




Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	216	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	Yes	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	N/A No Service Volume	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	291	HEART FAILURE SHOCK W MCC	No	\$ 14,686.95	\$ 5,517.78	\$ 31,074.55	\$7,244.88	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	460	Spinal fusion except cervical without major comorbid conditions or complications (MCC)	Yes	\$ 80,363.76	\$ 16,237.64	\$ 58,989.92	\$25,915.48	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	470	Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC).	Yes	\$ 38,980.36	\$ 8,070.44	\$ 37,721.88	\$18,307.70	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	473	Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC).	Yes	\$ 41,645.77	\$ 10,123.74	\$ 62,430.00	\$16,722.60	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


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

Last Updated: 12/14/2022										Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>	
Hospital Inpatient Stay	Hospital Inpatient	DRG	480	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	No	\$ 72,498.64	\$ 12,375.85	\$ 48,933.51	\$18,840.40	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Hospital Inpatient Stay	Hospital Inpatient	DRG	481	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	No	\$ 48,198.31	\$ 8,559.98	\$ 38,996.68	\$16,749.99	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Hospital Inpatient Stay	Hospital Inpatient	DRG	482	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	No	\$ 40,118.30	\$ 6,745.73	\$ 37,731.25	\$12,658.86	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Hospital Inpatient Stay	Hospital Inpatient	DRG	493	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W CC	No	\$ 46,895.03	\$ 9,438.20	\$ 41,283.64	\$14,245.33	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Hospital Inpatient Stay	Hospital Inpatient	DRG	494	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR W/O CC/MCC	No	\$ 34,116.50	\$ 7,426.74	\$ 43,066.25	\$9,724.21	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	743	Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	Yes	\$ 21,526.46	\$ 3,828.29	\$ 28,968.03	\$4,854.57	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	811	RED BLOOD CELL DISORDERS W MCC	No	\$ 19,365.15	\$ 4,255.93	\$ 31,015.82	\$5,396.86	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	812	RED BLOOD CELL DISORDERS W/O MCC	No	\$ 13,438.98	\$ 2,955.18	\$ 26,002.03	\$3,747.40	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	No	\$ 64,891.63	\$ 21,639.28	\$ 150,000.00	\$27,440.32	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	No	\$ 41,312.81	\$ 6,540.49	\$ 50,000.00	\$8,293.86	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Inpatient Stay	Hospital Inpatient	DRG	935	NON-EXTENSIVE BURNS	No	\$ 27,865.09	\$ 3,301.83	\$ 50,000.00	\$4,186.98	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	956	LIMB REATTACHMENT, HIP FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	No	\$ 96,217.06	\$ 16,085.53	\$ 200,000.00	\$58,311.70	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	No	\$ 138,424.38	\$ 30,888.17	\$ 200,000.00	\$43,650.76	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	No	\$ 74,941.66	\$ 17,182.69	\$ 125,000.00	\$29,437.61	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Hospital Inpatient Stay	Hospital Inpatient	DRG	964	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	No	\$ 29,995.11	\$ 6,123.35	\$ 50,000.00	\$11,652.34	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Maternity/Delivery	Hospital Inpatient	DRG	768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	No	\$ 9,936.12	\$ 2,464.00	\$ 27,462.61	\$10,869.72	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	783	CESAREAN SECTION W STERILIZATION W MCC	No	\$ 13,687.72	\$ 3,570.00	\$ 39,605.25	\$4,362.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	784	CESAREAN SECTION W STERILIZATION W CC	No	\$ 11,089.83	\$ 3,570.00	\$ 27,865.12	\$4,362.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	785	CESAREAN SECTION W STERILIZATION W/O CC/MCC	No	\$ 9,823.22	\$ 3,519.44	\$ 25,870.71	\$4,362.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	786	CESAREAN SECTION W/O STERILIZATION W MCC	No	\$ 14,089.97	\$ 3,570.00	\$ 35,011.06	\$5,357.15	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Maternity/Delivery	Hospital Inpatient	DRG	787	CESAREAN SECTION W/O STERILIZATION W CC	No	\$ 12,173.87	\$ 2,835.00	\$ 27,868.32	\$5,357.15	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	No	\$ 10,551.69	\$ 3,242.44	\$ 26,381.06	\$4,111.67	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	795	NORMAL NEWBORN	No	\$ 1,447.32	\$ 626.89	\$ 18,705.56	\$794.94	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	797	VAGINAL DELIVERY W STERILIZATION/D&C W CC	No	\$ 10,458.74	\$ 2,464.00	\$ 25,917.69	\$4,362.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS
Maternity/Delivery	Hospital Inpatient	DRG	798	VAGINAL DELIVERY W STERILIZATION/D&C W/O CC/MCC	No	\$ 6,698.97	\$ 2,464.00	\$ 25,917.69	\$4,362.27	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS

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


Last Updated: 12/14/2022										Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"											
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>	
Maternity/Delivery	Hospital Inpatient	DRG	805	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	No	\$ 8,202.42	\$ 2,464.00	\$ 27,817.08	\$5,357.15	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	806	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	No	\$ 7,660.38	\$ 2,464.00	\$ 24,277.74	\$5,357.15	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Maternity/Delivery	Hospital Inpatient	DRG	807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	No	\$ 6,410.90	\$ 2,464.00	\$ 23,397.98	\$4,111.67	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	DRG	LTC189	Pulmonary edema respiratory failure	No	\$ 37,402.18	\$ 74,931.49	\$ 74,931.49	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	DRG	LTC207	Respiratory system diagnosis w ventilator support >96 hours	No	\$ 96,998.14	\$ 37,703.24	\$ 37,703.24	Non-Par	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS	

