O DYE	No	\$ 1,231.00	\$ 134.01	\$ 1,400.92	\$169.35	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73721	MRI - Knee (outpatient)	Yes	\$ 1,224.32	\$ 246.65	\$ 1,828.36	\$295.27	Per Unit
Radiology Services		CFT	/3/21	With - Knee (outpatient)	105	Ş 1,224.32	Ş 240.05	Ş 1,020.30	<i>Ş</i> 255.27	reronit
Radiology Services	Hospital Outpatient	СРТ	74018	X-Ray - Abdomen	No	\$ 145.61	\$ 28.31	\$ 189.76	\$79.10	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74150	Ct abdomen w/o dye	No	\$ 977.64	\$ 142.38	\$ 1,446.99	\$184.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	7/170	Ct abdomen w/o & w/dye	No	\$ 1,824.18	\$ 207.86	\$ 2,144.29	\$257.49	Per Unit
Radiology Services		CFT	74170	ct abdomen w/o & w/uye	NU	Ş 1,024.10	\$ 207.80	\$ 2,144.25	3237.49	Peronic
				CT Scon Abdomon and Doluis with						
Radiology Services	Hospital Outpatient	СРТ	74177	CT Scan - Abdomen and Pelvis, with Contrast	No	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$452.88	Per Unit
	and the second se					, _,	, 100000	, 2,000.00		
				CT Scan - Abdomen and Pelvis, with						
Radiology Services	Hospital Outpatient	СРТ	74177	Contrast	Yes	\$ 2,748.11	\$ 286.79	\$ 3,568.86	\$452.88	Per Unit
									A	
Radiology Services	Hospital Outpatient	СРТ	74220	X-ray xm esophagus 1cntrst	No	\$ 394.10	\$ 56.38	\$ 563.71	\$194.82	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	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> <u>Charge</u>	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	74270	X-ray xm colon 1cntrst std	No	\$ 521.72	\$ 79.34	\$ 578.01	\$229.09	Per Unit
Radiology Services	Hospital Outpatient	СРТ	75571	Ct hrt w/o dye w/ca test	No	\$ 306.04	\$ 59.00	\$ 323.39	\$110.03	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76536	Ultrasound - Head and Neck	No	\$ 460.62	\$ 78.79	\$ 386.50	\$135.07	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76642	Ultrasound - Breast (outpatient)	No	\$ 152.68	\$ 78.52	\$ 249.30	\$117.88	Per Unit
Dediclose Comices	Userital Outputient	CDT	76700	Ultraceured Abdeminal Complete	Yes	\$ 361.43	¢ 01.00	¢ 422.80	6454.75	Dev Unit
Radiology Services	Hospital Outpatient	СРТ	76700	Ultrasound - Abdominal, Complete	Yes	\$ 361.43	\$ 91.69	\$ 433.80	\$154.75	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76705	Ultrasound - Abdominal, Limited	No	\$ 327.93	\$ 46.05	\$ 372.20	\$136.79	Per Unit
					-					
Maternity/Delivery	Hospital Outpatient	СРТ	76770	US EXAM ABDO BACK WALL COMP	No	\$ 456.58	\$ 76.54	\$ 400.80	\$148.57	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76801	OB US < 14 WKS SINGLE FETUS	No	\$ 391.57	\$ 86.65	\$ 396.27	\$168.76	Per Unit

r		1	1						A	<b>1</b>
									Amount We Estimate You	
									Will Owe *	
									Viii Owe	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	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
<u>service category</u>	<u>Service Setting</u>	Type	couc	Description	Scivice	casirritee	charge	charge	charge	Estimate Type
				Literacian December 2						
De diele en Comisse	Usersited Outpatient	CDT	70005	Ultrasound - Pregnancy	No	¢ 267.72	¢ 100.00	¢ 407.40	64.00.70	Devident
Radiology Services	Hospital Outpatient	СРТ	76805	(outpatient)	Yes	\$ 367.73	\$ 100.36	\$ 437.10	\$168.76	Per Unit
			-			÷	<b>A A A A A A A A A A</b>	<b>A FOR FO</b>	4227.04	<b>B 11 1</b>
Maternity/Delivery	Hospital Outpatient	СРТ	76811	OB US DETAILED SNGL FETUS	No	\$ 522.04	\$ 198.65	\$ 587.50	\$337.91	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76815	OB US LIMITED FETUS(S)	No	\$ 309.95	\$ 54.75	\$ 384.30	\$141.82	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76816	Ultrasound - Pregnancy Follow-Up	No	\$ 406.54	\$ 64.37	\$ 384.30	\$157.51	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76818	FETAL BIOPHYS PROFILE W/NST	No	\$ 476.50	\$ 82.20	\$ 387.27	\$173.19	Per Unit
		1								
Maternity/Delivery	Hospital Outpatient	СРТ	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 407.39	\$ 97.44	\$ 398.34	\$151.34	Per Unit
		1								
Radiology Services	Hospital Outpatient	СРТ	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 370.14	\$ 88.69	\$ 391.69	\$145.45	Per Unit
		1								
				Ultrasound - Transvaginal (non-						
Radiology Services	Hospital Outpatient	СРТ	76830	maternity)	Yes	\$ 475.43	\$ 98.63	\$ 463.90	\$145.16	Per Unit
						+ +/5/45	- 00.00	+ +00.50		

											Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	<u>Code</u> <u>Туре</u>	Code	Description	CMS Required Shoppable Service?		ounted h Price	<u>Mi</u> Neg	dentified nimum gotiated harge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Typ
Radiology Services	Hospital Outpatient	СРТ	76856	Ultrasound - Pelvic (outpatient)	No	\$	344.00	\$	70.34	\$ 408.50	\$144.65	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77065	Mammography of one breast	Yes	\$	546.40	\$	107.57	\$ 501.03	\$139.99	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77066	Mammography of both breasts	Yes	Ş	383.79	\$	135.81	\$ 629.70	\$175.56	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77067	Mammogram (outpatient)	Yes	\$	406.73	\$	109.22	\$ 504.02	\$140.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77080	Bone Density Scan (outpatient)	No	\$	247.25	\$	56.29	\$ 393.45	\$106.44	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77081	Dxa bone density/peripheral	No	\$	116.84	\$	33.80	\$ 171.64	\$80.76	Per Unit
Radiology Services	Hospital Outpatient	СРТ	78452	Myocardial Imaging (outpatient)	No	\$ :	1,010.04	\$	336.74	\$ 2,091.45	\$1,156.85	Per Unit

