|                                       |                          |              | I    | T   | ſ                  | I                     | I                    | 1                    |                      | 1                             |
|---------------------------------------|--------------------------|--------------|------|---|--------------------|-----------------------|----------------------|----------------------|----------------------|-------------------------------|
| United Commercial                     | Last Updated: 12/14/2021 |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      | Amount We            |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      | Estimate You         |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      | Will Owe *           |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
| To Search for a service Click "CTRL"  |                          |              |      |   |                    |                       |                      |                      |                      |                               |
| + "F"                                 |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   | <u>CMS</u>         |                       | De-Identified        |                      | Payer-               |                               |
|                                       |                          | Cada         |      |   | Required           | Discounted            | Minimum              | Maximum              | Specific Negations   |                               |
| Service Category                      | Service Setting          | Code<br>Type | Code | Description   | Shoppable Service? | Discounted Cash Price | Negotiated<br>Charge | Negotiated<br>Charge | Negotiated<br>Charge | Estimate Type                 |
| Screec dates of y                     | ocivice setting          | 1700         | couc | <u> </u>  | <u>service:</u>    | COSTTTTCC             | charge               | charge               | <u>charge</u>        |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
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|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Case Rate-                    |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Excluding                     |
|                                       |                          |              |      | Cardiac valve and other major                                     |                    |                       |                      | _                    |                      | Professional                  |
|                                       |                          |              |      | cardiothoracic procedures with cardiac catheterization with major |                    | N/A No<br>Service     | N/A No<br>Service    | N/A No<br>Service    | N/A No<br>Service    | Charges which are paid by     |
| Hospital Inpatient Stay               | Hospital Inpatient       | DRG          | 216  | complications or comorbidities                                    | Yes                | Volume                | Volume               | Volume               | Volume               | CPT/HCPCS                     |
| , , , , , , , , , , , , , , , , , , , | Top to prove             |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Case Rate-                    |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Excluding                     |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Professional<br>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         | \$16,590.96          | CPT/HCPCS                     |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      |                               |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Core D                        |
|                                       |                          |              |      |   |                    |                       |                      |                      |                      | Case Rate-<br>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         | \$48,659.30          | CPT/HCPCS                     |

|   |                    |              |      |  |  |                       |   |   | Amount We<br>Estimate You<br>Will Owe *    |  |
|---|--------------------|--------------|------|--|--|-----------------------|---|---|--|--|
| To Search for a service Click "CTRL"<br>+ "F" |                    |              |      |  |  |                       |   |   |  |  |
| Service Category                              | Service Setting    | Code<br>Type | Code | <u>Description</u>   | CMS<br>Required<br>Shoppable<br>Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified Maximum Negotiated Charge | Payer-<br>Specific<br>Negotiated<br>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-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
|   |                    |              |      |  |  |                       |   |   |  |  |
|   |                    |              |      |  |  |                       |   |   |  | Case Rate-<br>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                               | Г                     | I                                       |  |  | <del>, , , , , , , , , , , , , , , , , , , </del>                                    |
|---|--------------------|--------------|------|--|---------------------------------|-----------------------|---|--|--|--|
|   |                    |              |      |  |                                 |                       |   |  | Amount We                                  |  |
|   |                    |              |      |  |                                 |                       |   |  | Estimate You                               |  |
|   |                    |              |      |  |                                 |                       |   |  | Will Owe *                                 |  |
| To Search for a service Click "CTRL"<br>+ "F" |                    |              |      |  |                                 |                       |   |  |  |  |
| <u>Service Category</u>                       | Service Setting    | Code<br>Type | Code | <u>Description</u>                                 | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type  |
|   |                    |              |      |  |                                 |                       |   |  |  |  |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 480  | HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC      | No                              | \$ 58,727.97          | \$ 12,375.85                            | \$ 48,933.51                               | \$37,422.14                                | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
|   |                    |              |      |  |                                 |                       |   |  |  |  |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 481  | HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC       | No                              | \$ 48,507.14          | \$ 8,559.98                             | \$ 38,996.68                               | \$25,927.62                                | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
|   |                    |              |      |  |                                 |                       |   |  |  |  |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 482  | HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC | No                              | \$ 35,733.50          | \$ 6,745.73                             | \$ 37,731.25                               | \$20,375.86                                | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
|   |                    |              |      | LOWER EXTREM HUMER PROC                            |                                 |                       |   |  |  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by              |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 493  | EXCEPT HIP, FOOT, FEMUR W CC                       | No                              | \$ 46,392.83          | \$ 9,438.20                             | \$ 41,283.64                               | \$28,769.70                                | CPT/HCPCS  |

|                                      | T                  | 1    |      |                                   | 1                 |                       |                   | <u> </u>      |                    | · · · · · · · · · |
|--------------------------------------|--------------------|------|------|-----------------------------------|-------------------|-----------------------|-------------------|---------------|--------------------|-------------------|
|                                      |                    |      |      |                                   |                   |                       |                   |               | Amount We          |                   |
|                                      |                    |      |      |                                   |                   |                       |                   |               | Estimate You       |                   |
|                                      |                    |      |      |                                   |                   |                       |                   |               | Will Owe *         |                   |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    |                   |
| To Search for a service Click "CTRL" |                    |      |      |                                   |                   |                       |                   |               |                    |                   |
| + "F"                                |                    |      |      |                                   |                   |                       |                   |               |                    |                   |
| <del>+ F</del>                       |                    |      |      |                                   |                   |                       |                   |               |                    |                   |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    |                   |
|                                      |                    |      |      |                                   | CNAS              |                       | De Identified     | De-Identified | Davier             |                   |
|                                      |                    |      |      |                                   | CMS<br>Decreired  |                       | De-Identified     | Maximum       | Payer-<br>Specific |                   |
|                                      |                    | Cada |      |                                   | Required          | Discounted            | Minimum           |               | Negotiated         |                   |
| Samina Catagomi                      | Samiles Setting    | Code | Cada | Description                       | Shoppable Samina? | <u>Discounted</u>     | Negotiated        | Negotiated    |                    | Estimate Tune     |
| Service Category                     | Service Setting    | Type | Code | <u>Description</u>                | Service?          | Cash Price            | Charge            | <u>Charge</u> | Charge             | 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  | \$22,913.56        | 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  | \$14,009.95        | CPT/HCPCS         |
|                                      |                    |      |      | (mee)                             |                   | + 10,000.30           | + 0,010.23        | + 25,555,65   |                    |                   |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    | Case Rate-        |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    | Excluding         |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    | Professional      |
|                                      |                    |      |      |                                   |                   |                       |                   |               |                    | Charges which     |
|                                      |                    |      |      | RED BLOOD CELL DISORDERS W        |                   |                       |                   |               |                    | are paid by       |
| Hospital Inpations Stav              | Hasnital Innations | DRG  | 011  |                                   | No                | ¢ 22 221 02           | ¢ 4255.02         | ¢ 21.01E.02   | \$17.04E.04        |                   |
| Hospital Inpatient Stay              | Hospital Inpatient | DRG  | 811  | MCC                               | No                | <b>&gt; 25,221.02</b> | <b>3</b> 4,255.93 | \$ 31,015.82  | \$17,045.04        | CPT/HCPCS         |

|   |                    |              |             |   |                                 |                       |   |   | Amount We<br>Estimate You<br>Will Owe *    |  |
|---|--------------------|--------------|-------------|---|---------------------------------|-----------------------|---|---|--|--|
| To Search for a service Click "CTRL"<br>+ "F" |                    |              |             |   |                                 |                       |   |   |  |  |
| Service Category                              | Service Setting    | Code<br>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-<br>Specific<br>Negotiated<br>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                            |  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 928         | FULL THICKNESS BURN W SKIN<br>GRAFT OR INHAL INJ W CC/MCC   | No                              | \$ 81,430.86          | \$ 21,639.28                            | \$ 150,000.00                           |  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 929         | FULL THICKNESS BURN W SKIN<br>GRAFT OR INHAL INJ W/O CC/MCC | No                              | \$ 38,084.70          | \$ 6,540.49                             | \$ 50,000.00                            |  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Hospital Inpatient Stay                       | Hospital Inpatient | DRG          | 935         | NON-EXTENSIVE BURNS   | No                              | \$ 18,159.73          | \$ 3,301.83                             | \$ 50,000.00                            |  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |

| Case Rate- Excluding Professional Charges which are paid by  |                         |                    |      |      | T                          |      |               |               |               | Amenum title | 1             |
|--|-------------------------|--------------------|------|------|----------------------------|------|---------------|---------------|---------------|--------------|---------------|
| To Search for a service Click "CTRL"  Service Category  Service Setting  Code  Type  Code  Description  Code  Description  Code  Description  Service Category  Service Category  Service Setting  Code  Description  Code  Description  Declientified Maximum Mindimum Macoultated Charge  Charge  Charge  Charge  Charge  Code Charge  Charg   |                         |                    |      |      |                            |      |               |               |               |              |               |
| To Search for a service Click "CTRL"  Service Category  Service Setting  Service Category  Service Setting  Service Category  Service Setting  Type  Code  Description  Description  Description  Description  Description  Description  Maximum Maxim   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Service Category  Service Setting  Description  Service Setting  Description  Service Setting  Description  Service Setting  Maximum Megotiated Charge  Case Rate-Excluding Professional Charges which are paid by Maximum Service Setting Setting Setting Service Setting  |                         |                    |      |      |                            |      |               |               |               | Williowe     |               |
| Service Category  Service Setting  Servi   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Service Category  Service Setting  Servi   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Required, Service Category Service Setting Type Code Description Service? Cash Price Discounted Schoppable Discounted Schoppable Discounted Charge Cash Price Cash Price Charge Stimate Type Cash Price Cash Price Charge Stimate Type Discounted Charge Stimate Type Cash Price Ca   | + "F"                   |                    |      |      |                            |      |               |               |               |              |               |
| Required Service Category Service Setting Type Code Description Service? Cash Price Discounted Schoppable Discounted Charge Cash Price Cash Pri   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Required Service Category Service Setting Type Code Description Service? Cash Price Discounted Schoppable Discounted Charge Cash Price Cash Pri   |                         |                    |      |      |                            | CNAS |               | Do Identified | Do Identified | Daver        |               |
| Service Category Service Setting Type Code Description Service? Cash Price Charge Case Rate- Excluding Professional Charges which are paid by Charges wh   |                         |                    |      |      |                            |      |               |               |               |              |               |
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| LIMB REATTACHMENT, HIP FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA No \$ 105,373.59 \$ 16,085.53 \$ 200,000.00 \$47,621.20 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by MULTIPLE SIGNIFICANT TRAUMA No \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by MULTIPLE SIGNIFICANT TRAUMA No \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by MULTIPLE SIGNIFICANT TRAUMA No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT TRAUMA OTHER MULTIPLE SIGNIFICANT   | Service Category        | Service Setting    | 1    | Code | Description                |      |               |               |               |              | Estimate Type |
| Excluding Professional Charges which are paid by Hospital Inpatient Stay Hospital Inpatient DRG 956 SIGNIFICANT TRAUMA NO \$ 105,373.59 \$ 16,085.53 \$ 200,000.00 \$47,621.20 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT TRAUMA NO \$ 130,000.00 \$ 125,000.00 \$ 1 |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  PORGESIONAL  DRG   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Excluding Professional Charges which are paid by Hospital Inpatient Stay Hospital Inpatient DRG 956 SIGNIFICANT TRAUMA NO \$ 105,373.59 \$ 16,085.53 \$ 200,000.00 \$47,621.20 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT TRAUMA NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT TRAUMA NO \$ 130,000.00 \$ 125,000.00 \$ 1 |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  PORGESIONAL  DRG   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  H   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  Hospital Inpatient  DRG  DRG  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR  |                         |                    |      |      | LIMP DEATTACHMENT HID      |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG 956 SIGNIFICANT TRAUMA  No \$ 105,373.59 \$ 16,085.53 \$ 200,000.00 \$47,621.20 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  WMCC  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  No \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  No \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$ 91,817.56 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$ 52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  OTHER MULTIPLE SIGNIFICANT TRAUMA  No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$ 52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS  OTHER MULTIPLE SIGNIFICANT  OTHER MULTIPLE SIGNIFICANT  | Hospital Inpatient Stav | Hospital Inpatient | DRG  | 956  |                            | No   | \$ 105.373.59 | \$ 16.085.53  | \$ 200.000.00 | \$47.621.20  |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      | 7 200,010.00  | + ==,=====    | , 200,000.00  | 7 11,022120  | . ,           |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  Professional Charges which are paid by OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA No \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  Case Rate- Excluding Professional Charges which are paid by OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate- Excluding Professional Charges which are paid by OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA No \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate- Excluding Professional Charges which are paid by OTHER MULTIPLE SIGNIFICANT OTHER MULTIPLE SIGNIFICANT  |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  PS7  WMCC  NO  \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by WCC  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  NO  \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC  Case Rate-Excluding Professional Charges which are paid by CC   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG 957 W MCC  NO \$ 139,128.72 \$ 30,888.17 \$ 200,000.00 \$91,817.56 CPT/HCPCS  OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA  Hospital Inpatient Stay  Hospital Inpatient  DRG 958 W CC  OTHER MULTIPLE SIGNIFICANT  |                         |                    |      |      |                            |      |               |               |               |              |               |
| Case Rate-Excluding Professional Charges which are paid by CC NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CC NO \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS CASE RATE-Excluding Professional Charges which are paid by CPT/HCPCS CASE RATE-EXCLUDING PROFESSIONAL CHARGES WHICH ARE PAIR PROFESSIONAL CHARGES WHICH PROFESSIONAL CHARGES WHICH PROFESSIONAL CHARGES WHICH PROFESSIONAL CHARGES WHICH PROFESSIONAL CHARGES WH   | Hospital Innationt Stay | Hagnital Innations | DBC  | 057  |                            | No   | ¢ 120 120 72  | ¢ 20 000 17   | ¢ 200 000 00  | ¢01 917 F6   |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   | Hospital Inpatient Stay | Hospital Inpatient | DKG  | 337  | Wivice                     | NO   | \$ 139,126.72 | \$ 50,000.17  | \$ 200,000.00 | 391,817.30   | CP1/HCPC3     |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              | Case Rate-    |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  DRG  DRG  DRG  DRG  DRG  DRG  DR   |                         |                    |      |      |                            |      |               |               |               |              | Excluding     |
| Hospital Inpatient Stay  Hospital Inpatient  H   |                         |                    |      |      |                            |      |               |               |               |              | Professional  |
| Hospital Inpatient Stay  Hospital Inpatient  DRG  958 W CC  No  \$ 73,933.71 \$ 17,182.69 \$ 125,000.00 \$52,033.41 CPT/HCPCS  Case Rate-Excluding Professional Charges which are paid by  |                         |                    |      |      | OTHER O.R. PROCEDURES FOR  |      |               |               |               |              |               |
| Case Rate- Excluding Professional Charges which are paid by  |                         |                    |      |      |                            |      |               |               |               |              |               |
| Excluding Professional Charges which are paid by   | Hospital Inpatient Stay | Hospital Inpatient | DRG  | 958  | w cc                       | No   | \$ 73,933.71  | \$ 17,182.69  | \$ 125,000.00 | \$52,033.41  | CPT/HCPCS     |
| Excluding Professional Charges which are paid by   |                         |                    |      |      |                            |      |               |               |               |              | Coso Bata     |
| Professional Charges which OTHER MULTIPLE SIGNIFICANT Professional Charges which are paid by   |                         |                    |      |      |                            |      |               |               |               |              |               |
| Charges which OTHER MULTIPLE SIGNIFICANT Charges which are paid by   |                         |                    |      |      |                            |      |               |               |               |              |               |
| OTHER MULTIPLE SIGNIFICANT are paid by   |                         |                    |      |      |                            |      |               |               |               |              |               |
|  |                         |                    |      |      | OTHER MULTIPLE SIGNIFICANT |      |               |               |               |              |               |
|  | Hospital Inpatient Stay | Hospital Inpatient | DRG  | 964  | TRAUMA W CC                | No   | \$ 34,761.85  | \$ 6,123.35   | \$ 50,000.00  | N/A          | CPT/HCPCS     |

|  |                       |      |       | I                            |           |              |                |              | A               |               |
|--|-----------------------|------|-------|------------------------------|-----------|--------------|----------------|--------------|-----------------|---------------|
|  |                       |      |       |                              |           |              |                |              | Amount We       |               |
|  |                       |      |       |                              |           |              |                |              | Estimate You    |               |
|  |                       |      |       |                              |           |              |                |              | Will Owe *      |               |
|  |                       |      |       |                              |           |              |                |              |                 |               |
| To Soarch for a corvice Click "CTPI"       |                       |      |       |                              |           |              |                |              |                 |               |
| To Search for a service Click "CTRL" + "F" |                       |      |       |                              |           |              |                |              |                 |               |
| + F  |                       |      |       |                              |           |              |                |              |                 |               |
|  |                       |      |       |                              |           |              |                |              |                 |               |
|  |                       |      |       |                              |           |              | 5 11 20 1      | 5 11 26 1    | _               |               |
|  |                       |      |       |                              | CMS       |              | De-Identified  |              | Payer-          |               |
|  |                       |      |       |                              | Required  |              | <u>Minimum</u> | Maximum      | <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 |
|  |                       |      |       |                              |           |              |                |              |                 |               |
|  |                       |      |       |                              |           |              |                |              |                 |               |
|  |                       |      |       |                              |           |              |                |              |                 | 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 | \$5,179.00      | CPT/HCPCS     |
|  |                       |      |       |                              |           |              |                |              |                 |               |
|  |                       |      |       |                              |           |              |                |              |                 | Case Rate-    |
|  |                       |      |       |                              |           |              |                |              |                 | Excluding     |
|  |                       |      |       |                              |           |              |                |              |                 | Professional  |
|  |                       |      |       |                              |           |              |                |              |                 | Charges which |
|  |                       |      |       | CESAREAN SECTION W           |           |              |                |              |                 | are paid by   |
| Maternity/Delivery                         | Hospital Inpatient    | DRG  | 783   | STERILIZATION W MCC          | No        | \$ 11,915.22 | \$ 3,570.00    | \$ 39,605.25 | \$7,274.00      | 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 | \$7,274.00      | CPT/HCPCS     |
|  | - Copies III patients |      | 7.0-1 |                              |           | ÷ 3,340.40   | + 3,370.00     | ÷ 27,000.12  | 77,274.00       | ,             |
|  |                       |      |       |                              |           |              |                |              |                 | Case Rate-    |
|  |                       |      |       |                              |           |              |                |              |                 | Excluding     |
|  |                       |      |       |                              |           |              |                |              |                 | Professional  |
|  |                       |      |       |                              |           |              |                |              |                 | Charges which |
|  |                       |      |       | CESADEAN SECTION W           |           |              |                |              |                 |               |
| Bactomity / Dolivon                        | Heavital Investigat   | DBC  | 705   | CESAREAN SECTION W           | No        | ć 0.000.37   | ć 2.510.44     | ć 25.070.74  | ć7 274 CC       | are paid by   |
| Maternity/Delivery                         | Hospital Inpatient    | DRG  | 785   | STERILIZATION W/O CC/MCC     | No        | \$ 8,988.27  | \$ 3,519.44    | \$ 25,870.71 | \$7,274.00      | CPT/HCPCS     |
|  |                       |      |       |                              |           |              |                |              |                 | Casa Bota     |
|  |                       |      |       |                              |           |              |                |              |                 | Case Rate-    |
|  |                       |      |       |                              |           |              |                |              |                 | Excluding     |
|  |                       |      |       |                              |           |              |                |              |                 | Professional  |
|  |                       |      |       |                              |           |              |                |              |                 | Charges which |
|  |                       |      |       | CESAREAN SECTION W/O         |           |              |                |              |                 | are paid by   |
| Maternity/Delivery                         | Hospital Inpatient    | DRG  | 786   | STERILIZATION W MCC          | No        | \$ 12,696.27 | \$ 3,570.00    | \$ 35,011.06 | \$7,274.00      | CPT/HCPCS     |