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


Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Long Term Acute Care Inpatient Stay	Inpatient Long-Term Care Hospital	UB	200	Long Term Care Intensive Care Room & Board	No	70% Charges (Estimated as \$6,047.26 per diem)	\$1,040 Per Diem	\$1,929 Per Diem	\$0.00	Per Diem Per Day
Inpatient Rehabilitation Hospital Stay	Inpatient Rehabilitation Hospital	UB	118	Inpatient Rehabilitation Hospital Room & Board	No	52% Charges Estimated at \$2,341.96 Per Diem	\$ 416.15	\$ 3,152.00	\$416.15 Per Diem without Ventilator/ \$478.68 Per Diem With Ventilator	Per Diem Per Day
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	191	Subacute Care Level 1- Skilled Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 227.70	\$ 850.00	Non-Par	Per Diem Per Day
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	192	Subacute Care Level 2- Comprehensive Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 299.70	\$ 850.00	Non-Par	Per Diem Per Day
Skilled Nursing Inpatient Room & Board	Inpatient Skilled Nursing	UB	193	Subacute Care Level 3- Complex Care	No	52% Charges Estimated at \$1,109.30 Per Diem	\$ 370.00	\$ 850.00	Non-Par	Per Diem Per Day
Hospital Outpatient Procedure	Hospital Outpatient	CPT	19083	Bx breast 1st lesion us imag	No	\$ 1,957.09	\$ 381.25	\$ 2,964.36	\$1,146.74	Case Rate