									Amount We	î
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									Ť	
					CMS		De-Identified		Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price	Charge_	Charge_	Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 158.03	\$ 11.84	\$ 221.33	\$21.15	Per Unit
				Blood Test - Comprehensive						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80053	Metabolic Panel	Yes	\$ 93.73	\$ 14.78	\$ 136.89	\$26.40	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		Yes	Volume	Volume	Volume	Volume	Per Unit
Eaboratory & Fathology Scrittees			00000		103	Volume	volunie	Volunie	Volume	
				Blood Test - Cholesterol Test, Lipid						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80061	Panel	Yes	\$ 46.48	\$ 12.05	\$ 101.77	\$12.05	Per Unit
										1
				Right Test, Revel (Kidney)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80069	Blood Test - Renal (Kidney) Function Panel	Yes	\$ 17.24	\$ 8.68	\$ 34.59	\$21.70	Per Unit
Laboratory & Pathology Services		CFI	00009		162	<i>y</i> 17.24			\$21.70	reronit
				Blood Test - Hepatic (Liver)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80076	Function Panel	Yes	\$ 146.77	\$ 11.44	\$ 205.84	\$20.42	Per Unit
				•		•	•			

		1	1						Amount We	
									Estimate You	
									Will Owe *	
									winowe	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
							Minimum	Maximum	Specific	
		Carda			Required	Discountered				
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	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			\$55.93	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	\$7.92	Per Unit
Laboratory & Pathology Services		CFT	01001		Tes	ş 23.40	Ş 4.44	Ş 34.47	\$7.52	Perofit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81002	Urine Test - Urinalysis, Manual Test	Yes	\$ 7.24	\$ 2.67	\$ 14.00	\$3.13	Per Unit
				Urine Test - Automated without						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81003	Microscope	Yes	\$ 10.40	\$ 3.16	\$ 11.25	\$5.63	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	81025	Urine Test - Pregnancy	No	\$ 40.87	\$ 10.45	\$ 58.29	\$21.53	Per Unit
			55			+	+		+	
Laboratory & Pathology Convices	Hospital Outpatient	СРТ	92247	Bilirubin total	No	\$ 41.02	\$ 4.52	\$ 55.22	\$4.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	0224/		INU	ə 41.UZ	<i>२</i> 4.52	ə 55.22	<b>२</b> 4.5∠	rerunit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82306	Blood Test - Vitamin D-3 Level	No	\$ 188.74	\$ 26.64	\$ 254.08	\$26.64	Per Unit

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

										Amount We	
										Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
		Code			<u>CMS</u> <u>Required</u> Shoppable	Disc	counted	<u>De-Identified</u> <u>Minimum</u> Negotiated	De-Identified Maximum Negotiated	<u>Payer-</u> Specific Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?		h Price	Charge	Charge	Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82330	Assay of calcium	No	\$	35.11	\$ 12.31	\$ 67.00	\$12.31	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82375	Assay carboxyhb quant	No	\$	114.13	\$ 11.09	\$ 153.64	\$11.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82465	Assay bld/serum cholesterol	No	\$	15.28	\$ 3.92	\$ 23.76	\$3.92	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82550	Assay of ck (cpk)	No	\$	12.70	\$ 5.86	\$ 35.53	\$5.86	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82552	Assay of cpk in blood	No	\$	26.14	\$ 12.05	\$ 75.41	\$12.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82565	Assay of creatinine	Νο	\$	124.50	\$ 7.17	\$ 70.25	\$12.80	Per Unit
				Blood Test - Vitamin B-12							
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82607	(Cyanocobalamin) Level	No	\$	29.40	\$ 13.57	\$ 82.73	\$13.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82610	Cystatin c	No	\$	140.40	\$ 14.17	\$ 405.00	\$16.67	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82668	Assay of erythropoietin	No	\$	36.68	\$ 16.91	\$ 99.20	\$16.91	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82670	Assay of estradiol	No	\$	54.51	\$ 25.15	\$ 152.33	\$25.15	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 Minimum Negotiated Charge	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	82693	Assay of ethylene glycol	No	\$ 20.29	\$ 13.41	\$ 40.08	\$13.41	Per Unit
custored y a ratiology services			52055	source and a second		- 20.23	÷ 13.41	÷ 10.00	¥13.71	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 33.53	\$ 19.09	\$ 96.63	\$34.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82746	Blood Test - Folic Acid Level	No	\$ 37.75	\$ 13.23	\$ 79.52	\$13.23	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82803	Blood gases any combination	No	\$ 73.40	\$ 20.17	\$ 106.16	\$23.46	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82947	Assay glucose blood quant	No	\$ 34.04	\$ 5.51	\$ 49.42	\$9.83	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82962	Glucose blood test	No	\$ 45.55		\$ 61.82	\$8.20	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83018	Heavy metal quant each nes	No	\$ 172.97	\$ 19.76	\$ 498.96	\$19.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83036	Blood Test - Blood Glucose Control (Hemoglobin A1C)	No	\$ 71.27	\$ 8.74	\$ 95.94	\$8.74	Per Unit

