Optum Veterans Choice	Last Updated: 12/14/2021									
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified		Payer-	
		Code			Required Shoppable	Discounted	Minimum Negotiated	Maximum Negotiated	Specific Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
<u>Scrvice category</u>	Service Setting	1700	couc	<u> </u>	<u>JCTVICC.</u>	casirrice	charge	Charge	Charge	Estimate Type
										Case Rate-
										Excluding
				Cardiac valve and other major						Professional
				cardiothoracic procedures with		N/A No	N/A No	N/A No		Charges which
				cardiac catheterization with major		Service	Service	Service		are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	216	complications or comorbidities	Yes	Volume	Volume	Volume	Volume	CPT/HCPCS
										Case Rate-
										Excluding Professional
										Charges which
										are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	291	HEART FAILURE SHOCK W MCC	No	\$ 13,710.15	\$ 5,517.78	\$ 31,074.55	\$24,039.99	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
				Spinal fusion except cervical						Charges which
				without major comorbid conditions						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	460	or complications (MCC)	Yes	\$ 89,541.22	\$ 16,237.64	\$ 58,989.92	\$43,300.74	CPT/HCPCS

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

	1		T	I					1
								Will Owe *	
	Code			CMS Required Shoppable	Discounted	Minimum	<u>Maximum</u>	Payer- Specific Negotiated	
Service Setting		Code	Description						Estimate Type
<u>service setting</u>	<u> </u>	couc	<u> </u>	<u> </u>	<u>casii i iicc</u>	Charge	charge	charge	Estimate Type
Hospital Inpatient	DRG	480	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	No	\$ 58,727.97	\$ 12,375.85	\$ 48,933.51	\$36,551.52	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient	DRG	481	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	No	\$ 48,507.14	\$ 8,559.98	\$ 38,996.68	\$29,647.74	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient	DRG	482	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	No	\$ 35,733.50	\$ 6,745.73	\$ 37,731.25	\$26,313.26	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient	DRG	493	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W CC	No	\$ 46,392.83	\$ 9,438.20	\$ 41,283.64	\$31.354.73	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
	Hospital Inpatient  Hospital Inpatient	Hospital Inpatient DRG  Hospital Inpatient DRG  Hospital Inpatient DRG	Hospital Inpatient DRG 481  Hospital Inpatient DRG 482	Service Setting   Type   Code   Description	Service Setting  Code Type Code Description  Required Shoppable Service?  HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC  No  HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC  No  HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC  No  HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC  No  HOSpital Inpatient  DRG 481 HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC  No  HOSpital Inpatient  DRG 482 HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC  No  LOWER EXTREM HUMER PROCE	Code   Description   Price   Code   Description   Price   Cash Price	Service Setting  Code Type Code Description  Required Shoppable Discounted Cash Price Cash Price Cash Price Charge  HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC  No \$ 58,727.97 \$ 12,375.85  Hospital Inpatient  DRG 481 HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC No \$ 48,507.14 \$ 8,559.98  Hospital Inpatient  DRG 482 HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC No \$ 35,733.50 \$ 6,745.73  LOWER EXTREM HUMER PROCE	Service Setting  Code Description  Descripti	No   Service Setting   Service   Service   Service   Shoppable   Shoppable   Shoppable   Shoppable   Shoppable   Shoppable   Service   Shoppable   Service   Shoppable   Sho

				1	ı		1	1	1	
									Amount We	
									<b>Estimate You</b>	
									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	
Samiles Catagoni	Comice Cotting		Cada	Description						Fetimete Tune
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	Charge	<u>Charge</u>	<u>Charge</u>	Estimate Type
										Case Rate-
										Excluding
										Professional
				LOWER EXTREM HUMER PROC						Charges which
				EXCEPT HIP, FOOT, FEMUR W/O						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	494	CC/MCC	No	\$ 34,304.81	\$ 7,426.74	\$ 43,066.25	\$27,837.44	CPT/HCPCS
								-		
										Case Rate-
										Excluding
				Uterine and adnexa procedures for						Professional
				non-malignancy without comorbid						Charges which
				conditions (CC) or major comorbid						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	743	conditions or complications (MCC)	Yes	\$ 18,033.90	\$ 3,828.29	\$ 28,968.03	\$22,489.79	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				RED BLOOD CELL DISORDERS W						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	811	MCC	No	\$ 23,221.02	\$ 4,255.93	\$ 31,015.82	\$24,312.72	CPT/HCPCS
						,	+ .,	, J-,J-510E	,, / L	/ 55

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Hospital Inpatient Stay	Hospital Inpatient	DRG	812	RED BLOOD CELL DISORDERS W/O	No	\$ 17,544.11	\$ 2,955.18	\$ 26,002.03	\$20,612.61	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	No	\$ 81,430.86	\$ 21,639.28	\$ 150,000.00	\$62,521.37	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	No	\$ 38,084.70	\$ 6,540.49	\$ 50,000.00	\$36,435.59	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	935	NON-EXTENSIVE BURNS	No	\$ 18,159.73	\$ 3,301.83	\$ 50,000.00	\$28,442.36	Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS

				1					r	
									Amount We	
									Estimate You	
									Will Owe *	
To Company for a complete Click "CTRL"										
To Search for a service Click "CTRL" + "F"										
+ F										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
<u>service entegory</u>	<u>Jervice Jetting</u>	Турс	Couc	<u>Description</u>	<u>JCI VICC:</u>	casiiiiicc	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	\$42,677.24	CPT/HCPCS
, ,							. ,	. ,		
										Case Rate-
										Excluding
										Professional
				OTHER O.R. PROCEDURES FOR						Charges which
				MULTIPLE SIGNIFICANT TRAUMA						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	957	W MCC	No	\$ 139,128.72	\$ 30,888.17	\$ 200,000.00	\$69,222.28	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	958	w cc	No	\$ 73,933.71	\$ 17,182.69	\$ 125,000.00	\$45,327.29	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				OTHER MULTIPLE SIGNIFICANT						are paid by
Hospital Inpatient Stay	Hospital Inpatient	DRG	964	TRAUMA W CC	No	\$ 34,761.85	\$ 6,123.35	\$ 50,000.00	\$25,136.12	CPT/HCPCS

				I						1
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		<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
		1750		<u>=====================================</u>						
										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	\$18,939.73	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						_
			700	CESAREAN SECTION W		A 44 04 5 00	A 2 = = 0.00	A 20.50F.2F	407.040.07	are paid by
Maternity/Delivery	Hospital Inpatient	DRG	783	STERILIZATION W MCC	No	\$ 11,915.22	\$ 3,570.00	\$ 39,605.25	\$27,313.97	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	784	STERILIZATION W CC	No	\$ 9,940.40	\$ 3,570.00	\$ 27,865.12	\$19,217.33	CPT/HCPCS
, ,	· · ·					. ,		,		•
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	785	STERILIZATION W/O CC/MCC	No	\$ 8,988.27	\$ 3,519.44	\$ 25,870.71	\$17,841.87	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	786	STERILIZATION W MCC	No	\$ 12 606 27	\$ 2 570 00	\$ 35,011.06	\$24,145.56	CPT/HCPCS
iviate inity/ Delivery	nospital inpatient	טאט	/00	STERILIZATION W WICC	INU	7 12,030.27 د	3,570.00	à 22,011.00	924,143.50	CF1/HCPC3

	1			1						
									Amount We	
									<b>Estimate You</b>	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
<del>+</del>										
					CMS		<b>De-Identified</b>	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
<u> </u>	<u> </u>	-770	-	<u> </u>	<u> </u>		<u>Girange</u>	<u>Girange</u>	<u></u>	200
										Cose Boto
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	787	STERILIZATION W CC	No	\$ 11,322.59	\$ 2,835.00	\$ 27,868.32	\$19,219.53	CPT/HCPCS
indeninely, belivery	Troopital Impatient	Ditto	707	STERREIE/KITOTO VV CC	110	ÿ 11,522.55	Ψ 2,000.00	φ 27,000.02	\$13,E13.33	Ci 1/11Ci Co
										Corre Dotte
										Case Rate-
										Excluding
										Professional
										Charges which
				CESAREAN SECTION W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	788	STERILIZATION W/O CC/MCC	No	\$ 9,626.23	\$ 3,242.44	\$ 26,381.06	\$18,193.83	CPT/HCPCS
inaternity, benvery	Troopital Impatient	Ditto	700	STERRED TO TO TO CONTINUE	110	\$ 3,020.23	ψ 3)L-121-1-1	Ç 20,501.00	<b>710,133.03</b>	Ci 1/11Ci Co
										Case Rate-
										Excluding
										Professional
										Charges which
										are paid by
Maternity/Delivery	Hospital Inpatient	DRG	795	NORMAL NEWBORN	No	\$ 1,400.10	\$ 626.89	\$ 18,705.56	\$12,900.38	CPT/HCPCS
inaccinity, beneaty	Troopical impactoric	Ditto	7.55	TOTAL TELEVISION OF THE PROPERTY OF THE PROPER	110	7 1,400110	ψ 020.03	Ç 10,703.30	<b>\$12,500.50</b>	Ci 1/11Ci Co
										Case Rate-
										Excluding
										Professional
										Charges which
				VAGINAL DELIVERY W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	797	STERILIZATION/D&C W CC	No	\$ 12,785.73	\$ 2,464,00	\$ 25,917.69	\$17,874.27	CPT/HCPCS
		55		T. I.		Ţ 12,703.73	÷ 2,404.00	÷ 25,517.05	727,074.27	c. 1/11c1 co
										Corre Bot
										Case Rate-
										Excluding
										Professional
										Charges which
				VAGINAL DELIVERY W						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	798	STERILIZATION/D&C W/O CC/MCC	No	\$ 10 997 11	\$ 2,464,00	\$ 25,917.69	\$17 974 27	CPT/HCPCS
materinty/ Denvery	nospital inpatient	טווט	130	STERREIZATION DOC W/O CC/WICC	140	4 10,037.11	4 404.00	7 23,711،03	711,014.21	Ci 1/HCrC3

	1			1						
									Amount We	
									<b>Estimate You</b>	
									Will Owe *	
To Search for a service Click "CTRL"										
•										
+ "F"										
					CMS		<b>De-Identified</b>	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Comitoe Cotonomi	Samilar Sattina		0-4-	Description						Father to Tone
Service Category	Service Setting	Туре	Code	<u>Description</u>	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
										Case Rate-
										Excluding
1										Professional
										Charges which
				V4.000.41 DELIVEDY.14.40						_
				VAGINAL DELIVERY W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	805	STERILIZATION/D&C W MCC	No	\$ 10,518.03	\$ 2,464.00	\$ 27,817.08	\$19,184.19	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				VAGINAL DELIVERY W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	806	STERILIZATION/D&C W CC	No	\$ 8,616.42	\$ 2,464.00	\$ 24,277.74	\$16,743.27	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
				VAGINAL DELIVERY W/O						are paid by
Maternity/Delivery	Hospital Inpatient	DRG	807	STERILIZATION/D&C W/O CC/MCC	No	\$ 7,318.91	\$ 2,464.00	\$ 23,397.98	\$16,136.54	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
1										Charges which
Inpatient Rehabilitation Hospital										are paid by
Stay	Inpatient Rehabilitation Hospital	DRG	945	REHABILITATION W CC/MCC	No	N/A	\$ 14,553.00	\$ 14,553.00	N/A	CPT/HCPCS
							, _ :,:::::	, = ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		. ,
										Casa Bata
1										Case Rate-
										Excluding
										Professional
										Charges which
Inpatient Rehabilitation Hospital										are paid by
	Innationt Pohabilitation Hospital	DRG	046	DEHABILITATION W/O CC/MCC	No	N/A	\$ 10,970,00	\$ 10,070,00	NI/A	
Stay	Inpatient Rehabilitation Hospital	מאמ	946	REHABILITATION W/O CC/MCC	INO	IV/A	0.070,00 €	\$ 10,870.00	N/A	CPT/HCPCS