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




Last Updated: 12/14/2022										Amount We Estimate You Will Owe *
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	27818	Treatment of ankle fracture	No	\$ 5,944.56	\$ 395.00	\$ 2,581.00	\$856.55	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	32555	Aspirate pleura w/ imaging	No	\$ 7,293.50	\$ 288.54	\$ 1,852.06	\$856.55	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	49440	Place gastrostomy tube perc	No	\$ 3,073.24	\$ 445.12	\$ 3,166.61	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	59025	Fetal Non-Stress Test	No	\$ 581.33	\$ 118.53	\$ 1,596.22	\$12.45	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	69210	Remove impacted ear wax	No	\$ 302.36	\$ 48.93	\$ 1,604.78	\$23.40	Case Rate
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	No	\$ 804.63	\$ 127.22	\$ 1,318.18	\$231.31	Per Unit
Radiology Services	Hospital Outpatient	CPT	70482	Ct orbit/ear/fossa w/o&w/dye	No	\$ 1,715.77	\$ 207.79	\$ 2,657.02	\$346.37	Per Unit
Radiology Services	Hospital Outpatient	CPT	70486	Ct maxillofacial w/o dye	No	\$ 1,507.75	\$ 127.52	\$ 2,259.85	\$231.31	Per Unit
Radiology Services	Hospital Outpatient	CPT	70496	Ct angiography head	No	\$ 1,246.07	\$ 223.05	\$ 1,996.31	\$353.95	Per Unit
Radiology Services	Hospital Outpatient	CPT	70498	Ct angiography neck	No	\$ 1,001.14	\$ 223.05	\$ 1,677.63	\$353.95	Per Unit
Radiology Services	Hospital Outpatient	CPT	71250	CT THORAX W/O DYE	No	\$ 858.09	\$ 141.11	\$ 1,468.48	\$288.96	Per Unit
Radiology Services	Hospital Outpatient	CPT	71045	X-ray exam chest 1 view	No	\$ 121.75	\$ 19.91	\$ 181.37	\$13.49	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	71046	X-Ray - Chest (outpatient)	No	\$ 121.75	\$ 31.50	\$ 193.55	\$24.87	Per Unit
Radiology Services	Hospital Outpatient	CPT	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$ 1,246.07	\$ 200.76	\$ 2,034.88	\$346.37	Per Unit
Radiology Services	Hospital Outpatient	CPT	71275	Ct angiography chest	No	\$ 1,295.90	\$ 226.19	\$ 2,092.27	\$434.67	Per Unit
Radiology Services	Hospital Outpatient	CPT	72126	Ct neck spine w/dye	No	\$ 1,084.68	\$ 260.86	\$ 1,821.59	\$346.37	Per Unit
Radiology Services	Hospital Outpatient	CPT	72100	X-Ray - Spine (outpatient)	No	\$ 168.26	\$ 37.93	\$ 265.13	\$33.09	Per Unit
Radiology Services	Hospital Outpatient	CPT	72127	Ct neck spine w/o & w/dye	No	\$ 1,246.07	\$ 201.73	\$ 2,118.48	\$432.96	Per Unit
Radiology Services	Hospital Outpatient	CPT	72133	Ct lumbar spine w/o & w/dye	No	\$ 1,338.47	\$ 201.90	\$ 2,238.70	\$432.96	Per Unit
Radiology Services	Hospital Outpatient	CPT	73700	CT LOWER EXTREMITY W/O DYE	No	\$ 850.98	\$ 134.01	\$ 1,400.92	\$242.75	Per Unit
Radiology Services	Hospital Outpatient	CPT	74150	Ct abdomen w/o dye	No	\$ 846.65	\$ 142.38	\$ 1,446.99	\$277.03	Per Unit
Radiology Services	Hospital Outpatient	CPT	74170	Ct abdomen w/o & w/dye	No	\$ 1,270.98	\$ 207.86	\$ 2,144.29	\$415.92	Per Unit
Radiology Services	Hospital Outpatient	CPT	72190	X-RAY EXAM OF PELVIS	No	\$ 168.26	\$ 39.60	\$ 264.73	\$33.09	Per Unit
Radiology Services	Hospital Outpatient	CPT	73000	X-ray exam of collar bone	No	\$ 121.75	\$ 22.40	\$ 185.92	\$26.01	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	73010	X-ray exam of shoulder blade	No	\$ 168.26	\$ 26.01	\$ 251.93	\$26.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	73060	X-RAY EXAM OF HUMERUS	No	\$ 121.75	\$ 29.40	\$ 195.82	\$28.19	Per Unit
Radiology Services	Hospital Outpatient	CPT	73070	X-ray exam of elbow	No	\$ 121.75	\$ 25.07	\$ 191.42	\$26.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	73090	X-RAY EXAM OF FOREARM	No	\$ 91.32	\$ 26.40	\$ 151.82	\$26.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	73120	X-RAY EXAM OF HAND	No	\$ 168.26	\$ 24.40	\$ 249.73	\$24.58	Per Unit
Radiology Services	Hospital Outpatient	CPT	73130	X-Ray - Hand	No	\$ 121.75	\$ 32.72	\$ 198.42	\$26.52	Per Unit
Radiology Services	Hospital Outpatient	CPT	73552	X-RAY EXAM OF FEMUR 2/>	No	\$ 121.75	\$ 29.51	\$ 189.38	\$28.73	Per Unit
Radiology Services	Hospital Outpatient	CPT	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$ 176.40	\$ 32.40	\$ 266.82	\$26.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	73590	X-ray exam of lower leg	No	\$ 218.41	\$ 32.40	\$ 321.48	\$26.01	Per Unit
Radiology Services	Hospital Outpatient	CPT	73600	X-RAY EXAM OF ANKLE	No	\$ 188.76	\$ 31.98	\$ 278.60	\$24.58	Per Unit
Radiology Services	Hospital Outpatient	CPT	73610	X-Ray - Ankle (outpatient)	No	\$ 210.38	\$ 25.72	\$ 311.14	\$26.52	Per Unit
Radiology Services	Hospital Outpatient	CPT	73620	X-RAY EXAM OF FOOT	No	\$ 173.94	\$ 29.81	\$ 262.21	\$24.58	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	73630	X-Ray - Foot (outpatient)	No	\$ 188.76	\$ 33.95	\$ 289.60	\$26.52	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	No	\$ 2,500.65	\$ 286.79	\$ 3,568.86	\$333.71	Per Unit
Radiology Services	Hospital Outpatient	CPT	75571	Ct hrt w/o dye w/ca test	No	\$ 79.37	\$ 59.00	\$ 323.39	\$76.94	Per Unit
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	Yes	\$ 804.63	\$ 127.22	\$ 1,318.18	\$231.31	Per Unit
Radiology Services	Hospital Outpatient	CPT	72193	CT scan, pelvis, with contrast	Yes	\$ 1,341.96	\$ 197.29	\$ 2,142.05	\$335.18	Per Unit
Radiology Services	Hospital Outpatient	CPT	74220	X-ray xm esophagus 1cntrst	No	\$ 371.53	\$ 56.38	\$ 563.71	\$57.65	Per Unit
Radiology Services	Hospital Outpatient	CPT	74270	X-ray xm colon 1cntrst std	No	\$ 371.53	\$ 79.34	\$ 578.01	\$83.41	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	Yes	\$ 2,500.65	\$ 286.79	\$ 3,568.86	\$333.71	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76770	US EXAM ABDO BACK WALL COMP	No	\$ 224.35	\$ 76.54	\$ 400.80	\$96.33	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76801	OB US < 14 WKS SINGLE FETUS	No	\$ 224.35	\$ 86.65	\$ 396.27	\$51.46	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76811	OB US DETAILED SNGL FETUS	No	\$ 224.35	\$ 198.65	\$ 587.50	\$174.32	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76815	OB US LIMITED FETUS(S)	No	\$ 224.35	\$ 54.75	\$ 384.30	\$69.33	Per Unit