								Amount We	
								Estimate You	
								Will Owe *	
				<u>CMS</u>		De-Identified	De-Identified	Payer-	
				Required		Minimum	Maximum	Specific	
Service Setting		Code	Description		-				Estimate Type
Hospital Outpatient	СРТ	83088	Assay of histamine	No	\$ 75.84	\$ 26.58	\$ 218.76	\$26.58	Per Unit
Hospital Outpatient	СРТ	83518	Immunoassay dipstick	No	\$ 147.09	\$ 6.55	\$ 424.29	\$8.68	Per Unit
Hospital Outpatient	СРТ	83540	Blood Test - Iron Level	No	\$ 51.90	\$ 9.06	\$ 75.77	\$16.17	Per Unit
Hospital Outpatient	СРТ	83605	Assay of lactic acid	No	\$ 27.44	\$ 10.41	\$ 58.05	\$10.41	Per Unit
			Blood Test - Lipase (fat enzyme)						
Hospital Outpatient	СРТ	83690		No	\$ 69.47	\$ 6.20	\$ 93.51	\$6.20	Per Unit
Hospital Outpatient	СРТ	83735	Assay of magnesium	No	\$ 53.82	\$ 9.38	\$ 78.56	\$16.75	Per Unit
Hospital Outpatient	СРТ	83880	Assay of natriuretic peptide	No	\$ 172.55	\$ 35.33	\$ 232.27	\$35.33	Per Unit
Hospital Outpatient	СРТ	84100	Assay of phosphorus	No	\$ 61.73	\$ 6.64	\$ 87.67	\$11.85	Per Unit
Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	\$ 43.23	\$ 6.66	\$ 62.65	\$11.90	Per Unit
Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	Ś 43.23	\$ 6.66	\$ 62.65	\$11.90	Per Unit
	Hospital Outpatient	Hospital Outpatient       CPT         Hospital Outpatient       CPT	Service SettingTypeCodeHospital OutpatientCPT83088Hospital OutpatientCPT83518Hospital OutpatientCPT83540Hospital OutpatientCPT83605Hospital OutpatientCPT83690Hospital OutpatientCPT83735Hospital OutpatientCPT83880Hospital OutpatientCPT84100Hospital OutpatientCPT84132	Service SettingTypeCodeDescriptionHospital OutpatientCPT83088Assay of histamineHospital OutpatientCPT83518Immunoassay dipstickHospital OutpatientCPT83540Blood Test - Iron LevelHospital OutpatientCPT83605Assay of lactic acidHospital OutpatientCPT83690Blood Test - Lipase (fat enzyme) LevelHospital OutpatientCPT83690Assay of magnesiumHospital OutpatientCPT83735Assay of magnesiumHospital OutpatientCPT83880Assay of natriuretic peptideHospital OutpatientCPT84100Assay of phosphorusHospital OutpatientCPT84132Assay of serum potassium	Service SettingCode TypeDescriptionRequired. Shoppable Service?Hospital OutpatientCPT83088Assay of histamineNoHospital OutpatientCPT83518Immunoassay dipstickNoHospital OutpatientCPT83540Blood Test - Iron LevelNoHospital OutpatientCPT83605Assay of lactic acidNoHospital OutpatientCPT83605Assay of lactic acidNoHospital OutpatientCPT83690LevelNoHospital OutpatientCPT83735Assay of magnesiumNoHospital OutpatientCPT8380Assay of natriuretic peptideNoHospital OutpatientCPT84100Assay of phosphorusNoHospital OutpatientCPT84132Assay of serum potassiumNo	Service SettingCode TypeCodeDescriptionRequired ShoppableDisconted Cash PriceHospital OutpatientCPT83088Assay of histamineNo\$75.84Hospital OutpatientCPT83518Immunoassay dipstickNo\$147.09Hospital OutpatientCPT83569Blood Test - Iron LevelNo\$51.90Hospital OutpatientCPT83605Assay of lactic acidNo\$27.44Hospital OutpatientCPT83690Blood Test - Lipase (fat enzyme)No\$69.47Hospital OutpatientCPT83690Assay of magnesiumNo\$53.82Hospital OutpatientCPT83735Assay of natriuretic peptideNo\$51.73Hospital OutpatientCPT8380Assay of phosphorusNo\$61.73Hospital OutpatientCPT84100Assay of serum potassiumNo\$61.73Hospital OutpatientCPT84132Assay of serum potassiumNo\$43.23	Service SettingCode CodeDescriptionRequired Service1Discounted Cash PriceMinimum. Negotiated. Cash PriceHospital OutpatientCPT8308Assay of histamineNo\$75.84\$26.58Hospital OutpatientCPT83518Immunoassay dipstickNo\$147.09\$6.55Hospital OutpatientCPT83540Blood Test - Iron LevelNo\$51.90\$9.06Hospital OutpatientCPT83603Assay of lactic acidNo\$27.44\$9.06Hospital OutpatientCPT83603Assay of lactic acidNo\$27.44\$9.06Hospital OutpatientCPT83603Assay of lactic acidNo\$5.9.47\$9.6.20Hospital OutpatientCPT8369Assay of magnesiumNo\$5.3.82\$9.38Hospital OutpatientCPT8380Assay of magnesiumNo\$5.3.82\$9.38Hospital OutpatientCPT84100Assay of phosphorusNo\$5.1.73\$6.64Hospital OutpatientCPT84132Assay of serum potassiumNo\$43.23\$6.64Hospital OutpatientCPT84132Assay of serum potassiumNo\$43.23\$6.64	Code Service SettingCodeCodeDescriptionRequired Shoppable Service?Discutted CasP PriceMinimum Regoliated. ChargeHospital OutpatientCPT83088Assay of histamineNo\$75.84\$26.58\$218.76Hospital OutpatientCPT83518Immunoassay dipstickNo\$147.09\$6.55\$424.29Hospital OutpatientCPT83540Blood Test - Iron LevelNo\$559.06\$75.77Hospital OutpatientCPT83603Assay of lactic acidNo\$27.44\$10.41\$\$Hospital OutpatientCPT83690Blood Test - Lipase (fat enzyme)No\$6.9.47\$6.20\$9.3.51Hospital OutpatientCPT83690Blood Test - Lipase (fat enzyme)No\$56.9.47\$6.20\$9.3.51Hospital OutpatientCPT83690Assay of magnesiumNo\$53.82\$9.3.51\$7.8.56Hospital OutpatientCPT8380Assay of phosphorusNo\$172.55\$3.5.33\$2.2.2.27Hospital OutpatientCPT84100Assay of serum potassiumNo\$6.1.73\$6.66\$6.2.65Hospital OutpatientCPT84102Assay of serum potassiumNo\$6.1.73\$6.66\$6.2.65	Index

										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>	<u>Discounte</u> <u>Cash Price</u>	<u>N</u>	e-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	\$18.77	Per Unit
				Blood Test - Prostate Specific							
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84153	Antigen (PSA) Level	Yes	\$ 74.	1 \$	25.75	\$ 116.68	\$45.97	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	9/15/	PSA (prostate specific antigen)	Yes	\$ 106.	A Ś	16.55	\$ 143.15	\$16.55	Per Unit
		CFT	04134	roa (prostate specific antigen)	Tes	- <del></del>	94 Ş	10.55		\$10.55	Peronit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84182	Protein western blot test	No	\$ 382.	2 \$	18.76	\$ 588.80	\$26.29	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84295	Assay of serum sodium	No	\$ 42.3	.0 \$	4.33	\$ 56.67	\$4.33	Per Unit
				Blood Test - Thyroxine (Thyroid							
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84439	Chemical) Level, Free	No	\$ 66.3	1 \$	8.12	\$ 89.13	\$8.12	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 64.	)7 \$	23.52	\$ 119.09	\$42.00	Per Unit