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Inpatient Rehabilitation Hospital Stay	Inpatient Rehabilitation Hospital	UB	118	Inpatient Rehabilitation Hospital Room & Board	No	52% Charges Estimated at \$2,341.96 Per Diem			100% Medicare	Per Diem Per Day
				AFTERCARE, MUSCULOSKELETAL						Case Rate- Excluding Professional Charges which
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	559	SYSTEM AND CONNECTIVE TISSUE WITH MCC	No	N/A	\$ 18,018.00	\$ 18,018.00		are paid by CPT/HCPCS
Inpatient Skilled Nursing	Inpatient Skilled Nursing	DRG	560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	No	N/A	\$ 10,435.00	\$ 10,435.00		Case Rate- Excluding Professional Charges which are paid by CPT/HCPCS

	T	1	1	T	1	ı	I	1		ı
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified		Payer-	
					Required		Minimum	<u>Maximum</u>	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	<b>Estimate Type</b>
										Case Rate-
										Excluding
										Professional
				AETERCARE MUSCUI OSVELETAL						Charges which
				AFTERCARE, MUSCULOSKELETAL						_
		220		SYSTEM & CONNECTIVE TISSUE		21.6	A 7.474.00	A 7.474.00	21/2	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	failure	No	N/A	\$ 74,931.49	\$ 74,931.49	\$37,703.24	CPT/HCPCS
										Case Rate-
										Excluding
										Professional
										Charges which
Long Term Acute Care Inpatient	Inpatient Long-Term Care			Respiratory system diagnosis w						are paid by
Stay	Hospital	DRG	LTC207	ventilator support >96 hours	No	N/A	\$ 37 703 24	\$ 37,703.24	\$74,931.49	CPT/HCPCS
Stay	Hospital	DIG	LICZUI	ventuator support >30 nours	140	N/A	\$ 37,703.24	3 37,703.24	\$74,531.45	CF 1/TICF C3
						70% Charges				
						_				
						(Estimated as	44.040.0	44 000 0		
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	N/A	Day
						52% Charges				
						Estimated at				
Skilled Nursing Inpatient Room &						\$1,109.30 Per			100%	Per Diem Per
Board	Inpatient Skilled Nursing	UB	191	Subacute Care Level 1- Skilled Care	No	Diem	\$ 227.70	\$ 850.00	Medicare	Day
1					1	•				

		1		1	ı	1	1					
											Amount We	
											Estimate You Will Owe *	
											Will Owe *	
To Search for a service Click "CTRL"												
+ "F"												
, ,												
					CMS		Do I	dentified	De-Idei	.+ifi.ad	Daver	
					Required			nimum	Maxir		Payer- Specific	
		Cada				Discounted					Negotiated	
Comitoe Cotonomi	Complex Coasting	Code	CI-	Description	Shoppable	<u>Discounted</u>	_	otiated	Negoti			Estimate Toma
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	<u>C</u>	harge	Chai	ge	Charge	Estimate Type
						52% Charges						
						Estimated at						
Skilled Nursing Inpatient Room &				Subacute Care Level 2-		\$1,109.30 Per					100%	Per Diem Per
Board	Inpatient Skilled Nursing	UB	192	Comprehensive Care	No	Diem	\$	299.70	\$ 8	350.00	Medicare	Day
						52% Charges						
						Estimated at						
Skilled Nursing Inpatient Room &				Subacute Care Level 3- Complex		\$1,109.30 Per					100%	Per Diem Per
Board	Inpatient Skilled Nursing	UB	193	Care	No	Diem	\$	370.00	\$ 8	350.00	Medicare	Day
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 530.90	s	161.58	\$ 18	03.41	\$195.16	Case Rate
nospital outputient i roccuure	Troopital Outputient	C	11102	Biopsy Tungential Biopsy of Skill		Ç 330.30	~	101.50	7 1,0	00141	<b>\$133.10</b>	case nate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	11104	Biopsy - Punch Biopsy of Skin	No	\$ 584.92	ė	167.15	Ċ 10	29.27	\$204.72	Case Rate
nospital Outpatient Procedure	Hospital Outpatient	CFI	11104	Biopsy - Fullcii Biopsy of Skill	NO	3 304.32	ې	107.13	۶ 1,0	23.27	3204.72	Case Nate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	17000	Destruction of Lesion (outpatient)	No	\$ 1,131.70	\$	157.92	\$ 1,6	34.10	\$208.53	Case Rate
							١.					
Hospital Outpatient Procedure	Hospital Outpatient	CPT	19083	Bx breast 1st lesion us imag	No	\$ 3,052.42	\$	381.25	\$ 2,9	64.36	\$1,392.47	Case Rate
						N/A No					N/A No	
				Removal of 1 or more breast		Service					Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	19120	growth, open procedure	Yes	Volume	\$	_	\$	_	Volume	Case Rate
and the second s		1		S PRE PRESENT								

r				T		1						A 11/-	
												Amount We Estimate You	
												Will Owe *	
To Search for a service Click "CTRL" + "F"													
+ +													
					CMS			De-I	dentified	De	e-Identified	Payer-	
					Required			Mi	nimum	Ν	/laximum_	Specific	
		Code			<b>Shoppable</b>		Discounted	_	otiated	N	egotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?		Cash Price	<u>C</u>	harge_		Charge	<u>Charge</u>	Estimate Type
Injections	Hospital Outpatient	СРТ	20610	Arthrocentesis (outpatient)	No	\$	370.58	Ś	182.39	Ś	1,461.73	\$280.05	Case Rate
						Ť		-		-		72000	
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	CPT	27818	Treatment of ankle fracture	No	\$	1,243.48	\$	395.00	\$	2,581.00	\$1,634.13	Case Rate
							N/A No Service					N/A No	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	29826	Arthroscopic Shoulder Surgery	Yes		Volume	Ś	_	\$	_	Service Volume	Case Rate
nospital outputient i loccuure	nospital outputient	Ci i	23020	Artifioscopie siloulaer surgery	103		Volunic	<del>-</del>		7		Volume	cuse nate
							N/A No					N/A No	
				Arthroscopic Knee Surgery			Service					Service	
Hospital Outpatient Procedure	Hospital Outpatient	CPT	29881	(outpatient)	Yes		Volume	\$	-	\$	-	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	31575	Laryngoscopy - Diagnostic	No	\$	449.87	Ś	135.86	Ś	1,978.02	\$204.50	Case Rate
				, 6,		ľ		•			,		
Hospital Outpatient Procedure	Hospital Outpatient	CPT	32555	Aspirate pleura w/ imaging	No	\$	608.39	\$	288.54	\$	1,852.06	\$678.61	Case Rate
							N/A No					N/A No	
				Tonsillectomy with Adenoidectomy			Service					Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	42820	-	Yes		Volume	\$	_	\$	-	Volume	Case Rate
-	·			-									
				Upper Gastrointestinal Endoscopy -									
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	43235	Diagnostic	Yes	\$	2,027.21	\$	61.00	\$	1,867.74	\$827.47	Case Rate
	the same of the same			•		1 7	,				,	4.5	

T			T					Amazunt Ma	1
Service Setting	Code Type	Code	Description	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Hospital Outpatient	СРТ	43239	Upper Gastrointestinal Endoscopy - With Biopsy	Yes	\$ 1,259.34	\$ 372.00	\$ 2,229.48	\$842.87	Case Rate
Hospital Outpatient	СРТ	45378	Colonoscopy - Diagnostic	Yes	\$ 2.117.86	\$ 335.79	\$ 2.220.88	\$868.43	Case Rate
nospital outpution	C	43370	(outputient)	103	Ç 2,117.00	ψ 333.73	ψ 2,220.00	<b>4000140</b>	cuse nate
Hospital Outpatient	СРТ	45380	Colonoscopy - With Biopsy (outpatient)	Yes	\$ 3,082.66	\$ 343.06	\$ 4,110.45	\$1,100.53	Case Rate
			Colonoscopy - With Polyp Removal						
Hospital Outpatient	СРТ	45385		Yes	\$ 3,317.89	\$ 354.50	\$ 4,434.15	\$1,153.24	Case Rate
Hospital Outpatient	СРТ	4E2Q1	Ultrasound examination of lower	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
	Hospital Outpatient  Hospital Outpatient  Hospital Outpatient	Hospital Outpatient CPT  Hospital Outpatient CPT  Hospital Outpatient CPT  Hospital Outpatient CPT	Hospital Outpatient CPT 43239  Hospital Outpatient CPT 45378  Hospital Outpatient CPT 45380  Hospital Outpatient CPT 45385	Code   Description   CPT   Code   Description	Service Setting  Code Type Code Description  CPT 43239 Upper Gastrointestinal Endoscopy - Yes  Hospital Outpatient  CPT 45378 (outpatient)  CPT 45380 (outpatient)  CPT 45385 (Outpatient)  Colonoscopy - With Biopsy  Yes  Colonoscopy - With Biopsy  Yes  Colonoscopy - With Polyp Removal (outpatient)  Yes  Ultrasound examination of lower	Code   Description   Code   Description   Description   Description   Discounted   Shoppable   Discounted   Shoppable   Discounted   Cash Price	Code   Description   Service   Discounted   Shoppable   Discounted   Shoppable   Cash Price   Cash Price	Code   Description   Service Setting   Code   Description   Property   Code   Description   Service   Cash Price   Charge   Cha	Service Setting Type Code Description Service Setting Description Service Shoppable Discounted Shoppable Discounted Shoppable Discounted Shoppable Discounted Charge Cash Price Cash Price Cash Price Charge

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					<u>CMS</u>		De-Identified		Payer-	
		Code			Required Shoppable	Discounted	Minimum Negotiated	Maximum Negotiated	Specific Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	СРТ	47562	Gall Bladder Surgery (outpatient)	Yes	\$ 12,062.52	\$ 504.75	\$ 18,374.88	\$4,984.16	Case Rate
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	СРТ	49440	Place gastrostomy tube perc	No	\$ 3,111.60	\$ 445.12	\$ 3,166.61	\$1,605.86	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	49505	Repair of groin hernia patient age 5 years or older	Yes	\$ 9,867.85	\$ 470.98	\$ 15,040.03	\$3,298.20	Case Rate
nospital Outpatient Procedure	nospital outpatient	CFT	49303	years or order	163	3,807.83	Ş 470.56	7 13,040.03	73,238.20	case nate
Hasnital Outpatient Presedure	Hospital Quitnotions	СРТ	E1700	Uring Canacity Magazyramant	No	\$ 97.04	\$ -	\$ 1.579.20	\$58.86	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	31/96	Urine Capacity Measurement	No	\$ 37.04	<b>,</b> -	\$ 1,579.20	\$30.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	52000	Cystoscopy	No	\$ 1,173.22	\$ 282.78	\$ 1,596.52	\$580.47	Case Rate
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	СРТ	55700	Biopsy of prostate gland	Yes	\$ 1,165.04	\$ 284.76	\$ 2,631.84	\$1,725.00	Case Rate
				Surgical removal of prostate and		N/A No	N/A No	N/A No	N/A No	
Hospital Outpatient Presedure	Hospital Outpations	CDT	EEOCC	surrounding lymph nodes using an	Vos	Service	Service	Service	Service	Casa Pata
Hospital Outpatient Procedure	Hospital Outpatient	CPT	33806	endoscope	Yes	Volume	Volume	Volume	Volume	Case Rate