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

Last Updated: 12/14/2022										Amount We Estimate You Will Owe *
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	76816	Ultrasound - Pregnancy Follow-Up	No	\$ 224.35	\$ 64.37	\$ 384.30	\$54.24	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76818	FETAL BIOPHYS PROFILE W/NST	No	\$ 224.35	\$ 82.20	\$ 387.27	\$79.27	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 224.35	\$ 97.44	\$ 398.34	\$79.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 224.35	\$ 88.69	\$ 391.69	\$80.36	Per Unit
Radiology Services	Hospital Outpatient	CPT	77080	Bone Density Scan (outpatient)	No	\$ 168.26	\$ 56.29	\$ 393.45	\$122.93	Per Unit
Radiology Services	Hospital Outpatient	CPT	77081	Dxa bone density/peripheral	No	\$ 91.46	\$ 33.80	\$ 171.64	\$35.44	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80307	Drug test prsmv chem analyzr	No	\$ 147.41	\$ 55.93	\$ 199.53	\$112.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81025	Urine Test - Pregnancy	No	\$ 34.21	\$ 10.45	\$ 58.29	\$11.62	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82247	Bilirubin total	No	\$ 42.44	\$ 4.52	\$ 55.22	\$15.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82306	Blood Test - Vitamin D-3 Level	No	\$ 195.28	\$ 26.64	\$ 254.08	\$97.97	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82330	Assay of calcium	No	\$ 36.33	\$ 12.31	\$ 67.00	\$41.46	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82375	Assay carboxyhb quant	No	\$ 118.09	\$ 11.09	\$ 153.64	\$39.85	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	82465	Assay bld/serum cholesterol	No	\$ 58.15	\$ 3.92	\$ 23.76	\$14.70	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82550	Assay of ck (cpk)	No	\$ 13.14	\$ 5.86	\$ 35.53	\$21.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82552	Assay of cpk in blood	No	\$ 27.05	\$ 12.05	\$ 75.41	\$0.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82565	Assay of creatinine	No	\$ 47.70	\$ 7.17	\$ 70.25	\$17.54	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82610	Cystatin c	No	\$ 145.26	\$ 14.17	\$ 405.00	\$18.99	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82668	Assay of erythropoietin	No	\$ 37.95	\$ 16.91	\$ 99.20	\$61.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82670	Assay of estradiol	No	\$ 56.40	\$ 25.15	\$ 152.33	\$94.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82693	Assay of ethylene glycol	No	\$ 20.99	\$ 13.41	\$ 40.08	\$24.80	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82803	Blood gases any combination	No	\$ 75.94	\$ 20.17	\$ 106.16	\$65.69	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82947	Assay glucose blood quant	No	\$ 33.15	\$ 5.51	\$ 49.42	\$13.37	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83605	Assay of lactic acid	No	\$ 28.38	\$ 10.41	\$ 58.05	\$35.93	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83735	Assay of magnesium	No	\$ 52.14	\$ 9.38	\$ 78.56	\$22.62	Per Unit

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


Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	83880	Assay of natriuretic peptide	No	\$ 178.52	\$ 35.33	\$ 232.27	\$63.74	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84100	Assay of phosphorus	No	\$ 61.56	\$ 6.64	\$ 87.67	\$12.49	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 42.30	\$ 6.66	\$ 62.65	\$15.45	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 42.30	\$ 6.66	\$ 62.65	\$15.45	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84144	Assay of progesterone	No	\$ 55.44	\$ 18.77	\$ 96.68	\$59.83	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84295	Assay of serum sodium	No	\$ 43.56	\$ 4.33	\$ 56.67	\$16.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 56.72	\$ 23.52	\$ 119.09	\$57.06	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84480	Assay triiodothyronine (t3)	No	\$ 99.64	\$ 12.76	\$ 129.65	\$46.74	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84484	Assay of troponin quant	No	\$ 84.53	\$ 10.26	\$ 121.45	\$75.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84702	Chorionic gonadotropin test	No	\$ 130.13	\$ 11.54	\$ 169.31	\$51.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85014	Hematocrit	No	\$ 27.88	\$ 2.13	\$ 36.27	\$8.01	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85240	Clot factor viii ahg 1 stage	No	\$ 47.56	\$ 16.11	\$ 95.56	\$59.14	Per Unit

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


Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	85378	Fibrin degrade semiquant	No	\$ 55.42	\$ 7.44	\$ 72.11	\$36.41	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85613	Russell viper venom diluted	No	\$ 25.46	\$ 8.24	\$ 70.98	\$34.21	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85660	RBC SICKLE CELL TEST	No	\$ 45.07	\$ 4.96	\$ 71.77	\$14.60	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85732	Thromboplastin time partial	No	\$ 13.06	\$ 5.82	\$ 36.42	\$21.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86140	C-reactive protein	No	\$ 50.17	\$ 4.66	\$ 65.28	\$14.89	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86360	T cell absolute count/ratio	No	\$ 67.25	\$ 42.28	\$ 211.59	\$130.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86361	T cell absolute count	No	\$ 137.38	\$ 24.10	\$ 383.03	\$127.72	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86431	Rheumatoid factor quant	No	\$ 54.53	\$ 5.10	\$ 70.95	\$16.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 39.12	\$ 3.84	\$ 50.90	\$11.73	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 39.12	\$ 3.84	\$ 50.90	\$11.73	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86611	Bartonella antibody	No	\$ 59.36	\$ 9.16	\$ 165.50	\$19.75	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86677	Helicobacter pylori antibody	No	\$ 29.29	\$ 15.13	\$ 63.03	\$39.00	Per Unit

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




Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86692	Hepatitis delta agent antbdy	No	\$ 30.17	\$ 15.44	\$ 50.98	\$23.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86698	Histoplasma antibody	No	\$ 33.21	\$ 12.41	\$ 107.23	\$42.55	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86704	HEP B CORE ANTIBODY TOTAL	No	\$ 89.09	\$ 10.85	\$ 115.92	\$36.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86705	HEP B CORE ANTIBODY IGM	No	\$ 23.77	\$ 10.59	\$ 57.38	\$35.51	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86706	HEP B SURFACE ANTIBODY	No	\$ 102.41	\$ 9.67	\$ 133.25	\$32.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86708	Hepatitis a antibody	No	\$ 23.49	\$ 11.15	\$ 56.71	\$35.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86762	Rubella antibody	No	\$ 65.86	\$ 12.95	\$ 225.56	\$16.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86765	Rubeola antibody	No	\$ 26.01	\$ 11.59	\$ 72.53	\$29.04	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86769	86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 53.26	\$ -	\$ 112.07	\$72.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86790	Virus antibody nos	No	\$ 26.01	\$ 11.59	\$ 76.53	\$47.36	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86850	Rbc antibody screen	No	\$ 21.03	\$ 5.00	\$ 66.92	\$33.82	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86885	Coombs test indirect qual	No	\$ 253.19	\$ 5.65	\$ 329.43	\$15.46	Per Unit