|   |                    |              |      |  |                                 |                       |  |   | Amount We                                  |  |
|---|--------------------|--------------|------|--|---------------------------------|-----------------------|--|---|--|--|
|   |                    |              |      |  |                                 |                       |  |   | Estimate You<br>Will Owe *                 |  |
| To Search for a service Click "CTRL"<br>+ "F" |                    |              |      |  |                                 |                       |  |   |  |  |
| <u>Service Category</u>                       | Service Setting    | Code<br>Type | Code | <u>Description</u>                                 | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified  Minimum  Negotiated  Charge | De-Identified Maximum Negotiated Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type  |
| Maternity/Delivery                            | Hospital Inpatient | DRG          | 787  | CESAREAN SECTION W/O STERILIZATION W CC            | No                              | \$ 11,322.59          | \$ 2,835.00                                | \$ 27,868.32                            | \$7,274.00                                 | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Maternity/Delivery                            | Hospital Inpatient | DRG          | 788  | CESAREAN SECTION W/O STERILIZATION W/O CC/MCC      | No                              | \$ 9,626.23           | \$ 3,242.44                                | \$ 26,381.06                            | \$7,274.00                                 | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Maternity/Delivery                            | Hospital Inpatient | DRG          | 795  | NORMAL NEWBORN                                     | No                              | \$ 1,400.10           | \$ 626.89                                  | \$ 18,705.56                            | \$1,203.00                                 | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Maternity/Delivery                            | Hospital Inpatient | DRG          | 797  | VAGINAL DELIVERY W<br>STERILIZATION/D&C W CC       | No                              | \$ 12,785.73          | \$ 2,464.00                                | \$ 25,917.69                            | \$5,179.00                                 | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |
| Maternity/Delivery                            | Hospital Inpatient | DRG          | 798  | VAGINAL DELIVERY W<br>STERILIZATION/D&C W/O CC/MCC | No                              | \$ 10,897.11          | \$ 2,464.00                                | \$ 25,917.69                            | \$5,179.00                                 | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |

|                                      | 1                                 |      |      |                              |           |                   |                      |               |                     |               |
|--------------------------------------|-----------------------------------|------|------|------------------------------|-----------|-------------------|----------------------|---------------|---------------------|---------------|
|                                      |                                   |      |      |                              |           |                   |                      |               | Amount We           |               |
|                                      |                                   |      |      |                              |           |                   |                      |               | <b>Estimate You</b> |               |
|                                      |                                   |      |      |                              |           |                   |                      |               | Will Owe *          |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
| To Search for a service Click "CTRL" |                                   |      |      |                              |           |                   |                      |               |                     |               |
| 1                                    |                                   |      |      |                              |           |                   |                      |               |                     |               |
| + "F"                                |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              | CMS       |                   | <b>De-Identified</b> | De-Identified | Payer-              |               |
|                                      |                                   |      |      |                              | Required  |                   | Minimum              | Maximum       | Specific            |               |
|                                      |                                   | Code |      |                              | Shoppable | Discounted        | Negotiated           | Negotiated    | Negotiated          |               |
| Comico Catagoni                      | Service Setting                   |      | Code | Description                  | Service?  | Cash Price        |                      |               |                     | Estimata Tuna |
| Service Category                     | Service Setting                   | Type | code | Description                  | Servicer  | <u>Cash Price</u> | Charge               | Charge        | <u>Charge</u>       | Estimate Type |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Case Rate-    |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Excluding     |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Professional  |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Charges which |
|                                      |                                   |      |      | VAGINAL DELIVERY W/O         |           |                   |                      |               |                     | are paid by   |
|                                      |                                   |      |      |                              |           |                   |                      |               | 4                   |               |
| Maternity/Delivery                   | Hospital Inpatient                | DRG  | 805  | STERILIZATION/D&C W MCC      | No        | \$ 10,518.03      | \$ 2,464.00          | \$ 27,817.08  | \$5,179.00          | 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  | \$5,179.00          | 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  | \$5,179.00          | 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     |
| •                                    |                                   | _    |      | 1 1, 00                      | -         | ,                 | . ,                  | . ,           | •                   | , , , ,       |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Case Rate-    |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     |               |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Excluding     |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Professional  |
|                                      |                                   |      |      |                              |           |                   |                      |               |                     | Charges which |
| Inpatient Rehabilitation Hospital    |                                   |      |      |                              |           |                   |                      |               |                     | are paid by   |
| Stay                                 | Inpatient Rehabilitation Hospital | DRG  | 946  | REHABILITATION W/O CC/MCC    | No        | N/A               | \$ 10.870.00         | \$ 10,870.00  | N/A                 | CPT/HCPCS     |
| July                                 | inputient Kenabilitation nospital | סוום | J+0  | REHADILITATION W/O CC/WICC   | 140       | IN/M              | A 10,010.00          | 4 TO,070.00   | IV/M                | Ci 1/HCPC3    |

|   |                                   |              |      |  |                                 |   |   |  | Amount We<br>Estimate You<br>Will Owe *    |  |
|---|-----------------------------------|--------------|------|--|---------------------------------|---|---|--|--|--|
| To Search for a service Click "CTRL"<br>+ "F" |                                   |              |      |  |                                 |   |   |  | -  |  |
| Service Category                              | Service Setting                   | Code<br>Type | Code | <u>Description</u>   | CMS Required Shoppable Service? | <u>Discounted</u><br><u>Cash Price</u>                | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type  |
| Inpatient Rehabilitation Hospital<br>Stay     | Inpatient Rehabilitation Hospital | UB           | 118  | Inpatient Rehabilitation Hospital<br>Room & Board                      | No                              | 52% Charges<br>Estimated at<br>\$2,341.96 Per<br>Diem |   |  | \$958 Per<br>Diem                          | Per Diem Per<br>Day  |
|   |                                   |              |      |  |                                 |   |   |  |  | Case Rate-<br>Excluding<br>Professional  |
| Inpatient Skilled Nursing                     | Inpatient Skilled Nursing         | DRG          | 559  | AFTERCARE, MUSCULOSKELETAL<br>SYSTEM AND CONNECTIVE TISSUE<br>WITH MCC | No                              | N/A   | \$ 18,018.00                            | \$ 18,018.00                               | N/A  | Charges which are paid by CPT/HCPCS  |
| Inpatient Skilled Nursing                     | Inpatient Skilled Nursing         | DRG          | 560  | AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC             | No                              | N/A   | \$ 10,435.00                            | \$ 10,435.00                               | N/A  | Case Rate-<br>Excluding<br>Professional<br>Charges which<br>are paid by<br>CPT/HCPCS |

|                                      |                           |      | 1         | 1   |                 | 1              | ı             | ı             |              |                              |
|--------------------------------------|---------------------------|------|-----------|---|-----------------|----------------|---------------|---------------|--------------|------------------------------|
|                                      |                           |      |           |   |                 |                |               |               | Amount We    |                              |
|                                      |                           |      |           |   |                 |                |               |               | Estimate You |                              |
|                                      |                           |      |           |   |                 |                |               |               | Will Owe *   |                              |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
| To Search for a service Click "CTRL" |                           |      |           |   |                 |                |               |               |              |                              |
| + "F"                                |                           |      |           |   |                 |                |               |               |              |                              |
| , ,                                  |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   | CMS             |                | De-Identified | De-Identified | Payer-       |                              |
|                                      |                           |      |           |   | Required        |                | Minimum       | Maximum       | Specific     |                              |
|                                      |                           | Code |           |   | Shoppable       | Discounted     | Negotiated    | Negotiated    | Negotiated   |                              |
| Service Category                     | Service Setting           | Type | Code      | Description   | Service?        | Cash Price     | Charge        | Charge        | Charge       | Estimate Type                |
| <u>Service Category</u>              | <u>Service Setting</u>    | туре | coue      | Description   | <u>Service:</u> | Casii Fiice    | Charge        | Charge        | charge       | Littilate Type               |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 |                |               |               |              | Case Rate-                   |
|                                      |                           |      |           |   |                 |                |               |               |              | Excluding                    |
|                                      |                           |      |           |   |                 |                |               |               |              | Professional                 |
|                                      |                           |      |           | AFTERCARE MUSCULOSVELETAL                             |                 |                |               |               |              |                              |
|                                      |                           |      |           | AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE |                 |                |               |               |              | Charges which<br>are paid by |
| Inneticat Skilled Number             | Innetions Chilled Number  | DRG  | FC1       |   | Nie             | N1 / A         | ¢ 7.474.00    | ¢ 7.474.00    | D1/0         | CPT/HCPCS                    |
| Inpatient Skilled Nursing            | Inpatient Skilled Nursing | DKG  | 561       | W/O CC/MCC  | No              | N/A            | \$ 7,474.00   | \$ 7,474.00   | N/A          | CP1/HCPCS                    |
|                                      |                           |      |           |   |                 |                |               |               |              | C D-t-                       |
|                                      |                           |      |           |   |                 |                |               |               |              | Case Rate-                   |
|                                      |                           |      |           |   |                 |                |               |               |              | Excluding<br>Professional    |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
| Lana Tama Assida Cara Installant     | Investigant I am Tama Com |      |           | Deliner and device and device                         |                 |                |               |               |              | Charges which                |
| Long Term Acute Care Inpatient       | Inpatient Long-Term Care  |      | . = 04.00 | Pulmonary edema respiratory                           |                 | 21.6           | A 74.004.40   | A 74.004.40   |              | are paid by                  |
| Stay                                 | Hospital                  | DRG  | L1C189    | failure   | No              | N/A            | \$ 74,931.49  | \$ 74,931.49  | N/A          | CPT/HCPCS                    |
|                                      |                           |      |           |   |                 |                |               |               |              | C D-t-                       |
|                                      |                           |      |           |   |                 |                |               |               |              | Case Rate-                   |
|                                      |                           |      |           |   |                 |                |               |               |              | Excluding                    |
|                                      |                           |      |           |   |                 |                |               |               |              | Professional                 |
|                                      |                           |      |           |   |                 |                |               |               |              | Charges which                |
| Long Term Acute Care Inpatient       | Inpatient Long-Term Care  |      |           | Respiratory system diagnosis w                        |                 |                |               |               |              | are paid by                  |
| Stay                                 | Hospital                  | DRG  | LTC207    | ventilator support >96 hours                          | No              | N/A            | \$ 37,703.24  | \$ 37,703.24  | N/A          | CPT/HCPCS                    |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 | 700/ 61        |               |               |              |                              |
|                                      |                           |      |           |   |                 | 70% Charges    |               |               |              |                              |
|                                      |                           |      |           |   |                 | (Estimated as  | 44.040.0      | 44 000 0      | 44           |                              |
| Long Term Acute Care Inpatient       | Inpatient Long-Term Care  |      | 200       | Long Term Care Intensive Care                         |                 | \$6,047.26 per | \$1,040 Per   | \$1,929 Per   | \$1,575 Per  | Per Diem Per                 |
| Stay                                 | Hospital                  | UB   | 200       | Room & Board  | No              | diem)          | Diem          | Diem          | Diem         | Day                          |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 |                |               |               |              |                              |
|                                      |                           |      |           |   |                 | 52% Charges    |               |               |              |                              |
|                                      |                           |      |           |   |                 | Estimated at   |               |               |              |                              |
| Skilled Nursing Inpatient Room &     |                           |      |           |   |                 | \$1,109.30 Per |               |               | \$638 Per    | Per Diem Per                 |
| Board                                | Inpatient Skilled Nursing | UB   | 191       | Subacute Care Level 1- Skilled Care                   | No              | Diem           | \$ 227.70     | \$ 850.00     | Diem         | Day                          |

|                                      |                           | 1    |       | T  | I               | 1              |       |           |    |              |                         |               |
|--------------------------------------|---------------------------|------|-------|--|-----------------|----------------|-------|-----------|----|--------------|-------------------------|---------------|
|                                      |                           |      |       |  |                 |                |       |           |    |              | Amount We               |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              | Estimate You Will Owe * |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              | Will Owe *              |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| To Search for a service Click "CTRL" |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| + "F"                                |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| , ,                                  |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  | CMS             |                | De-la | dentified | De | e-Identified | Payer-                  |               |
|                                      |                           |      |       |  | Required        |                |       | nimum     | _  | /laximum     | Specific                |               |
|                                      |                           | Code |       |  | Shoppable       | Discounted     |       | otiated   | _  | egotiated    | Negotiated              |               |
| Service Category                     | Service Setting           | Туре | Code  | Description  | Service?        | Cash Price     |       | harge     |    | Charge       | Charge                  | Estimate Type |
| Service dategory                     | <u>service setting</u>    | турс | couc  | <u> </u>   | <u>ocrvice:</u> | CUSTITIEC      |       | large     |    | charge       | charge                  | Estimate Type |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         | ļ             |
|                                      |                           |      |       |  |                 | 52% Charges    |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 | Estimated at   |       |           |    |              |                         |               |
| Skilled Nursing Inpatient Room &     |                           |      |       | Subacute Care Level 2-   |                 | \$1,109.30 Per |       |           |    |              | \$638 Per               | Per Diem Per  |
| Board                                | Inpatient Skilled Nursing | UB   | 192   | Comprehensive Care   | No              | Diem           | Ś     | 299.70    | Ġ  | 850.00       | Diem                    | Day           |
| Board                                | inputient skined (varsing | 00   | 132   | comprehensive care   | 110             | Dicili         | 7     | 233.70    | 7  | 030.00       | Dicin                   | Day           |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 | 52% Charges    |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 | Estimated at   |       |           |    |              |                         |               |
| Skilled Nursing Inpatient Room &     |                           |      |       | Subacute Care Level 3- Complex   |                 | \$1,109.30 Per |       |           |    |              | \$638 Per               | Per Diem Per  |
| Board                                | Inpatient Skilled Nursing | UB   | 193   | Care   | No              | Diem           | Ś     | 370.00    | ć  | 850.00       | Diem                    | Day           |
| Board                                | inpatient skilled Wursing | ОВ   | 193   | Care   | NU              | Dieiii         | ٦     | 370.00    | Ą  | 830.00       | Dielli                  | Day           |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| Hospital Outpatient Procedure        | Hospital Outpatient       | СРТ  | 11102 | Biopsy - Tangential Biopsy of Skin   | No              | \$ 530.90      | ė     | 161.58    | ć  | 1,803.41     | \$57.55                 | Case Rate     |
| nospital Outpatient Procedure        | Hospital Outpatient       | CFI  | 11102 | Biopsy - Tangential Biopsy of Skill  | NU              | \$ 550.90      | ۶     | 101.56    | Ą  | 1,003.41     | 337.33                  | Case Nate     |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| Hospital Outpatient Procedure        | Hospital Outpatient       | СРТ  | 11104 | Biopsy - Punch Biopsy of Skin  | No              | \$ 584.92      | ė     | 167.15    | Ġ  | 1,829.27     | \$72.27                 | Case Rate     |
| Tiospital Outpatient Procedure       | nospital Outpatient       | CFT  | 11104 | Biopsy - Functi Biopsy of Skill  | 140             | 3 304.32       | 7     | 107.13    | 7  | 1,023.27     | \$12.21                 | Case Nate     |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| Hospital Outpatient Procedure        | Hospital Outpatient       | СРТ  | 17000 | Destruction of Lesion (outpatient)   | No              | \$ 1,131.70    | ė     | 157.92    | Ġ  | 1,634.10     | \$739.47                | Case Rate     |
| nospital outpatient Procedure        | nospital Outpatient       | CFT  | 17000 | Destruction of Lesion (outpatient)   | 140             | 3 1,131.70     | 7     | 137.32    | 7  | 1,034.10     | \$733.47                | Case Nate     |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
| Hospital Outpatient Procedure        | Hospital Outpatient       | СРТ  | 19083 | Bx breast 1st lesion us imag   | No              | \$ 3,052.42    | s     | 381.25    | \$ | 2,964.36     | \$1,646.64              | Case Rate     |
|                                      |                           |      | 15005 | and the state of t |                 | 7 3,032.42     | 7     | 302.23    | Ψ. | _,50-1.50    | <del></del>             | - CLUC HALL   |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 |                |       |           |    |              |                         |               |
|                                      |                           |      |       |  |                 | N/A No         |       |           |    |              | N/A No                  |               |
|                                      |                           |      |       | Removal of 1 or more breast  |                 | Service        |       |           |    |              | Service                 |               |
| Hospital Outpatient Procedure        | Hospital Outpatient       | СРТ  | 10120 | growth, open procedure   | Yes             | Volume         | Ś     | _         | \$ |              | Volume                  | Case Rate     |
| nospital Outpatient Procedure        | nospitai Outpatient       | CPT  | 12170 | growth, open procedure   | 168             | voiume         | P     | -         | Þ  | -            | voiume                  | case rate     |

|  | T                          |      |       | T                                  |           | 1  |            |          |           | Г        |                 | A 14/-                    |               |
|--|----------------------------|------|-------|------------------------------------|-----------|----|------------|----------|-----------|----------|-----------------|---------------------------|---------------|
|  |                            |      |       |                                    |           |    |            |          |           |          |                 | Amount We<br>Estimate You |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 | Will Owe *                |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| T. C I. C                                  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| To Search for a service Click "CTRL" + "F" |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| <i>T F</i>                                 |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    | CMS       |    |            | De-l     | dentified | De       | e-Identified    | Payer-                    |               |
|  |                            |      |       |                                    | Required  |    |            |          | nimum     | _        | <u> Maximum</u> | <u>Specific</u>           |               |
|  |                            | Code |       |                                    | Shoppable |    | oiscounted | _        | otiated   | <u>N</u> | legotiated      | Negotiated                |               |
| Service Category                           | Service Setting            | Type | Code  | <u>Description</u>                 | Service?  | 9  | Cash Price | <u>C</u> | harge     |          | Charge          | <u>Charge</u>             | Estimate Type |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| Injections                                 | <b>Hospital Outpatient</b> | СРТ  | 20610 | Arthrocentesis (outpatient)        | No        | \$ | 370.58     | \$       | 182.39    | \$       | 1,461.73        | \$723.31                  | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| Hospital Outpatient Procedure              | Hospital Outpatient        | СРТ  | 27818 | Treatment of ankle fracture        | No        | \$ | 1,243.48   | \$       | 395.00    | \$       | 2,581.00        | \$1,498.20                | Case Rate     |
|  |                            |      |       |                                    |           |    | N/A No     |          |           |          |                 | N/A No                    |               |
|  |                            |      |       |                                    |           |    | Service    |          |           |          |                 | Service                   |               |
| <b>Hospital Outpatient Procedure</b>       | Hospital Outpatient        | СРТ  | 29826 | Arthroscopic Shoulder Surgery      | Yes       |    | Volume     | \$       | _         | \$       | -               | Volume                    | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    | N/A No     |          |           |          |                 | N/A No                    |               |
| Hasnital Outpatient Brasadura              | Hasnital Outpationt        | CDT  | 20001 | Arthroscopic Knee Surgery          | Vos       |    | Service    | ė        | _         | ė        |                 | Service                   | Casa Bata     |
| Hospital Outpatient Procedure              | Hospital Outpatient        | CPT  | 29881 | (outpatient)                       | Yes       |    | Volume     | \$       | -         | \$       | -               | Volume                    | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| <b>Hospital Outpatient Procedure</b>       | Hospital Outpatient        | CPT  | 31575 | Laryngoscopy - Diagnostic          | No        | \$ | 449.87     | \$       | 135.86    | \$       | 1,978.02        | \$770.49                  | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
| Heavital Cutrations Brossdans              | Hamital Outrations         | СРТ  | 22555 | Assistanta ulasses su / imagina    | Na        | \$ | C00 20     | \$       | 200 54    | \$       | 1 053 00        | ć1 010 01                 | Casa Data     |
| Hospital Outpatient Procedure              | Hospital Outpatient        | CPI  | 32333 | Aspirate pleura w/ imaging         | No        | Ş  | 608.39     | ş        | 288.54    | Ģ        | 1,852.06        | \$1,019.81                | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    | N/A No     |          |           |          |                 | N/A No                    |               |
|  |                            |      |       | Tonsillectomy with Adenoidectomy   |           |    | Service    |          |           | ١.       |                 | Service                   |               |
| Hospital Outpatient Procedure              | Hospital Outpatient        | СРТ  | 42820 | (outpatient)                       | Yes       |    | Volume     | \$       | -         | \$       | -               | Volume                    | Case Rate     |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       |                                    |           |    |            |          |           |          |                 |                           |               |
|  |                            |      |       | Upper Gastrointestinal Endoscopy - |           |    |            |          |           |          |                 |                           |               |
| Hospital Outpatient Procedure              | <b>Hospital Outpatient</b> | CPT  | 43235 | Diagnostic                         | Yes       | \$ | 2,027.21   | \$       | 61.00     | \$       | 1,867.74        | \$1,360.37                | Case Rate     |