	1	1		T				_	1		1		
												Amount We	
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL"													
+ "F"													
+ F													
												_	
					<u>CMS</u>				dentified		-Identified	Payer-	
					Required				nimum	_	<u>laximum</u>	Specific	
		Code			<u>Shoppable</u>		scounted		gotiated		<u>egotiated</u>	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	C	ash Price	<u>C</u>	harge		Charge	<u>Charge</u>	Estimate Type
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	CPT	58100	Biopsy - Endometrial (Uterus)	No	\$	375.83	\$	144.00	\$	1,697.39	\$211.79	Case Rate
<b>Hospital Outpatient Procedure</b>	<b>Hospital Outpatient</b>	CPT	58300	Insert intrauterine device	No	\$	632.24	\$	48.93	\$	1,749.37	\$8.45	Case Rate
<b>Hospital Outpatient Procedure</b>	<b>Hospital Outpatient</b>	CPT	58301	Remove intrauterine device	No	\$	273.85	\$	32.34	\$	1,495.58	\$309.32	Case Rate
<b>Hospital Outpatient Procedure</b>	<b>Hospital Outpatient</b>	CPT	59025	Fetal Non-Stress Test	No	\$	260.79	\$	118.53	\$	1,596.22	\$177.36	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	\$1,997.58	Case Rate
	1.0.033/offai ScrateC3	51.1	33400	denvery cure	103	7	-,-50.21	7	2-72.00	7	3,270.70	ψ±,557.50	case nate
Professional Services Associated													
with Inpatient Stay	Professional Services	СРТ	59/10	Obstetrical care	No	\$	2,230.06	ċ	133.91	\$	1,625.81	\$984.35	Case Rate
with inpatient stay	1 Totessional Services	CFI	33410	Obstatical care	140	۶	۷,230.00	ب	133.71	٧	1,023.01	3304.33	case nate
													<b> </b>
													<b> </b>
													<b> </b>
				Routine obstetric care for cesarean									
Professional Services Associated				delivery, including pre-and post-		١.		١.					
with Inpatient Stay	Professional Services	CPT	59510	delivery care	Yes	\$	4,966.56	\$	246.05	\$	3,619.13	\$2,205.19	Case Rate

	T			T						
									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>	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>		-775					5.11.20			
				Routine obstetric care for vaginal						
				delivery after prior cesarean						
Professional Services Associated				delivery including pre-and post-						
	Professional Comicas	CDT	F0C40		W	ć 4.70C.F0	ć 20F.00	ć 2.420.24	ć2 000 C2	Corre Dote
with Inpatient Stay	Professional Services	CPT	59610	delivery care	Yes	\$ 4,706.58	\$ 305.08	\$ 3,429.34	\$2,090.62	Case Rate
				Injustice of substance into suinal						
				Injection of substance into spinal						
				canal of lower back or sacrum using						
Hospital Outpatient Procedure	Hospital Outpatient	CPT	62322	imaging guidance	Yes	\$ 1,055.18	\$ 379.33	\$ 1,880.39	\$646.00	Case Rate
				Injection of substance into spinal						
				canal of lower back or sacrum using						
<b>Hospital Outpatient Procedure</b>	Hospital Outpatient	CPT	62323	imaging guidance	Yes	\$ 1,665.98	\$ 305.01	\$ 1,988.33	\$660.43	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	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
				Injections of anesthetic and/or steroid drug into lower or sacral						
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	64483	spine nerve root using imaging guidance	Yes	\$ 1,776.21	\$ 358.46	\$ 1,980.49	\$840.76	Case Rate
				Removal of recurring cataract in		N/A No Service			N/A No Service	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	66821	lens capsule using laser	Yes	Volume	\$ -	\$ -	Volume	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	66984	Removal of cataract with insertion of lens	Yes	N/A No Service Volume	\$ -	\$ -	N/A No Service Volume	Case Rate
			22304			2 3.31110	Ŧ	Ŧ	- Control	
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	69210	Remove impacted ear wax	No	\$ 168.99	\$ 48.93	\$ 1,604.78	\$81.69	Case Rate
Radiology Services	Hospital Outpatient	СРТ	70450	CT Scan - Head/Brain, without Contrast	No	\$ 901.06	\$ 127.22	\$ 1,318.18	\$97.92	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	<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> Jervice Category</u>	<u> </u>	Туре	coue	Description	Service:	Casii File	Charge	Charge	Charge	Littillate Type
				CT Scan - Head/Brain, without						
Radiology Services	<b>Hospital Outpatient</b>	CPT	70450	Contrast	Yes	\$ 901.06	\$ 127.22	\$ 1,318.18	\$142.70	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	\$226.16	Per Unit
Radiology Services	Tiospital Outpatient	CFT	70402	ct orbit/ear/1033a w/ 00cw/ dye	140	\$ 2,333.00	\$ 207.75	7 2,037.02	\$220.10	reronit
Radiology Services	Hospital Outpatient	CPT	70486	Ct maxillofacial w/o dye	No	\$ 1,668.57	\$ 127.52	\$ 2,259.85	\$143.02	Per Unit
Radiology Services	<b>Hospital Outpatient</b>	CPT	70496	Ct angiography head	No	\$ 1,871.05	\$ 223.05	\$ 1,996.31	\$249.86	Per Unit
Radiology Services	Hospital Outpatient	СРТ	70498	Ct angiography neck	No	\$ 1,632.72	\$ 223.05	\$ 1,677.63	\$249.86	Per Unit
				ar angregicapiny mean		7 3,000	,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7=10100	
Padialam: Caminas	Heavital Outrations	CDT	70554	MADI DDAINI STEMA WAYO DVE	No	ć 1 F10 10	ć 252.20	ć 2.270.20	¢202.04	Day Unit
Radiology Services	Hospital Outpatient	СРТ	/0551	MRI BRAIN STEM W/O DYE	No	\$ 1,518.19	\$ 252.20	\$ 2,270.30	\$282.84	Per Unit
Radiology Services	Hospital Outpatient	CPT	70553	MRI - Brain (outpatient)	Yes	\$ 2,314.59	\$ 406.50	\$ 3,409.54	\$456.53	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71045	X-ray exam chest 1 view	No	\$ 138.11	\$ 19.91	\$ 181.37	\$80.92	Per Unit
-07		-		,						
Padialani Camina	Hamital Outmations	CDT	71046	V. Boy. Chast (autmationt)	N.	ć 140.00	ć 21 FO	ć 102.55	¢02.60	Don Huit
Radiology Services	Hospital Outpatient	CPT	/1046	X-Ray - Chest (outpatient)	No	\$ 148.99	\$ 31.50	\$ 193.55	\$82.68	Per Unit

	1			T				1				Amount We	
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL" + "F"													
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?		scounted ash Price	Mi Neg	dentified nimum otiated harge	No.	e-Identified Maximum egotiated 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	\$115.60	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71250	CT THORAX W/O DYE	No	\$	1,024.52	\$	141.11	\$	1,468.48	\$157.77	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$	1,448.52	\$	200.76	\$	2,034.88	\$225.40	Per Unit
Radiology Services	Hospital Outpatient	СРТ	71275	Ct angiography chest	No	\$	1,935.65	\$	226.19	\$	2,092.27	\$253.36	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72040	X-Ray - Neck, Cervical Spine	No	\$	154.65	\$	37.93	\$	204.42	\$83.01	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72070	X-Ray - Middle Back, Thoracic Spine	No	\$	251.61	\$	33.93	\$	338.99	\$111.06	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72100	X-Ray - Spine (outpatient)	No	\$	199.60	\$	37.93	\$	265.13	\$112.11	Per Unit
Radiology Services	Hospital Outpatient	СРТ	72110	X-Ray, lower back, minimum four	Yes	Ś	213.64	Ś	52.80	s	284.93	\$113.87	Per Unit
Managed Sciences	Hospital Outputient	5	, 2110	*10**3	1 63	7	213.04	7	32.00	7	207.53	7113.07	. Cr Oint

	T			_									
												Amount We	
												<b>Estimate You</b>	
												Will Owe *	
To Search for a service Click "CTRL"													
+ "F"													
												· ·	
					CMS			De-	<u>Identified</u>	De	e-Identified	Payer-	
					Required			M	linimum	l r	Maximum	Specific	
		Code			Shoppable	_ D	iscounted	_	gotiated	_	legotiated	Negotiated	
						_				18			
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	<u>C</u>	ash Price	9	<u>Charge</u>		Charge	<u>Charge</u>	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	72125	Ct neck spine w/o dye	No	\$	1,459.37	\$	136.86	\$	1,750.92	\$150.06	Per Unit
Radiology Services	Hospital Outpatient	CFT	72123	ct neck spine w/o uye	140	7	1,433.37	7	130.80	7	1,730.32	\$130.00	reronic
		1											
Radiology Services	<b>Hospital Outpatient</b>	CPT	72126	Ct neck spine w/dye	No	\$	1,293.16	\$	260.86	\$	1,821.59	\$404.05	Per Unit
		1				_				Ė			
Radiology Services	Hospital Outpatient	CPT	72127	Ct neck spine w/o & w/dye	No	\$	1,815.93	\$	201.73	\$	2,118.48	\$226.48	Per Unit
												4	
Radiology Services	Hospital Outpatient	CPT	/2129	Ct chest spine w/dye	No	\$	1,520.66	\$	199.82	\$	1,805.90	\$224.03	Per Unit
Radiology Services	<b>Hospital Outpatient</b>	СРТ	72122	Ct lumbar spine w/dye	No	\$	1,518.43	Ġ	260.86	Ġ	1,805.90	\$404.05	Per Unit
Radiology Services	nospital Outpatient	CFT	72132	ct fullbal spille w/uye	140	7	1,310.43	7	200.00	7	1,803.30	3404.03	reronic
Radiology Services	Hospital Outpatient	CPT	72133	Ct lumbar spine w/o & w/dye	No	\$	1,904.42	\$	201.90	\$	2,238.70	\$226.16	Per Unit
<u> </u>													
						١.		١.		١.			
Radiology Services	Hospital Outpatient	CPT	72141	MRI NECK SPINE W/O DYE	No	\$	1,441.84	\$	252.20	\$	2,177.11	\$282.84	Per Unit
Padialogy Convices	Hospital Outpationt	CPT	721/10	MRI - Back (outpatient)	Yes	\$	1,381.13	ė	252.20	خ	2,137.12	\$282.84	Per Unit
Radiology Services	Hospital Outpatient	CFI	/2140	Wiki - Back (Outpatient)	163	Ą	1,361.13	Ą	232.20	Ą	2,137.12	3202.04	rei Ollit
		1											
Radiology Services	<b>Hospital Outpatient</b>	CPT	72170	X-Ray - Pelvis	No	\$	249.04	\$	28.72	\$	327.10	\$109.65	Per Unit
<u> </u>		1		· ·				Ė				-	
		1											
		1				١.		١.		١.			
Radiology Services	Hospital Outpatient	CPT	72190	X-RAY EXAM OF PELVIS	No	\$	208.53	\$	39.60	\$	264.73	\$113.51	Per Unit
		1											
		1											
		1				١.		١.				4	
Radiology Services	Hospital Outpatient	CPT	72193	CT scan, pelvis, with contrast	Yes	\$	1,536.96	Ş	197.29	Ş	2,142.05	\$221.03	Per Unit