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

Last Updated: 12/14/2022										Amount We Estimate You Will Owe *
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 205.88	\$ 3.78	\$ 267.88	\$13.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 205.88	\$ 3.78	\$ 267.88	\$13.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 62.33	\$ 3.78	\$ 81.10	\$13.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 62.33	\$ 3.78	\$ 81.10	\$13.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$ 6.02	\$ 4.84	\$ 383.37	\$5.88	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86920	COMPATIBILITY TEST SPIN	No	\$ 253.19	\$ 13.44	\$ 344.22	\$38.00	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87040	Blood culture for bacteria	No	\$ 138.54	\$ 9.29	\$ 180.25	\$35.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87110	Chlamydia culture	No	\$ 135.26	\$ 17.64	\$ 175.99	\$66.56	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87340	Lab Test - Detection test for Hepatitis B Surface Antigen	No	\$ 65.75	\$ 9.30	\$ 85.55	\$26.40	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87389	Lab Test - Detection test for HIV-1 and HIV-2	No	\$ 114.26	\$ 21.67	\$ 148.66	\$47.95	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87425	Rotavirus ag ia	No	\$ 38.74	\$ 10.78	\$ 108.00	\$0.00	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	87591	Urine Test - Gonorrhoeae (Neisseria Gonorrhoeae Bacteria)	No	\$ 93.25	\$ 31.58	\$ 171.03	\$105.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87635	87635 - SARS-COV-2 COVID-19 AMP PRB	No	\$ 55.21	\$ -	\$ 136.48	\$88.75	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87798	Detect agent nos dna amp	No	\$ 93.25	\$ 31.58	\$ 171.03	\$105.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87880	Strep Test (Streptococcus, group A)	No	\$ 89.94	\$ 19.87	\$ 143.48	\$34.54	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	88185	Flowcytometry/tc add-on	No	\$ 71.19	\$ -	\$ 120.30	\$31.00	Per Unit
Vaccinations	Hospital Outpatient	CPT	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 81.80	\$7.73	Per Unit
Vaccinations	Hospital Outpatient	CPT	90472	Immunization Administration Each Additional Component	No	\$ 12.56	\$ -	\$ 38.51	\$7.90	Per Unit
Chemotherapy	Hospital Outpatient	CPT	96413	Chemo iv infusion 1 hr	No	\$ 583.25			\$229.72	Per Unit
Chemotherapy	Hospital Outpatient	CPT	96415	Chemo iv infusion addl hr	No	\$ 114.07			\$52.01	Per Unit
Chemotherapy	Hospital Outpatient	CPT	96417	Chemo iv infus each addl seq	No	\$ 114.07			\$112.41	Per Unit
Radiology Services	Hospital Outpatient	CPT	70491	Ct soft tissue neck w/dye	No	\$ 1,069.80			\$277.03	Per Unit


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

Last Updated: 12/14/2022								Amount We Estimate You Will Owe *		
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	71271	Ct thorax lung cancer scr c-	No	\$ 152.19			\$122.27	Per Unit
Injections	Hospital Outpatient	CPT	96402	Chemo hormon antineopl sq/im	No	\$ 123.61	\$ 66.86	\$ 196.20	\$61.91	Case Rate
Pet Scan	Hospital Outpatient	CPT	78815	Pet image w/ct skull-thigh	No	\$ 3,017.62			\$1,308.19	Per Unit
Pet Scan	Hospital Outpatient	CPT	78816	Pet image w/ct full body	No	\$ 3,017.62			\$1,308.19	Per Unit
Medicine Hyberbaric	Hospital Outpatient	CPT	G0277	Hbot, full body chamber, 30m	No	\$ 111.89	\$ 46.24	\$ 1,424.46	\$63.46	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97116	GAIT TRAINING THERAPY	No	\$ 80.30	\$ 22.90	\$ 104.48	\$22.90	Per Unit
Exablate	Hospital Outpatient	CPT	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	\$ 11,272.90	\$-	Case Rate
Vaccinations	Hospital Outpatient	CPT	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$ -	\$ 126.95	\$7.02	Per Unit
Vaccinations	Hospital Outpatient	CPT	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$ -	\$ -	\$7.02	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97530	Physical Therapy - Therapeutic Activities	No	\$ 83.07	\$ 17.40	\$ 124.45	\$38.07	Per Unit
Medicine Occupational Therapy	Hospital Outpatient	CPT	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$ 187.14	\$ 77.05	\$ 245.32	\$112.03	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Medicine Occupational Therapy	Hospital Outpatient	CPT	97166	OT EVAL MOD COMPLEX 45 MIN	No	\$ 187.14	\$ 72.00	\$ 245.32	\$112.03	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	G0480	Drug test def 1-7 classes	No	\$ 492.51	\$ -	\$ 732.35	\$120.47	Per Unit
Injections	Hospital Outpatient	HCPCS	J1071	Inj testosterone cypionate	No	\$ 0.18	\$ 0.03	\$ 0.34	\$-	Per Unit
Injections	Hospital Outpatient	HCPCS	J1815	Insulin injection	No	\$ 2.35	\$ 0.78	\$ 3.27	\$1.14	Per Unit
Injections	Hospital Outpatient	HCPCS	J7325	Synvisc or synvisc-one	No	\$ 30.80	\$ -	\$ 89.11	\$56.05	Per Unit
Injections	Hospital Outpatient	CPT	J9217	Eligard	No	\$ 816.35	\$ -	\$ 4,336.21	\$1,163.49	Per Unit
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 447.50	\$ 161.58	\$ 1,803.41	\$-	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11104	Biopsy - Punch Biopsy of Skin	No	\$ 804.56	\$ 167.15	\$ 1,829.27	\$-	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	17000	Destruction of Lesion (outpatient)	No	\$ 781.92	\$ 157.92	\$ 1,634.10	\$30.43	Case Rate
Injections	Hospital Outpatient	CPT	20610	Arthrocentesis (outpatient)	No	\$ 1,185.82	\$ 182.39	\$ 1,461.73	\$35.11	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	31575	Laryngoscopy - Diagnostic	No	\$ 377.88	\$ 135.86	\$ 1,978.02	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43235	Upper Gastrointestinal Endoscopy - Diagnostic	Yes	\$ 2,532.81	\$ 61.00	\$ 1,867.74	\$856.55	Case Rate