|  | T                          |             |       | T                                     | I         |             |               | I             | Amazunt Ma                | 1             |
|--|----------------------------|-------------|-------|---------------------------------------|-----------|-------------|---------------|---------------|---------------------------|---------------|
|  |                            |             |       |                                       |           |             |               |               | Amount We<br>Estimate You |               |
|  |                            |             |       |                                       |           |             |               |               | Will Owe *                |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
| 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            | <u>Type</u> | Code  | <u>Description</u>                    | Service?  | Cash Price  | Charge        | Charge        | <u>Charge</u>             | Estimate Type |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       | Upper Gastrointestinal Endoscopy -    |           |             |               |               |                           |               |
| Hospital Outpatient Procedure              | Hospital Outpatient        | СРТ         | 43239 | With Biopsy                           | Yes       | \$ 1,259.34 | \$ 372.00     | \$ 2,229.48   | \$1,400.14                | Case Rate     |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       | Colonoccon Diamentic                  |           |             |               |               |                           |               |
| Hospital Outpatient Procedure              | Hospital Outpatient        | СРТ         | 45378 | Colonoscopy - Diagnostic (outpatient) | Yes       | \$ 2,117.86 | \$ 335.79     | \$ 2,220.88   | \$1,467.22                | Case Rate     |
| Hospital Outpatient Procedure              | nospital Outpatient        | CFI         | 43376 | (outpatient)                          | 163       | \$ 2,117.80 | 3 333.73      | \$ 2,220.88   | \$1,407.22                | Case Nate     |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       | Colonoscopy - With Biopsy             |           |             |               |               |                           |               |
| Hospital Outpatient Procedure              | Hospital Outpatient        | СРТ         | 45380 | (outpatient)                          | Yes       | \$ 3,082.66 | \$ 343.06     | \$ 4,110.45   | \$388.80                  | Case Rate     |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       | Colonoscopy - With Polyp Removal      |           |             |               |               |                           |               |
| <b>Hospital Outpatient Procedure</b>       | <b>Hospital Outpatient</b> | СРТ         | 45385 |                                       | Yes       | \$ 3,317.89 | \$ 354.50     | \$ 4,434.15   | \$461.36                  | Case Rate     |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           |             |               |               |                           |               |
|  |                            |             |       |                                       |           | N/A No      |               |               | N/A No                    |               |
|  |                            |             |       | Ultrasound examination of lower       |           | Service     |               |               | Service                   |               |
| <b>Hospital Outpatient Procedure</b>       | Hospital Outpatient        | CPT         | 45391 | large bowel using an endoscope        | Yes       | Volume      | \$ -          | \$ -          | Volume                    | Case Rate     |

|                     |  |   |  |   |  |   |  | Amount We  |  |
|---------------------|--|---|--|---|--|---|--|--|--|
|                     |  |   |  |   |  |   |  |  |  |
|                     |  |   |  |   |  |   |  |  |  |
| Service Setting     | <u>Code</u><br>Type  | Code  | Description  | CMS Required Shoppable Service?                                       | Discounted Cash Price  | Minimum<br>Negotiated   | Maximum<br>Negotiated  | Payer- Specific Negotiated Charge  | Estimate Type  |
|                     |  |   |  |   |  |   |  |  |  |
| Hospital Outpatient | СРТ  | 47562   | Gall Bladder Surgery (outpatient)  | Yes   | \$ 12,062.52   | \$ 504.75   | \$ 18,374.88   | \$965.78   | Case Rate  |
| Hospital Outpatient | СРТ  | 49440   | Place gastrostomy tube perc  | No  | \$ 3,111.60  | \$ 445.12   | \$ 3,166.61  | \$1,740.88   | Case Rate  |
|                     |  |   |  |   |  |   |  |  |  |
| Hospital Outpatient | СРТ  | 49505   | Repair of groin hernia patient age 5 years or older  | Yes   | \$ 9,867.85  | \$ 470.98   | \$ 15,040.03   | \$765.57   | Case Rate  |
| Hospital Outpatient | СРТ  | 51798   | Urine Capacity Measurement   | No  | \$ 97.04   | \$ -  | \$ 1,579.20  | \$683.51   | Case Rate  |
| Hospital Outpatient | СРТ  | 52000   | Cystoscopy   | No  | \$ 1,173.22  | \$ 282.78   | \$ 1,596.52  | \$1,037.19   | Case Rate  |
| Hospital Outpatient | СРТ  | 55700   | Biopsy of prostate gland   | Yes   | \$ 1,165.04  | \$ 284.76   | \$ 2,631.84  | \$1,609.38   | Case Rate  |
|                     |  |   |  |   |  |   |  |  |  |
|                     |  |   |  |   |  |   |  |  |  |
| Hospital Outpatient | СРТ  | 55866   | Surgical removal of prostate and surrounding lymph nodes using an endoscope  | Yes   | N/A No<br>Service<br>Volume  | N/A No<br>Service<br>Volume   | N/A No<br>Service<br>Volume  | N/A No<br>Service<br>Volume  | Case Rate  |
|                     | Hospital Outpatient  Hospital Outpatient  Hospital Outpatient  Hospital Outpatient | Hospital Outpatient CPT  Hospital Outpatient CPT | Hospital Outpatient CPT 47562  Hospital Outpatient CPT 49440  Hospital Outpatient CPT 49505  Hospital Outpatient CPT 51798  Hospital Outpatient CPT 52000  Hospital Outpatient CPT 55700 | Hospital Outpatient   CPT   47562   Gall Bladder Surgery (outpatient) | Service Setting  Code Type Code Description  Required Shoppable Service?  Hospital Outpatient  CPT 47562 Gall Bladder Surgery (outpatient)  Yes  Hospital Outpatient  CPT 49440 Place gastrostomy tube perc  No  Repair of groin hernia patient age 5 years or older  Yes  Hospital Outpatient  CPT 51798 Urine Capacity Measurement  No  Hospital Outpatient  CPT 52000 Cystoscopy  No  Hospital Outpatient  CPT 55700 Biopsy of prostate gland  Yes  Surgical removal of prostate and surrounding lymph nodes using an | Code   Description   Required   Shoppable   Discounted   Service   Cash Price | Code   Description   Service   Code   Description   Desc | Service Setting Type Code Description Shoppable Discounted Shoppable Discounted Cash Price Code Description Service Setting Discounted Negotiated Charge Charge.  Hospital Outpatient CPT 47562 Gall Bladder Surgery (outpatient) Yes \$ 12,062.52 \$ 504.75 \$ 18,374.88  Hospital Outpatient CPT 49440 Place gastrostomy tube perc No \$ 3,111.60 \$ 445.12 \$ 3,166.61  Hospital Outpatient CPT 49505 Pears or older Yes \$ 9,867.85 \$ 470.98 \$ 15,040.03  Hospital Outpatient CPT 51798 Urine Capacity Measurement No \$ 97.04 \$ - \$ 1,579.20  Hospital Outpatient CPT 52000 Cystoscopy No \$ 1,173.22 \$ 282.78 \$ 1,596.52  Hospital Outpatient CPT 55700 Biopsy of prostate gland Yes \$ 1,165.04 \$ 284.76 \$ 2,631.84 | Estimate You will Owe *  Code Description Service Setting Type Code Description Service Service Service Service Setting Type Code Description Service Servic |

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| To Search for a service Click "CTRL" |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
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|                                      |                            |      |       |                                     | <u>CMS</u> |    |           |          | dentified       |    | e-Identified         | Payer-          |               |
|                                      |                            |      |       |                                     | Required   |    |           |          | nimum_          | _  | <u>/laximum</u>      | <u>Specific</u> |               |
|                                      |                            | Code |       | <b>5</b>                            | Shoppable  |    | iscounted |          | <u>gotiated</u> | _  | <u>egotiated</u>     | Negotiated      |               |
| Service Category                     | Service Setting            | Type | Code  | <u>Description</u>                  | Service?   | C  | ash Price | <u>C</u> | harge           |    | Charge               | Charge          | Estimate Type |
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|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
| Hospital Outpatient Procedure        | Hospital Outpatient        | CPT  | 58100 | Biopsy - Endometrial (Uterus)       | No         | \$ | 375.83    | \$       | 144.00          | \$ | 1,697.39             | \$787.13        | Case Rate     |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
| Hospital Outpatient Procedure        | Hospital Outpatient        | CPT  | 58300 | Insert intrauterine device          | No         | \$ | 632.24    | \$       | 48.93           | \$ | 1,749.37             | \$732.39        | Case Rate     |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
| <b>Hospital Outpatient Procedure</b> | Hospital Outpatient        | CPT  | 58301 | Remove intrauterine device          | No         | \$ | 273.85    | \$       | 32.34           | \$ | 1,495.58             | \$757.16        | 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             | \$704.51        | Case Rate     |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
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|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
|                                      |                            |      |       | 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  | Ś        | 242.00          | \$ | 3,278.48             | \$1,928.52      | Case Rate     |
| , ,                                  |                            |      |       | ,                                   |            | Ė  | ,         | i        |                 |    | ,                    | . ,             |               |
| Professional Services Associated     |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
| with Inpatient Stay                  | Professional Services      | СРТ  | 59410 | Obstetrical care                    | No         | \$ | 2,230.06  | Ś        | 133.91          | Ś  | 1,625.81             | \$956.36        | Case Rate     |
|                                      |                            | -    |       |                                     |            | Ť  | _,_30.00  | -        |                 | -  | _,                   | +               | 1,000 1100    |
|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
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|                                      |                            |      |       |                                     |            |    |           |          |                 |    |                      |                 |               |
|                                      |                            |      |       | Doubling abstatula f                |            |    |           |          |                 |    |                      |                 |               |
| Professional Comp.                   |                            |      |       | Routine obstetric care for cesarean |            |    |           |          |                 |    |                      |                 |               |
| Professional Services Associated     |                            |      | E05:5 | delivery, including pre-and post-   | .,,        | _  | 4.000 ==  |          | 0.45 55         |    | 0.040.45             | 40.455.55       | 0 5 :         |
| with Inpatient Stay                  | Professional Services      | CPT  | 59510 | delivery care                       | Yes        | \$ | 4,966.56  | \$       | 246.05          | Ş  | 3,619.13             | \$2,128.90      | Case Rate     |

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| To Search for a service Click "CTRL" |                            |       |       |                                     |           |             |                      |                      |              |               |
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|                                      |                            |       |       |                                     | 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 |
|                                      |                            | 3/100 |       |                                     |           |             |                      |                      |              |               |
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|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
|                                      |                            |       |       | Routine obstetric care for vaginal  |           |             |                      |                      |              |               |
|                                      |                            |       |       | delivery after prior cesarean       |           |             |                      |                      |              |               |
| Bunfandan I Camban Assaulated        |                            |       |       |                                     |           |             |                      |                      |              |               |
| Professional Services Associated     |                            |       |       | delivery including pre-and post-    |           |             |                      |                      |              |               |
| with Inpatient Stay                  | Professional Services      | CPT   | 59610 | delivery care                       | Yes       | \$ 4,706.58 | \$ 305.08            | \$ 3,429.34          | \$2,017.26   | Case Rate     |
|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
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|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
|                                      |                            |       |       | Injection of substance into spinal  |           |             |                      |                      |              |               |
|                                      |                            |       |       | canal of lower back or sacrum using |           |             |                      |                      |              |               |
| <b>Hospital Outpatient Procedure</b> | <b>Hospital Outpatient</b> | CPT   | 62322 | imaging guidance                    | Yes       | \$ 1,055.18 | \$ 379.33            | \$ 1,880.39          | \$979.19     | Case Rate     |
|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
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|                                      |                            |       |       |                                     |           |             |                      |                      |              |               |
|                                      |                            |       |       | Injection of substance into spinal  |           |             |                      |                      |              | <b> </b>      |
|                                      |                            |       |       | canal of lower back or sacrum using |           |             |                      |                      |              | <b> </b>      |
| Hospital Outpatient Procedure        | Hospital Outpatient        | СРТ   | 62323 | imaging guidance                    | Yes       | \$ 1,665.98 | \$ 305.01            | \$ 1,988.33          | \$997.76     | Case Rate     |
| nospitai Outpatient Procedure        | Hospital Outpatient        | CFI   | 02323 | maging guidance                     | 162       | ۵۶.۵۵۵, ب   | 205.01               | 1,700.33 ب           | 755/./0      | case nate     |

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|                                      |                     |       |       |                                    |           |             |               |               | Will Owe *          |               |
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| To Search for a service Click "CTRL" |                     |       |       |                                    |           |             |               |               |                     |               |
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|                                      |                     |       |       |                                    | CMS       |             | De-Identified | De-Identified | Payer-              |               |
|                                      |                     |       |       |                                    | Required  |             | Minimum       | Maximum       | Specific            |               |
|                                      |                     | C- d- |       |                                    |           | Discounted  |               |               |                     |               |
|                                      |                     | Code  |       |                                    | Shoppable | Discounted  | Negotiated    | Negotiated    | Negotiated          |               |
| Service Category                     | Service Setting     | Type  | Code  | <u>Description</u>                 | Service?  | Cash Price  | Charge        | <u>Charge</u> | <u>Charge</u>       | Estimate Type |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
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|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       | Injections of anesthetic and/or    |           |             |               |               |                     |               |
|                                      |                     |       |       | steroid drug into lower or sacral  |           |             |               |               |                     |               |
|                                      |                     |       |       | spine nerve root using imaging     |           |             |               |               |                     |               |
| Hospital Outpatient Procedure        | Hospital Outpatient | СРТ   | 64483 | guidance                           | Yes       | \$ 1,776.21 | \$ 358.46     | \$ 1,980.49   | \$1,023.59          | Case Rate     |
| nospital Outpatient Procedure        | nospital Outpatient | CFT   | 04403 | guidance                           | 163       | 3 1,770.21  | 3 338.40      | 3 1,360.43    | \$1,023.33          | Case Nate     |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
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|                                      |                     |       |       |                                    |           | N/A No      |               |               | N/A No              |               |
|                                      |                     |       |       | Removal of recurring cataract in   |           | Service     |               |               | Service             |               |
| <b>Hospital Outpatient Procedure</b> | Hospital Outpatient | CPT   | 66821 | lens capsule using laser           | Yes       | Volume      | \$ -          | \$ -          | Volume              | Case Rate     |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
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|                                      |                     |       |       |                                    |           | N/A No      |               |               | N/A No              |               |
|                                      |                     |       |       | Removal of cataract with insertion |           | Service     |               |               | Service             |               |
| <b>Hospital Outpatient Procedure</b> | Hospital Outpatient | CPT   | 66984 | of lens                            | Yes       | Volume      | \$ -          | \$ -          | Volume              | Case Rate     |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     | CDT   | 60515 |                                    |           |             | A             |               | 470:                |               |
| Hospital Outpatient Procedure        | Hospital Outpatient | CPT   | 69210 | Remove impacted ear wax            | No        | \$ 168.99   | \$ 48.93      | \$ 1,604.78   | \$704.25            | Case Rate     |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       |                                    |           |             |               |               |                     |               |
|                                      |                     |       |       | CT Coon Hood/Proin without         |           |             |               |               |                     |               |
|                                      |                     |       |       | CT Scan - Head/Brain, without      |           |             |               |               | 4000                |               |
| Radiology Services                   | Hospital Outpatient | CPT   | 70450 | Contrast                           | No        | \$ 901.06   | \$ 127.22     | \$ 1,318.18   | \$951.56            | Per Unit      |

|                                      |                            |            |       |                                 |           |             |               |                       | A 1 1 4 -      |               |
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| To Search for a service Click "CTRL" |                            |            |       |                                 |           |             |               |                       |                |               |
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|                                      |                            |            |       |                                 | 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>Jervice Jetting</u>     | туре       | coue  | Description                     | Service:  | Casii Fiice | Charge        | Charge                | Charge         | Estimate Type |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       | CT Scan - Head/Brain, without   |           |             |               |                       |                |               |
| Radiology Services                   | Hospital Outpatient        | CPT        | 70450 | Contrast                        | Yes       | \$ 901.06   | \$ 127.22     | \$ 1,318.18           | \$951.56       | 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           | \$995.62       | Per Unit      |
| Radiology Services                   | nospital Outpatient        | CFT        | 70402 | ct orbit/ear/1033a w/ 00cw/ dye | 140       | \$ 2,333.00 | \$ 207.75     | 7 2,037.02            | 3333.02        | reronic       |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Radiology Services                   | Hospital Outpatient        | CPT        | 70486 | Ct maxillofacial w/o dye        | No        | \$ 1,668.57 | \$ 127.52     | \$ 2,259.85           | \$973.50       | Per Unit      |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Radiology Services                   | <b>Hospital Outpatient</b> | CPT        | 70496 | Ct angiography head             | No        | \$ 1,871.05 | \$ 223.05     | \$ 1,996.31           | \$1,017.91     | Per Unit      |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Radiology Services                   | Hospital Outpatient        | СРТ        | 70498 | Ct angiography neck             | No        | \$ 1,632.72 | \$ 223.05     | \$ 1,677.63           | \$1,017.92     | Per Unit      |
|                                      |                            | <b>.</b> . | 70.50 | at an Brography noon            |           | Ţ 1,002.72  | 7             | <del>+ -)011100</del> | <del>+-,</del> |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       | 4              |               |
| Radiology Services                   | Hospital Outpatient        | CPT        | /0551 | MRI BRAIN STEM W/O DYE          | No        | \$ 1,518.19 | \$ 252.20     | \$ 2,270.30           | \$109.25       | Per Unit      |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Radiology Services                   | <b>Hospital Outpatient</b> | CPT        | 70553 | MRI - Brain (outpatient)        | Yes       | \$ 2,314.59 | \$ 406.50     | \$ 3,409.54           | \$1,203.00     | Per Unit      |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Radiology Services                   | Hospital Outpatient        | СРТ        | 71045 | X-ray exam chest 1 view         | No        | \$ 138.11   | \$ 19.91      | \$ 181.37             | \$374.51       | Per Unit      |
|                                      |                            | -          |       | . ,                             |           |             |               |                       | 7              |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
|                                      |                            |            |       |                                 |           |             |               |                       |                |               |
| Padialana Camba                      | Usesited Contrast          | CDT        | 74046 | V David Chart (aut. 11 1)       |           | A 440.65    | 6 24 ==       | A 400 F-              | 6277.40        | Bandlett.     |
| Radiology Services                   | Hospital Outpatient        | CPT        | /1046 | X-Ray - Chest (outpatient)      | No        | \$ 148.99   | \$ 31.50      | \$ 193.55             | \$377.18       | Per Unit      |

|   | 1                   |              |       | I  |  |                           |            |  |           |  | Amount We                                  |               |
|---|---------------------|--------------|-------|--|--|---------------------------|------------|--|-----------|--|--|---------------|
|   |                     |              |       |  |  |                           |            |  |           |  | Estimate You                               |               |
|   |                     |              |       |  |  |                           |            |  |           |  | Will Owe *                                 |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | Description                                    | CMS<br>Required<br>Shoppable<br>Service? | <br>scounted<br>ash Price | Mii<br>Neg | dentified<br>nimum<br>otiated<br>harge | Ma<br>Neg | dentified<br>aximum<br>gotiated<br>harge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 71110 | X-ray exam ribs bil 3 views                    | No                                       | \$<br>205.20              | \$         | 38.07                                  | \$        | 271.73                                   | \$381.36                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 71250 | CT THORAX W/O DYE                              | No                                       | \$<br>1,024.52            | \$         | 141.11                                 | \$        | 1,468.48                                 | \$75.04                                    | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 71260 | CT Scan - Chest, with Contrast<br>(outpatient) | No                                       | \$<br>1,448.52            | \$         | 200.76                                 | \$        | 2,034.88                                 | \$980.99                                   | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | CPT          | 71275 | Ct angiography chest                           | No                                       | \$<br>1,935.65            | \$         | 226.19                                 | \$        | 2,092.27                                 | \$1,030.38                                 | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72040 | X-Ray - Neck, Cervical Spine                   | No                                       | \$<br>154.65              | \$         | 37.93                                  | \$        | 204.42                                   | \$378.23                                   | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72070 | X-Ray - Middle Back, Thoracic Spine            | No                                       | \$<br>251.61              | \$         | 33.93                                  | \$        | 338.99                                   | \$377.66                                   | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72100 | X-Ray - Spine (outpatient)                     | No                                       | \$<br>199.60              | \$         | 37.93                                  | \$        | 265.13                                   | \$378.24                                   | Per Unit      |
|   |                     |              |       |  |  |                           |            |  |           |  |  |               |
| _ "   |                     |              |       | X-Ray, lower back, minimum four                |  |                           |            |  |           |  | 400  |               |
| Radiology Services                            | Hospital Outpatient | CPT          | 72110 | views  | Yes                                      | \$<br>213.64              | \$         | 52.80                                  | Ş         | 284.93                                   | \$384.60                                   | Per Unit      |

