




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	\$ 19,770.89	\$21,378.59	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	\$ 119,500.01	\$40,682.71	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	\$ 57,963.36	\$26,015.09	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	\$ 61,926.79	\$30,020.70	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	\$ 111,536.38	\$33,747.25	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	\$ 74,151.25	\$26,894.26	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	\$ 61,720.46	\$23,636.02	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	\$ 72,146.20	\$28,471.47	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	\$ 52,486.93	\$24,859.06	Case Rate-Excluding Professional Charges which are paid by CPT/HCPCS


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

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	\$ 32,009.60	\$19,977.95	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	\$ 29,792.54	\$21,390.22	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	\$ 20,675.36	\$17,932.44	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	\$ 99,833.27	\$57,135.91	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	\$ 63,558.17	\$33,180.28	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	\$ 42,869.37	\$25,749.27	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	\$ 143,073.70	\$40,409.53	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	\$ 205,835.50	\$66,993.85	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	\$ 111,437.41	\$42,379.94	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	\$ 44,602.39	\$22,518.28	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	\$ 14,774.90	\$18,939.73	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	\$ 20,353.48	\$27,313.97	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	\$ 16,490.45	\$19,217.33	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	\$ 14,607.02	\$17,841.87	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	\$ 20,951.63	\$24,145.56	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	\$ 18,102.41	\$19,219.53	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	\$ 15,690.25	\$18,193.83	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	\$ 2,152.15	\$12,900.38	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	\$ 15,552.03	\$17,874.27	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	\$ 9,961.29	\$17,874.27	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	\$ 12,196.90	\$19,184.19	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	\$ 11,390.90	\$16,743.27	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	\$ 9,532.94	\$16,136.54	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	Non-Par	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	Non-Par	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	Non-Par	Non-Par	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	\$1,351.80 Per Diem	Non-Par	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	80% Charges (Estimated as \$1,706.61 Per Diem)	90% Medicare	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	80% Charges (Estimated as \$1,706.61 Per Diem)	90% Medicare	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	80% Charges (Estimated as \$1,706.61 Per Diem)	90% Medicare	Per Diem Per Day
Hospital Outpatient Procedure	Hospital Outpatient	CPT	19083	Bx breast 1st lesion us imag	No	\$ 1,957.09	\$ 381.25	\$ 2,685.54	\$1,283.11	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	\$ 8,157.20	\$1,270.18	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	32555	Aspirate pleura w/ imaging	No	\$ 7,293.50	\$ 288.54	\$ 10,008.23	\$492.93	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	49440	Place gastrostomy tube perc	No	\$ 3,073.24	\$ 445.12	\$ 4,217.14	\$1,481.18	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	59025	Fetal Non-Stress Test	No	\$ 581.33	\$ 118.53	\$ 797.71	\$155.36	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	69210	Remove impacted ear wax	No	\$ 302.36	\$ 48.93	\$ 414.90	\$50.76	Case Rate