-							_	1	_	
									Amount We	
									<b>Estimate You</b>	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
, ,										
					<u>CMS</u>		De-Identified	De-Identified	Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
<u> </u>		3775							-	
Radiology Services	Hospital Outpatient	CPT	72197	MRI - Pelvis (outpatient)	No	\$ 2,448.72	\$ 402.71	\$ 3,522.33	\$451.62	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73000	X-ray exam of collar bone	No	\$ 147.59	\$ 22.40	\$ 185.92	\$80.19	Per Unit
		-				· -	7	7	700.20	
Radiology Services	Hospital Outpatient	CPT	73010	X-ray exam of shoulder blade	No	\$ 196.93	\$ 26.01	\$ 251.93	\$109.98	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73030	X-Ray - Shoulder (outpatient)	No	\$ 149.50	\$ 28.33	\$ 196.92	\$81.24	Per Unit
naurology controct	поортан с агранено		70000	A nay oncomes (coopensis)		Ţ		7 250.52	<b>VOLUE</b> :	
B 11 1 6 1		CDT	70000	V DAY 5V444 OF 1111455116		4 47 6		405.00	400.40	
Radiology Services	Hospital Outpatient	СРТ	/3060	X-RAY EXAM OF HUMERUS	No	\$ 147.62	\$ 29.40	\$ 195.82	\$80.19	Per Unit
Radiology Services	Hospital Outpatient	CPT	73070	X-ray exam of elbow	No	\$ 146.83	\$ 25.07	\$ 191.42	\$80.19	Per Unit
Radiology Services	<b>Hospital Outpatient</b>	СРТ	73080	X-RAY EXAM OF ELBOW	No	\$ 122.83	\$ \$ 26.72	\$ 154.02	\$80.55	Per Unit
naaiology services	1103pital Outpatient	CF I	73000	A-NAT EARING OF ELDOW	140	7 122.03	20.72	7 134.02	300.33	i ei oiiit
Radiology Services	Hospital Outpatient	CPT	73090	X-RAY EXAM OF FOREARM	No	\$ 117.10	\$ 26.40	\$ 151.82	\$80.19	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73110	X-Ray - Wrist (outpatient)	No	\$ 156.52	\$ 30.72	\$ 196.19	\$80.55	Per Unit
37		1	3 2 2 2 2			÷ 250131	7 33172	7 253125	755.55	
B 11 1 6 1		6DE		V BAV 5VAA 05					44.00	S
Radiology Services	Hospital Outpatient	CPT	73120	X-RAY EXAM OF HAND	No	\$ 192.03	\$ 24.40	\$ 249.73	\$109.29	Per Unit

												Amount We	
												Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"													
Service Category	Service Setting	Code Type	<u>Code</u>	<u>Description</u>	CMS Required Shoppable Service?		ounted h Price	Mi Neg	dentified nimum gotiated harge	<u>N</u>	e-Identified Maximum legotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Radiology Services	Hospital Outpatient	СРТ	73130	X-Ray - Hand	No	\$	151.54	\$	32.72	\$	198.42	\$80.55	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73221	MRI - Shoulder, Elbow, or Wrist	No	\$ 1	1,211.82	\$	246.65	\$	1,702.46	\$277.17	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73502	X-Ray - Hip	No	\$	129.58	\$	37.77	\$	197.91	\$83.01	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73552	X-RAY EXAM OF FEMUR 2/>	No	\$	150.51	\$	29.51	\$	189.38	\$80.92	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$	201.92	\$	32.40	\$	266.82	\$80.19	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73562	X-Ray - Knee (outpatient)	No	\$	263.50	\$	36.52	\$	351.25	\$81.24	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73590	X-ray exam of lower leg	No	\$	239.62	\$	32.40	\$	321.48	\$79.87	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73600	X-RAY EXAM OF ANKLE	No	\$	191.55	\$	31.98	\$	278.60	\$80.19	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73610	X-Ray - Ankle (outpatient)	No	\$	239.05	\$	25.72	\$	311.14	\$80.55	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73620	X-RAY EXAM OF FOOT	No	\$	196.24	\$	29.81	\$	262.21	\$79.55	Per Unit

										Ι	1	Amount We	<u> </u>
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL" + "F"													
Service Category	Service Setting	Code Type	Code	Description	CMS Required Shoppable Service?		scounted	Mi Neg	dentified nimum gotiated harge	N	e-Identified Maximum legotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
		7/65											
Radiology Services	Hospital Outpatient	СРТ	73630	X-Ray - Foot (outpatient)	No	\$	216.05	\$	33.95	\$	289.60	\$80.23	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73700	CT LOWER EXTREMITY W/O DYE	No	\$	1,231.00	\$	134.01	\$	1,400.92	\$150.06	Per Unit
Radiology Services	Hospital Outpatient	СРТ	73721	MRI - Knee (outpatient)	Yes	\$	1,224.32	\$	246.65	\$	1,828.36	\$276.48	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74018	X-Ray - Abdomen	No	\$	145.61	\$	28.31	\$	189.76	\$80.92	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74150	Ct abdomen w/o dye	No	\$	977.64	\$	142.38	\$	1,446.99	\$159.36	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74170	Ct abdomen w/o & w/dye	No	\$	1,824.18	\$	207.86	\$	2,144.29	\$232.83	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74177	CT Scan - Abdomen and Pelvis, with Contrast	No	\$	2,748.11	\$	286.79	\$	3,568.86	\$433.70	Per Unit
						<b>T</b>	_,,	-	200.70	T	3,000.00	7.00.00	
Radiology Services	Hospital Outpatient	СРТ	74177	CT Scan - Abdomen and Pelvis, with Contrast	Yes	\$	2,748.11	\$	286.79	\$	3,568.86	\$433.70	Per Unit
Radiology Services	Hospital Outpatient	СРТ	74220	X-ray xm esophagus 1cntrst	No	\$	394.10	\$	56.38	\$	563.71	\$193.66	Per Unit

											Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	Code Type	Code	Description	CMS Required Shoppable Service?	Discount Cash Pri	ed_	De-Identified  Minimum  Negotiated  Charge	M Ne	Identified aximum egotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Radiology Services	Hospital Outpatient	СРТ	74270	X-ray xm colon 1cntrst std	No	\$ 521	.72	\$ 79.34	\$	578.01	\$215.08	Per Unit
Radiology Services	Hospital Outpatient	СРТ	75571	Ct hrt w/o dye w/ca test	No	\$ 306	.04	\$ 59.00	¢	323.39	\$100.25	Per Unit
Radiology Services	Trospital Outpatient	CFT	73371	ct iii t w/o dye w/ca test	140	<del>у</del> 300	.04	33.00	Ţ	323.33	3100.23	reronit
Radiology Services	Hospital Outpatient	СРТ	76536	Ultrasound - Head and Neck	No	\$ 460	.62	\$ 78.79	\$	386.50	\$128.63	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76642	Ultrasound - Breast (outpatient)	No	\$ 152	.68	\$ 78.52	\$	249.30	\$105.16	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76700	Ultrasound - Abdominal, Complete	Yes	\$ 361	.43	\$ 91.69	\$	433.80	\$140.93	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76705	Ultrasound - Abdominal, Limited	No	\$ 327	.93	\$ 46.05	\$	372.20	\$129.71	Per Unit
- Carrier and Carr				The state of the s		7 321		+ +0.03	~	5,2.20	Y123.71	. S. Oint
Maternity/Delivery	Hospital Outpatient	СРТ	76770	US EXAM ABDO BACK WALL COMP	No	\$ 456	.58	\$ 76.54	\$	400.80	\$137.07	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76801	OB US < 14 WKS SINGLE FETUS	No	\$ 391	.57	\$ 86.65	\$	396.27	\$149.69	Per Unit

				I	1		- 1		T		1
										Amount We	
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL"											
+ "F"											
					CMS			De-Identified	De-Identifie	d Payer-	
					Required			Minimum	Maximum		
		Code			Shoppable	Discoun	ted	Negotiated	Negotiated		
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Pr		Charge	Charge	Charge	Estimate Type
Service Category	Service Setting	туре	coue	Description	<u>Jervice:</u>	Casii Fi	ice	Charge	Charge	Charge	Estimate Type
				Ultrasound - Pregnancy							
Radiology Services	<b>Hospital Outpatient</b>	CPT	76805	(outpatient)	Yes	\$ 36	7.73	\$ 100.36	\$ 437.1	0 \$149.69	Per Unit
Maternity/Delivery	Hospital Outpatient	СРТ	76911	OB US DETAILED SNGL FETUS	No	\$ 52	2.04	\$ 198.65	\$ 587.5	0 \$303.13	Per Unit
iviaternity/ Derivery	Tiospital Outpatient	CFT	70011	OB 03 DETAILED SINGETETOS	140	7 32	2.04	7 130.03	3 307.5	0 9303.13	reronit
Maternity/Delivery	Hospital Outpatient	CPT	76815	OB US LIMITED FETUS(S)	No	\$ 30	9.95	\$ 54.75	\$ 384.3	0 \$132.85	Per Unit
Radiology Services	Hospital Outpatient	CPT	76816	Ultrasound - Pregnancy Follow-Up	No	\$ 40	6.54	\$ 64.37	\$ 384.3	0 \$142.66	Per Unit
Maternity/Polivery	Hospital Outpations	CDT	76010	EETAL BIODHYS BROEHE W/NST	No	\$ 47	6 50	ć 92.20	\$ 387.2	7 \$152.46	Dor Unit
Maternity/Delivery	Hospital Outpatient	CPT	70919	FETAL BIOPHYS PROFILE W/NST	No	\$ 47	6.50	\$ 82.20	\$ 387.2	7 \$152.46	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 40	7.39	\$ 97.44	\$ 398.3	4 \$138.80	Per Unit
Radiology Services	Hospital Outpatient	СРТ	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 37	0.14	\$ 88.69	\$ 391.6	9 \$135.12	Per Unit
<u> </u>										-	
				Ultrasound - Transvaginal (non-		١.					
Radiology Services	Hospital Outpatient	CPT	76830	maternity)	Yes	\$ 47	5.43	\$ 98.63	\$ 463.9	0 \$134.94	Per Unit

											Amount We	Ī
											Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	Code Type	<u>Code</u>	<u>Description</u>	CMS Required Shoppable Service?	scounted sh Price	Mi Ne	dentified inimum gotiated charge	Ma Ne	Identified aximum gotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Radiology Services	Hospital Outpatient	СРТ	76856	Ultrasound - Pelvic (outpatient)	No	\$ 344.00	\$	70.34	\$	408.50	\$134.62	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77065	Mammography of one breast	Yes	\$ 546.40	\$	107.57	\$	501.03	\$124.54	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77066	Mammography of both breasts	Yes	\$ 383.79	\$	135.81	\$	629.70	\$156.97	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77067	Mammogram (outpatient)	Yes	\$ 406.73	\$	109.22	Ś	504.02	\$126.94	Per Unit
Radiology Services	Hospital Outpatient	СРТ	/7080	Bone Density Scan (outpatient)	No	\$ 247.25	Ş	56.29	\$	393.45	\$110.74	Per Unit
Radiology Services	Hospital Outpatient	СРТ	77081	Dxa bone density/peripheral	No	\$ 116.84	\$	33.80	\$	171.64	\$81.96	Per Unit
Radiology Services	Hospital Outpatient	СРТ	78452	Myocardial Imaging (outpatient)	No	\$ 1,010.04	\$	336.74	\$	2,091.45	\$1,224.96	Per Unit