|   |                     |              |       |                                |  |                        |         |  |    |   | Amount We                                  |               |
|---|---------------------|--------------|-------|--------------------------------|--|------------------------|---------|--|----|---|--|---------------|
|   |                     |              |       |                                |  |                        |         |  |    |   | Estimate You Will Owe *                    |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |                                |  |                        |         |  |    |   |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | <u>Description</u>             | CMS<br>Required<br>Shoppable<br>Service? | iscounted<br>ash Price | M<br>Ne | Identified<br>inimum<br>gotiated<br>Charge | N  | e-Identified<br>Maximum<br>legotiated<br>Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72125 | Ct neck spine w/o dye          | No                                       | \$<br>1,459.37         | \$      | 136.86                                     | \$ | 1,750.92  | \$967.74                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72126 | Ct neck spine w/dye            | No                                       | \$<br>1,293.16         | \$      | 260.86                                     | \$ | 1,821.59  | \$978.92                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72127 | Ct neck spine w/o & w/dye      | No                                       | \$<br>1,815.93         | \$      | 201.73                                     | \$ | 2,118.48  | \$982.62                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72129 | Ct chest spine w/dye           | No                                       | \$<br>1,520.66         | \$      | 199.82                                     | \$ | 1,805.90  | \$978.92                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72132 | Ct lumbar spine w/dye          | No                                       | \$<br>1,518.43         | \$      | 260.86                                     | \$ | 1,805.90  | \$978.92                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72133 | Ct lumbar spine w/o & w/dye    | No                                       | \$<br>1,904.42         | \$      | 201.90                                     | \$ | 2,238.70  | \$982.12                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72141 | MRI NECK SPINE W/O DYE         | No                                       | \$<br>1,441.84         | \$      | 252.20                                     | \$ | 2,177.11  | \$118.30                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72148 | MRI - Back (outpatient)        | Yes                                      | \$<br>1,381.13         | \$      | 252.20                                     | \$ | 2,137.12  | \$1,203.00                                 | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72170 | X-Ray - Pelvis                 | No                                       | \$<br>249.04           | \$      | 28.72                                      | \$ | 327.10  | \$374.54                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72190 | X-RAY EXAM OF PELVIS           | No                                       | \$<br>208.53           | \$      | 39.60                                      | \$ | 264.73  | \$16.69                                    | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 72193 | CT scan, pelvis, with contrast | Yes                                      | \$<br>1,536.96         | \$      | 197.29                                     | \$ | 2,142.05  | \$974.66                                   | Per Unit      |

|   |                     |             |       |                               |                              |          |             |                                  |                       | Amount We<br>Estimate You        |               |
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|   |                     |             |       |                               |                              |          |             |                                  |                       | Will Owe *                       |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |             |       |                               |                              |          |             |                                  |                       |                                  |               |
|   |                     | <u>Code</u> |       |                               | CMS<br>Required<br>Shoppable | Discount |             | De-Identified Minimum Negotiated | Maximum<br>Negotiated | Payer-<br>Specific<br>Negotiated |               |
| Service Category                              | Service Setting     | Type        | Code  | <u>Description</u>            | Service?                     | Cash Pri | ce_         | <u>Charge</u>                    | <u>Charge</u>         | Charge                           | Estimate Type |
| Radiology Services                            | Hospital Outpatient | СРТ         | 72197 | MRI - Pelvis (outpatient)     | No                           | \$ 2,448 | 3.72        | \$ 402.71                        | \$ 3,522.33           | \$1,203.00                       | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73000 | X-ray exam of collar bone     | No                           | \$ 147   | 7.59        | \$ 22.40                         | \$ 185.92             | \$373.42                         | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73010 | X-ray exam of shoulder blade  | No                           | \$ 196   | 5.93        | \$ 26.01                         | \$ 251.93             | \$375.02                         | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73030 | X-Ray - Shoulder (outpatient) | No                           | \$ 149   | ).50        | \$ 28.33                         | \$ 196.92             | \$375.56                         | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73060 | X-RAY EXAM OF HUMERUS         | No                           | \$ 147   | .62         | \$ 29.40                         | \$ 195.82             | \$12.96                          | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73070 | X-ray exam of elbow           | No                           | \$ 146   | 5.83        | \$ 25.07                         | \$ 191.42             | \$372.87                         | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73080 | X-RAY EXAM OF ELBOW           | No                           | \$ 122   | 2.83        | \$ 26.72                         | \$ 154.02             | \$12.96                          | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73090 | X-RAY EXAM OF FOREARM         | No                           | \$ 117   | <b>7.10</b> | \$ 26.40                         | \$ 151.82             | \$12.42                          | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73110 | X-Ray - Wrist (outpatient)    | No                           | \$ 156   | 5.52        | \$ 30.72                         | \$ 196.19             | \$373.96                         | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ         | 73120 | X-RAY EXAM OF HAND            | No                           | \$ 192   | 2.03        | \$ 24.40                         | \$ 249.73             | \$12.42                          | Per Unit      |

|   |                     |              |       |                                 |                                 |       |                 |            |  |                |  | Amount We                                  |               |
|---|---------------------|--------------|-------|---------------------------------|---------------------------------|-------|-----------------|------------|--|----------------|--|--|---------------|
|   |                     |              |       |                                 |                                 |       |                 |            |  |                |  | Estimate You<br>Will Owe *                 |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |                                 |                                 |       |                 |            |  |                |  |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | <u>Description</u>              | CMS Required Shoppable Service? |       | ounted<br>Price | Mii<br>Neg | dentified<br>nimum<br>otiated<br>narge | N <sub>0</sub> | e-Identified<br>Maximum<br>egotiated<br>Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73130 | X-Ray - Hand                    | No                              | \$    | 151.54          | \$         | 32.72                                  | \$             | 198.42   | \$373.96                                   | Per Unit      |
|   |                     |              | _     |                                 |                                 |       |                 |            |  |                |  |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73221 | MRI - Shoulder, Elbow, or Wrist | No                              | \$ 1, | ,211.82         | \$         | 246.65                                 | \$             | 1,702.46                                       | \$1,203.00                                 | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73502 | X-Ray - Hip                     | No                              | \$    | 129.58          | \$         | 37.77                                  | \$             | 197.91   | \$377.66                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73552 | X-RAY EXAM OF FEMUR 2/>         | No                              | \$    | 150.51          | \$         | 29.51                                  | \$             | 189.38   | \$14.00                                    | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73560 | X-RAY EXAM OF KNEE 1 OR 2       | No                              | \$    | 201.92          | \$         | 32.40                                  | \$             | 266.82   | \$14.02                                    | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73562 | X-Ray - Knee (outpatient)       | No                              | \$    | 263.50          | \$         | 36.52                                  | \$             | 351.25   | \$375.56                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73590 | X-ray exam of lower leg         | No                              | \$    | 239.62          | \$         | 32.40                                  | \$             | 321.48   | \$373.96                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73600 | X-RAY EXAM OF ANKLE             | No                              | \$    | 191.55          | \$         | 31.98                                  | \$             | 278.60   | \$12.42                                    | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73610 | X-Ray - Ankle (outpatient)      | No                              | \$    | 239.05          | \$         | 25.72                                  | \$             | 311.14   | \$373.96                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73620 | X-RAY EXAM OF FOOT              | No                              | \$    | 196.24          | \$         | 29.81                                  | \$             | 262.21   | \$11.44                                    | Per Unit      |

|   |                     |              |       |                                    |                                 |    |                |            |  |    |   | Amount We                                  |               |
|---|---------------------|--------------|-------|------------------------------------|---------------------------------|----|----------------|------------|--|----|---|--|---------------|
|   |                     |              |       |                                    |                                 |    |                |            |  |    |   | Estimate You                               |               |
|   |                     |              |       |                                    |                                 |    |                |            |  |    |   | Will Owe *                                 |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |                                    |                                 |    |                |            |  |    |   |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | Description                        | CMS Required Shoppable Service? |    | scounted       | Mii<br>Neg | dentified<br>nimum<br>otiated<br>harge | N  | e-Identified<br>Maximum<br>legotiated<br>Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Service eurogory                              | <u> </u>            | турс         | couc  | <u> </u>                           | <u> SCIVICE:</u>                | Ca | isii i i i i i | <u></u>    | nuige                                  |    | charge  | charge                                     | Estimate Type |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73630 | X-Ray - Foot (outpatient)          | No                              | \$ | 216.05         | \$         | 33.95                                  | \$ | 289.60  | \$373.48                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73700 | CT LOWER EXTREMITY W/O DYE         | No                              | \$ | 1,231.00       | \$         | 134.01                                 | \$ | 1,400.92  | \$74.03                                    | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 73721 | MRI - Knee (outpatient)            | Yes                             | \$ | 1,224.32       | \$         | 246.65                                 | \$ | 1,828.36  | \$1,203.00                                 | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 74018 | X-Ray - Abdomen                    | No                              | \$ | 145.61         | \$         | 28.31                                  | \$ | 189.76  | \$374.50                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 74150 | Ct abdomen w/o dye                 | No                              | \$ | 977.64         | \$         | 142.38                                 | \$ | 1,446.99  | \$976.79                                   | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 74170 | Ct abdomen w/o & w/dye             | No                              | \$ | 1,824.18       | \$         | 207.86                                 | \$ | 2,144.29  | \$992.42                                   | Per Unit      |
|   |                     |              |       | CT Scan - Abdomen and Pelvis, with |                                 |    |                |            |  |    |   |  |               |
| Radiology Services                            | Hospital Outpatient | СРТ          | 74177 | Contrast                           | No                              | \$ | 2,748.11       | \$         | 286.79                                 | \$ | 3,568.86  | \$1,023.19                                 | Per Unit      |
|   |                     |              |       | CT Scan - Abdomen and Pelvis, with |                                 |    |                |            |  |    |   |  |               |
| Radiology Services                            | Hospital Outpatient | CPT          | 74177 | Contrast                           | Yes                             | \$ | 2,748.11       | \$         | 286.79                                 | \$ | 3,568.86  | \$1,023.19                                 | Per Unit      |
| Radiology Services                            | Hospital Outpatient | СРТ          | 74220 | X-ray xm esophagus 1cntrst         | No                              | \$ | 394.10         | \$         | 56.38                                  | \$ | 563.71  | \$395.21                                   | Per Unit      |

|   |                       |              |       |                                  |  |                         |                   |   |  | Amount We<br>Estimate You<br>Will Owe * |               |
|---|-----------------------|--------------|-------|----------------------------------|--|-------------------------|-------------------|---|--|---|---------------|
| To Search for a service Click "CTRL"<br>+ "F" |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Service Category                              | Service Setting       | Code<br>Type | Code  | <u>Description</u>               | CMS<br>Required<br>Shoppable<br>Service? | Discounte<br>Cash Price | <u>d</u> <u>N</u> | e-Identified<br>Minimum<br>Vegotiated<br>Charge | De-Identif<br>Maximur<br>Negotiate<br>Charge | n Specific                              | Estimate Type |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Radiology Services                            | Hospital Outpatient   | СРТ          | 74270 | X-ray xm colon 1cntrst std       | No                                       | \$ 521.                 | 72 \$             | 79.34   | \$ 578                                       | 01 \$411.93                             | Per Unit      |
| De dieleme Comitee                            | Hamilton Contractions | CDT          | 75574 | Character and a second           | N-                                       | ć 20C                   | 0.4               | F0.00   | ć 222  | 20 6024.42                              | Day Hait      |
| Radiology Services                            | Hospital Outpatient   | СРТ          | /55/1 | Ct hrt w/o dye w/ca test         | No                                       | \$ 306.                 | 04 \$             | 59.00   | \$ 323                                       | 39 \$931.13                             | Per Unit      |
| Radiology Services                            | Hospital Outpatient   | СРТ          | 76536 | Ultrasound - Head and Neck       | No                                       | \$ 460.                 | <b>62</b> \$      | 78.79   | \$ 386                                       | 50 \$434.60                             | Per Unit      |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Radiology Services                            | Hospital Outpatient   | СРТ          | 76642 | Ultrasound - Breast (outpatient) | No                                       | \$ 152.                 | 58 \$             | 78.52   | \$ 249                                       | 30 \$443.66                             | Per Unit      |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Radiology Services                            | Hospital Outpatient   | СРТ          | 76700 | Ultrasound - Abdominal, Complete | Yes                                      | \$ 361.                 | 43 \$             | 91.69   | \$ 433                                       | .80 \$452.90                            | Per Unit      |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Radiology Services                            | Hospital Outpatient   | СРТ          | 76705 | Ultrasound - Abdominal, Limited  | No                                       | \$ 327.                 | 93 \$             | 46.05   | \$ 372                                       | \$436.23                                | Per Unit      |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Maternity/Delivery                            | Hospital Outpatient   | СРТ          | 76770 | US EXAM ABDO BACK WALL COMP      | No                                       | \$ 456.                 | 58 \$             | 76.54   | \$ 400                                       | 80 \$54.62                              | Per Unit      |
|   |                       |              |       |                                  |  |                         |                   |   |  |   |               |
| Maternity/Delivery                            | Hospital Outpatient   | СРТ          | 76801 | OB US < 14 WKS SINGLE FETUS      | No                                       | \$ 391.                 | 57 \$             | 86.65   | \$ 396                                       | .27 \$73.81                             | Per Unit      |

|                                      | T                          |      |       | I                                | 1         |       |        |       |          |          |               |               |                |
|--------------------------------------|----------------------------|------|-------|----------------------------------|-----------|-------|--------|-------|----------|----------|---------------|---------------|----------------|
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               | Amount We     |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               | Estimate You  |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               | Will Owe *    |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| T 6 1 6                              |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| To Search for a service Click "CTRL" |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| + "F"                                |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  | CMS       |       |        | De-Id | entified | De-      | Identified    | Payer-        |                |
|                                      |                            |      |       |                                  | Required  |       |        | Min   | imum     | Ma       | <u>aximum</u> | Specific      |                |
|                                      |                            | Code |       |                                  | Shoppable | Disco | unted  | Nego  | otiated  | Ne       | gotiated      | Negotiated    |                |
| Service Category                     | Service Setting            | Type | Code  | Description                      | Service?  | Cash  | Price  | Ch    | arge     |          | Charge        | Charge        | Estimate Type  |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       | Ultrasound - Pregnancy           |           |       |        |       |          |          |               |               |                |
| Radiology Services                   | Hospital Outpatient        | СРТ  | 76805 | (outpatient)                     | Yes       | \$    | 367.73 | \$    | 100.36   | \$       | 437.10        | \$467.30      | Per Unit       |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Maternity/Delivery                   | <b>Hospital Outpatient</b> | CPT  | 76811 | OB US DETAILED SNGL FETUS        | No        | \$    | 522.04 | \$    | 198.65   | \$       | 587.50        | \$143.97      | Per Unit       |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Maternity/Delivery                   | Hospital Outpatient        | СРТ  | 76815 | OB US LIMITED FETUS(S)           | No        | \$    | 309.95 | \$    | 54.75    | \$       | 384.30        | \$47.89       | Per Unit       |
| ,                                    | ·                          |      |       |                                  |           |       |        |       |          |          |               | •             |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Padialana Cambana                    | Hamital Outrations         | CDT  | 70046 |                                  | B1-       |       | 406 54 |       | 64.27    | _        | 204.20        | 6457.24       | Description to |
| Radiology Services                   | Hospital Outpatient        | CPT  | 76816 | Ultrasound - Pregnancy Follow-Up | No        | \$    | 406.54 | \$    | 64.37    | >        | 384.30        | \$457.24      | Per Unit       |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Maternity/Delivery                   | <b>Hospital Outpatient</b> | CPT  | 76818 | FETAL BIOPHYS PROFILE W/NST      | No        | \$    | 476.50 | \$    | 82.20    | \$       | 387.27        | \$79.52       | Per Unit       |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Maternity/Delivery                   | Hospital Outpatient        | СРТ  | 76819 | FETAL BIOPHYS PROFIL W/O NST     | No        | \$    | 407.39 | \$    | 97.44    | \$       | 398.34        | \$57.92       | Per Unit       |
| ,                                    |                            | 1    |       | , , , , ,                        |           | i –   |        |       |          | <u> </u> |               |               | -              |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
| Padialogy Convices                   | Hospital Outpationt        | СРТ  | 76021 | MIDDLE CEREBRAL ARTERY ECHO      | No        | \$    | 370.14 | ċ     | 88.69    | ċ        | 391.69        | \$53.14       | Per Unit       |
| Radiology Services                   | Hospital Outpatient        | CPT  | 70821 | IVIIDDLE CEREBRAL ARTERY ECHO    | INO       | Þ     | 3/0.14 | Ģ     | 00.09    | Ģ        | 221.09        | <b>333.14</b> | rei Ullit      |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |
|                                      |                            |      |       | Ultrasound - Transvaginal (non-  |           |       |        |       |          |          |               |               |                |
| Radiology Services                   | <b>Hospital Outpatient</b> | CPT  | 76830 | maternity)                       | Yes       | \$    | 475.43 | \$    | 98.63    | \$       | 463.90        | \$444.62      | Per Unit       |
|                                      |                            |      |       |                                  |           |       |        |       |          |          |               |               |                |

|   |                     |              |             |                                  |  |    |                      |          |   |          |  | Amount We                                  |                |
|---|---------------------|--------------|-------------|----------------------------------|--|----|----------------------|----------|---|----------|--|--|----------------|
|   |                     |              |             |                                  |  |    |                      |          |   |          |  | Estimate You<br>Will Owe *                 |                |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |             |                                  |  |    |                      |          |   |          |  |  |                |
| Service Category                              | Service Setting     | Code<br>Type | <u>Code</u> | <u>Description</u>               | CMS<br>Required<br>Shoppable<br>Service? |    | scounted<br>sh Price | Mi<br>Ne | dentified<br>inimum<br>gotiated<br>charge | Ma<br>Ne | Identified<br>aximum<br>gotiated<br>Charge | Payer-<br>Specific<br>Negotiated<br>Charge | _Estimate Type |
|   |                     |              |             |                                  |  |    |                      |          |   |          |  |  |                |
| Radiology Services                            | Hospital Outpatient | СРТ          | 76856       | Ultrasound - Pelvic (outpatient) | No                                       | \$ | 344.00               | \$       | 70.34                                     | \$       | 408.50                                     | \$443.64                                   | Per Unit       |
| Radiology Services                            | Hospital Outpatient | СРТ          | 77065       | Mammography of one breast        | Yes                                      | \$ | 546.40               | \$       | 107.57                                    | \$       | 501.03                                     | \$331.74                                   | Per Unit       |
| Radiology Services                            | Hospital Outpatient | СРТ          | 77066       | Mammography of both breasts      | Yes                                      | \$ | 383.79               | \$       | 135.81                                    | \$       | 629.70                                     | \$345.80                                   | Per Unit       |
| Radiology Services                            | Hospital Outpatient | СРТ          | 77067       | Mammogram (outpatient)           | Yes                                      | Ś  | 406.73               | Ś        | 109.22                                    | Ś        | 504.02                                     | \$328.74                                   | Per Unit       |
|   |                     |              |             |                                  |  | •  |                      |          |   |          |  |  |                |
| Radiology Services                            | Hospital Outpatient | CPT          | 77080       | Bone Density Scan (outpatient)   | No                                       | \$ | 247.25               | \$       | 56.29                                     | Ş        | 393.45                                     | \$376.09                                   | Per Unit       |
| Radiology Services                            | Hospital Outpatient | СРТ          | 77081       | Dxa bone density/peripheral      | No                                       | \$ | 116.84               | \$       | 33.80                                     | \$       | 171.64                                     | \$377.66                                   | Per Unit       |
| Radiology Services                            | Hospital Outpatient | СРТ          | 78452       | Myocardial Imaging (outpatient)  | No                                       | \$ | 1,010.04             | \$       | 336.74                                    | \$       | 2,091.45                                   | \$1,006.97                                 | Per Unit       |