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

Last Updated: 12/14/2022										Amount We Estimate You Will Owe *
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43239	Upper Gastrointestinal Endoscopy - With Biopsy	Yes	\$ 3,909.14	\$ 372.00	\$ 2,229.48	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45378	Colonoscopy - Diagnostic (outpatient)	Yes	\$ 2,399.03	\$ 335.79	\$ 2,220.88	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45380	Colonoscopy - With Biopsy (outpatient)	Yes	\$ 2,423.51	\$ 343.06	\$ 4,110.45	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45385	Colonoscopy - With Polyp Removal (outpatient)	Yes	\$ 2,553.22	\$ 354.50	\$ 4,434.15	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	51798	Urine Capacity Measurement	No	\$ 248.09	\$ -	\$ 1,579.20	\$-	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	52000	Cystoscopy	No	\$ 948.42	\$ 282.78	\$ 1,596.52	\$856.55	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	55700	Biopsy of prostate gland	Yes	\$ 702.11	\$ 284.76	\$ 2,631.84	\$1,146.74	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58100	Biopsy - Endometrial (Uterus)	No	\$ 354.58	\$ 144.00	\$ 1,697.39	\$39.78	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58300	Insert intrauterine device	No	\$ 536.76	\$ 48.93	\$ 1,749.37	\$51.49	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58301	Remove intrauterine device	No	\$ 669.25	\$ 32.34	\$ 1,495.58	\$35.11	Case Rate
Medicine Speech Therapy	Hospital Outpatient	CPT	92507	SPEECH/HEARING THERAPY	No	\$ 163.49	\$ 17.40	\$ 251.43	\$48.52	Per Unit
Radiology Services	Hospital Outpatient	CPT	72125	Ct neck spine w/o dye	No	\$ 1,075.17	\$ 136.86	\$ 1,750.92	\$288.96	Per Unit

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


Last Updated: 12/14/2022										Amount We Estimate You Will Owe *
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	72040	X-Ray - Neck, Cervical Spine	No	\$ 121.75	\$ 37.93	\$ 204.42	\$29.66	Per Unit
Radiology Services	Hospital Outpatient	CPT	72070	X-Ray - Middle Back, Thoracic Spine	No	\$ 224.35	\$ 33.93	\$ 338.99	\$32.12	Per Unit
Radiology Services	Hospital Outpatient	CPT	72110	X-Ray, lower back, minimum four views	Yes	\$ 168.26	\$ 52.80	\$ 284.93	\$44.75	Per Unit
Medicine Cardiac Stress Test	Hospital Outpatient	CPT	93017	CARDIOVASCULAR STRESS TEST	No	\$ 487.71	\$ 61.00	\$ 634.57	\$88.65	Per Unit
Radiology Services	Hospital Outpatient	CPT	72170	X-Ray - Pelvis	No	\$ 224.35	\$ 28.72	\$ 327.10	\$26.01	Per Unit
Medicine Other	Hospital Outpatient	CPT	93306	Tte w/doppler complete	No	\$ 953.92	\$ 322.26	\$ 1,593.05	\$257.33	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	CPT	G0378	Hospital observation per hr	No	\$ 255.22	\$ 605.00	\$ 24,131.86	\$0.00	Per Unit
Radiology Services	Hospital Outpatient	CPT	73030	X-Ray - Shoulder (outpatient)	No	\$ 121.75	\$ 28.33	\$ 196.92	\$28.19	Per Unit
Radiology Services	Hospital Outpatient	CPT	73110	X-Ray - Wrist (outpatient)	No	\$ 121.75	\$ 30.72	\$ 196.19	\$26.52	Per Unit
Radiology Services	Hospital Outpatient	CPT	70551	MRI BRAIN STEM W/O DYE	No	\$ 1,344.67	\$ 252.20	\$ 2,270.30	\$548.97	Per Unit
Radiology Services	Hospital Outpatient	CPT	73502	X-Ray - Hip	No	\$ 121.75	\$ 37.77	\$ 197.91	\$37.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73562	X-Ray - Knee (outpatient)	No	\$ 233.07	\$ 36.52	\$ 351.25	\$28.19	Per Unit