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	No	\$ 804.63	\$ 127.22	\$ 1,331.30	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	70482	Ct orbit/ear/fossa w/o&w/dye	No	\$ 1,715.77	\$ 207.79	\$ 2,691.70	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	70486	Ct maxillofacial w/o dye	No	\$ 1,507.75	\$ 127.52	\$ 2,382.36	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	70496	Ct angiography head	No	\$ 1,246.07	\$ 223.05	\$ 1,993.25	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	70498	Ct angiography neck	No	\$ 1,001.14	\$ 223.05	\$ 1,629.05	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	71250	CT THORAX W/O DYE	No	\$ 858.09	\$ 141.11	\$ 1,416.34	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	71045	X-ray exam chest 1 view	No	\$ 121.75	\$ 19.91	\$ 192.16	\$73.76	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	\$ 194.36	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	71260	CT Scan - Chest, with Contrast (outpatient)	No	\$ 1,246.07	\$ 200.76	\$ 1,993.25	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	71275	Ct angiography chest	No	\$ 1,295.90	\$ 226.19	\$ 2,067.34	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	72126	Ct neck spine w/dye	No	\$ 1,084.68	\$ 260.86	\$ 1,753.26	\$335.82	Per Unit
Radiology Services	Hospital Outpatient	CPT	72100	X-Ray - Spine (outpatient)	No	\$ 168.26	\$ 37.93	\$ 263.91	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	72127	Ct neck spine w/o & w/dye	No	\$ 1,246.07	\$ 201.73	\$ 1,993.25	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	72133	Ct lumbar spine w/o & w/dye	No	\$ 1,338.47	\$ 201.90	\$ 2,130.65	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	73700	CT LOWER EXTREMITY W/O DYE	No	\$ 850.98	\$ 134.01	\$ 1,405.75	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	74150	Ct abdomen w/o dye	No	\$ 846.65	\$ 142.38	\$ 1,399.32	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	74170	Ct abdomen w/o & w/dye	No	\$ 1,270.98	\$ 207.86	\$ 2,030.30	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	72190	X-RAY EXAM OF PELVIS	No	\$ 168.26	\$ 39.60	\$ 262.99	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	73000	X-ray exam of collar bone	No	\$ 121.75	\$ 22.40	\$ 191.26	\$73.76	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	\$ 261.26	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	73060	X-RAY EXAM OF HUMERUS	No	\$ 121.75	\$ 29.40	\$ 191.26	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73070	X-ray exam of elbow	No	\$ 121.75	\$ 25.07	\$ 190.82	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73090	X-RAY EXAM OF FOREARM	No	\$ 91.32	\$ 26.40	\$ 146.00	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73120	X-RAY EXAM OF HAND	No	\$ 168.26	\$ 24.40	\$ 260.41	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	73130	X-Ray - Hand	No	\$ 121.75	\$ 32.72	\$ 191.71	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73552	X-RAY EXAM OF FEMUR 2/>	No	\$ 121.75	\$ 29.51	\$ 192.56	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73560	X-RAY EXAM OF KNEE 1 OR 2	No	\$ 176.40	\$ 32.40	\$ 272.51	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73590	X-ray exam of lower leg	No	\$ 218.41	\$ 32.40	\$ 334.99	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73600	X-RAY EXAM OF ANKLE	No	\$ 188.76	\$ 31.98	\$ 290.90	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73610	X-Ray - Ankle (outpatient)	No	\$ 210.38	\$ 25.72	\$ 323.50	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73620	X-RAY EXAM OF FOOT	No	\$ 173.94	\$ 29.81	\$ 268.05	\$73.76	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	\$ 290.94	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	No	\$ 2,500.65	\$ 286.79	\$ 3,858.80	\$335.82	Per Unit
Radiology Services	Hospital Outpatient	CPT	75571	Ct hrt w/o dye w/ca test	No	\$ 79.37	\$ 59.00	\$ 258.38	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	70450	CT Scan - Head/Brain, without Contrast	Yes	\$ 804.63	\$ 127.22	\$ 1,331.30	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	72193	CT scan, pelvis, with contrast	Yes	\$ 1,341.96	\$ 197.29	\$ 2,135.84	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	74220	X-ray xm esophagus 1cntrst	No	\$ 371.53	\$ 56.38	\$ 580.59	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	74270	X-ray xm colon 1cntrst std	No	\$ 371.53	\$ 79.34	\$ 594.34	\$162.89	Per Unit
Radiology Services	Hospital Outpatient	CPT	74177	CT Scan - Abdomen and Pelvis, with Contrast	Yes	\$ 2,500.65	\$ 286.79	\$ 3,858.80	\$335.82	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76770	US EXAM ABDO BACK WALL COMP	No	\$ 224.35	\$ 76.54	\$ 378.51	\$99.28	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76801	OB US < 14 WKS SINGLE FETUS	No	\$ 224.35	\$ 86.65	\$ 394.20	\$99.28	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76811	OB US DETAILED SNGL FETUS	No	\$ 224.35	\$ 198.65	\$ 451.77	\$209.84	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76815	OB US LIMITED FETUS(S)	No	\$ 224.35	\$ 54.75	\$ 373.29	\$99.28	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	\$ 386.56	\$99.28	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76818	FETAL BIOPHYS PROFILE W/NST	No	\$ 224.35	\$ 82.20	\$ 399.21	\$99.28	Per Unit