|  |                            |              |       | T                                    |                    |                       |                      |                       | Amount We              | T             |
|--|----------------------------|--------------|-------|--------------------------------------|--------------------|-----------------------|----------------------|-----------------------|------------------------|---------------|
|  |                            |              |       |                                      |                    |                       |                      |                       | Estimate You           |               |
|  |                            |              |       |                                      |                    |                       |                      |                       | Will Owe *             |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
| To Search for a service Click "CTRL"       |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
| + "F"                                      |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       | _                      |               |
|  |                            |              |       |                                      | <u>CMS</u>         |                       | De-Identified        |                       | Payer-                 |               |
|  |                            | Cada         |       |                                      | Required           | Discounted            | Minimum              | Maximum<br>Negotiated | Specific<br>Negotiated |               |
| Service Category                           | Service Setting            | Code<br>Type | Code  | Description                          | Shoppable Service? | Discounted Cash Price | Negotiated<br>Charge | Charge                | Charge                 | Estimate Type |
| <u>Service Category</u>                    | Service Setting            | Туре         | coue  | Description                          | <u>Jervice:</u>    | Casii Fiice           | Charge               | Charge                | Charge                 | Estimate Type |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT          | 80048 | Blood Test - Basic Metabolic Panel   | Yes                | \$ 158.03             | \$ 11.84             | \$ 221.33             | \$15.46                | Per Unit      |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       | Blood Test - Comprehensive           |                    |                       |                      |                       |                        |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | СРТ          | 20053 | Metabolic Panel                      | Yes                | \$ 93.73              | \$ 14.78             | \$ 136.89             | \$19.31                | Per Unit      |
| Laboratory & Patriology Services           | Tiospital Outpatient       | CFT          | 80033 | Wetabolic Faller                     | 163                | 3 33.73               | 3 14.76              | 3 130.83              | \$15.51                | reronic       |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    | N/A No                | N/A No               | N/A No                | N/A No                 |               |
|  |                            |              |       | Blood Test - Pregnancy (Obstetric)   |                    | Service               | Service              | Service               | Service                |               |
| <b>Laboratory &amp; Pathology Services</b> | <b>Hospital Outpatient</b> | CPT          | 80055 | Panel                                | Yes                | Volume                | Volume               | Volume                | Volume                 | Per Unit      |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            | CD=          | 00064 | Blood Test - Cholesterol Test, Lipid |                    | 45.40                 | 40.05                | 404 ==                | 445.07                 |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | СРТ          | 80061 | Panel                                | Yes                | \$ 46.48              | \$ 12.05             | \$ 101.77             | \$16.97                | Per Unit      |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       | Blood Test - Renal (Kidney)          |                    |                       |                      |                       |                        |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | СРТ          | 80069 | Function Panel                       | Yes                | \$ 17.24              | \$ 8.68              | \$ 34.59              | \$15.74                | Per Unit      |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       |                                      |                    |                       |                      |                       |                        |               |
|  |                            |              |       | Blood Test - Hepatic (Liver)         |                    |                       |                      |                       |                        |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT          | 80076 | Function Panel                       | Yes                | \$ 146.77             | \$ 11.44             | \$ 205.84             | \$15.08                | Per Unit      |

|                                      |                            |       |       | I                                    |           |            |               |               | Amount We    |               |
|--------------------------------------|----------------------------|-------|-------|--------------------------------------|-----------|------------|---------------|---------------|--------------|---------------|
|                                      |                            |       |       |                                      |           |            |               |               | Estimate You |               |
|                                      |                            |       |       |                                      |           |            |               |               | Will Owe *   |               |
|                                      |                            |       |       |                                      |           |            |               |               | Will Owe     |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| To Search for a service Click "CTRL" |                            |       |       |                                      |           |            |               |               |              |               |
| + "F"                                |                            |       |       |                                      |           |            |               |               |              |               |
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|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      | CMS       |            | De-Identified | De-Identified | Payer-       |               |
|                                      |                            |       |       |                                      | Required  |            | Minimum       | Maximum       | Specific     |               |
|                                      |                            | Code  |       |                                      | Shoppable | Discounted | Negotiated    | Negotiated    | Negotiated   |               |
| Service Category                     | Service Setting            | Туре  | Code  | Description                          | Service?  | Cash Price | Charge        | Charge        | Charge       | Estimate Type |
| <u> </u>                             |                            | -11-5 |       |                                      | <u> </u>  |            | -             |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ   | 80307 | Drug test prsmv chem anlyzr          | No        | \$ 128.65  | \$ 55.93      | \$ 199.53     | \$71.83      | Per Unit      |
|                                      |                            |       | 22307 | =0 +00+ prome enem umyzi             |           | N/A No     | N/A No        | N/A No        | N/A No       |               |
|                                      |                            |       |       |                                      |           | Service    | Service       | Service       | Service      |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ   | 81000 | Urinalysis nonauto w/scope           | Yes       | Volume     | Volume        | Volume        | Volume       | Per Unit      |
| Laboratory at atmology services      | nospital Gatpatient        | C     | 01000 | ormarysis nonauto wyscope            | 103       | voidine    | volunie       | voidine       | voidine      | r cr onic     |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       | Urine Test - Automated with          |           |            |               |               | 4            |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT   | 81001 | Microscope Examination               | Yes       | \$ 23.46   | \$ 4.44       | \$ 34.47      | \$7.06       | Per Unit      |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT   | 81002 | Urine Test - Urinalysis, Manual Test | Yes       | \$ 7.24    | \$ 2.67       | \$ 14.00      | \$3.24       | Per Unit      |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       | Urine Test - Automated without       |           |            |               |               |              |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT   | 81003 | Microscope                           | Yes       | \$ 10.40   | \$ 3.16       | \$ 11.25      | \$5.00       | Per Unit      |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT   | 81025 | Urine Test - Pregnancy               | No        | \$ 40.87   | \$ 10.45      | \$ 58.29      | \$14.10      | Per Unit      |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT   | 82247 | Bilirubin total                      | No        | \$ 41.02   | \$ 4.52       | \$ 55.22      | \$6.35       | Per Unit      |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
|                                      |                            |       |       |                                      |           |            |               |               |              |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT   | 82306 | Blood Test - Vitamin D-3 Level       | No        | \$ 188.74  | \$ 26.64      | \$ 254.08     | \$37.49      | Per Unit      |
|                                      | •                          |       |       |                                      |           |            |               |               |              |               |

|                                      | T.                         | 1        | 1     | I                           | 1         | ı   |            |              |         |               |                   |               |
|--------------------------------------|----------------------------|----------|-------|-----------------------------|-----------|-----|------------|--------------|---------|---------------|-------------------|---------------|
|                                      |                            |          |       |                             |           |     |            |              |         |               | Amount We         |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               | Estimate You      |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               | Will Owe *        |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| To Search for a service Click "CTRL" |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| + "F"                                |                            |          |       |                             |           |     |            |              |         |               |                   |               |
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|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             | CMS       |     |            | De-Ide       | ntified | De-Identifie  | d Payer-          |               |
|                                      |                            |          |       |                             | Required  |     |            | Minin        |         | Maximum       | Specific          |               |
|                                      |                            | Code     |       |                             | Shoppable | Die | scounted   | Negot        |         | Negotiated    |                   |               |
| Comica Catagoni                      | Samina Satting             |          | Codo  | Description                 | Service?  |     | sh Price   |              |         |               |                   | Estimata Tuna |
| Service Category                     | Service Setting            | Type     | Code  | <u>Description</u>          | Services  | Ca  | ISII PIICE | Cha          | ige     | <u>Charge</u> | Charge            | Estimate Type |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82330 | Assay of calcium            | No        | \$  | 35.11      | \$           | 12.31   | \$ 67.0       | 0 \$17.31         | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82375 | Assay carboxyhb quant       | No        | \$  | 114.13     | \$           | 11.09   | \$ 153.6      | 4 \$15.62         | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     | 45.00      |              | 2.02    |               | 4= ==             | B             |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82465 | Assay bld/serum cholesterol | No        | \$  | 15.28      | Ş            | 3.92    | \$ 23.7       | 6 \$5.52          | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT      | 82550 | Assay of ck (cpk)           | No        | \$  | 12.70      | \$           | 5.86    | \$ 35.5       | \$8.25            | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ      | 82552 | Assay of cpk in blood       | No        | \$  | 26.14      | Ś            | 12.05   | \$ 75.4       | 1 \$16.97         | Per Unit      |
|                                      |                            | <b>U</b> | 02002 |                             |           | _   |            | <del>*</del> |         | 7011          | 420.07            |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratoria O Dothologia Comitoria   | Hamital Cotostiant         | CDT      | 02565 | A of our estatus            |           |     | 124 50     |              | 7.47    | ć 70.3        | 640.03            | Devilleda.    |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82505 | Assay of creatinine         | No        | \$  | 124.50     | Ş            | 7.17    | \$ 70.2       | 5 \$10.02         | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       | Blood Test - Vitamin B-12   |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ      | 82607 | (Cyanocobalamin) Level      | No        | \$  | 29.40      | Ś            | 13.57   | \$ 82.7       | \$19.09           | Per Unit      |
| ,                                    |                            | 1        |       |                             |           | -   | _55        | *            |         |               | +                 |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Dathalogy Comisses      | Hasnital Outpations        | СРТ      | 92610 | Custatin                    | No        | \$  | 140.40     | ė            | 14.17   | \$ 405.0      | 0 \$17.22         | Dor Unit      |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 02010 | Cystatin c                  | No        | Ģ   | 140.40     | ş            | 14.17   | ې 405.0       | υ <u>\$1</u> /.22 | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82668 | Assay of erythropoietin     | No        | \$  | 36.68      | \$           | 16.91   | \$ 99.2       | 0 \$23.81         | Per Unit      |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
|                                      |                            |          |       |                             |           |     |            |              |         |               |                   |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT      | 82670 | Assay of estradiol          | No        | \$  | 54.51      | \$           | 25.15   | \$ 152.3      | \$35.39           | Per Unit      |
| , ,,                                 |                            | -        |       |                             | 1         |     |            | •            |         |               |                   | l             |

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| To Search for a service Click "CTRL"<br>+ "F" |                        |              |       |  |                                 |                       |   |  |  |               |
| <u>Service Category</u>                       | <u>Service Setting</u> | Code<br>Type | Code  | <u>Description</u>                                     | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                        |              |       |  |                                 |                       |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient    | CPT          | 82693 | Assay of ethylene glycol                               | No                              | \$ 20.29              | \$ 13.41                                | \$ 40.08                                   | \$18.86                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 82728 | Blood Test - Ferritin (Blood Protein)<br>Level         | No                              | \$ 33.53              | \$ 19.09                                | \$ 96.63                                   | \$26.62                                    | Per Unit      |
|   |                        |              |       |  |                                 |                       |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 82746 | Blood Test - Folic Acid Level                          | No                              | \$ 37.75              | \$ 13.23                                | \$ 79.52                                   | \$18.62                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 82803 | Blood gases any combination                            | No                              | \$ 73.40              | \$ 20.17                                | \$ 106.16                                  | \$24.50                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 82947 | Assay glucose blood quant                              | No                              | \$ 34.04              | \$ 5.51                                 | \$ 49.42                                   | \$8.74                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 82962 | Glucose blood test                                     | No                              | \$ 45.55              | \$ 3.89                                 | \$ 61.82                                   | \$5.21                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 83018 | Heavy metal quant each nes                             | No                              | \$ 172.97             | \$ 19.76                                | \$ 498.96                                  | \$27.82                                    | Per Unit      |
|   |                        |              |       |  |                                 |                       |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient    | СРТ          | 83036 | Blood Test - Blood Glucose Control<br>(Hemoglobin A1C) | No                              | \$ 71.27              | \$ 8.74                                 | \$ 95.94                                   | \$12.29                                    | Per Unit      |

|   |                     |              |       |   |  |    |                     |   |    |   | Amount We                                  |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |   |  |    |                     |   |    |   |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | <u>Description</u>                        | CMS<br>Required<br>Shoppable<br>Service? |    | counted<br>th Price | De-Identified Minimum Negotiated Charge | N  | -Identified<br>Maximum<br>egotiated<br>Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83088 | Assay of histamine                        | No                                       | Ś  | 75.84               | \$ 26.58                                | Ś  | 218.76  | \$37.40                                    | Per Unit      |
| Laboratory & Patriology Services              | nospitai Outpatient | CFI          | 83088 | Assay of histalline                       | NO                                       | 7  | 75.04               | \$ 20.38                                | ۶  | 218.70  | 337.40                                     | rei oiiit     |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83518 | Immunoassay dipstick                      | No                                       | \$ | 147.09              | \$ 6.55                                 | \$ | 424.29  | \$10.74                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83540 | Blood Test - Iron Level                   | No                                       | \$ | 51.90               | \$ 9.06                                 | \$ | 75.77   | \$12.66                                    | Per Unit      |
|   |                     |              |       |   |  |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83605 | Assay of lactic acid                      | No                                       | \$ | 27.44               | \$ 10.41                                | \$ | 58.05   | \$13.53                                    | Per Unit      |
|   |                     |              |       |   |  |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83690 | Blood Test - Lipase (fat enzyme)<br>Level | No                                       | \$ | 69.47               | \$ 6.20                                 | \$ | 93.51   | \$8.72                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83735 | Assay of magnesium                        | No                                       | \$ | 53.82               | \$ 9.38                                 | \$ | 78.56   | \$13.10                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 83880 | Assay of natriuretic peptide              | No                                       | \$ | 172.55              | \$ 35.33                                | \$ | 232.27  | \$42.99                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84100 | Assay of phosphorus                       | No                                       | \$ | 61.73               | \$ 6.64                                 | \$ | 87.67   | \$9.01                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84132 | Assay of serum potassium                  | No                                       | \$ | 43.23               | \$ 6.66                                 | \$ | 62.65   | \$8.98                                     | Per Unit      |
|   |                     |              |       |   |  |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | CPT          | 84132 | Assay of serum potassium                  | No                                       | \$ | 43.23               | \$ 6.66                                 | \$ | 62.65   | \$8.98                                     | Per Unit      |

|   |                     |              |       |  |                                 |  |   |  | Amount We                                  |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |  |                                 |  |   |  |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | <u>Description</u>                                       | CMS Required Shoppable Service? | <u>Discounted</u><br><u>Cash Price</u> | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84144 | Assay of progesterone                                    | No                              | \$ 52.59                               | \$ 18.77                                | \$ 96.68                                   | \$26.42                                    | Per Unit      |
|   |                     |              |       |  |                                 |  |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84153 | Blood Test - Prostate Specific<br>Antigen (PSA) Level    | Yes                             | \$ 74.21                               | \$ 25.75                                | \$ 116.68                                  | \$35.95                                    | Per Unit      |
| , ,,  |                     |              |       |  |                                 | •                                      |   | ·  | ·  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84154 | PSA (prostate specific antigen)                          | Yes                             | \$ 106.34                              | \$ 16.55                                | \$ 143.15                                  | \$23.30                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84182 | Protein western blot test                                | No                              | \$ 382.72                              | \$ 18.76                                | \$ 588.80                                  | \$22.80                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84295 | Assay of serum sodium                                    | No                              | \$ 42.10                               | \$ 4.33                                 | \$ 56.67                                   | \$6.09                                     | Per Unit      |
|   |                     |              |       |  |                                 |  |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84439 | Blood Test - Thyroxine (Thyroid<br>Chemical) Level, Free | No                              | \$ 66.21                               | \$ 8.12                                 | \$ 89.13                                   | \$11.42                                    | Per Unit      |
|   |                     |              |       |  |                                 |  |   |  |  |               |
|   |                     |              |       |  |                                 |  |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84443 | Blood Test - Thyroid Stimulating<br>Hormone (TSH) Level  | No                              | \$ 64.07                               | \$ 23.52                                | \$ 119.09                                  | \$32.83                                    | Per Unit      |

|   | T                   |              |             | I                                |                                 |                       |   |   | Amount We                                  |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                     |              |             |                                  |                                 |                       |   |   |  |               |
| Service Category                              | Service Setting     | Code<br>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-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
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|   |                     |              |             |                                  |                                 |                       |   |   |  |               |
|   |                     |              |             | Blood Test - Thyroid Stimulating |                                 |                       |   |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | CPT          | 84443       | Hormone (TSH) Level              | Yes                             | \$ 64.07              | \$ 23.52                                | \$ 119.09                               | \$32.83                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 84480       | Assay triiodothyronine (t3)      | No                              | \$ 96.31              | \$ 12.76                                | \$ 129.65                               | \$17.96                                    | 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 | CPT          | 84702       | Chorionic gonadotropin test      | No                              | \$ 125.77             | \$ 11.54                                | \$ 169.31                               | \$19.07                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 85014       | Hematocrit                       | No                              | \$ 26.95              | \$ 2.13                                 | \$ 36.27                                | \$3.00                                     | Per Unit      |
|   |                     |              |             | Blood Test - Complete Blood Cell |                                 |                       |   |   | 4  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | CPT          | 85025       | Count and Automated WBC          | Yes                             | \$ 77.98              | \$ 10.88                                | \$ 112.06                               | \$15.20                                    | Per Unit      |
|   |                     |              |             | Blood Test - Complete Blood Cell |                                 |                       |   |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | CPT          | 85027       | Count (Hemoglobin)               | Yes                             | \$ 60.79              | \$ 5.82                                 | \$ 81.83                                | \$8.20                                     | Per Unit      |

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| To Search for a service Click "CTRL" |                            |      |        |                              |           |                   |               |               |               |               |
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|                                      |                            |      |        |                              | CMS       |                   | De-Identified | De-Identified | Payer-        |               |
|                                      |                            |      |        |                              | Required  |                   | Minimum       | Maximum       | Specific      |               |
|                                      |                            | Code |        |                              | Shoppable | Discounted        | Negotiated    | Negotiated    | Negotiated    |               |
| Samisa Catagoni                      | Comica Sotting             |      | Codo   | Description                  | Service?  | Cash Price        |               |               |               | Estimata Tuna |
| Service Category                     | Service Setting            | Type | Code   | <u>Description</u>           | Servicer  | <u>Cash Price</u> | Charge        | Charge        | <u>Charge</u> | Estimate Type |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 85240  | Clot factor viii ahg 1 stage | No        | \$ 45.97          | \$ 16.11      | \$ 95.56      | \$22.68       | Per Unit      |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 85378  | Fibrin degrade semiquant     | No        | \$ 53.57          | \$ 7.44       | \$ 72.11      | \$9.03        | Per Unit      |
|                                      |                            | -    |        |                              |           | , ,               |               | 7             | 75.55         |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      | 05640  | DI 17 . CI .: T              |           | A 44.04           |               |               | 40.76         |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 85610  | Blood Test - Clotting Time   | Yes       | \$ 44.81          | \$ 6.01       | \$ 64.27      | \$8.76        | Per Unit      |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT  | 85613  | Russell viper venom diluted  | No        | \$ 24.61          | \$ 8.24       | \$ 70.98      | \$12.12       | Per Unit      |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 85660  | RBC SICKLE CELL TEST         | No        | \$ 53.32          | \$ 4.96       | \$ 71.77      | \$0.00        | Per Unit      |
|                                      | and the second second      |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        | Blood Test - Coagulation     |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 85730  | Assessment                   | Yes       | \$ 46.01          | \$ 5.41       | \$ 61.94      | \$7.61        | Per Unit      |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT  | 85732  | Thromboplastin time partial  | No        | \$ 12.63          | \$ 5.82       | \$ 36.42      | \$8.20        | Per Unit      |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 86140  | C-reactive protein           | No        | \$ 48.49          | \$ 4.66       | \$ 65.28      | \$6.55        | Per Unit      |
|                                      | - Copital Garpanelle       |      | 301-10 | - Course protein             |           | ÷ 43.43           | 7 7.00        | ÷ 55.20       | 70.55         |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
|                                      |                            |      |        |                              |           |                   |               |               |               |               |
| la a a a a a a a a                   |                            |      |        |                              |           |                   |               |               |               |               |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 86360  | T cell absolute count/ratio  | No        | \$ 65.00          | \$ 42.28      | \$ 211.59     | \$59.51       | Per Unit      |