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


Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	70553	MRI - Brain (outpatient)	Yes	\$ 2,005.53	\$ 406.50	\$ 3,409.54	\$1,219.30	Per Unit
Radiology Services	Hospital Outpatient	CPT	74018	X-Ray - Abdomen	No	\$ 121.75	\$ 28.31	\$ 189.76	\$23.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	72197	MRI - Pelvis (outpatient)	No	\$ 2,065.91	\$ 402.71	\$ 3,522.33	\$1,219.02	Per Unit
Radiology Services	Hospital Outpatient	CPT	76536	Ultrasound - Head and Neck	No	\$ 224.35	\$ 78.79	\$ 386.50	\$69.33	Per Unit
Radiology Services	Hospital Outpatient	CPT	76642	Ultrasound - Breast (outpatient)	No	\$ 121.75	\$ 78.52	\$ 249.30	\$69.29	Per Unit
Radiology Services	Hospital Outpatient	CPT	76700	Ultrasound - Abdominal, Complete	Yes	\$ 224.35	\$ 91.69	\$ 433.80	\$96.33	Per Unit
Radiology Services	Hospital Outpatient	CPT	76705	Ultrasound - Abdominal, Limited	No	\$ 224.35	\$ 46.05	\$ 372.20	\$69.33	Per Unit
Radiology Services	Hospital Outpatient	CPT	76805	Ultrasound - Pregnancy (outpatient)	Yes	\$ 224.35	\$ 100.36	\$ 437.10	\$102.87	Per Unit
Radiology Services	Hospital Outpatient	CPT	76830	Ultrasound - Transvaginal (non-maternity)	Yes	\$ 224.35	\$ 98.63	\$ 463.90	\$74.90	Per Unit
Radiology Services	Hospital Outpatient	CPT	76856	Ultrasound - Pelvic (outpatient)	No	\$ 224.35	\$ 70.34	\$ 408.50	\$74.90	Per Unit
Radiology Services	Hospital Outpatient	CPT	77065	Mammography of one breast	Yes	\$ 271.82	\$ 107.57	\$ 501.03	\$120.09	Per Unit
Radiology Services	Hospital Outpatient	CPT	77066	Mammography of both breasts	Yes	\$ 343.48	\$ 135.81	\$ 629.70	\$153.68	Per Unit

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




Last Updated: 12/14/2022								Amount We Estimate You Will Owe *		
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Radiology Services	Hospital Outpatient	CPT	77067	Mammogram (outpatient)	Yes	\$ 276.60	\$ 109.22	\$ 504.02	\$126.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	78452	Myocardial Imaging (outpatient)	No	\$ 539.40	\$ 336.74	\$ 2,091.45	\$375.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 159.70	\$ 11.84	\$ 221.33	\$15.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80053	Blood Test - Comprehensive Metabolic Panel	Yes	\$ 92.22	\$ 14.78	\$ 136.89	\$18.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80061	Blood Test - Cholesterol Test, Lipid Panel	Yes	\$ 48.09	\$ 12.05	\$ 101.77	\$62.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80069	Blood Test - Renal (Kidney) Function Panel	Yes	\$ 13.92	\$ 8.68	\$ 34.59	\$15.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80076	Blood Test - Hepatic (Liver) Function Panel	Yes	\$ 148.16	\$ 11.44	\$ 205.84	\$15.15	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81001	Urine Test - Automated with Microscope Examination	Yes	\$ 5.22	\$ 4.44	\$ 34.47	\$3.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81003	Urine Test - Automated without Microscope	Yes	\$ 22.60	\$ 3.16	\$ 11.25	\$3.10	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82607	Blood Test - Vitamin B-12 (Cyanocobalamin) Level	No	\$ 30.42	\$ 13.57	\$ 82.73	\$51.20	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 27.50	\$ 19.09	\$ 96.63	\$46.30	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	82746	Blood Test - Folic Acid Level	No	\$ 39.06	\$ 13.23	\$ 79.52	\$49.21	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83036	Blood Test - Blood Glucose Control (Hemoglobin A1C)	No	\$ 73.74	\$ 8.74	\$ 95.94	\$32.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83540	Blood Test - Iron Level	No	\$ 50.28	\$ 9.06	\$ 75.77	\$21.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83690	Blood Test - Lipase (fat enzyme) Level	No	\$ 71.87	\$ 6.20	\$ 93.51	\$23.40	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84153	Blood Test - Prostate Specific Antigen (PSA) Level	Yes	\$ 67.06	\$ 25.75	\$ 116.68	\$23.20	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84154	PSA (prostate specific antigen)	Yes	\$ 110.02	\$ 16.55	\$ 143.15	\$55.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84439	Blood Test - Thyroxine (Thyroid Chemical) Level, Free	No	\$ 68.50	\$ 8.12	\$ 89.13	\$25.62	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	Yes	\$ 56.72	\$ 23.52	\$ 119.09	\$57.06	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85025	Blood Test - Complete Blood Cell Count and Automated WBC	Yes	\$ 76.57	\$ 10.88	\$ 112.06	\$26.19	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85027	Blood Test - Complete Blood Cell Count (Hemoglobin)	Yes	\$ 62.89	\$ 5.82	\$ 81.83	\$21.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85610	Blood Test - Clotting Time	Yes	\$ 44.12	\$ 6.01	\$ 64.27	\$13.37	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Laboratory & Pathology Services	Hospital Outpatient	CPT	85730	Blood Test - Coagulation Assessment	Yes	\$ 47.60	\$ 5.41	\$ 61.94	\$20.38	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86803	Blood Test - Hepatitis C Antibody Level	No	\$ 69.98	\$ 12.84	\$ 91.06	\$43.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87070	Bacterial Culture - Swab	No	\$ 143.43	\$ 7.76	\$ 186.61	\$29.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87077	Bacterial Culture - Aerobic Isolates	No	\$ 62.53	\$ 7.27	\$ 81.35	\$15.69	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87081	Test for Disease-Causing (Pathogenic) Organisms, Not Limited to a Specific Condition	No	\$ 67.18	\$ 5.97	\$ 109.26	\$21.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87086	Urine Test - Bacterial Culture, Quantitative Colony Count	No	\$ 85.00	\$ 7.26	\$ 110.60	\$26.19	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87088	Urine Test - Bacterial Culture	No	\$ 16.35	\$ 7.28	\$ 43.86	\$27.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87186	Evaluation of Antimicrobial Drug (antibiotic, antifungal, antiviral)	No	\$ 71.55	\$ 7.79	\$ 93.10	\$29.35	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87205	Lab Test - Smear for Microorganism	No	\$ 51.65	\$ 3.84	\$ 67.21	\$13.28	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87491	Urine Test - Chlamydia	No	\$ 112.18	\$ 31.58	\$ 171.03	\$105.84	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87804	Lab Test - Detection test for Influenza Virus	No	\$ 35.62	\$ 19.82	\$ 70.50	\$22.26	Per Unit