				T					Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	<u>Charge</u>	<u>Charge</u>	Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 158.03	\$ 11.84	\$ 221.33	\$16.92	Per Unit
	nospital outputient	C	00040	Dioda rest Busic Metabolic runer	103	7 130.03	<b>V</b> 11.04	<b>V</b> 221.55	<b>\$10.52</b>	T CT OTHE
				Blood Test - Comprehensive						
Laboratory & Pathology Services	Hospital Outpatient	CPT	80053	Metabolic Panel	Yes	\$ 93.73	\$ 14.78	\$ 136.89	\$21.12	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	CPT	80055		Yes	Volume	Volume	Volume	Volume	Per Unit
				Pland Test Chalestoral Test Linid						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80061	Blood Test - Cholesterol Test, Lipid	Yes	\$ 46.48	\$ 12.05	\$ 101.77	\$13.39	Per Unit
Laboratory & Fathology Scrvices	Tiospital outputient	Ci i	00001	Tanci	103	7 40.40	7 12.03	y 101.77	<b>Ģ13.33</b>	T CT OTHE
				Blood Test - Renal (Kidney)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80069	Function Panel	Yes	\$ 17.24	\$ 8.68	\$ 34.59	\$17.36	Per Unit
				Blood Test - Hepatic (Liver)						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	80076	Function Panel	Yes	\$ 146.77	\$ 11.44	\$ 205.84	\$16.34	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
									Will Owe	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	De-Identified	Payer-	
					Required		<b>Minimum</b>	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	80307	Drug test prsmv chem anlyzr	No	\$ 128.65	\$ 55.93	\$ 199.53	\$62.14	Per Unit
						N/A No	N/A No	N/A No	N/A No	
						Service	Service	Service	Service	
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	81000	Urinalysis nonauto w/scope	Yes	Volume	Volume	Volume	Volume	Per Unit
				Urine Test - Automated with						
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	81001	Microscope Examination	Yes	\$ 23.46	\$ 4.44	\$ 34.47	\$6.34	Per Unit
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	81002	Urine Test - Urinalysis, Manual Test	Yes	\$ 7.24	\$ 2.67	\$ 14.00	\$3.48	Per Unit
				Urine Test - Automated without						
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	81003	Microscope	Yes	\$ 10.40	\$ 3.16	\$ 11.25	\$4.50	Per Unit
<b>Laboratory &amp; Pathology Services</b>	<b>Hospital Outpatient</b>	CPT	81025	Urine Test - Pregnancy	No	\$ 40.87	\$ 10.45	\$ 58.29	\$17.22	Per Unit
<b>Laboratory &amp; Pathology Services</b>	Hospital Outpatient	CPT	82247	Bilirubin total	No	\$ 41.02	\$ 4.52	\$ 55.22	\$5.02	Per Unit
Laboratory & Pathology Services	<b>Hospital Outpatient</b>	CPT	82306	Blood Test - Vitamin D-3 Level	No	\$ 188.74	\$ 26.64	\$ 254.08	\$29.60	Per Unit

	1								Amount We	
									Estimate You	
									Will Owe *	
									Will Owe	
To Search for a service Click "CTRL"										
+ "F"										
· ·										
					CMS		De-Identified	De-Identified	Payer-	
								Maximum		
					Required	B	Minimum		<u>Specific</u>	
	6 . 6	Code		<b>.</b>	Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	Charge	<u>Charge</u>	Charge	Estimate Type
									_	
Laboratory & Pathology Services	Hospital Outpatient	CPT	82330	Assay of calcium	No	\$ 35.11	\$ 12.31	\$ 67.00	\$13.68	Per Unit
Laboratory & Pathology Services	<b>Hospital Outpatient</b>	CPT	82375	Assay carboxyhb quant	No	\$ 114.13	\$ 11.09	\$ 153.64	\$12.32	Per Unit
Laboratory & Pathology Services	<b>Hospital Outpatient</b>	CPT	82465	Assay bld/serum cholesterol	No	\$ 15.28	\$ 3.92	\$ 23.76	\$4.35	Per Unit
, ,,										
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82550	Assay of ck (cpk)	No	\$ 12.70	\$ 5.86	\$ 35.53	\$6.51	Per Unit
		- C	02000	rissay or on (opiny		Ţ	Ţ 0.00	7 00.00	70.02	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82552	Assay of cpk in blood	No	\$ 26.14	\$ 12.05	\$ 75.41	\$13.39	Per Unit
Laboratory & Patriology Services	nospital Outpatient	CFT	02332	Assay of cpk in blood	140	ÿ 20.14	ÿ 12.03	7 73.41	ÿ13.33	reronic
Laboratore & Dathalam Comicas	Heavital Outrations	CDT	02565	A of overticing	No	ć 124 FO	ć 7.17	ć 70.3F	¢10.24	Don Huit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82505	Assay of creatinine	No	\$ 124.50	\$ 7.17	\$ 70.25	\$10.24	Per Unit
				Blood Test - Vitamin B-12						
Laboratory & Pathology Services	Hospital Outpatient	CPT	82607	(Cyanocobalamin) Level	No	\$ 29.40	\$ 13.57	\$ 82.73	\$15.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82610	Cystatin c	No	\$ 140.40	\$ 14.17	\$ 405.00	\$18.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82668	Assay of erythropoietin	No	\$ 36.68	\$ 16.91	\$ 99.20	\$18.79	Per Unit
									-	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82670	Assay of estradiol	No	\$ 54.51	\$ 25.15	\$ 152.33	\$27.94	Per Unit
-and action y on a definition by set vices		<u> </u>	02070	. Loury or contamor	.40	7 37.31	7 23.13	T 132.33	Y=7.54	. Cr Offic

									Amount We	
									Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	Code Type	<u>Code</u>	<u>Description</u>	CMS Required Shoppable Service?	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	82693	Assay of ethylene glycol	No	\$ 20.29	\$ 13.41	\$ 40.08	\$14.90	Per Unit
					-					
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 33.53	\$ 19.09	\$ 96.63	\$27.26	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82746	Blood Test - Folic Acid Level	No	\$ 37.75	\$ 13.23	\$ 79.52	\$14.70	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82803	Blood gases any combination	No	\$ 73.40	\$ 20.17	\$ 106.16	\$26.07	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82947	Assay glucose blood quant	No	\$ 34.04	\$ 5.51	\$ 49.42	\$7.86	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	82962	Glucose blood test	No	\$ 45.55	\$ 3.89	\$ 61.82	\$6.56	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83018	Heavy metal quant each nes	No	\$ 172.97	\$ 19.76	\$ 498.96	\$21.96	Per Unit
,			22.52.5	, , , , , , , , , , , , , , , , , , , ,		, 2,2,3,7	. 25370	, 133.30	Ţ-2100	
				Blood Test - Blood Glucose Control						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83036	(Hemoglobin A1C)	No	\$ 71.27	\$ 8.74	\$ 95.94	\$9.71	Per Unit

											Amount We	
											Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	Discounte	<u>d</u>	De-Identified Minimum Negotiated Charge	N	e-Identified Maximum egotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83088	Assay of histamine	No	\$ 75.	84 \$	26.58	\$	218.76	\$29.53	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83518	Immunoassay dipstick	No	\$ 147.	09 \$	6.55	\$	424.29	\$9.64	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83540	Blood Test - Iron Level	No	\$ 51.	90 \$	9.06	\$	75.77	\$12.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83605	Assay of lactic acid	No	\$ 27.	14 \$	10.41	\$	58.05	\$11.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83690	Blood Test - Lipase (fat enzyme) Level	No	\$ 69.	47 \$	6.20	\$	93.51	\$6.89	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83735	Assay of magnesium	No	\$ 53.	82 \$	9.38	\$	78.56	\$13.40	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	83880	Assay of natriuretic peptide	No	\$ 172.	55 \$	35.33	\$	232.27	\$39.26	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84100	Assay of phosphorus	No	\$ 61.	73 \$	6.64	\$	87.67	\$9.48	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	\$ 43.	23 \$	6.66	\$	62.65	\$9.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84132	Assay of serum potassium	No	\$ 43.	23 5	6.66	Ś	62.65	\$9.52	Per Unit

									Amount We	
									Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	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	84144	Assay of progesterone	No	\$ 52.59	\$ 18.77	\$ 96.68	\$20.86	Per Unit
				Blood Test - Prostate Specific						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84153	Antigen (PSA) Level	Yes	\$ 74.21	\$ 25.75	\$ 116.68	\$36.78	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84154	PSA (prostate specific antigen)	Yes	\$ 106.34	\$ 16.55	\$ 143.15	\$18.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84182	Protein western blot test	No	\$ 382.72	\$ 18.76	\$ 588.80	\$29.21	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84295	Assay of serum sodium	No	\$ 42.10	\$ 4.33	\$ 56.67	\$4.81	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84439	Blood Test - Thyroxine (Thyroid Chemical) Level, Free	No	\$ 66.21	\$ 8.12	\$ 89.13	\$9.02	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 64.07	\$ 23.52	\$ 119.09	\$33.60	Per Unit

	T			I			1	1	Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	<u>Code</u>	<u>Description</u>	CMS Required Shoppable Service?	<u>Discounted</u> <u>Cash Price</u>	De-Identified Minimum Negotiated Charge	De-Identified  Maximum  Negotiated  Charge	Payer- Specific Negotiated Charge	Estimate Type
				Blood Test - Thyroid Stimulating						
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Hormone (TSH) Level	Yes	\$ 64.07	\$ 23.52	\$ 119.09	\$33.60	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84480	Assay triiodothyronine (t3)	No	\$ 96.31	\$ 12.76	\$ 129.65	\$14.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84484	Assay of troponin quant	No	\$ 81.70	\$ 10.26	\$ 121.45	\$12.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	84702	Chorionic gonadotropin test	No	\$ 125.77	\$ 11.54	\$ 169.31	\$15.05	Per Unit
						•	-		-	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85014	Hematocrit	No	\$ 26.95	\$ 2.13	\$ 36.27	\$2.37	Per Unit
				Blood Test - Complete Blood Cell						
Laboratory & Pathology Services	Hospital Outpatient	CPT	85025	Count and Automated WBC	Yes	\$ 77.98	\$ 10.88	\$ 112.06	\$15.54	Per Unit
Johannton ( Path-law Comi	Hamital Outratit	CDT	95027	Blood Test - Complete Blood Cell	Vee	<u> </u>	6 500	6 24 55	66.47	Par Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85027	Count (Hemoglobin)	Yes	\$ 60.79	\$ 5.82	\$ 81.83	\$6.47	Per Unit

	T			T			_	1		
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									Ť	
					CMS		De-Identified	De-Identified	Payer-	
								Maximum		
					Required		Minimum		<u>Specific</u>	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85240	Clot factor viii ahg 1 stage	No	\$ 45.97	\$ 16.11	\$ 95.56	\$17.90	Per Unit
Education y & 1 athology services	nospital outputient	CIT	03240	Clot ractor viii ang 1 stage	140	7 43.37	7 10.11	33.30	Ş17.50	T CT OTHE
Laboratory & Pathology Services	Hospital Outpatient	CPT	85378	Fibrin degrade semiquant	No	\$ 53.57	\$ 7.44	\$ 72.11	\$9.72	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	85610	Blood Test - Clotting Time	Yes	\$ 44.81	\$ 6.01	\$ 64.27	\$8.58	Per Unit
Laboratory & Patriology Services	Hospital Outpatient	CFI	83010	Blood rest - Clotting Time	163	\$ 44.01	\$ 0.01	3 04.27	30.30	rei oiiit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85613	Russell viper venom diluted	No	\$ 24.61	\$ 8.24	\$ 70.98	\$9.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85660	RBC SICKLE CELL TEST	No	\$ 53.32	\$ 4.96	\$ 71.77	\$5.51	Per Unit
Education y de l'attrology services	nospital outputient	C	05000	NDC STOKEE CEEE TEST		ÿ 33.32	7 4.50	7 72.77	<b>V</b> 3.31	i ci oiiic
				Blood Test - Coagulation						
Laboratory & Pathology Services	Hospital Outpatient	CPT	85730	Assessment	Yes	\$ 46.01	\$ 5.41	\$ 61.94	\$6.01	Per Unit
lahawatawa 8 Bath I - C - C	Hamital Outrati	CDT	05700	The same hand a sale of the sa					66.47	Devilled:
Laboratory & Pathology Services	Hospital Outpatient	CPT	85/32	Thromboplastin time partial	No	\$ 12.63	\$ 5.82	\$ 36.42	\$6.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86140	C-reactive protein	No	\$ 48.49	\$ 4.66	\$ 65.28	\$5.18	Per Unit
Laboratori Q Dathalam Carrier	Heavital Outrations	CDT	00200	T cell checkute count /retic	No	¢ (F.00	6 42 20	6 211 50	¢4C 00	Dou I Init
Laboratory & Pathology Services	Hospital Outpatient	CPT	86360	T cell absolute count/ratio	No	\$ 65.00	\$ 42.28	\$ 211.59	\$46.98	Per Unit