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|--------------------------------------|----------------------------|------|-------|------------------------------|------------------|------|---------|---|---------------|--------------|-----------------|
|                                      |                            |      |       |                              |                  |      |         |   |               | Amount We    |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               | Estimate You |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               | Will Owe *   |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| To Search for a service Click "CTRL" |                            |      |       |                              |                  |      |         |   |               |              |                 |
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|                                      |                            |      |       |                              | CMS              |      |         | <b>De-Identified</b>                    | De-Identified | Payer-       |                 |
|                                      |                            |      |       |                              | Required         |      |         | Minimum                                 | Maximum       | Specific     |                 |
|                                      |                            | Code |       |                              | Shoppable        | Disc | ounted  | Negotiated                              | Negotiated    | Negotiated   |                 |
| Service Category                     | Service Setting            | Туре | Code  | Description                  | Service?         |      | h Price | Charge                                  | Charge        | Charge       | Estimate Type   |
| <u> </u>                             | Service Setting            | 1700 | couc  | <u> </u>                     | <u>JC: FICC.</u> |      | 111100  | charge                                  | charge        | Charge       | Localitate Type |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratoria O Dothologia Comitoria   | Harrist Contractions       | CDT  | 00204 | T cell abandos accord        |                  | _    | 422.70  | ć 24.40                                 | ¢ 202.02      | 622.00       | Dan Haite       |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 86361 | T cell absolute count        | No               | \$   | 132.78  | \$ 24.10                                | \$ 383.03     | \$33.90      | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  | ١.   |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 86431 | Rheumatoid factor quant      | No               | \$   | 52.70   | \$ 5.10                                 | \$ 70.95      | \$7.18       | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT  | 86592 | Syphilis test non-trep qual  | No               | \$   | 37.81   | \$ 3.84                                 | \$ 50.90      | \$5.41       | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 86592 | Syphilis test non-trep qual  | No               | \$   | 37.81   | \$ 3.84                                 | \$ 50.90      | \$5.41       | Per Unit        |
|                                      |                            | -    |       | - Aprilia coo in a sp quai   |                  | -    |         | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7 30.00       | 70112        | 7 0. 01.110     |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Dathology Comises       | Hospital Outpationt        | СРТ  | 96611 | Partanalla antihadu          | No               | \$   | 57.37   | \$ 9.16                                 | \$ 165.50     | \$12.89      | Per Unit        |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPI  | 90011 | Bartonella antibody          | No               | ş    | 37.37   | 3 9.10                                  | \$ 105.50     | \$12.09      | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  | ١.   |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 86615 | Bordetella antibody          | No               | \$   | 25.74   | \$ 11.87                                | \$ 81.45      | \$16.70      | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 86651 | Encephalitis californ antbdy | No               | \$   | 25.74   | \$ 11.87                                | \$ 110.13     | \$16.70      | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | СРТ  | 86652 | Encephaltis east eqne anbdy  | No               | \$   | 25.74   | \$ 11.87                                | \$ 110.13     | \$16.70      | Per Unit        |
|                                      |                            |      | 30032 |                              |                  | 7    | 23.74   | <del>+</del> 11.07                      | Ţ 115.15      | 720.70       |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Bathology Services      | Hospital Outpationt        | СРТ  | 96653 | Enconhaltic et louis anthody | No               | \$   | 25 74   | \$ 11.87                                | \$ 110.13     | \$16.70      | Per Unit        |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPI  | 80055 | Encephaltis st louis antbody | No               | Ş    | 25.74   | 3 11.8/                                 | φ 110.13      | 310.70       | rei Ullit       |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  | ١.   |         |   |               |              |                 |
| Laboratory & Pathology Services      | Hospital Outpatient        | CPT  | 86654 | Encephaltis west eqne antbdy | No               | \$   | 25.74   | \$ 11.87                                | \$ 110.13     | \$16.70      | Per Unit        |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
|                                      |                            |      |       |                              |                  |      |         |   |               |              |                 |
| Laboratory & Pathology Services      | <b>Hospital Outpatient</b> | CPT  | 86663 | Epstein-barr antibody        | No               | \$   | 25.60   | \$ 11.81                                | \$ 83.21      | \$16.61      | Per Unit        |
|                                      | •                          | _    |       | •                            |                  | _    |         |   | •             | •            |                 |

|  |                            | 1    |       | T                            |                 |              |           | _   |              |     |           |                     |               |
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|  |                            |      |       |                              |                 |              |           |     |              |     |           | Amount We           |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           | <b>Estimate You</b> |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           | Will Owe *          |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| T 6 16 : 61:1    GTP1                      |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| To Search for a service Click "CTRL"       |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| + "F"                                      |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
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|  |                            |      |       |                              |                 |              |           | L . |              | l   |           | _                   |               |
|  |                            |      |       |                              | CMS             |              |           |     | dentified    | _   | dentified | Payer-              |               |
|  |                            |      |       |                              | Required        |              |           | Mi  | <u>nimum</u> | Ma  | ximum     | Specific            |               |
|  |                            | Code |       |                              | Shoppable       | Disc         | ounted    | Neg | otiated      | Nes | otiated   | Negotiated          |               |
| Service Category                           | Service Setting            | Туре | Code  | Description                  | Service?        |              | h Price   |     | harge        |     | harge     | Charge              | Estimate Type |
| Service category                           | <u>Service Setting</u>     | Турс | Couc  | Description                  | <u>SCIVICE:</u> | Cusi         | ii i iicc |     | luige        |     | naige     | charge              | Estimate Type |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT  | 86677 | Helicobacter pylori antibody | No              | \$           | 30.68     | \$  | 15.13        | \$  | 63.03     | \$18.38             | Per Unit      |
|  | ·                          |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT  | 86692 | Hepatitis delta agent antbdy | No              | \$           | 29.16     | \$  | 15.44        | \$  | 50.98     | \$21.74             | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT  | 86698 | Histoplasma antibody         | No              | \$           | 79.65     | \$  | 12.41        | \$  | 107.23    | \$15.83             | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      | 06704 | UED D CODE ANTIDODY TOTAL    |                 | _            | 00.44     |     | 40.05        | _   | 445.00    | 40.00               |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT  | 86704 | HEP B CORE ANTIBODY TOTAL    | No              | \$           | 86.11     | Ş   | 10.85        | \$  | 115.92    | \$0.00              | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laborata de O Dathala de Camila de         |                            | СРТ  | 00705 | HED D CODE ANTIDODY ICAA     | N1-             | \$           | 22.98     |     | 10.59        | _   | F7 20     | \$0.00              | Devilleda.    |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPI  | 86705 | HEP B CORE ANTIBODY IGM      | No              | Ş            | 22.98     | \$  | 10.59        | \$  | 57.38     | \$0.00              | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | <b>Hospital Outpatient</b> | СРТ  | 86706 | HEP B SURFACE ANTIBODY       | No              | \$           | 98.98     | ė   | 9.67         | \$  | 133.25    | \$0.00              | Per Unit      |
| Laboratory & Patriology Services           | Hospital Outpatient        | CFI  | 80700 | HEF B JORFACE ANTIBODT       | NO              | ş            | 30.30     | Ą   | 5.07         | Ą   | 133.23    | Ş0.00               | rei Oilit     |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| <b>Laboratory &amp; Pathology Services</b> | <b>Hospital Outpatient</b> | CPT  | 86707 | Hepatitis be antibody        | No              | \$           | 22.56     | \$  | 10.41        | \$  | 65.09     | \$14.65             | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           | -                   |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           | 4                   |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | CPT  | 86708 | Hepatitis a antibody         | No              | \$           | 22.71     | \$  | 11.15        | \$  | 56.71     | \$15.69             | Per Unit      |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | Hospital Outpatient        | СРТ  | 26762 | Rubella antibody             | No              | \$           | 78.19     | ė   | 12.95        | Ġ   | 225.56    | \$18.23             | Per Unit      |
| Laboratory & Fathology Services            | nospitai Outpatielit       | GF I | 00/02 | nabella altubouy             | NU              | 7            | 70.15     | Y   | 12.33        | ٧   | 223.30    | 710.23              | i ci Oiiit    |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
|  |                            |      |       |                              |                 |              |           |     |              |     |           |                     |               |
| Laboratory & Pathology Services            | <b>Hospital Outpatient</b> | CPT  | 86765 | Rubeola antibody             | No              | \$           | 25.14     | \$  | 11.59        | \$  | 72.53     | \$16.32             | Per Unit      |
| , ,  | Annual Conference          |      |       |                              | +               | <del> </del> |           |     |              |     |           |                     |               |

|   |                     |              |       |   |                                 |                       |   |   | Amount We                                  |               |
|---|---------------------|--------------|-------|---|---------------------------------|-----------------------|---|---|--|---------------|
|   |                     |              |       |   |                                 |                       |   |   | Estimate You                               |               |
|   |                     |              |       |   |                                 |                       |   |   | Will Owe *                                 |               |
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |   |                                 |                       |   |   |  |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | Description                             | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified Maximum Negotiated Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                     | 15-          |       |   |                                 |                       |   |   |  | 7,50          |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86769 | 86769 - SARS-COV-2 COVID-19<br>ANTIBODY | No                              | \$ 51.48              | \$ -                                    | \$ 112.07                               | \$0.00                                     | Per Unit      |
|   |                     |              |       |   |                                 |                       |   |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86790 | Virus antibody nos                      | No                              | \$ 25.14              | \$ 11.59                                | \$ 76.53                                | \$16.32                                    | Per Unit      |
|   |                     |              |       | Blood Test - Hepatitis C Antibody       |                                 |                       |   |   |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | CPT          | 86803 | Level                                   | No                              | \$ 67.64              | \$ 12.84                                | \$ 91.06                                | \$18.07                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86804 | Hep c ab test confirm                   | No                              | \$ 23.09              | \$ 13.94                                | \$ 66.62                                | \$19.62                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86850 | Rbc antibody screen                     | No                              | \$ 20.32              | \$ 5.00                                 | \$ 66.92                                | \$13.44                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86885 | Coombs test indirect qual               | No                              | \$ 244.72             | \$ 5.65                                 | \$ 329.43                               | \$7.25                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86900 | Blood typing serologic abo              | No                              | \$ 198.99             | \$ 3.78                                 | \$ 267.88                               | \$3.78                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86900 | Blood typing serologic abo              | No                              | \$ 198.99             | \$ 3.78                                 | \$ 267.88                               | \$3.78                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 86901 | Blood typing serologic rh(d)            | No                              | \$ 60.24              | \$ 3.78                                 | \$ 81.10                                | \$3.78                                     | Per Unit      |
|   | p.ion. waspanelle   | J            | 55552 |   |                                 | T 00124               | 7 3170                                  | 7 02120                                 | 70.70                                      |               |

|  |  |              |             |                                      |                                 |    |                     |   |    |   | Amount We<br>Estimate You<br>Will Owe *    |               |
|--|--|--------------|-------------|--------------------------------------|---------------------------------|----|---------------------|---|----|---|--|---------------|
| To Search for a service Click "CTRL"<br>+ "F"                    |  |              |             |                                      |                                 |    |                     |   |    |   |  |               |
| Service Category   | Service Setting                          | Code<br>Type | <u>Code</u> | Description                          | CMS Required Shoppable Service? |    | counted<br>sh Price | De-Identified Minimum Negotiated Charge | 1  | De-Identified Maximum Negotiated Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|  |  |              |             |                                      |                                 |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services                                  | Hospital Outpatient                      | СРТ          | 86901       | Blood typing serologic rh(d)         | No                              | \$ | 60.24               | \$ 3.78                                 | \$ | 81.10                                   | \$3.78                                     | Per Unit      |
|  |  |              |             |                                      |                                 |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services                                  | Hospital Outpatient                      | СРТ          | 86902       | BLOOD TYPE ANTIGEN DONOR EA          | No                              | \$ | 5.82                | \$ 4.84                                 | \$ | 383.37                                  | \$0.00                                     | Per Unit      |
| Laboratory & Pathology Services                                  | Hospital Outpatient                      | СРТ          | 86920       | COMPATIBILITY TEST SPIN              | No                              | \$ | 244.72              | \$ 13.44                                | \$ | 344.22                                  | \$0.00                                     | Per Unit      |
|  |  |              |             |                                      |                                 |    |                     |   |    |   |  |               |
| Laboratory & Pathology Services                                  | Hospital Outpatient                      | СРТ          | 87040       | Blood culture for bacteria           | No                              | \$ | 133.90              | \$ 9.29                                 | \$ | 180.25                                  | \$13.08                                    | Per Unit      |
| Laboratory & Pathology Services                                  | Hospital Outpatient                      | СРТ          | 87070       | Bacterial Culture - Swab             | No                              | \$ | 138.63              | \$ 7.76                                 | \$ | 186.61                                  | \$10.91                                    | Per Unit      |
| Laboratory Q Dathology Comices                                   | Hamital Outrations                       | CDT          | 07077       | Package Cultura Associated           | No                              | ć  | CO 43               | ć 7.27                                  | ć  | 94.25                                   | ¢10.22                                     | Double's      |
| Laboratory & Pathology Services                                  | nospital Outpatient                      | СРТ          | 87077       | Bacterial Culture - Aerobic Isolates | NO                              | ş  | 60.45               | \$ 7.27                                 | Ş  | 61.55                                   | \$10.25                                    | Per Offit     |
|  |  |              |             |                                      |                                 |    |                     |   |    |   |  |               |
|  |  |              |             | Test for Disease Causing             |                                 |    |                     |   |    |   |  |               |
| Lahoratory & Pathology Convices                                  | Hospital Outpations                      | CDT          | Q7001       | (Pathogenic) Organisms, Not          | No                              | ¢  | 91 17               | ¢ 507                                   | ć  | 100 26                                  | \$g 40                                     | Per Unit      |
| Laboratory & Pathology Services  Laboratory & Pathology Services | Hospital Outpatient  Hospital Outpatient | СРТ          |             |                                      | No<br>No                        | \$ | 60.43               | \$ 7.27<br>\$ 5.97                      |    | 81.35                                   | \$10.23<br>\$8.40                          | Per Unit      |

|   |                      |              |       | 1  |                                 |          |                |  |            |  | Amount We                                  |               |
|---|----------------------|--------------|-------|--|---------------------------------|----------|----------------|--|------------|--|--|---------------|
|   |                      |              |       |  |                                 |          |                |  |            |  | Estimate You                               |               |
|   |                      |              |       |  |                                 |          |                |  |            |  | Will Owe *                                 |               |
| To Search for a service Click "CTRL"<br>+ "F" |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| <u>Service Category</u>                       | Service Setting      | Code<br>Type | Code  | <u>Description</u>   | CMS Required Shoppable Service? |          | unted<br>Price | De-Identif<br>Minimur<br>Negotiate<br>Charge | n<br>ed    | De-Identified Maximum Negotiated Charge          | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| Laboratori O Both dom Comitor                 | Hereited Outerations | CDT          | 07000 | Urine Test - Bacterial Culture,                                      | N -                             | _        | 02.46          | ć -  |            | ć 440.60   | Ć40 22                                     | Day Haite     |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87086 | Quantitative Colony Count  | No                              | \$       | 82.16          | \$ 7.  | 26         | \$ 110.60  | \$10.22                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87088 | Urine Test - Bacterial Culture                                       | No                              | \$       | 15.80          | \$ 7.  | 28         | \$ 43.86   | \$10.26                                    | Per Unit      |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87110 | Chlamydia culture  | No                              | \$       | 130.74         | \$ 17.                                       | 64         | \$ 175.99  | \$24.81                                    | Per Unit      |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87186 | Evaluation of Antimicrobial Drug (antibiotic, antifungal, antiviral) | No                              | \$       | 69.16          | \$ 7.  | <b>7</b> 9 | \$ 93.10   | \$10.95                                    | Per Unit      |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87205 | Lab Test - Smear for Microorganism                                   | No                              | \$       | 49.93          | \$ 3.  | 84         | \$ 67.21   | \$5.41                                     | Per Unit      |
|   |                      | <b>.</b>     | 0.200 |  |                                 |          | 15.50          | <del>,</del>                                 |            | <del>y                                    </del> | 70112                                      |               |
|   |                      |              |       |  |                                 |          |                |  |            |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | СРТ          | 87340 | Lab Test - Detection test for<br>Hepatitis B Surface Antigen         | No                              | Ś        | 63.55          | \$ Q   | 30         | \$ 85.55   | \$13.08                                    | Per Unit      |
| Edwardtory & Facilities Services              | nospital Outputtent  |              | 0,340 | reputitio o outrace Attugen  | 140                             | <b>,</b> | 03.33          | <del>у</del> э.                              | 50         | <del>y</del> 63.33                               | 913.00                                     | . Cr Omt      |
|   |                      |              |       | Lab Test - Detection test for HIV-1                                  |                                 |          |                |  |            |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | CPT          | 87389 | and HIV-2  | No                              | \$       | 110.43         | \$ 21.                                       | 67         | \$ 148.66  | \$30.71                                    | Per Unit      |

|   |                     |              |       |  |                                 |                          |   |  | Amount We<br>Estimate You<br>Will Owe *    |               |
|---|---------------------|--------------|-------|--|---------------------------------|--------------------------|---|--|--|---------------|
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |  |                                 |                          |   |  | WillOwe                                    |               |
| <u>Service Category</u>                       | Service Setting     | Code<br>Type | Code  | <u>Description</u>   | CMS Required Shoppable Service? | Discounted<br>Cash Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87425 | Rotavirus ag ia  | No                              | \$ 37.44                 | \$ 10.78                                | \$ 108.00                                  | \$15.19                                    | Per Unit      |
| , ,,  |                     |              |       |  |                                 | ·                        |   |  |  |               |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87491 | Urine Test - Chlamydia                                       | No                              | \$ 108.43                | \$ 31.58                                | \$ 171.03                                  | \$44.45                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87591 | Urine Test - Gonorrhoeae<br>(Neisseria Gonorrhoeae Bacteria) | No                              | \$ 90.13                 | \$ 31.58                                | \$ 171.03                                  | \$44.45                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87635 | 87635 - SARS-COV-2 COVID-19<br>AMP PRB                       | No                              | \$ 53.36                 | \$ -                                    | \$ 136.48                                  | \$0.00                                     | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          |       | Detect agent nos dna amp                                     | No                              | \$ 90.13                 |   |  | \$44.45                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87804 | Lab Test - Detection test for<br>Influenza Virus             | No                              | \$ 37.58                 | \$ 19.82                                | \$ 70.50                                   | \$26.21                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 87880 | Strep Test (Streptococcus, group A)                          | No                              | \$ 101.56                | \$ 19.87                                | \$ 143.48                                  | \$26.21                                    | Per Unit      |
| Laboratory & Pathology Services               | Hospital Outpatient | СРТ          | 88185 | Flowcytometry/tc add-on                                      | No                              | \$ 68.81                 | \$ -                                    | \$ 120.30                                  | \$15.36                                    | Per Unit      |

|  |                            |             |       |                                   |           |            |                      |                | Amount We       |               |
|--|----------------------------|-------------|-------|-----------------------------------|-----------|------------|----------------------|----------------|-----------------|---------------|
|  |                            |             |       |                                   |           |            |                      |                | Estimate You    |               |
|  |                            |             |       |                                   |           |            |                      |                | Will Owe *      |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
| To Sourch for a complex Click "CTD!"       |                            |             |       |                                   |           |            |                      |                |                 |               |
| To Search for a service Click "CTRL" + "F" |                            |             |       |                                   |           |            |                      |                |                 |               |
| , ,  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   | 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  | <u>Description</u>                | Service?  | Cash Price | <u>Charge</u>        | <u>Charge</u>  | Charge          | Estimate Type |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       | Immunization Administration First |           |            |                      |                |                 |               |
| Vaccinations                               | Physician Office           | СРТ         | 90460 | Component                         | No        | \$ 40.10   | \$ 11.68             | \$ 75.93       | \$37.89         | Per Unit      |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       | Immunization Administration Each  |           |            |                      |                |                 |               |
| Vaccinations                               | Physician Office           | СРТ         | 90461 |                                   | No        | \$ 25.13   | \$ 10.49             | \$ 38.51       | \$18.72         | Per Unit      |
|  | ,                          |             |       |                                   |           | ,          | ,                    |                | , -             |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
| Vaccinations                               | Hospital Outpatient        | CPT         | 90471 | Immunization Administration       | No        | \$ 44.49   | \$ 7.02              | \$ 81.80       | \$37.89         | Per Unit      |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
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|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       | Immunization Administration Each  |           |            |                      |                |                 |               |
| Vaccinations                               | <b>Hospital Outpatient</b> | CPT         | 90472 | Additional Component              | No        | \$ 12.56   | \$ -                 | \$ 38.51       | \$18.72         | Per Unit      |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
| Vaccinations                               | Hospital Outpatient        | CPT         | 90651 | 9V HPV Vaccine 2/3 Dose           | No        | \$ 142.32  | \$ 9.56              | \$ 227.93      | \$0.00          | Per Unit      |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       |                                   |           |            |                      |                |                 |               |
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|  |                            |             |       |                                   |           |            |                      |                |                 |               |
|  |                            |             |       | Vaccine - Pneumococcal Conjugate  |           |            |                      |                |                 |               |
| Vaccination                                | <b>Hospital Outpatient</b> | CPT         | 90670 | for Injection into Muscle         | No        | \$ 285.59  | \$ 9.56              | \$ 345.21      | \$274.61        | Per Unit      |