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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Vaccination	Hospital Outpatient	CPT	90670	Vaccine - Pneumococcal Conjugate for Injection into Muscle	No	\$ 285.59	\$ 9.56	\$ 345.21	\$481.48	Per Unit
Vaccination	Hospital Outpatient	CPT	90715	Vaccine - Tetanus, Diphtheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection into Muscle	No	\$ 57.74	\$ -	\$ 77.73	\$94.51	Per Unit
Medicine Other	Hospital Outpatient	CPT	93005	Electrocardiogram (ECG or EKG)	No	\$ 109.68	\$ -	\$ 295.26	\$23.71	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97032	Physical Therapy - Manual Electrical Stimulation Therapy, 15 minutes	No	\$ 32.34	\$ 12.56	\$ 59.90	\$21.81	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97035	Physical Therapy - Ultrasound Therapy	No	\$ 27.85	\$ 11.95	\$ 40.29	\$22.37	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97110	Physical Therapy - Therapeutic Exercises	Yes	\$ 91.82	\$ 17.40	\$ 119.46	\$35.11	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97112	Physical Therapy - Neuromuscular Reeducation	No	\$ 72.35	\$ 26.14	\$ 104.78	\$26.14	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97140	Physical Therapy - Manual Therapy	No	\$ 58.15	\$ 23.73	\$ 93.92	\$34.58	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97161	Physical Therapy - Low Complexity Evaluation	No	\$ 173.88	\$ 71.97	\$ 252.78	\$115.44	Per Unit

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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97162	Physical Therapy - Moderate Complexity Evaluation	No	\$ 173.88	\$ 71.97	\$ 252.78	\$115.44	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97163	Physical Therapy - High Complexity Evaluation	No	\$ 173.88	\$ 71.97	\$ 252.78	\$115.44	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97164	Physical Therapy - Re-Evaluation	No	\$ 117.26	\$ 48.67	\$ 170.97	\$78.08	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97535	Physical Therapy - Self-care or Home Management Training	No	\$ 71.27	\$ -	\$ 109.03	\$28.18	Per Unit
Emergency Room Visit	Hospital Outpatient	CPT	99281	Emergency Department Visit - Minor (outpatient)	No	\$ 218.75	\$ 74.98	\$ 689.88	\$58.52	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99282	Emergency Department Visit - Low Complexity (outpatient)	No	\$ 404.82	\$ 93.52	\$ 1,114.22	\$58.52	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99283	Emergency Department Visit - Moderate Complexity (outpatient)	No	\$ 929.87	\$ 182.62	\$ 2,714.83	\$128.72	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99284	Emergency Department Visit - Higher Complexity (outpatient)	No	\$ 2,470.23	\$ 270.43	\$ 4,475.48	\$198.93	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99285	Emergency Department Visit - High Complexity (outpatient)	No	\$ 3,326.63	\$ 458.20	\$ 5,806.95	\$374.45	Case Rate

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

Last Updated: 12/14/2022									Amount We Estimate You Will Owe *	
To Search for a service Click "CTRL" + "F"										
<u>Service Category</u>	<u>Service Setting</u>	<u>Code Type</u>	<u>Code</u>	<u>Description</u>	<u>CMS Required Shoppable Service?</u>	<u>Discounted Cash Price</u>	<u>De-Identified Minimum Negotiated Charge</u>	<u>De-Identified Maximum Negotiated Charge</u>	<u>Payer-Specific Negotiated Charge</u>	<u>Estimate Type</u>
Emergency Room Visit	Hospital Outpatient	CPT	99291	Emergency Department Visit - Critical Care (outpatient)	No	\$ 19,712.86	\$ 425.50	\$ 6,308.07	\$631.88	Case Rate

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