	T				T		1		ı .	1	A 14/-	
											Amount We Estimate You	
											Will Owe *	
To Connels for a consider Clieb #CTD!#												
To Search for a service Click "CTRL" + "F"												
- 1												
					CMS			De-Identified		dentified	Payer-	
					Required			Minimum		aximum_	<u>Specific</u>	
Service Category	Service Setting	Code	Code	Description	Shoppable Service?		counted sh Price	Negotiated Charge		gotiated Charge	Negotiated Charge	Estimate Type
<u>Service Category</u>	<u>Service Setting</u>	Type	coue	Description	<u>Service:</u>	Cas	SII FIICE	Charge		illarge	Charge	Estillate Type
Laboratory & Pathology Services	Hospital Outpatient	CPT	86361	T cell absolute count	No	\$	132.78	\$ 24.10	\$	383.03	\$26.78	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86431	Rheumatoid factor quant	No	\$	52.70	\$ 5.10	Ś	70.95	\$5.67	Per Unit
			30.01	The state of the s		Ť	02.70	<del>y</del> 5.125	Ť	70.50	Ψο.σ.	
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$	37.81	\$ 3.84	\$	50.90	\$4.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86592	Syphilis test non-trep qual	No	\$	37.81	\$ 3.84	\$	50.90	\$4.27	Per Unit
				- April - Apri		-		,	7		· · · · · ·	
Laboratory & Pathology Services	Hospital Outpatient	CPT	86611	Bartonella antibody	No	\$	57.37	\$ 9.16	\$	165.50	\$10.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86615	Bordetella antibody	No	\$	25.74	\$ 11.87	Ś	81.45	\$13.19	Per Unit
, , ,												
											4.2.2	
Laboratory & Pathology Services	Hospital Outpatient	CPT	86651	Encephalitis californ antbdy	No	\$	25.74	\$ 11.87	\$	110.13	\$13.19	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86652	Encephaltis east eqne anbdy	No	\$	25.74	\$ 11.87	\$	110.13	\$13.19	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86653	Encephaltis st louis antbody	No	\$	25.74	\$ 11.87	\$	110.13	\$13.19	Per Unit
		J	30033		110	~	23.74	7 11.07	7	110.13	Y20.23	
Laboratory & Pathology Services	Hospital Outpatient	CPT	86654	Encephaltis west eqne antbdy	No	\$	25.74	\$ 11.87	\$	110.13	\$13.19	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86663	Epstein-barr antibody	No	\$	25.60	\$ 11.81	\$	83.21	\$13.12	Per Unit

	1									Amount We	
										Estimate You	
										Will Owe *	
To Search for a service Click "CTRL" + "F"											
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	ounted h Price	Min Nego	entified imum otiated arge	De-Identifi Maximum Negotiate Charge	Specific	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86677	Helicobacter pylori antibody	No	\$ 30.68	\$	15.13	\$ 63.	3 \$16.85	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86692	Hepatitis delta agent antbdy	No	\$ 29.16	\$	15.44	\$ 50.	98 \$17.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86698	Histoplasma antibody	No	\$ 79.65	\$	12.41	\$ 107.	23 \$13.79	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86704	HEP B CORE ANTIBODY TOTAL	No	\$ 86.11	\$	10.85	\$ 115.	92 \$12.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86705	HEP B CORE ANTIBODY IGM	No	\$ 22.98	\$	10.59	\$ 57.	\$11.77	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86706	HEP B SURFACE ANTIBODY	No	\$ 98.98	\$	9.67	\$ 133.	25 \$10.74	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86707	Hepatitis be antibody	No	\$ 22.56	\$	10.41	\$ 65.	9 \$11.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86708	Hepatitis a antibody	No	\$ 22.71	\$	11.15	\$ 56.	71 \$12.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86762	Rubella antibody	No	\$ 78.19	\$	12.95	\$ 225.	\$14.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86765	Rubeola antibody	No	\$ 25.14	\$	11.59	\$ 72.	53 \$12.88	Per Unit

									Amount We	
									Estimate You Will Owe *	
									Will Owe	
To Search for a service Click "CTRL" + "F"										
					<u>CMS</u>		De-Identified		Payer-	
		Code			Required Shoppable	Discounted	Minimum Negotiated	Maximum Negotiated	Specific Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
				OCTOD SARS COV 2 COVID 10						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86769	86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 51.48	\$ -	\$ 112.07	\$42.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86790	Virus antibody nos	No	\$ 25.14	\$ 11.59	\$ 76.53	\$12.88	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86803	Blood Test - Hepatitis C Antibody Level	No	\$ 67.64	\$ 12.84	\$ 91.06	\$14.27	Per Unit
						7	·	7 02.00	7=11=1	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86804	Hep c ab test confirm	No	\$ 23.09	\$ 13.94	\$ 66.62	\$15.49	Per Unit
Euspiratory & Futiliology Scrinces	Trospital Gatpatient	C	00004	Trep c as test commi		Ţ 25.05	Ų 13:34	<b>V</b> 00102	<b>\$25.43</b>	T CI OIIIC
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86850	Rbc antibody screen	No	\$ 20.32	\$ 5.00	\$ 66.92	\$44.61	Per Unit
Eustratory & Fathology Scrinces	nospital outputient	Ci i	00030	not anabody screen	140	7 20.32	ÿ 3.00	ÿ 00.32	Ş44.01	T CI OIIIC
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86885	Coombs test indirect qual	No	\$ 244.72	\$ 5.65	\$ 329.43	\$129.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$98.32	Per Unit
			05005			400.55	4 2	A 257.55	400.00	
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86900	Blood typing serologic abo	No	\$ 198.99	\$ 3.78	\$ 267.88	\$98.32	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$ 60.24	\$ 3.78	\$ 81.10	\$30.15	Per Unit

												Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"													
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	_	scounted sh Price	Mini Nego	entified imum itiated arge	<u>N</u>	-Identified laximum egotiated Charge	Payer- Specific Negotiated Charge	_Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86901	Blood typing serologic rh(d)	No	\$	60.24	\$	3.78	\$	81.10	\$30.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$	5.82	\$	4.84	\$	383.37	\$255.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	86920	COMPATIBILITY TEST SPIN	No	\$	244.72	\$	13.44	\$	344.22	\$129.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87040	Blood culture for bacteria	No	\$	133.90	\$	9.29	\$	180.25	\$10.32	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87070	Bacterial Culture - Swab	No	\$	138.63	\$	7.76	\$	186.61	\$8.62	Per Unit
Laboratory 2 Dathology Comicos	Harnital Outnotions	СРТ	97077	Bacterial Culture - Aerobic Isolates	No	\$	60.43	ć	7.27	ė	81.35	\$8.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87077	bacterial Culture - Aerobic Isolates	NO	Ş	60.45	<b>3</b>	1.21	ş	01.33	\$8.06	Per Offit
				Test for Disease-Causing (Pathogenic) Organisms, Not									
Laboratory & Pathology Services	<b>Hospital Outpatient</b>	CPT	87081	Limited to a Specific Condition	No	\$	81.17	\$	5.97	\$	109.26	\$6.63	Per Unit

				1								Amount We	
												Estimate You	
												Will Owe *	
To Search for a service Click "CTRL"													
+ "F"													
					CMS			De-Ider	ntified	De-	-Identified	Payer-	
					Required			Minin		_	laximum	Specific	
		Code			Shoppable		counted	Negoti			egotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cas	sh Price	Char	ge	9	<u>Charge</u>	Charge	Estimate Type
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87086	Urine Test - Bacterial Culture, Quantitative Colony Count	No	\$	82.16	Ġ	7.26	\$	110.60	\$8.07	Per Unit
Education of a national of services	nospital outputient	<u> </u>	07000	quantitative colony count	110	_	02.110	<b>Y</b>	7.20	7	110.00	ψ0.07	r er ome
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87088	Urine Test - Bacterial Culture	No	\$	15.80	\$	7.28	\$	43.86	\$8.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87110	Chlamydia culture	No	\$	130.74	\$	17.64	\$	175.99	\$19.60	Per Unit
Laboratory & Pathology Convices	Hospital Outpatient	СРТ	87186	Evaluation of Antimicrobial Drug (antibiotic, antifungal, antiviral)	No	\$	69.16	ċ	7.79	\$	93.10	\$8.65	Per Unit
Laboratory & Pathology Services	nospital Outpatient	CPT	0/100	(antibiotic, antifungal, antiviral)	INO	7	09.10	ş	7.79	ş	95.10	\$6.05	Per Offic
Laboratory & Pathology Services	Hospital Outpatient	CPT	87205	Lab Test - Smear for Microorganism	No	\$	49.93	\$	3.84	Ş	67.21	\$4.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	972/10	Lab Test - Detection test for Hepatitis B Surface Antigen	No	\$	63.55	ċ	9.30	\$	85.55	\$10.33	Per Unit
Laboratory & Fathology Services	nospital Outpatient	CFI	37340	ricpatitis b surface Affugeri	IVO	ş	03.33	7	3.30	ş	63.35	310.33	reconit
Laboratory & Dathology Comises	Hospital Outpations	СРТ	97290	Lab Test - Detection test for HIV-1	No	Ś	110.42	ė .	21 67	ċ	1/10 66	\$24.00	Por Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	0/389	and HIV-2	No	P	110.43	ş	21.67	P	148.66	\$24.08	Per Unit