		1		1	1							
											Amount We	
											Estimate You Will Owe *	
							_				will Owe *	
To Search for a service Click "CTRL"												
+ "F"												
											· ·	
					CMS		De-l	dentified	De-Ide	ntified	Payer-	
					Required			nimum	Maxi		Specific	
		Code			Shoppable	Discounted		otiated	Negot		Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	<b>Cash Price</b>		harge	Cha		Charge	Estimate Type
	<u> </u>						-			0-		
				Blood Test - Thyroid Stimulating								
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84443		Yes	\$ 64.07	1 \$	23.52	Ś	119.09	\$42.00	Per Unit
, , ,							<u> </u>					
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84480	Assay triiodothyronine (t3)	No	\$ 96.33	L \$	12.76	\$	129.65	\$12.76	Per Unit
									-		-	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84484	Assay of troponin quant	No	\$ 81.70	) \$	10.26	\$	121.45	\$11. <b>22</b>	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84702	Chorionic gonadotropin test	No	\$ 125.7	7 \$	11.54	\$	169.31	\$13.55	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85014	Hematocrit	No	\$ 26.9	5 \$	2.13	\$	36.27	\$2.13	Per Unit
				Blood Test - Complete Blood Cell								
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85025	Count and Automated WBC	Yes	\$ 77.98	3 \$	10.88	\$	11 <mark>2.0</mark> 6	\$19.42	Per Unit
				Blood Test - Complete Blood Cell								
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85027	Count (Hemoglobin)	Yes	\$ 60.79	\$	5.82	\$	81.83	\$5.82	Per Unit
				Count and Automated WBC Blood Test - Complete Blood Cell								

									Amount We	
									Estimate You	
									Will Owe *	
To Connet for a comise Click "CTP!"										
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		<b>De-Identified</b>	<b>De-Identified</b>	Payer-	
					<b>Required</b>		<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
	<u>_</u>									
Laboratory & Dathalany Constant	User its Contractions	СРТ	05240			¢ 45.07	¢ 46.44	¢ 05.50	64C 44	Developerate
Laboratory & Pathology Services	Hospital Outpatient	CPI	85240	Clot factor viii ahg 1 stage	No	\$ 45.97	\$ 16.11	\$ 95.56	\$16.11	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85378	Fibrin degrade semiquant	No	\$ 53.57	\$ 7.44	\$ 72.11	\$8.75	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85610	Blood Test - Clotting Time	Yes	\$ 44.81	\$ 6.01	\$ 64.27	\$10.72	Per Unit
						+	7		7-0	
		0.07	05640				<b>A A A A</b>	÷ == ==	40.50	<b>D</b>
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85613	Russell viper venom diluted	No	\$ 24.61	\$ 8.24	\$ 70.98	\$8.62	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85660	RBC SICKLE CELL TEST	No	\$ 53.32	\$ 4.96	\$ 71.77	\$4.96	Per Unit
				Blood Test - Coagulation						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85730	Assessment	Yes	\$ 46.01	\$ 5.41	\$ 61.94	\$5.41	Per Unit
	a second s		50.00			+	+	+ 0104		
Laboratory & Dathalamy Comitant	Upprited Outpotient	CDT	05722	Theorem and posting times an entirely	No	¢ 12.02	¢ 5.00	¢ 20.42	ĆE 93	Deviluit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85/32	Thromboplastin time partial	No	\$ 12.63	\$ 5.82	\$ 36.42	\$5.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86140	C-reactive protein	No	\$ 48.49	\$ 4.66	\$ 65.28	\$4.66	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86360	T cell absolute count/ratio	No	\$ 65.00	\$ 42.28	\$ 211.59	\$42.28	Per Unit
	and the second sec								+	

										Amount We	
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL" + "F"											
					CMC			Do Identified	De-Identified	Dever	
					<u>CMS</u> Required			De-Identified Minimum	Maximum	Payer- Specific	
		Code			Shoppable	Discount	ed	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Pric	_	Charge	Charge	Charge	Estimate Type
							_				
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86361	T cell absolute count	No	\$ 132	.78	\$ 24.10	\$ 383.03	\$24.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86431	Rheumatoid factor quant	No	\$ 52	.70	\$ 5.10	\$ 70.95	\$5.10	Per Unit
Laboratory & Pathology Services		Cri	00431		NO	Ş 32		Ş 3.10	Ş 70.55	<b>\$5.10</b>	reronit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86592	Syphilis test non-trep qual	No	\$ 37	.81	\$ 3.84	\$ 50.90	\$3.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86592	Syphilis test non-trep qual	No	\$ 37	.81	\$ 3.84	\$ 50.90	\$3.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86611	Bartonella antibody	No	\$ 57	.37	\$ 9.16	\$ 165.50	\$9.16	Per Unit
		CFT	00011		NO	Ş 37	.57	Ş 5.10	Ş 105.50	<b>\$5.10</b>	reronit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86615	Bordetella antibody	No	\$ 25	.74	\$ 11.87	\$ 81.45	\$11.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86651	Encephalitis californ antbdy	No	\$ 25	.74	\$ 11.87	\$ 110.13	\$11.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86652	Encephaltis east eqne anbdy	No	\$ 25	.74	\$ 11.87	\$ 110.13	\$11.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86653	Encephaltis st louis antbody	No	\$ 25	.74	\$ 11.87	\$ 110.13	\$11.87	Per Unit
	i contrato de la contrato										
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86654	Encephaltis west eqne antbdy	No	\$ 25	.74	\$ 11.87	\$ 110.13	\$11.87	Per Unit
Lasoratory & Fathology Services			30034	Encopriantis west eque antibuy	NU	φ 23		y 11.0/	÷ 110.15		
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86663	Epstein-barr antibody	No	\$ 25	.60	\$ 11.81	\$ 83.21	\$11.81	Per Unit