|   | T                      |      |       | T.                                |           | _   |          |       | -        |               | T -                                   | , ,           |
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|   |                        |      |       |                                   |           |     |          |       |          |               | Amount We                             |               |
|   |                        |      |       |                                   |           |     |          |       |          |               | <b>Estimate You</b>                   |               |
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|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
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| To Search for a service Click "CTRL"        |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
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|   |                        |      |       |                                   | CMS       |     |          | De-Id | entified | De-Identified | Payer-                                |               |
|   |                        |      |       |                                   | Required  |     |          | Min   | imum     | Maximum       | Specific                              |               |
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|   | 6 . 6                  |      |       | - · · ·                           |           |     |          |       |          |               |                                       |               |
| Service Category                            | Service Setting        | Type | Code  | <u>Description</u>                | Service?  | Ca  | sh Price | Ch    | arge     | <u>Charge</u> | <u>Charge</u>                         | Estimate Type |
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|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
|   |                        |      |       | Vaccine - Tetanus, Diptheria      |           |     |          |       |          |               |                                       |               |
|   |                        |      |       | Toxoids, and Acellular Pertussis  |           |     |          |       |          |               |                                       |               |
|   |                        |      |       | (Whooping Cough) for Injection    |           |     |          |       |          |               |                                       |               |
| Vessinstian                                 | Heavital Outrations    | СРТ  | 00715 | into Muscle                       | No        | \$  | 57.74    | 4     | _        | \$ 77.73      | \$0.00                                | Per Unit      |
| Vaccination                                 | Hospital Outpatient    | CPI  | 90/15 | into iviuscie                     | No        | ş   | 37.74    | Ģ     | -        | 3 //./3       | \$0.00                                | Per Unit      |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
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|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services  | CPT  | 90791 | Psychiatric Diagnostic Evaluation | No        | \$  | 308.81   | \$    | 118.93   | \$ 198.74     | \$181.46                              | Per Unit      |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services  | СРТ  | 90832 | Psychotherapy - 30 Minutes        | Yes       | \$  | 88.03    | \$    | 57.92    | \$ 99.25      | \$76.32                               | Per Unit      |
| Evaluation & Management Services            | . Totastoliai services |      | 30032 | - Sychotherapy - 30 minutes       | 103       | 7   | 00.03    | 7     | 37.32    | 7 33.23       | 770.52                                | . c. ome      |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services  | CPT  | 90834 | Psychotherapy - 45 Minutes        | Yes       | \$  | 116.77   | \$    | 77.37    | \$ 132.34     | \$114.66                              | Per Unit      |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
| Fuelveties 9 Mesesses ont Comitee           | Duefoccional Comicae   | CDT  | 00027 | Develope the remove CO Minutes    | Vac       | \$  | 174.00   | 4     | 110.00   | ć 100.33      | ć172 O2                               | Day Unit      |
| Evaluation & Management Services            | Professional Services  | СРТ  | 9083/ | Psychotherapy - 60 Minutes        | Yes       |     | 174.90   | Þ     | 116.00   | -             | \$172.83                              | Per Unit      |
|   |                        |      |       |                                   |           |     | N/A No   |       |          | N/A No        | N/A No                                |               |
|   |                        |      |       |                                   |           | S   | ervice   |       |          | Service       | Service                               |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services  | СРТ  | 90846 | Family psytx w/o pt 50 min        | Yes       | V   | olume    | \$    | _        | Volume        | Volume                                | Per Unit      |
|   |                        |      |       | . The land of the programme       |           |     |          | т     |          |               |                                       |               |
|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
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|   |                        |      |       |                                   |           |     |          |       |          |               |                                       |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services  | CPT  | 90847 | Psychotherapy - Family Session    | Yes       | \$  | 146.15   | \$    | 97.13    | \$ 166.18     | \$143.12                              | Per Unit      |
| •   | l .                    |      |       |                                   |           |     |          |       |          |               | · · · · · · · · · · · · · · · · · · · |               |

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|---|----------------------------|------|-------|---------------------------------------|-----------|----------|-----------|------|-----------|---|---------------------|----------------------|
|   |                            |      |       |                                       |           |          |           |      |           |   | Amount We           |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   | <b>Estimate You</b> |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   | Will Owe *          |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
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|   |                            |      |       |                                       | CMS       |          |           | De-I | dentified | De-Identified                           | Payer-              |                      |
|   |                            |      |       |                                       | Required  |          |           | Mi   | nimum     | Maximum                                 | <u>Specific</u>     |                      |
|   |                            | Code |       |                                       | Shoppable | Di       | scounted  | Neg  | otiated   | Negotiated                              | Negotiated          |                      |
| Service Category                            | Service Setting            | Type | Code  | Description                           | Service?  | C        | ash Price | С    | harge     | Charge                                  | Charge              | <b>Estimate Type</b> |
|   |                            |      |       |                                       |           | <u> </u> |           | _    |           |   |                     |                      |
|   |                            |      |       |                                       |           |          | N/A No    |      |           | N/A No                                  | N/A No              |                      |
|   |                            |      |       |                                       |           |          | -         |      |           | -                                       |                     |                      |
|   |                            |      |       |                                       |           |          | Service   |      |           | Service                                 | Service             |                      |
| <b>Evaluation &amp; Management Services</b> | Professional Services      | CPT  | 90853 | Psychotherapy - Group Session         | Yes       | ١        | Volume    | \$   | -         | Volume                                  | Volume              | Per Unit             |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
| Medicine Speech Therapy                     | <b>Hospital Outpatient</b> | CPT  | 92507 | SPEECH/HEARING THERAPY                | No        | \$       | 52.00     | \$   | 17.40     | \$ 251.43                               | \$176.00            | Per Unit             |
| том оргостина пру                           |                            | -    |       |                                       |           | T        |           | -    |           | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 72.000              | 7 0.1 0.1.10         |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
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|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       | Electrocardiogram, routine, with      |           |          |           |      |           |   |                     |                      |
| Medicine Cardiovascular                     | Professional Services      | СРТ  | 93000 | _                                     | Yes       | \$       | 36.27     | Ś    | 28.12     | \$ 95.52                                | \$26.93             | Per Unit             |
|   |                            |      | 30000 |                                       |           | Ť        |           | Ŧ    |           | 7 30.01                                 | 720.00              |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
| Medicine Other                              | Hospital Outpatient        | CPT  | 93005 | Electrocardiogram (ECG or EKG)        | No        | \$       | 142.29    | \$   | -         | \$ 295.26                               | \$275.46            | Per Unit             |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
| Medicine Cardiac Stress Test                | Hospital Outpatient        | СРТ  | 93017 | CARDIOVASCULAR STRESS TEST            | No        | \$       | 471.40    | Ġ    | 61.00     | \$ 634.57                               | \$0.00              | Per Unit             |
| ivieuiciie cardiac stress rest              | nospital Outpatient        | CFI  | 33017 | CANDIO VASCOLAN STRESS TEST           | 140       | 7        | 471.40    | Ą    | 01.00     | ÿ 034.37                                | Ş0.00               | reronic              |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     | <b> </b>             |
| Medicine Other                              | <b>Hospital Outpatient</b> | CPT  | 93306 | Tte w/doppler complete                | No        | \$       | 1,404.83  | \$   | 322.26    | \$ 1,593.05                             | \$879.38            | Per Unit             |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     | <b> </b>             |
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|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       | Insertion of catheter into left heart |           |          |           |      |           |   |                     |                      |
| <b>Hospital Outpatient Procedure</b>        | <b>Hospital Outpatient</b> | CPT  | 93452 | for diagnosis                         | Yes       | \$       | 8,847.45  | \$   | 579.93    | \$ 12,920.92                            | \$373.81            | Case Rate            |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
|   |                            |      |       |                                       |           |          |           |      |           |   |                     |                      |
| Medicine Other                              | Hospital Outpatient        | СРТ  | 02071 | Extremity study                       | No        | Ś        | 240.64    | ċ    | 92.64     | \$ 400.67                               | \$399.98            | Per Unit             |
| Wedicine Other                              | Hospital Outpatient        | CFI  | 333/1 | Extremity study                       | 140       | ې        | 240.04    | Ą    | JZ.04     | 400.07                                  | و <b>ت.</b> تودد    | r er omt             |

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|                                      |                            |       |       |                                    | CMS       |             | De-Identified                           | De-Identified | Payer-       |                 |
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|                                      |                            | Code  |       |                                    | Shoppable | Discounted  | Negotiated                              | Negotiated    | Negotiated   |                 |
| Service Category                     | Service Setting            | Туре  | Code  | Description                        | Service?  | Cash Price  | Charge                                  | Charge        | Charge       | Estimate Type   |
| Service Category                     | Jervice Setting            | туре  | code  | Description                        | Service:  | Casii Fiice | Charge                                  | charge        | Charge       | Littiliate Type |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       | 05044 |                                    |           | 400.00      |   | 4 4 220 52    | 4450.00      |                 |
| Medicine Other                       | Hospital Outpatient        | CPT   | 95044 | Allergy patch tests                | No        | \$ 189.82   | -                                       | \$ 1,229.53   | \$159.00     | Per Unit        |
|                                      |                            |       |       |                                    |           | N/A No      | N/A No                                  | N/A No        | N/A No       |                 |
| Medicine Neurology and               |                            |       |       |                                    |           | Service     | Service                                 | Service       | Service      |                 |
| Neuromuscular                        | Hospital Outpatient        | CPT   | 95810 | Sleep study                        | Yes       | Volume      | Volume                                  | Volume        | Volume       | Per Unit        |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
| Injections                           | <b>Hospital Outpatient</b> | CPT   | 96402 | Chemo hormon antineopl sq/im       | No        | \$ 110.26   | \$ 66.86                                | \$ 196.20     | \$597.78     | Case Rate       |
| ,                                    |                            |       |       |                                    |           | ,           | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7 200.20      | 700000       |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
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|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       | Physical Therapy - Manual          |           |             |   |               |              |                 |
| Medicine Physical Medicine and       |                            |       |       | Electrical Stimulation Therapy, 15 |           |             |   |               |              |                 |
| Rehabilitation                       | Hospital Outpatient        | CPT   | 97032 | minutes                            | No        | \$ 31.26    | \$ 12.56                                | \$ 59.90      | \$176.00     | Per Unit        |
|                                      |                            |       |       |                                    |           |             |   |               | -            |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
| Medicine Physical Medicine and       |                            |       |       | Physical Therapy - Ultrasound      |           |             |   |               |              |                 |
|                                      | Harmital Outrations        | СРТ   | 07025 |                                    | No        | \$ 26.92    | \$ 11.95                                | \$ 40.29      | \$176.00     | Day Unit        |
| Rehabilitation                       | Hospital Outpatient        | CPT   | 97033 | Therapy                            | No        | \$ 20.92    | \$ 11.95                                | 3 40.29       | \$176.00     | Per Unit        |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
| Medicine Physical Medicine and       |                            |       |       | Physical Therapy - Therapeutic     |           |             |   |               |              |                 |
| Rehabilitation                       | Hospital Outpatient        | CPT   | 97110 | Exercises                          | Yes       | \$ 88.74    | \$ 17.40                                | \$ 119.46     | \$176.00     | Per Unit        |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
|                                      |                            |       |       |                                    |           |             |   |               |              |                 |
| Medicine Physical Medicine and       |                            |       |       | Physical Therapy - Neuromuscular   |           |             |   |               |              |                 |
| Rehabilitation                       | Hospital Outpatient        | СРТ   | 97112 | Reeducation                        | No        | \$ 69.93    | \$ 26.14                                | \$ 104.78     | \$176.00     | Per Unit        |
| Terrabilitation                      |                            | Cir I | 3,112 | necaucation                        | 140       | y 03.33     | y 20.14                                 | 7 104.78      | 9170.00      | . cr omt        |
| Madiaina Dhuaisal Madiaina and       |                            |       |       |                                    |           |             |   |               |              |                 |
| Medicine Physical Medicine and       | Hamital Outrasit           | CD-   | 07446 | CALT TRAINING TUES A SY            |           |             | 6 00.00                                 |               | 6476.00      | Des Helt        |
| Rehabilitation                       | Hospital Outpatient        | CPT   | 9/116 | GAIT TRAINING THERAPY              | No        | \$ 77.61    | \$ 22.90                                | \$ 104.48     | \$176.00     | Per Unit        |

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|                                      |                      |      |       |  |           |     |          |      |           |    |             | Amount We               |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             | Estimate You Will Owe * |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             | Will Owe                |               |
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| To Search for a service Click "CTRL" |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
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|                                      |                      |      |       |  | CMS       |     |          | De-I | 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>                             |                      | 2712 |       |  |           | _   |          | _    |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Physical Medicine and       |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Rehabilitation                       | Hospital Outpatient  | СРТ  | 97140 | Physical Therapy - Manual Therapy  | No        | \$  | 56.20    | \$   | 23.73     | Ś  | 93.92       | \$176.00                | Per Unit      |
|                                      |                      |      | 0     | The state of the s |           | *   |          | *    |           | *  |             | 7=10100                 |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Physical Medicine and       |                      |      |       | Physical Therapy - Low Complexity  |           |     |          |      |           |    |             |                         |               |
| Rehabilitation                       | Hospital Outpatient  | СРТ  | 97161 | Evaluation   | No        | \$  | 168.06   | Ś    | 71.97     | Ś  | 252.78      | \$176.00                | Per Unit      |
|                                      |                      |      | 57252 |  |           | _   |          | _    | 7 2.07    | _  | 202.70      | <del>+</del>            |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Physical Medicine and       |                      |      |       | Physical Therapy - Moderate  |           |     |          |      |           |    |             |                         |               |
| Rehabilitation                       | Hospital Outpatient  | СРТ  | 97162 |  | No        | Ś   | 62.40    | Ś    | 71.97     | Ś  | 252.78      | \$176.00                | Per Unit      |
|                                      |                      |      | 37232 |  |           | Ť   |          | Ť    | 7 2.07    | _  | 202.70      | <del>+</del> 210.00     |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Physical Medicine and       |                      |      |       | Physical Therapy - High Complexity   |           |     |          |      |           |    |             |                         |               |
| Rehabilitation                       | Hospital Outpatient  | СРТ  | 97163 | Evaluation   | No        | Ś   | 168.06   | Ś    | 71.97     | Ś  | 252.78      | \$176.00                | Per Unit      |
|                                      |                      |      | 3.230 |  |           | _   |          | -    |           |    | 202.70      | 7                       |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Physical Medicine and       |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Rehabilitation                       | Hospital Outpatient  | СРТ  | 97164 | Physical Therapy - Re-Evaluation   | No        | Ś   | 113.34   | Ś    | 48.67     | Ś  | 170.97      | \$176.00                | Per Unit      |
|                                      |                      | -    | 3.104 | The Every Tree Every Control of the Every Control o |           | _   |          | Ť    | .3.07     | 7  | 2.0.57      | <del>+</del>            |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
|                                      |                      |      |       |  |           |     |          |      |           |    |             |                         |               |
| Medicine Occupational Therapy        | Hospital Outpatient  | СРТ  | 97165 | OT EVAL LOW COMPLEX 30 MIN   | No        | Ś   | 180.88   | Ś    | 77.05     | Ś  | 245.32      | \$176.00                | Per Unit      |
|                                      | press. a melanetaris |      | 0.100 | C. C   |           | 7   |          | 7    |           | T  | _ 75.52     | Ţ=. 0.00                |               |

|   |                       |              |       | 1                                 | 1                               |    |                     |             |   |        |   |                                   |               |
|---|-----------------------|--------------|-------|-----------------------------------|---------------------------------|----|---------------------|-------------|---|--------|---|-----------------------------------|---------------|
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   | Amount We                         |               |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   | <b>Estimate You</b>               |               |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   | Will Owe *                        |               |
| To Search for a service Click "CTRL"<br>+ "F" |                       |              |       |                                   |                                 |    |                     |             |   |        |   |                                   |               |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   | Ť                                 |               |
| Service Category                              | Service Setting       | Code<br>Type | Code  | <u>Description</u>                | CMS Required Shoppable Service? |    | counted<br>sh Price | Mi<br>Neg   | dentified<br>nimum<br>gotiated<br>harge | N<br>N | e-Identified<br>Maximum<br>legotiated<br>Charge | Payer- Specific Negotiated Charge | Estimate Type |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   |                                   |               |
| Medicine Occupational Therapy                 | Hospital Outpatient   | СРТ          | 97166 | OT EVAL MOD COMPLEX 45 MIN        | No                              | \$ | 62.40               | \$          | 72.00                                   | \$     | 245.32  | \$176.00                          | Per Unit      |
| Medicine Physical Medicine and                |                       |              |       | Physical Therapy - Therapeutic    |                                 |    |                     |             |   |        |   |                                   |               |
| Rehabilitation                                | Hospital Outpatient   | СРТ          | 97530 | Activities                        | No                              | \$ | 92.45               | خ           | 17.40                                   | ė      | 124.45  | \$176.00                          | Per Unit      |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   |                                   |               |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   |                                   |               |
| Medicine Physical Medicine and                |                       |              |       | Physical Therapy - Self-care or   |                                 |    |                     |             |   |        |   |                                   |               |
| Rehabilitation                                | Hospital Outpatient   | CPT          | 97535 | Home Management Training          | No                              | \$ | 68.89               | \$          | -                                       | \$     | 109.03  | \$176.00                          | Per Unit      |
| Evaluation & Management Services              | Professional Services | СРТ          | 99024 | Postop follow-up visit            | No                              | \$ | -                   | \$          | _                                       | \$     | 14.27   | \$0.00                            | Per Unit      |
|   |                       |              |       |                                   |                                 |    |                     |             |   |        |   |                                   |               |
| Evaluation & Management Services              | Professional Services | СРТ          | 99202 | Office Visit - New Patient, Minor | No                              | \$ | 167.93              | Ś           | 90.34                                   | Ś      | 200.08  | \$74.13                           | Per Unit      |
| Evaluation & Wanagement Services              | riolessional services | CFT          | 33202 | Office Visit - New Patient, Immo  | NO                              | ,  | 107.53              | 7           | 30.34                                   | 7      | 200.00  | <i>\$74.</i> 13                   | recont        |
| Evaluation & Management Samilars              | Professional Samisas  | CDT          | 00202 |                                   | Vos                             | ا  | 102.00              | ے           | 122 54                                  | ے      | 272.00  | ¢112.06                           | Dor Unit      |
| <b>Evaluation &amp; Management Services</b>   | Professional Services | CPT          | 99203 | Complexity                        | Yes                             | \$ | 182.06              | <b>&gt;</b> | 132.54                                  | >      | 273.99  | \$113.06                          | Per Unit      |