									Amount We Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	Description	CMS Required Shoppable Service?	ounted n Price	De-Identified Minimum Negotiated Charge	De-Identified  Maximum  Negotiated  Charge	Payer- Specific Negotiated Charge	Estimate Type
<u> </u>		3/100						<u> </u>		
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87425	Rotavirus ag ia	No	\$ 37.44	\$ 10.78	\$ 108.00	\$11.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87491	Urine Test - Chlamydia	No	\$ 108.43	\$ 31.58	\$ 171.03	\$35.09	Per Unit
				Urine Test - Gonorrhoeae						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87591	(Neisseria Gonorrhoeae Bacteria)	No	\$ 90.13	\$ 31.58	\$ 171.03	\$35.09	Per Unit
				87635 - SARS-COV-2 COVID-19					4	
Laboratory & Pathology Services	Hospital Outpatient	CPT	87635	AMP PRB	No	\$ 53.36	\$ -	\$ 136.48	\$51.31	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87798	Detect agent nos dna amp	No	\$ 90.13	\$ 31.58	\$ 171.03	\$35.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87804	Lab Test - Detection test for Influenza Virus	No	\$ 37.58	\$ 19.82	\$ 70.50	\$33.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	87880	Strep Test (Streptococcus, group A)	No	\$ 101.56	\$ 19.87	\$ 143.48	\$33.06	Per Unit
,				, , , , , , , , , , , , , , , , , , , ,						
Laboratory & Pathology Services	Hospital Outpatient	СРТ	88185	Flowcytometry/tc add-on	No	\$ 68.81	\$ -	\$ 120.30	\$20.07	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Sourch for a complex Click "CTD!"										
To Search for a service Click "CTRL" + "F"										
, ,							1			
					CMS		<b>De-Identified</b>	De-Identified	Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	<u>Specific</u>	
		<u>Code</u>			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	<u>Charge</u>	Estimate Type
				Immunization Administration First						
Vaccinations	Physician Office	CPT	90460	Component	No	\$ 40.10	\$ 11.68	\$ 75.93	\$13.44	Per Unit
				Immunization Administration Each						
Vaccinations	Physician Office	СРТ	90461		No	\$ 25.13	\$ 10.49	\$ 38.51	\$12.07	Per Unit
	- II,					,	,	7 55.52	,	
Vaccinations	Hospital Outpatient	CPT	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 81.80	\$67.97	Per Unit
				Immunization Administration Each						
Vaccinations	Hospital Outpatient	СРТ	90472	Additional Component	No	\$ 12.56	\$ -	\$ 38.51	\$24.14	Per Unit
Vaccinations	Hospital Outpatient	СРТ	90651	9V HPV Vaccine 2/3 Dose	No	\$ 142.32	\$ 9.56	\$ 227.93	\$0.00	Per Unit
				Vaccine - Pneumococcal Conjugate						
Vaccination	Hospital Outpatient	СРТ	90670	for Injection into Muscle	No	\$ 285.59	\$ 9.56	\$ 345.21	\$230.14	Per Unit

	T	,		T.			-		-		T -	-
											Amount We	
											<b>Estimate You</b>	
											Will Owe *	
To Search for a service Click "CTRL"												
+ "F"												
+ F												
					CMS			De-Id	entified	<b>De-Identified</b>	Payer-	
					Required			Min	imum	Maximum	Specific	
		Code			Shoppable	Di	scounted		tiated	Negotiated	Negotiated	
Comitoe Cotonomi	Samilar Samilar		C- d-	Description.				_				Fathers Tone
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Ca	sh Price	Ch	arge	<u>Charge</u>	Charge	Estimate Type
				Vaccine - Tetanus, Diptheria								
				Toxoids, and Acellular Pertussis								
				(Whooping Cough) for Injection								
Massination	Heavital Outrations	CDT	00715		No	4	F7 74	4		\$ 77.73	¢24.20	Day Huit
Vaccination	Hospital Outpatient	CPT	90/15	into Muscle	No	\$	57.74	Þ	-	\$ 77.73	\$34.28	Per Unit
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	90791	Psychiatric Diagnostic Evaluation	No	\$	308.81	\$	118.93	\$ 198.74	\$124.21	Per Unit
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	00022	Psychotherapy - 30 Minutes	Yes	\$	88.03	Ś	57.92	\$ 99.25	\$62.03	Per Unit
Evaluation & ivianagement services	riolessional services	CPI	30832	r sychotherapy - 30 Minutes	res	ş	08.03	Ģ	57.92	25.85 د	<b>⊅0∠.</b> U3	rei Ullit
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	90834	Psychotherapy - 45 Minutes	Yes	\$	116.77	\$	77.37	\$ 132.34	\$82.71	Per Unit
181 1131						Ė			-			-
						١.						
<b>Evaluation &amp; Management Services</b>	Protessional Services	CPT	90837	Psychotherapy - 60 Minutes	Yes	\$	174.90	\$	116.00		\$123.89	Per Unit
							N/A No			N/A No	N/A No	
						9	Service			Service	Service	
Evaluation & Management Services	Professional Services	СРТ	00046	Family psytx w/o pt 50 min	Yes		/olume	\$		Volume	Volume	Per Unit
Evaluation & Management Services	r i oressionar services	CFI	20040	i anny psyck w/o pt 30 iiiiii	162	<b>—</b> `	olulile	Ą	-	volulile	voiume	recount
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	90847	Psychotherapy - Family Session	Yes	Ś	146.15	Ġ	97.13	\$ 166.18	\$103.86	Per Unit
Evaluation & Management Services	FI DIESSIUIIAI SEI VICES	CFT	30047	r sychodiciapy - raining session	162	Ą	140.13	ų	31.13	100.10 ب	3103.00	rei Oilit

											Amount We	
											Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"												
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	_	counted h Price	Mir Neg	dentified nimum otiated narge	De-Identified  Maximum  Negotiated  Charge	Payer- Specific Negotiated Charge	Estimate Type
							/A No ervice			N/A No Service	N/A No Service	
Evaluation & Management Services	Professional Services	СРТ	90853	Psychotherapy - Group Session	Yes	1	olume	\$	-	Volume	Volume	Per Unit
Medicine Speech Therapy	Hospital Outpatient	СРТ	92507	SPEECH/HEARING THERAPY	No	\$	52.00	\$	17.40	\$ 251.43	\$76.97	Per Unit
Medicine Cardiovascular	Professional Services	СРТ	93000	Electrocardiogram, routine, with interpretation and report	Yes	\$	36.27	\$	28.12	\$ 95.52	\$15.89	Per Unit
											4	
Medicine Other	Hospital Outpatient	CPT	93005	Electrocardiogram (ECG or EKG)	No	\$	142.29	Ş	-	\$ 295.26	\$57.24	Per Unit
Medicine Cardiac Stress Test	Hospital Outpatient	СРТ	93017	CARDIOVASCULAR STRESS TEST	No	\$	471.40	\$	61.00	\$ 634.57	\$228.24	Per Unit
Medicine Other	Hospital Outpatient	СРТ	93306	Tte w/doppler complete	No	\$ :	1,404.83	\$	322.26	\$ 1,593.05	\$506.50	Per Unit
Hospital Outpatient Procedure	Hospital Outpatient	СРТ	93452	Insertion of catheter into left heart for diagnosis	Yes	\$ 1	8,847.45	\$	579.93	\$ 12,920.92	\$2,797.49	Case Rate
Medicine Other	Hospital Outpatient	СРТ	93971	Extremity study	No	\$	240.64	\$	92.64	\$ 400.67	\$122.72	Per Unit

						ı	I	T	T	T
									Amount We	
									Estimate You	
									Will Owe *	
To Conrob for a complex Click "CTD!"										
To Search for a service Click "CTRL"										
+ "F"										
									_	
					<u>CMS</u>		De-Identified		Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	<u>Negotiated</u>	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	Charge	Charge	Charge	Estimate Type
Medicine Other	Hospital Outpatient	CPT	95044	Allergy patch tests	No	\$ 189.82		\$ 1,229.53	\$819.69	Per Unit
L						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	\$83.77	Case Rate
				Physical Therapy - Manual						
Medicine Physical Medicine and				Electrical Stimulation Therapy, 15						
Rehabilitation	<b>Hospital Outpatient</b>	CPT	97032	minutes	No	\$ 31.26	\$ 12.56	\$ 59.90	\$14.39	Per Unit
Medicine Physical Medicine and				Physical Therapy - Ultrasound						
Rehabilitation	<b>Hospital Outpatient</b>	CPT	97035	Therapy	No	\$ 26.92	\$ 11.95	\$ 40.29	\$13.91	Per Unit
Medicine Physical Medicine and				Physical Therapy - Therapeutic						
Rehabilitation	Hospital Outpatient	CPT	97110	Exercises	Yes	\$ 88.74	\$ 17.40	\$ 119.46	\$29.56	Per Unit
Medicine Physical Medicine and				Physical Therapy - Neuromuscular						
Rehabilitation	Hospital Outpatient	СРТ	97112	Reeducation	No	\$ 69.93	\$ 26.14	\$ 104.78	\$33.95	Per Unit
									,	
Medicine Physical Medicine and										
Rehabilitation	Hospital Outpatient	СРТ	97116	GAIT TRAINING THERAPY	No	\$ 77.61	\$ 22.90	\$ 104.48	\$29.23	Per Unit
	pa. e aspassens	<del>-</del>	30			701	·	7 20 11-10	7-0:	

	1	I		T		ı						A	
												Amount We Estimate You	
												Will Owe *	
												Will Owe	
To Search for a service Click "CTRL"													
+ "F"													
					CMS			De-lo	dentified	De	-Identified	Payer-	
					Required				nimum		laximum	Specific	
		Code			Shoppable	Dis	counted		otiated	_	egotiated	Negotiated	
Service Category	Service Setting	Туре	Code	Description	Service?		sh Price		harge		Charge	Charge	Estimate Type
<u> </u>		3/1/2				_		_					
Medicine Physical Medicine and													
Rehabilitation	Hospital Outpatient	СРТ	97140	Physical Therapy - Manual Therapy	No	\$	56.20	\$	23.73	Ś	93.92	\$27.22	Per Unit
		J	572.0	injoids merupy mandar merupy		Ť		_		_	55.52	<del></del>	
Medicine Physical Medicine and				Physical Therapy - Low Complexity									
Rehabilitation	Hospital Outpatient	СРТ	97161	Evaluation	No	\$	168.06	Ġ	71.97	Ġ	252.78	\$82.43	Per Unit
Renadilitation	nospital outputient	Ci i	37101	Evaluation	110	7	100.00	7	71.57	7	232.70	<b>302.43</b>	i ci oiiic
Medicine Physical Medicine and				Physical Therapy - Moderate									
Rehabilitation	Hospital Outpatient	СРТ	97162		No	Ś	62.40	\$	71.97	Ś	252.78	\$82.43	Per Unit
Nerradina di Grandia d	Trospital Gatpatient	C	37102	Complexity Evaluation	110	~	02140	~	72.37	~	232170	<b>VOL.</b> 110	T CI OIIIC
Medicine Physical Medicine and				Physical Therapy - High Complexity									
Rehabilitation	Hospital Outpatient	СРТ	97162	Evaluation	No	Ś	168.06	5	71.97	Ġ	252.78	\$82.43	Per Unit
Terraditation	Troopital Outputient	51.1	37103	2.0100001	140	7	100.00	7	71.37	7	232.70	702.43	. c. ome
Medicine Physical Medicine and													
Rehabilitation	Hospital Outpatient	СРТ	97164	Physical Therapy - Re-Evaluation	No	\$	113.34	Ś	48.67	Ś	170.97	\$56.43	Per Unit
		5	3,104			7	113.34	7	-3.07	7	2.0.57	<b>450.43</b>	. 5. 5
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$	180.88	\$	77.05	Ś	245.32	\$87.28	Per Unit
meanine occupational merapy	Hospital Outputient	U 1	21103	O. LUME FOR COMILETY 20 MIN	140	7	100.00	7	, , , , , ,	7	243.32	707.20	. Cr Omt