											Amount We	
											Estimate You	
											Will Owe *	
To Search for a service Click "CTRL" + "F"												
					CMS			De-Identi	fied	De-Identified	Daviar	
					Required			Minimu		Maximum	Payer- Specific	
		Code			Shoppable	Disco	ounted	Negotiat		Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash	n Price	Charge	2	Charge	Charge	Estimate Type
Laboratory & Pathology Sonvisos	Hospital Outpatient	СРТ	96677	Holicobactor pylori antibody	No	s	30.68	¢ 15	.13	\$ 63.03	\$15.17	Per Unit
Laboratory & Pathology Services		CPT	86677	Helicobacter pylori antibody	INU	<b>&gt;</b>	50.00	2 I2	.15	\$ 05.05	\$15.17	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86692	Hepatitis delta agent antbdy	No	\$	29.16	\$ 15	.44	\$ 50.98	\$15.44	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86698	Histoplasma antibody	No	\$	79.65	\$ 12	.41	\$ 107.23	\$12.41	Per Unit
						•				+	+	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86704	HEP B CORE ANTIBODY TOTAL	No	\$	86.11	\$ 10	.85	\$ 115.92	\$10.85	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86705	HEP B CORE ANTIBODY IGM	No	\$	22.98	\$ 10	.59	\$ 57.38	\$10.59	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86706	HEP B SURFACE ANTIBODY	No	\$	98.98	\$ 9	.67	\$ 133.25	\$9.67	Per Unit
			50700			7	50.50	÷ ,		- 100.20	<i>43.07</i>	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86707	Hepatitis be antibody	No	\$	22.56	\$ 10	.41	\$ 65.09	\$10.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86708	Hepatitis a antibody	No	\$	22.71	\$ 11	.15	\$ 56.71	\$11.15	Per Unit
						Ŧ					+	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86762	Rubella antibody	No	\$	78.19	\$ 12	.95	\$ 225.56	\$12.95	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86765	Rubeola antibody	No	Ś	25.14	\$ 11	.59	\$ 72.53	\$11.59	Per Unit
casoratory or ratiology services	nospital outpatient		00703	nascolu ultusouy	110	Ŷ	23.14	γ II		y 12.33	Y11.33	. cromt

									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	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ		86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 51.48	\$-	\$ 112.07	\$37.92	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86790	Virus antibody nos	No	\$ 25.14	\$ 11.59	\$ 76.53	\$11.59	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86803	Blood Test - Hepatitis C Antibody Level	No	\$ 67.64	\$ 12.84	\$ 91.06	\$12.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86804	Hep c ab test confirm	No	\$ 23.09	\$ 13.94	\$ 66.62	\$13.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86850	Rbc antibody screen	No	\$ 20.32	\$	\$ 66.92	\$40.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86885	Coombs test indirect qual	No	\$ 244.72	\$ 5.65	\$ 329.43	\$116.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$88.49	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$88.49	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$27.13	Per Unit

		1	1							
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
, ,										
					<u>CMS</u> <u>Required</u>		De-Identified Minimum	Maximum	Payer- Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge_	Charge_	Charge_	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$27.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$ 5.82	\$ 4.84	\$ 383.37	\$230.02	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86920	COMPATIBILITY TEST SPIN	Νο	\$ 244.72	\$ 13.44	\$ 344.22	\$116.47	Per Unit
		-								
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87040	Blood culture for bacteria	No	\$ 133.90	\$ 9.29	\$ 180.25	\$9.29	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87070	Bacterial Culture - Swab	No	\$ 138.63	\$ 7.76	\$ 186.61	\$7.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87077	Bacterial Culture - Aerobic Isolates	No	\$ 60.43	\$ 7.27	\$ 81.35	\$7.27	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	\$5.97	Per Unit

<b></b>		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
				<b>_</b>						
				Urine Test - Bacterial Culture,					47.00	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87086	Quantitative Colony Count	No	\$ 82.16	\$ 7.26	\$ 110.60	\$7.26	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87088	Urine Test - Bacterial Culture	No	\$ 15.80	\$ 7.28	\$ 43.86	\$7.28	Per Unit
			0,000			<i>ϕ</i> 10.00	<i>v</i> 7120	¢ 45100	Ç7120	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87110	Chlamydia culture	No	\$ 130.74	\$ 17.64	\$ 175.99	\$17.64	Per Unit
				Evaluation of Antimicrobial Drug						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87186	(antibiotic, antifungal, antiviral)	No	\$ 69.16	\$ 7.79	\$ 93.10	\$7.79	Per Unit
	nospital outputient		07100	(antibiotic, antifungai, antifuna)	110	<i>y</i> 05.10	<i>y 1.15</i>	<i>y</i> 55.10	<i>Ş</i> 7.75	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87205	Lab Test - Smear for Microorganism	No	\$ 49.93	\$ 3.84	\$ 67.21	\$3.84	Per Unit
				Lab Test. Detection test for						
Laboratory & Patholomy Services	Hospital Outpatient	СРТ		Lab Test - Detection test for	No	\$ 63.55	\$ 9.30	\$ 85.55	\$9.30	Per Unit
Laboratory & Pathology Services		CPT	07540	Hepatitis B Surface Antigen	No	<i>ş</i> 05.55	ə 5.30	ə 00.00	\$ <b>7.</b> 50	Per Unit
				Lab Test - Detection test for HIV-1						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	<b>87389</b>	and HIV-2	No	\$ 110.43	\$ 21.67	\$ 148.66	\$21.67	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>Disco</u> <u>Cash</u>		De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87425	Rotavirus ag ia	No	\$	37.44	\$ 10.78	\$ 108.00	\$10.78	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87491	Urine Test - Chlamydia	No	\$	108.43	\$ 31.58	\$ 171.03	\$31.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87591	Urine Test - Gonorrhoeae (Neisseria Gonorrhoeae Bacteria)	No	\$	90.13	\$ 31.58	\$ 171.03	\$31.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87635	87635 - SARS-COV-2 COVID-19 AMP PRB	No	\$	53.36	\$ -	\$ 136.48	\$46.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87798	Detect agent nos dna amp	No	\$	90.13	\$ 31.58	\$ 171.03	\$31.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87804	Lab Test - Detection test for Influenza Virus	No	\$	37.58	\$ 19.82	\$ 70.50	\$41.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87880	Strep Test (Streptococcus, group A)	No	\$	101.56	\$ 19.87	\$ 143.48	\$41.33	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	88185	Flowcytometry/tc add-on	No	\$	68.81	\$ -	\$ 120.30	\$18.06	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	\$21.50	Per Unit
Vaccinations	Physician Office	СРТ		Immunization Administration Each Additional Component	No	\$ 25.13	\$ 10.49	\$ 38.51	\$19.31	Per Unit
Vaccinations	Hospital Outpatient	СРТ	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 81.80	\$70.58	Per Unit
Vaccinations	Hospital Outpatient	СРТ		Immunization Administration Each Additional Component	No	\$ 12.56	\$-	\$ 38.51	\$30.17	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	\$207.13	Per Unit