|   |                       |              |       |   |                    |                  |       |                          |                          | Amount We<br>Estimate You |               |
|---|-----------------------|--------------|-------|---|--------------------|------------------|-------|--------------------------|--------------------------|---------------------------|---------------|
|   |                       |              |       |   |                    |                  |       |                          |                          | Will Owe *                |               |
| To Search for a service Click "CTRL"<br>+ "F" |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          | _                         |               |
|   |                       |              |       |   | CMS<br>Required    |                  |       | De-Identified<br>Minimum | De-Identified<br>Maximum | Payer-<br>Specific        |               |
| Service Category                              | Service Setting       | Code<br>Type | Code  | <u>Description</u>                              | Shoppable Service? | Discou<br>Cash P |       | Negotiated<br>Charge     | Negotiated<br>Charge     | Negotiated<br>Charge      | Estimate Type |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
| Evaluation & Management Services              | Professional Services | СРТ          | 99204 | Office Visit - New Patient, Moderate Complexity | Yes                | \$ 2             | 50.69 | \$ 177.01                | \$ 432.49                | \$193.09                  | Per Unit      |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       | New patient office of other                     |                    |                  |       |                          |                          |                           |               |
| Evaluation & Management Services              | Professional Services | СРТ          | 99205 | outpatient visit, typically 60 min              | Yes                | \$ 4             | 48.04 | \$ 156.38                | \$ 553.76                | \$248.69                  | Per Unit      |
| Fundamentary O. Management Complete           | Professional Constant | CDT          | 00242 | Office Minit Produ                              |                    | 4                | F0 74 | 6 45 44                  | ć 422.24                 | 627.04                    | Deville!      |
| Evaluation & Management Services              | Professional Services | CPT          | 99212 | Office Visit - Basic                            | No                 | \$               | 58.74 | \$ 46.41                 | \$ 133.24                | \$37.04                   | Per Unit      |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       |   |                    |                  |       |                          |                          |                           |               |
|   |                       |              |       | Office Visit - Established Patient,             |                    |                  |       |                          |                          | 4                         |               |
| Evaluation & Management Services              | Professional Services | СРТ          | 99213 | Low Complexity                                  | No                 | \$               | 99.67 | \$ 81.71                 | \$ 201.59                | \$75.33                   | 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                | \$116.27                  | Per Unit      |

|  |                       |              |       |   |                                 |                             |                |   |  | Amount We<br>Estimate You<br>Will Owe *    |                |
|--|-----------------------|--------------|-------|---|---------------------------------|-----------------------------|----------------|---|--|--|----------------|
| To Search for a service Click "CTRL"<br>+ "F"        |                       |              |       |   |                                 |                             |                |   |  |  |                |
| Service Category                                     | Service Setting       | Code<br>Type | Code  | <u>Description</u>                              | CMS Required Shoppable Service? | <u>Disco</u><br><u>Cash</u> | unted<br>Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | _Estimate Type |
|  |                       |              |       | Office Visit - Established Patient,             |                                 |                             |                |   |  |  |                |
| Evaluation & Management Services                     | Professional Services | СРТ          | 99215 | High Complexity                                 | No                              | \$                          | 315.87         | \$ 192.33                               | \$ 385.34                                  | \$163.82                                   | Per Unit       |
| Professional Services Associated with Inpatient Stay | Professional Services | СРТ          | 99232 | Subsequent hospital care                        | No                              | \$                          | 159.88         | \$ 50.60                                | \$ 111.92                                  | \$106.78                                   | Per Unit       |
| Evaluation & Management Services                     | Professional Services | СРТ          | 99243 | Patient office consultation, typically 40 min   | Yes                             | \$                          | 212.43         | \$-                                     | \$ 142.18                                  | \$142.18                                   | Per Unit       |
|  |                       |              |       | Patient office consultation,                    |                                 |                             |                |   |  |  |                |
| Evaluation & Management Services                     | Professional Services | CPT          | 99244 | typically 60 min                                | Yes                             | \$                          | 338.80         | \$-                                     | \$ 226.38                                  | \$226.38                                   | Per Unit       |
| Emergency Room Visit                                 | Hospital Outpatient   | СРТ          | 99281 | Emergency Department Visit - Minor (outpatient) | No                              | \$                          | 230.81         | \$ 74.98                                | \$ 689.88                                  | \$686.22                                   | Case Rate      |

|   |                     |              |       |   |  |                          |   |  | Amount We<br>Estimate You                  |               |
|---|---------------------|--------------|-------|---|--|--------------------------|---|--|--|---------------|
| To Search for a service Click "CTRL"<br>+ "F" |                     |              |       |   |  |                          |   |  | Will Owe *                                 |               |
| Service Category                              | Service Setting     | Code<br>Type | Code  | Description   | CMS<br>Required<br>Shoppable<br>Service? | Discounted<br>Cash Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                     |              |       |   |  |                          |   |  |  |               |
| Emergency Room Visit                          | Hospital Outpatient | СРТ          | 99282 | Emergency Department Visit - Low Complexity (outpatient)      | No                                       | \$ 430.38                | \$ 93.52                                | \$ 1,114.22                                | \$1,108.14                                 | Case Rate     |
| Emergency Room Visit                          | Hospital Outpatient | СРТ          | 99283 | Emergency Department Visit - Moderate Complexity (outpatient) | No                                       | \$ 932.99                | \$ 182.62                               | \$ 2,714.83                                | \$2,705.44                                 | Case Rate     |
|   |                     |              |       | Emergency Department Visit -                                  |  |                          |   |  |  |               |
| Emergency Room Visit                          | Hospital Outpatient | СРТ          | 99284 | Higher Complexity (outpatient)                                | No                                       | \$ 2,400.69              | \$ 270.43                               | \$ 4,475.48                                | \$4,465.46                                 | Case Rate     |
| Emergency Room Visit                          | Hospital Outpatient | СРТ          | 99285 | Emergency Department Visit - High Complexity (outpatient)     | No                                       | \$ 3,149.91              | \$ 458.20                               | \$ 5,806.95                                | \$4,964.97                                 | Case Rate     |

| Anount Ve Strimate You Will Ove *  To Scorch for a service Circle **CFIR**  Service Category Service Setting Code Type Code Description Service*  Service Category Service Setting Type Code Description Service*  Service Code Code Description Service*  Service Cash Price Cash Price Cash Price Cash Price Cash Price Charge Cha |   | T                            |      |       | T                               | 1        |              |               |               |            | -             |
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| To Search for a service Cite's "CTRL"  Code  Description  Service Category  Service Category  Service Setting  Code  Description  Description  Description  Service Category   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Foreignery Room Visit  Service Category  Service Setting  Code Type  Code Type Type  Code Type Type Type Type Type Type Type Typ   |   |                              |      |       |                                 |          |              |               |               |            |               |
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| Service Category Service Setting Type Code Description Service Category Se |   |                              |      |       |                                 |          |              |               |               |            |               |
| Service Category  Service Setting  Type Code Description Service? Cash Price Cash Price Cash Price Charge Charge Charge Charge Satimate Type  Emergency Room Visit Hospital Outpatient  CPT 99291 Critical Care (outpatient)  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, Younger than 1 Year Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation and Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Visit - Comprehensive Preventive Medicine Evaluation And Management Services  Office Vis |   |                              | Cada |       |                                 |          | Discounted   |               |               |            |               |
| Emergency Room Visit  Hospital Outpatient  CPT  99291 Critical Care (outpatient)  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, Vounger than 1 Year Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, No  S 17,860.61 \$ 425.50 \$ 6,308.07 \$6,295.91 Case Rate  CPT  99381 Vounger than 1 Year Old  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, No  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  | Service Category                            | Service Setting              | Туре | Code  | Description                     | Service? | Cash Price   | Charge        | Charge        | Charge     | Estimate Type |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| CPT 99291 Critical Care (outpatient) No \$ 17,860.61 \$ 425.50 \$ 6,308.07 \$ 56,295.91 Case Rate  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
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| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   | Emergency Room Visit                        | Hospital Outpatient          | CPT  | 99291 | Critical Care (outpatient)      | No       | \$ 17,860.61 | \$ 425.50     | \$ 6,308.07   | \$6,295.91 | Case Rate     |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       | Office Visit Community          |          |              |               |               |            |               |
| Evaluation & Management Services Professional Services CPT 99381 Younger than 1 Year Old No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       | -                               |          |              |               |               |            |               |
| Evaluation & Management Services Professional Services CPT 99381 Younger than 1 Year Old No \$ 156.75 \$ - \$ 225.38 \$114.32 Per Unit  Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   | <b>Evaluation &amp; Management Services</b> | Professional Services        | CPT  | 99381 | Younger than 1 Year Old         | No       | \$ 156.75    | \$ -          | \$ 225.38     | \$114.32   | Per Unit      |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       |                                 |          |              |               |               |            |               |
| Preventive Medicine Evaluation and Management, New Patient, 1-   |   |                              |      |       | Office Minite Course I :        |          |              |               |               |            |               |
| and Management, New Patient, 1-  |   |                              |      |       |                                 |          |              |               |               |            |               |
|  |   |                              |      |       |                                 |          |              |               |               |            |               |
| Evaluation & Management Services   Professional Services   CPT   99382   4 Years Old   No   \$ 163.82   \$ -   \$ 236.91   \$121.44   Per Unit   |   |                              |      |       | and Management, New Patient, 1- |          |              |               |               |            |               |
|  | <b>Evaluation &amp; Management Services</b> | <b>Professional Services</b> | CPT  | 99382 | 4 Years Old                     | No       | \$ 163.82    | \$ -          | \$ 236.91     | \$121.44   | Per Unit      |

|   |                       |      |       |                                  |           |            |                      |               | Amount We           |               |
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|   |                       |      |       |                                  |           |            |                      |               | <b>Estimate You</b> |               |
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| To Search for a service Click "CTRL"        |                       |      |       |                                  |           |            |                      |               |                     |               |
| + "F"                                       |                       |      |       |                                  |           |            |                      |               |                     |               |
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|   |                       |      |       |                                  | CMS       |            | <b>De-Identified</b> | 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 |
|   |                       |      |       |                                  |           |            |                      |               |                     |               |
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|   |                       |      |       |                                  |           |            |                      |               |                     |               |
|   |                       |      |       | Office Visit - Comprehensive     |           |            |                      |               |                     |               |
|   |                       |      |       | Preventive Medicine Evaluation   |           |            |                      |               |                     |               |
|   |                       |      |       | and Management, New Patient, 5-  |           |            |                      |               |                     |               |
|   |                       |      |       |                                  |           |            |                      |               |                     |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services | CPT  | 99383 | 11 Years Old                     | No        | \$ 170.96  | \$ -                 | \$ 413.46     | \$129.12            | Per Unit      |
|   |                       |      |       |                                  |           |            |                      |               |                     |               |
|   |                       |      |       |                                  |           |            |                      |               |                     |               |
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|   |                       |      |       | Office Visit - Comprehensive     |           |            |                      |               |                     |               |
|   |                       |      |       | Preventive Medicine Evaluation   |           |            |                      |               |                     |               |
|   |                       |      |       |                                  |           |            |                      |               |                     |               |
|   |                       |      |       | and Management, New Patient, 12- |           |            |                      |               |                     |               |
| <b>Evaluation &amp; Management Services</b> | Professional Services | CPT  | 99384 | 17 Years Old                     | No        | \$ 193.58  | \$ -                 | \$ 280.75     | \$152.18            | Per Unit      |

|   |                       |              |       |   |                                 |                       |   |   | Amount We<br>Estimate You<br>Will Owe *    |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                       |              |       |   |                                 |                       |   |   |  |               |
| Service Category                              | Service Setting       | Code<br>Type | Code  | <u>Description</u>  | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified Maximum Negotiated Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                       |              |       |   |                                 |                       |   |   |  |               |
|   |                       |              |       |   |                                 |                       |   |   |  |               |
| Evaluation & Management Services              | Professional Services | СРТ          |       | Office Visit - Comprehensive Preventive Medicine Evaluation and Management, New Patient, 18- 39 Years Old | Yes                             | \$ 187.80             | \$ 59.23                                | \$ 347.60                               | \$146.35                                   | Per Unit      |
| Evaluation & Management Services              | Trotessional services | CIT          | 33363 | 35 Fedits Old   | 163                             | 7 107.00              | <del>y</del> 33.23                      | <del>y 347.00</del>                     | <b>7140.33</b>                             | Terome        |
|   |                       |              |       |   |                                 |                       |   |   |  |               |
|   |                       |              |       | Office Visit - Comprehensive<br>Preventive Medicine Evaluation<br>and Management, New Patient, 40-        |                                 |                       |   |   |  |               |
| <b>Evaluation &amp; Management Services</b>   | Professional Services | CPT          | 99386 | 64 Years Old  | Yes                             | \$ 217.32             | \$ 91.72                                | \$ 1,293.56                             | \$177.06                                   | Per Unit      |

|   |                       |              |       |  |  |                       |   |  | Amount We<br>Estimate You<br>Will Owe *    |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                       |              |       |  |  |                       |   |  |  |               |
| Service Category                              | Service Setting       | Code<br>Type | Code  | Description  | CMS<br>Required<br>Shoppable<br>Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge | De-Identified  Maximum  Negotiated  Charge | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                       |              |       |  |  |                       |   |  |  |               |
|   |                       |              |       |  |  |                       |   |  |  |               |
|   |                       |              |       | Office Visit - Comprehensive Preventive Medicine Reevaluation and Management, Younger than 1 |  |                       |   |  | 4  |               |
| Evaluation & Management Services              | Professional Services | СРТ          | 99391 | Year Old   | No                                       | \$ 141.19             | \$ -                                    | \$ 267.83                                  | \$104.03                                   | Per Unit      |
|   |                       |              |       |  |  |                       |   |  |  |               |
|   |                       |              |       |  |  |                       |   |  |  |               |
|   |                       |              |       | Office Visit - Comprehensive<br>Preventive Medicine Reevaluation                             |  |                       |   |  |  |               |
| <b>Evaluation &amp; Management Services</b>   | Professional Services | CPT          | 99392 | and Management, 1-4 Years Old  | No                                       | \$ 150.93             | \$ -                                    | \$ 305.91                                  | \$114.32                                   | Per Unit      |

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| To Search for a service Click "CTRL"        |                       |      |       |                                  |                  |            |                |                |                 |                      |
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|   |                       |      |       |                                  | CNAC             |            | De-Identified  | De-Identified  | Davies          |                      |
|   |                       |      |       |                                  | CMS              |            |                | 1              | 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> |
|   |                       |      |       |                                  |                  |            |                |                |                 |                      |
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|   |                       |      |       | 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      | \$114.32        | Per Unit             |
|   |                       |      |       | -                                |                  |            |                |                |                 |                      |
|   |                       |      |       |                                  |                  |            |                |                |                 |                      |
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|   |                       |      |       | Office Visit - Comprehensive     |                  |            |                |                |                 |                      |
|   |                       |      |       | Preventive Medicine Reevaluation |                  |            |                |                |                 |                      |
| <b>Evaluation &amp; Management Services</b> | Professional Services | CPT  | 99394 | and Management, 12-17 Years Old  | No               | \$ 165.14  | \$ -           | \$ 398.57      | \$129.12        | Per Unit             |
|   |                       |      |       |                                  |                  |            |                |                |                 |                      |
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|   |                       |      |       |                                  |                  |            |                |                |                 |                      |
|   |                       |      |       | Office Visit - Comprehensive     |                  |            |                |                |                 |                      |
|   |                       |      |       | Preventive Medicine Reevaluation |                  |            |                |                |                 |                      |
| <b>Evaluation &amp; Management Services</b> | Professional Services | CPT  | 99395 | and Management, 18-39 Years Old  | No               | \$ 168.81  | \$ 37.07       | \$ 304.60      | \$132.82        | Per Unit             |
| •   |                       |      |       |                                  |                  |            |                |                |                 |                      |

|   |                        |              |       |   |                                 |                       |   |   | Amount We<br>Estimate You<br>Will Owe *    |               |
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| To Search for a service Click "CTRL"<br>+ "F" |                        |              |       |   |                                 |                       |   |   |  |               |
| Service Category                              | Service Setting        | Code<br>Type | Code  | <u>Description</u>  | CMS Required Shoppable Service? | Discounted Cash Price | De-Identified Minimum Negotiated Charge   | De-Identified  Maximum  Negotiated  Charge  | Payer-<br>Specific<br>Negotiated<br>Charge | Estimate Type |
|   |                        |              |       |   |                                 |                       |   |   |  |               |
|   |                        |              |       |   |                                 |                       |   |   |  |               |
| Evaluation & Management Services              | Professional Services  | СРТ          | 99396 | Office Visit - Comprehensive<br>Preventive Medicine Reevaluation<br>and Management, 40-64 Years Old | No                              | \$ 180.12             | \$ 64.57  | \$ 429.79   | \$144.48                                   | Per Unit      |
| - Tanada a Management Sci Necs                | Trocasional activities |              | 33330 | and management, 40 of 1 cars on   |                                 | 7 100112              | <del>-</del> | <del>-</del> | ŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢŢ     | T C T S III C |
| Evablete                                      | Hospital Outrations    | CDT          | 02007 | Ecoured Illtracound   | No                              | Ć 22 120 FG           | ć 11 272 00   | ć 11.272.00   | Service Not<br>Covered by                  | Coso Boto     |
| Exablate                                      | Hospital Outpatient    | СРТ          | 03981 | Focused Ultrasound  | No                              | \$ 32,139.56          | \$ 11,272.90  | \$ 11,272.90  | Payer                                      | Case Rate     |
| Vaccinations                                  | Hospital Outpatient    | СРТ          | G0008 | Admin influenza virus vaccine   | No                              | \$ 70.15              | \$ -  | \$ 126.95   | \$37.89                                    | Per Unit      |
| Vaccinations                                  | Hospital Outpatient    | СРТ          | G0009 | Admin pneumococcal vaccine  | No                              | \$ 27.43              | \$ -  | \$ -  | \$37.89                                    | Per Unit      |
| Medicine Hyberbaric                           | Hospital Outpatient    | СРТ          | G0277 | Hbot, full body chamber, 30m  | No                              | \$ 773.99             | \$ 46.24  | \$ 1,424.46   | \$64.11                                    | Per Unit      |
| Hospital Observation Per Hour                 | Hospital Outpatient    | СРТ          | G0378 | Hospital observation per hr   | No                              | \$ 15,685.71          | \$ 605.00   | \$ 24,131.86  | \$2,664.00                                 | Per Unit      |

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| To Search for a service Click "CTRL"<br>+ "F" |                      |       |       |                             |           |             |               |               |              |               |
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|   |                      |       |       |                             | CMS       |             | De-Identified | De-Identifi   | ed Payer-    |               |
|   |                      |       |       |                             | Required  |             | Minimum       | Maximum       | Specific     |               |
|   |                      | Code  |       |                             | Shoppable | Discounted  | Negotiated    | Negotiate     | d Negotiated |               |
| Service Category                              | Service Setting      | Туре  | Code  | Description                 | Service?  | Cash Price  | Charge        | Charge        | Charge       | Estimate Type |
| <u> </u>                                      |                      | 3755  | 3000  |                             |           |             |               | 5.14.180      |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
| Evaluation & Management Services              | Hospital Outpatient  | СРТ   | 60463 | Hospital outpt clinic visit | No        | \$ 130.00   | \$ 74.02      | \$ 200.       | 00 \$159.00  | Per Unit      |
| Evaluation & Management Services              | Tiospital Outpatient | CFI   | 00403 | riospital outpt chine visit | 140       | ÿ 130.00    | \$ 74.02      | <b>y</b> 200. | JI JIJ.00    | reronit       |
|   |                      |       |       |                             |           |             |               |               |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
| Laboratory & Pathology Services               | Hospital Outpatient  | CPT   | G0480 | Drug test def 1-7 classes   | No        | \$ 476.03   | Ş -           | \$ 732.       | \$0.00       | Per Unit      |
|   |                      |       |       |                             |           |             |               |               |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
| Injections                                    | Hospital Outpatient  | HCPCS | J1071 | Inj testosterone cypionate  | No        | \$ 0.22     | \$ 0.03       | \$ 0.3        | \$0.00       | Per Unit      |
|   |                      |       |       |                             |           |             |               |               |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
| Injections                                    | Hospital Outpatient  | HCPCS | J1815 | Insulin injection           | No        | \$ 2.13     | \$ 0.78       | \$ 3.3        | \$0.00       | Per Unit      |
|   |                      |       |       | ,                           | -         |             |               |               |              |               |
|   |                      |       |       |                             |           |             |               |               |              |               |
| Injections                                    | Hospital Outpatient  | HCPCS | J7325 | Synvisc or synvisc-one      | No        | \$ 26.95    | <b>Š</b> -    | \$ 89.        | \$0.00       | Per Unit      |
| Injections                                    | nospital Outpatient  | ncrcs | 1/325 | Symple of Symple-one        | INU       | φ 20.95     | <i>-</i>      | <i>y</i> 89.  | 30.00        | rei Ullit     |
|   |                      |       |       |                             |           |             |               |               |              |               |
| l   |                      |       |       |                             |           |             |               |               |              |               |
| Injections                                    | Hospital Outpatient  | CPT   | J9217 | Eligard                     | No        | \$ 2,818.54 | \$ -          | \$ 4,336.2    | \$0.00       | Per Unit      |