					1					_			
												Amount We	
												<b>Estimate You</b>	
												Will Owe *	
To Search for a service Click "CTRL"													
+ "F"													
					CMS			Do-I	dentified	De	e-Identified	Payer-	
					Required				nimum	l —	Vaximum	Specific	
										_			
		Code			Shoppable		counted		otiated	_	legotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cas	sh Price	<u>C</u>	harge		Charge	<u>Charge</u>	Estimate Type
Medicine Occupational Therapy	Hospital Outpatient	СРТ	97166	OT EVAL MOD COMPLEX 45 MIN	No	\$	62.40	Ś	72.00	Ś	245.32	\$86.96	Per Unit
у при						т .		-		-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Medicine Physical Medicine and				Physical Therapy - Therapeutic									
Rehabilitation	Hospital Outpatient	CPT	97530	Activities	No	\$	92.45	\$	17.40	\$	124.45	\$37.61	Per Unit
Medicine Physical Medicine and				Physical Therapy - Self-care or									
		CDT					60.00	_			400.00	400 70	5 11 11
Rehabilitation	Hospital Outpatient	СРТ	9/535	Home Management Training	No	\$	68.89	\$	-	\$	109.03	\$32.79	Per Unit
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99024	Postop follow-up visit	No	\$	-	\$	-	\$	14.27	\$0.00	Per Unit
Evaluation & Management Services	Professional Services	СРТ	00202	Office Visit - New Patient, Minor	No	\$	167.93	ė	90.34	ė	200.08	\$48.49	Per Unit
Evaluation & Ivianagement Services	FIGUESSIONAL SERVICES	CPT	33202	Office visit - New Patient, Milhor	NU	ş	107.93	Þ	30.34	Þ	200.08	340.45	rei Ullit
				Office Visit - New Patient, Low									
<b>Evaluation &amp; Management Services</b>	Professional Services	СРТ	99203	Complexity	Yes	\$	182.06	Ś	132.54	Ġ	273.99	\$72.73	Per Unit
Evaluation & Management Services	i i oressional services	GF I	33203	Complexity	163	7	102.00	7	132.34	7	213.33	712.13	i ci oiiit

										Amount We Estimate You	
										Will Owe *	
To Search for a service Click "CTRL" + "F"											
					CMS Required			De-Identified Minimum	De-Identified Maximum	Payer- Specific	
		Code			Shoppable	Discou		Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash P	rice	Charge	Charge	Charge	Estimate Type
Evaluation & Management Services	Professional Services	СРТ	99204	Office Visit - New Patient, Moderate Complexity	Yes	\$ 2	50.69	\$ 177.01	\$ 432.49	\$124.44	Per Unit
0					100			,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· ·	
Fundament Commission	Duefoccional Comicos	CDT	00305	New patient office of other	Vaa	\$ 4	40.04	ć 1FC 20	ć FF2.70	ć162.60	Dou I Init
Evaluation & Management Services	Professional Services	СРТ	99205	outpatient visit, typically 60 min	Yes	\$ 4	48.04	\$ 156.38	\$ 553.76	\$162.60	Per Unit
Evaluation & Management Services	Professional Services	СРТ	00212	Office Visit - Basic	No	\$ !	58.74	\$ 46.41	\$ 133.24	\$24.72	Per Unit
Evaluation & Management Services	Froiessional Services	CFI	33212	Office visit - basic	NO	<b>y</b>	30.74	3 40.41	3 133.24	324.72	rei Ollit
				Office Visit - Established Patient,							
Evaluation & Management Services	Professional Services	СРТ	99213	Low Complexity	No	\$	99.67	\$ 81.71	\$ 201.59	\$49.43	Per Unit
				Office Visit - Established Patient,							
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99214	Moderate Complexity	No	\$ 1	51.19	\$ 140.90	\$ 279.47	\$76.23	Per Unit

										Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?		ounted n Price	De-Identified Minimum Negotiated Charge	De-Identified  Maximum  Negotiated  Charge	Payer- Specific Negotiated Charge	Estimate Type
				Office Visit - Established Patient,							
Evaluation & Management Services	Professional Services	CPT	99215	High Complexity	No	\$	315.87	\$ 192.33	\$ 385.34	\$107.72	Per Unit
Professional Services Associated with Inpatient Stay	Professional Services	СРТ	99232	Subsequent hospital care	No	\$	159.88	\$ 50.60	\$ 111.92	\$69.95	Per Unit
Evaluation & Management Services	Professional Services	СРТ	99243	Patient office consultation, 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 Room Visit	Hospital Outpatient	СРТ	99281	Emergency Department Visit - Minor (outpatient)	No	Ś	230.81	\$ 74.98	\$ 689.88	\$85.57	Case Rate

					1		1		A	-
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
					CMS		<b>De-Identified</b>	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
<u> </u>	<u>Service Setting</u>	туре	Code	Description	Service:	Casii Fiice	Charge	Charge	Charge	Littiliate Type
				Emergency Department Visit - Low						
Emergency Room Visit	Hospital Outpatient	СРТ	00292	Complexity (outpatient)	No	\$ 430.38	\$ 93.52	\$ 1,114.22	\$201.14	Case Rate
Emergency Room visit	nospital Outpatient	CFI	33282	Complexity (outpatient)	INO	3 430.36	3 33.32	3 1,114.22	3201.14	Case Nate
				Emergency Department Visit -						
Emanage Pages Visit	Hassital Outrations	CDT	00202		No	\$ 932.99	ć 100.C0	ć 2.714.02	\$288.93	Cose Boto
Emergency Room Visit	Hospital Outpatient	CPT	99283	Moderate Complexity (outpatient)	No	\$ 932.99	\$ 182.62	\$ 2,714.83	\$288.93	Case Rate
				Emergency Department Visit						
F	Hamital Outrati	CDT	00224	Emergency Department Visit -		A 2 400 55	6 270 45	A	6422 = 4	Cara Bat
Emergency Room Visit	Hospital Outpatient	CPT	99284	Higher Complexity (outpatient)	No	\$ 2,400.69	\$ 270.43	\$ 4,475.48	\$432.54	Case Rate
				F						
				Emergency Department Visit - High						
Emergency Room Visit	Hospital Outpatient	CPT	99285	Complexity (outpatient)	No	\$ 3,149.91	\$ 458.20	\$ 5,806.95	\$1,279.05	Case Rate

	T.			T						1
									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									Ť	
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Cada				Discounted				
		<u>Code</u>			Shoppable	Discounted	<u>Negotiated</u>	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	<u>Charge</u>	Charge	Charge	Estimate Type
				Emergency Department Visit -						
Emergency Room Visit	Hospital Outpatient	CPT	99291	Critical Care (outpatient)	No	\$ 17,860.61	\$ 425.50	\$ 6,308.07	\$1,723.05	Case Rate
				Office Visit - Comprehensive						
				-						
				Preventive Medicine Evaluation						
				and Management, New Patient,						
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99381	Younger than 1 Year Old	No	\$ 156.75	\$ -	\$ 225.38	\$0.00	Per Unit
				Office Visit - Comprehensive						
				Preventive Medicine Evaluation						
				and Management, New Patient, 1-						
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99382	4 Years Old	No	\$ 163.82	\$ -	\$ 236.91	\$0.00	Per Unit

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Evaluation & Management Services	Professional Services	СРТ		Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 5- 11 Years Old	No	\$ 170.96	\$ -	\$ 413.46	\$0.00	Per Unit
Evaluation & Management Services	Drefessional Continue	СРТ		Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 12- 17 Years Old	No	\$ 193.58	\$ -	\$ 280.75	\$0.00	Per Unit

							Amount We Estimate You Will Owe *	
<u>Code</u> <u>Type</u>	Code	<u>Description</u>	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
СРТ	99385		Yes	\$ 187.80	\$ 59.23	\$ 347.60	\$68.65	Per Unit
					<b>.</b>	<b>.</b>	404.70	Per Unit
	СРТ	CPT 99385	Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- 39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 40-	Code Type Code Description  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18-39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18-39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 40-	Code Type Code Description  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- 39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- April 18	Code Type Code Description  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- 39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- 39 Years Old  Office Visit - Comprehensive Preventive Medicine Evaluation Analysis of the Comprehensive Preventive Medicine Evaluation and Management, New Patient, 40-	Code Type Code Description Service? Discounted Cash Price Discounted Cash Price Charge	Code Type Code Description  Code D

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	Description	CMS Required Shoppable Service?	Discounted Cash Price	De-Identified Minimum Negotiated Charge	De-Identified  Maximum  Negotiated  Charge	Payer- Specific Negotiated 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	\$ -	\$ 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

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL"										
+ "F"										
									•	
					CNAC		De-Identified	De-Identified	Davier	
					CMS			il.	Payer-	
					Required		<u>Minimum</u>	<u>Maximum</u>	<u>Specific</u>	
		Code			<u>Shoppable</u>	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	Description	Service?	Cash Price	Charge	Charge	Charge	<b>Estimate Type</b>
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
<b>Evaluation &amp; Management Services</b>	Professional Services	CPT	99393	and Management, 5-11 Years Old	No	\$ 150.44	\$ -	\$ 305.91	\$0.00	Per Unit
					_					
				Office Visit - Comprehensive						
				<b>Preventive Medicine Reevaluation</b>						
<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
<u> </u>				, , , , , , , , , , , , , , , , , , , ,						
				Office Visit - Comprehensive						
				Preventive Medicine Reevaluation						
Evaluation & Management Services	Professional Services	СРТ	99305	and Management, 18-39 Years Old	No	\$ 168.81	\$ 37.07	\$ 304.60	\$37.07	Per Unit
Evaluation & ivialiagement services	r i diessidilai sei VICES	CFI	22323	and Management, 10-33 fedis Old	140	10.61 ب	37.07	304.00 ب	937.UI	recount

									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
Service Category	Service Setting	Code Type	Code	<u>Description</u>	CMS Required Shoppable Service?	<u>Discounted</u> <u>Cash Price</u>	De-Identified Minimum Negotiated Charge	De-Identified Maximum Negotiated Charge	Payer- Specific Negotiated Charge	Estimate Type
Evaluation & Management Services	Professional Services	СРТ	99396	Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, 40-64 Years Old	No	\$ 180.12	\$ 64.57	\$ 429.79	\$64.57	Per Unit
			33030			,	<u> </u>		yoor	
Exablate	Hospital Outpatient	CPT	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	\$ 11,272.90	\$11,272.90	Case Rate
Vaccinations	Hospital Outpatient	СРТ	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$ -	\$ 126.95	\$46.26	Per Unit
Vaccinations	Hospital Outpatient	СРТ	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$ -	\$ -	\$49.34	Per Unit
Medicine Hyberbaric	Hospital Outpatient	СРТ	G0277	Hbot, full body chamber, 30m	No	\$ 773.99	\$ 46.24	\$ 1,424.46	\$247.42	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	СРТ	G0378	Hospital observation per hr	No	\$ 15,685.71	\$ 605.00	\$ 24,131.86	\$2,167.25	Per Unit

									Amount We	
									Estimate You	
									Will Owe *	
To Search for a service Click "CTRL" + "F"										
					CMS		De-Identified	De-Identified	Payer-	
					Required		Minimum	Maximum	Specific	
		Code			Shoppable	Discounted	Negotiated	Negotiated	Negotiated	
Service Category	Service Setting	Type	Code	<u>Description</u>	Service?	Cash Price	Charge	Charge	<u>Charge</u>	Estimate Type
Evaluation & Management Services	Hospital Outpatient	СРТ	G0463	Hospital outpt clinic visit	No	\$ 130.00	\$ 74.02	\$ 200.00	\$104.55	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	СРТ	G0480	Drug test def 1-7 classes	No	\$ 476.03	\$ -	\$ 732.35	\$114.43	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	\$0.87	Per Unit
Injections	Hospital Outpatient	HCPCS	J7325	Synvisc or synvisc-one	No	\$ 26.95	\$ -	\$ 89.11	\$10.22	Per Unit
Injections	Hospital Outpatient	СРТ	J9217	Eligard	No	\$ 2,818.54	\$ -	\$ 4,336.21	\$224.45	Per Unit