								Amount We Estimate You Will Owe *	
Service Setting	<u>Code</u> Type	Code	Description	<u>CMS</u> <u>Required</u> <u>Shoppable</u> Service?	Discounted Cash Price	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u> Charge	<u>Maximum</u> Negotiated	<u>Payer-</u> <u>Specific</u> <u>Negotiated</u> Charge	Estimate Type
						<u> </u>			
			Vaccine - Tetanus, Diptheria Toxoids, and Acellular Pertussis (Wheeping Courts) for Injection						
ospital Outpatient	СРТ			No	\$ 57.74	\$ -	\$ 77.73	\$30.85	Per Unit
rofessional Services	СРТ	90791	Psychiatric Diagnostic Evaluation	No	\$ 308.81	\$ 118.93	\$ 198.74	\$198.74	Per Unit
rofessional Services	СРТ	90832	Psychotherapy - 30 Minutes	Yes	\$ 88.03	\$ 57.92	\$ 99.25	\$99.25	Per Unit
rofessional Services	СРТ	90834	Psychotherapy - 45 Minutes	Yes	\$ 116.77	\$ 77.37	\$ 132.34	\$132.34	Per Unit
rofessional Services	СРТ	90837	Psychotherapy - 60 Minutes	Yes		\$ 116.00		\$198.22	Per Unit
rofessional Services	СРТ	90846	Family psytx w/o pt 50 min	Yes	N/A NO Service Volume	\$ -	N/A NO Service Volume	N/A NO Service Volume	Per Unit
	Service Setting  Service Setting  Service Setting  Service Setting  Services  Services Services Services  Services Services Services Services Services Services Services Services Services	Service Setting     Type       Iospital Outpatient     CPT       rofessional Services     CPT	Service SettingTypeCodeIospital OutpatientCPT90715rofessional ServicesCPT90791rofessional ServicesCPT90832rofessional ServicesCPT90834rofessional ServicesCPT90834	Service SettingTypeCodeDescriptionInspirationImage: Service SettingImage: Service SettingImage: Service Setting Settin	Service SettingCode TypeCodeDescriptionRequired. Shoppable. Service?Service SettingTypeCodeDescriptionService?Vaccine - Tetanus, Diptheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection into MuscleNoIospital OutpatientCPT90715Stociatric Diagnostic EvaluationNorofessional ServicesCPT90832Psychotherapy - 30 MinutesYesrofessional ServicesCPT90832Psychotherapy - 45 MinutesYesrofessional ServicesCPT90837Psychotherapy - 60 MinutesYes	Service SettingCode TypeCodeDescriptionRequired Shopable Service?Discounted Cash PriceService SettingVVVDescriptionVV	Service SettingCode TypeCodeDescriptionRequired Shopable Service?Discounted Cash PriceMinimum. Negotiated ChargeIospital OutpatientCPT90715Vaccine - Tetanus, Diptheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection into MuscleNo\$57.74\$-rofessional ServicesCPT90791Psychiatric Diagnostic EvaluationNo\$308.81\$118.93rofessional ServicesCPT90832Psychotherapy - 30 MinutesYes\$88.03\$\$7.7.37rofessional ServicesCPT90834Psychotherapy - 45 MinutesYes\$116.77\$77.37rofessional ServicesCPT90837Psychotherapy - 60 MinutesYes\$116.77\$77.37rofessional ServicesCPT90837Psychotherapy - 60 MinutesYes\$116.77\$77.37	Service SettingCode TypeCodeDescriptionRequired Shopable Service?Minimum Discounted Cash PriceMaximum. Negotiated ChargeService SettingIII	Image: service Setting       Code       Image: service Setting       Code       Description       CMS       Beguired       Description       Description

											Amount We	î
											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>		scounted ish Price	<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>	<u>Estimate Type</u>
							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	\$69.27	Per Unit
Medicine Cardiovascular	Professional Services	СРТ	93000	Electrocardiogram, routine, with interpretation and report	Yes	Ś	36.27	ć	28.12	\$ 95.52	\$25.42	Per Unit
	Professional Services	Cri	53000		163	•	30.27	~	20.12	<del>,</del> 55.52	<i>923.42</i>	
Medicine Other	Hospital Outpatient	СРТ	93005	Electrocardiogram (ECG or EKG)	No	\$	142.29	\$	-	\$ 295.26	\$56.86	Per Unit
Martinian Cardina Characteri	Harris I O donation t	CDT	02017				474 40	<u>,</u>	61.00	é	6205 42	Den Hait
Medicine Cardiac Stress Test	Hospital Outpatient	СРТ	93017	CARDIOVASCULAR STRESS TEST	No	\$	471.40	>	61.00	\$ 634.57	\$205.42	Per Unit
Medicine Other	Hospital Outpatient	СРТ	93306	Tte w/doppler complete	No	\$	1,404.83	\$	322.26	\$ 1,593.05	\$506.40	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	\$2,676.94	Case Rate
Medicine Other	Hospital Outpatient	СРТ	93971	Extremity study	No	\$	240.64	\$	92.64	\$ 400.67	\$125.61	Per Unit

		1		1		1	1			
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CDAC		De-Identified	De-Identified	Dever	
					<u>CMS</u>				Payer-	
		Carda			Required	Discountered	<u>Minimum</u>	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	<u>Charge</u>	Charge_	Charge	Estimate Type
Medicine Other	Hospital Outpatient	СРТ	95044	Allergy patch tests	No	\$ 189.82		\$ 1,229.53	\$737.72	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	CPT	96402	Chemo hormon antineopl sq/im	No	\$ 110.26	\$ 66.86	\$ 196.20	\$95.86	Case Rate
				Physical Therapy - Manual						
Medicine Physical Medicine and				Electrical Stimulation Therapy, 15						
Rehabilitation	Hospital Outpatient	СРТ	97032	minutes	No	\$ 31.26	\$ 12.56	\$ 59.90	\$12.95	Per Unit
							-	-	-	
Medicine Physical Medicine and				Physical Therapy - Ultrasound						
Rehabilitation	Hospital Outpatient	СРТ	97035	Therapy	No	\$ 26.92	\$ 11.95	\$ 40.29	\$12.52	Per Unit
						•	·	· · · · ·	·	
Medicine Physical Medicine and				Physical Therapy - Therapeutic						
Rehabilitation	Hospital Outpatient	СРТ	97110	Exercises	Yes	\$ 88.74	\$ 17.40	\$ 119.46	\$26.60	Per Unit
			5.115			- 00.74	+ 17.40	+ 115.40	Q20.00	. cr onit
Medicine Dhysical Medicine and				Dhusical Thorapy Aleuromuscular						
Medicine Physical Medicine and	Usersited Outputient	COT	07442	Physical Therapy - Neuromuscular	N	¢	¢	¢ 104.70	630 FC	Devilation
Rehabilitation	Hospital Outpatient	СРТ	9/112	Reeducation	No	\$ 69.93	\$ 26.14	\$ 104.78	\$30.56	Per Unit
Medicine Physical Medicine and	Usersited Output	COT	07000				¢		626.24	Devilation
Rehabilitation	Hospital Outpatient	СРТ	31110	GAIT TRAINING THERAPY	No	\$ 77.61	\$ 22.90	\$ 104.48	\$26.31	Per Unit

		1		1					1		A	
											Amount We	
											Estimate You Will Owe *	
											will Owe	
To Search for a service Click "CTRL"												
+ "F"												
					CMS			e-Identified		Identified	Payer-	
					<b>Required</b>			<u> Minimum</u>		aximum_	Specific	
		Code			Shoppable	Discounted		egotiated		gotiated	Negotiated	
Service Category	Service Setting	Туре	<u>Code</u>	Description	Service?	Cash Price		Charge_	<u> </u>	Charge_	Charge_	Estimate Type
Realistics Discrimination and												
Medicine Physical Medicine and	Upperitel Outpetient	CDT	07140	Dhusiaal Theremy, Manual Theremy	Ne	\$ 56.2		23.73	~	93.92	¢24.50	Deviluit
Rehabilitation	Hospital Outpatient	СРТ	97140	Physical Therapy - Manual Therapy	No	Ş 50.2	0\$	23.73	Ş	93.92	\$24.50	Per Unit
Medicine Physical Medicine and				Physical Therapy - Low Complexity								
Rehabilitation	Hospital Outpatient	СРТ	97161	Evaluation	No	\$ 168.0	6 Ś	71.97	Ś	252.78	\$74.19	Per Unit
		-										
Medicine Physical Medicine and				Physical Therapy - Moderate								
Rehabilitation	Hospital Outpatient	СРТ	<b>97162</b>	Complexity Evaluation	No	\$ 62.4	0\$	71.97	\$	252.78	\$74.19	Per Unit
Medicine Physical Medicine and	Usersited Outpaties	CDT	074.00	Physical Therapy - High Complexity		A				252.70	674.40	Devillet
Rehabilitation	Hospital Outpatient	СРТ	97163	Evaluation	No	\$ 168.0	6 \$	71.97	Ş	252.78	\$74.19	Per Unit
Medicine Physical Medicine and												
Rehabilitation	Hospital Outpatient	СРТ	97164	Physical Therapy - Re-Evaluation	No	\$ 113.3	a s	48.67	s	170.97	\$50.79	Per Unit
nendom du lon			57104	in the contract of the contrac	110	y 113.3	~ ~	-0.07	Ý	170.57	<i>430.75</i>	i ci onic
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$ 180.8	8 \$	77.05	\$	245.32	\$78.55	Per Unit
	the second se	1			-		· •					·

										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>	counted h Price	De-Iden Minim <u>Negoti</u> Char	num ated	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97166	OT EVAL MOD COMPLEX 45 MIN	No	\$ 62.40	\$ 7	72.00	\$ 245.32	\$78.26	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	СРТ	97530	Physical Therapy - Therapeutic Activities	No	\$ 92.45	\$ 1	17.40	\$ 124.45	\$33.85	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	СРТ	97535	Physical Therapy - Self-care or Home Management Training	No	\$ 68.89	\$	_	\$ 109.03	\$29.51	Per Unit
Evaluation & Management Services	Professional Services	СРТ	99024	Postop follow-up visit	No	\$ -	\$	-	\$ 14.27	\$0.00	Per Unit
Evaluation & Management Services	Professional Services	СРТ	99202	Office Visit - New Patient, Minor	No	\$ 167.93	\$ 9	90.34	\$ 200.08	\$77.58	Per Unit
Evaluation & Management Services	Professional Services	СРТ	99203	Office Visit - New Patient, Low Complexity	Yes	\$ 182.06	\$ 13	32.54	\$ 273.99	\$116.37	Per Unit

							1	1	1	
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CMS		De-Identifie	De-Identified	Deview	
									Payer-	
					Required		Minimum	Maximum	Specific	
		<u>Code</u>			Shoppable	Discounted		Negotiated	<b>Negotiated</b>	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	<u>Charge</u>	Charge	Charge	Estimate Type
				Office Minite New Detrient						
				Office Visit - New Patient,						-
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99204	Moderate Complexity	Yes	\$ 250.6	9 \$ 177.01	\$ 432.49	\$199.10	Per Unit
				New patient office of other						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99205	outpatient visit, typically 60 min	Yes	\$ 448.0	4 \$ 156.38	\$ \$ 553.76	\$260.16	Per Unit
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99212	Office Visit - Basic	No	\$ 58.7	4 \$ 46.41	\$ 133.24	\$39.55	Per Unit
						+			+	
				Office Visit - Established Patient,						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99213	Low Complexity	No	\$ 99.6	7 \$ 81.71	\$ 201.59	\$79.09	Per Unit
- talaation of management services			55215	Terr complexity		÷ 55.0			<i>φ,</i> 3.03	
				Office Visit - Established Patient,						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99214	Moderate Complexity	No	\$ 151.1	9 \$ 140.90	\$ 279.47	\$121.97	Per Unit
Evaluation & management services		<b>U</b>	22214	moderate complexity	140	Ý 191.1			9161.37	. cronit

r					1					Amount We	
										Estimate You	
										Will Owe *	
										Villowe	
To Search for a service Click "CTRL"											
+ "F"											
					CMS			De-Identified		Payer-	
					<b>Required</b>			<u>Minimum</u>	<u>Maximum</u>	Specific	
		<u>Code</u>			Shoppable		ounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	<u>Type</u>	<u>Code</u>	Description	Service?	Cas	h Price	Charge	Charge	Charge_	Estimate Type
				Office Visit - Established Patient,							
Evoluation & Management Convices	Drofossional Convisos	СРТ	00215		No	Ś	315.87	\$ 192.33	\$ 385.34	\$172.35	Per Unit
Evaluation & Management Services	Professional Services	CPT	99212	High Complexity	NO	>	315.87	\$ 192.33	\$ 385.34	\$172.35	Per Unit
Professional Services Associated											
with Inpatient Stay	Professional Services	СРТ	99232	Subsequent hospital care	No	Ś	159.88	\$ 50.60	\$ 111.92	\$111.92	Per Unit
the input of the stary		<b>C</b>	55262			Ŷ	100.00	<i>\$</i> 50.00	<b>V</b>	ÇIII.JL	
				Patient office consultation,							
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99243	typically 40 min	Yes	\$	212.43	\$-	\$ 142.18	\$0.00	Per Unit
				Patient office consultation,							
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99244	typically 60 min	Yes	\$	338.80	\$-	\$ 226.38	\$0.00	Per Unit
				Emergency Department Visit -							
Emergency Room Visit	Hospital Outpatient	СРТ	99281	Minor (outpatient)	No	\$	230.81	\$ 74.98	\$ 689.88	\$92.27	Case Rate

							-			i
									Amount We Estimate You	
									Will Owe *	
<u> </u>										
To Search for a service Click "CTRL"										
+ "F"										
							<b>D</b> 11 110 1	5 H	-	
					<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
		<u></u>								
Freezen av De erre Misit	Upprited Outpotions	CDT		Emergency Department Visit - Low	No	\$ 430.38	ć 02.52	ć 1 114 22	6210.44	Core Data
Emergency Room Visit	Hospital Outpatient	СРТ	99282	Complexity (outpatient)	No	\$ 430.38	\$ 93.52	\$ 1,114.22	\$210.44	Case Rate
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	СРТ	99283	Moderate Complexity (outpatient)	No	\$ 932.99	\$ 182.62	\$ 2,714.83	\$304.15	Case Rate
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	СРТ		Higher Complexity (outpatient)	No	\$ 2,400.69	\$ 270.43	\$ 4,475.48	\$470.00	Case Rate
				Emorgoncy Dopartment Visit						
Emorgonov Room Visit	Hospital Outpatient	СРТ		Emergency Department Visit - High	No	\$ 3,149.91	\$ 458.20	¢ E 906 05	\$1,268.37	Case Rate
Emergency Room Visit	Hospital Outpatient	CPI	33792	Complexity (outpatient)	No	ə 5,149.91	ə 458.2U	\$ 5,806.95	Ş1,208.3∕	Case Rate

	1		1							
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
+ "F"										
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	Payer-	
					<b>Required</b>		<u>Minimum</u>	<u>Maximum</u>	Specific	
		<u>Code</u>			Shoppable	Discounted	<b>Negotiated</b>	Negotiated	<b>Negotiated</b>	
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	\$1,700.84	Case Rate
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient,						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ		Younger than 1 Year Old	No	\$ 156.75	Ś -	\$ 225.38	\$0.00	Per Unit
0							•	,	+	
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 1-						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99382	4 Years Old	No	\$ 163.82	\$-	\$ 236.91	\$0.00	Per Unit
• • • • • • • • • • • • • • • • • • •	L								1	. <u>I</u>

							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 *	
									Villowe	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	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
	<u>service setting</u>	1700	0000	Description	<u>bervice.</u>	casirritee	charge	enarge	charge	Lotinute Type
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 18-						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99385	39 Years Old	Yes	\$ 187.80	\$ 59.23	\$ 347.60	\$109.84	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 40-						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ		64 Years Old	Yes	\$ 217.32	\$ 91.72	\$ 1,293.56	\$146.75	Per Unit
a than a than agement bet thes			55555		100	Ψ	+ J1/L	+ 1,235,30	91-10170	

					-				Amount We	I
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified		Payer-	
					<b>Required</b>		<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						
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99392	and Management, 1-4 Years Old	No	\$ 150.93	\$ -	\$ 305.91	\$0.00	Per Unit

						1			1	
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	<b>De-Identified</b>	Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	Specific	
		Code			<b>Shoppable</b>	Discounted	Negotiated	<b>Negotiated</b>	<b>Negotiated</b>	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
<b>Evaluation &amp; Management Services</b>	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						
<b>Evaluation &amp; Management Services</b>	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						
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ		and Management, 18-39 Years Old	No	\$ 168.81	\$ 37.07	\$ 304.60	\$59.31	Per Unit
Evaluation & management services	i i oressional services	GF I	33333	and Management, 10-33 Teals Old	NU	γ 100.01	γ 31.01	U0.400 ب	499.9T	i ei onit

									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	Professional Services	СРТ		Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 40-64 Years Old	Νο	\$ 180.12	\$ 64.57	\$ 429.79	\$103.32	Per Unit
							¢ chor	<del>,</del>	Ç.LOSISL	
Exablate	Hospital Outpatient	СРТ	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	\$ 11,272.90	\$0.00	Case Rate
Vaccinations	Hospital Outpatient	СРТ	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$-	\$ 126.95	\$49.95	Per Unit
Vaccinations	Hospital Outpatient	СРТ	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$-	\$-	\$ <b>54.8</b> 8	Per Unit
Medicine Hyberbaric	Hospital Outpatient	СРТ	G0277	Hbot, full body chamber, 30m	No	\$ 773.99	\$ 46.24	\$ 1,424.46	\$309.28	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	СРТ	G0378	Hospital observation per hr	No	\$ 15,685.71	\$ 605.00	\$ 24,131.86	\$1,950.53	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
		<u>Code</u>			<u>CMS</u> <u>Required</u> Shoppable	Discounted	<u>De-Identified</u> <u>Minimum</u> <u>Negotiated</u>	De-Identified Maximum Negotiated	<u>Payer-</u> Specific Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Evaluation & Management Services		СРТ		Hospital outpt clinic visit	No	\$ 130.00			\$94.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	G0480	Drug test def 1-7 classes	No	\$ 476.03	\$-	\$ 732.35	\$102.99	Per Unit
Injections	Hospital Outpatient	HCPCS	J1071	Inj testosterone cypionate	No	\$ 0.22	\$ 0.03	\$ 0.34	\$0.03	Per Unit
Injections	Hospital Outpatient	HCPCS	J1815	Insulin injection	No	\$ 2.13	\$ 0.78	\$ 3.27	\$0.78	Per Unit
	Hospital Outpatient	HCPCS		Synvisc or synvisc-one	No	\$ 26.95		\$ 89.11	\$9.20	Per Unit
Injections	Hospital Outpatient	СРТ	J9217	Eligard	No	\$ 2,818.54	\$-	\$ 4,336.21	\$202.01	Per Unit