Maternity/Delivery	Hospital Outpatient	CPT	76819	FETAL BIOPHYS PROFIL W/O NST	No	\$ 224.35	\$ 97.44	\$ 381.13	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76821	MIDDLE CEREBRAL ARTERY ECHO	No	\$ 224.35	\$ 88.69	\$ 377.20	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	77080	Bone Density Scan (outpatient)	No	\$ 168.26	\$ 56.29	\$ 262.60	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	77081	Dxa bone density/peripheral	No	\$ 91.46	\$ 33.80	\$ 149.31	\$73.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80307	Drug test prsmv chem analyzr	No	\$ 147.41	\$ 55.93	\$ 197.92	\$62.14	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81025	Urine Test - Pregnancy	No	\$ 34.21	\$ 10.45	\$ 58.32	\$8.61	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82247	Bilirubin total	No	\$ 42.44	\$ 4.52	\$ 63.11	\$5.02	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82306	Blood Test - Vitamin D-3 Level	No	\$ 195.28	\$ 26.64	\$ 290.38	\$29.60	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82330	Assay of calcium	No	\$ 36.33	\$ 12.31	\$ 54.02	\$13.68	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82375	Assay carboxyhb quant	No	\$ 118.09	\$ 11.09	\$ 175.59	\$12.32	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	\$ 23.50	\$4.35	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82550	Assay of ck (cpk)	No	\$ 13.14	\$ 5.86	\$ 19.54	\$6.51	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82552	Assay of cpk in blood	No	\$ 27.05	\$ 12.05	\$ 10.71	\$13.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82565	Assay of creatinine	No	\$ 47.70	\$ 7.17	\$ 76.41	\$5.12	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82610	Cystatin c	No	\$ 145.26	\$ 14.17	\$ 216.00	\$18.52	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82668	Assay of erythropoietin	No	\$ 37.95	\$ 16.91	\$ 56.43	\$18.79	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82670	Assay of estradiol	No	\$ 56.40	\$ 25.15	\$ 83.86	\$27.94	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82693	Assay of ethylene glycol	No	\$ 20.99	\$ 13.41	\$ 31.22	\$14.90	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82803	Blood gases any combination	No	\$ 75.94	\$ 20.17	\$ 112.92	\$26.07	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82947	Assay glucose blood quant	No	\$ 33.15	\$ 5.51	\$ 53.50	\$3.93	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83605	Assay of lactic acid	No	\$ 28.38	\$ 10.41	\$ 42.21	\$11.57	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83735	Assay of magnesium	No	\$ 52.14	\$ 9.38	\$ 84.69	\$6.70	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	\$ 265.46	\$39.26	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84100	Assay of phosphorus	No	\$ 61.56	\$ 6.64	\$ 96.59	\$4.74	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 42.30	\$ 6.66	\$ 67.82	\$4.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84132	Assay of serum potassium	No	\$ 42.30	\$ 6.66	\$ 67.82	\$4.76	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84144	Assay of progesterone	No	\$ 55.44	\$ 18.77	\$ 80.90	\$20.86	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84295	Assay of serum sodium	No	\$ 43.56	\$ 4.33	\$ 64.77	\$4.81	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	No	\$ 56.72	\$ 23.52	\$ 102.31	\$16.80	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84480	Assay triiodothyronine (t3)	No	\$ 99.64	\$ 12.76	\$ 148.17	\$14.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84484	Assay of troponin quant	No	\$ 84.53	\$ 10.26	\$ 125.69	\$12.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84702	Chorionic gonadotropin test	No	\$ 130.13	\$ 11.54	\$ 193.50	\$15.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85014	Hematocrit	No	\$ 27.88	\$ 2.13	\$ 41.46	\$2.37	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85240	Clot factor viii ahg 1 stage	No	\$ 47.56	\$ 16.11	\$ 70.72	\$17.90	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	\$ 82.42	\$9.72	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85613	Russell viper venom diluted	No	\$ 25.46	\$ 8.24	\$ 37.86	\$9.58	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85660	RBC SICKLE CELL TEST	No	\$ 45.07	\$ 4.96	\$ 82.02	\$5.51	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85732	Thromboplastin time partial	No	\$ 13.06	\$ 5.82	\$ 19.42	\$6.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86140	C-reactive protein	No	\$ 50.17	\$ 4.66	\$ 74.60	\$5.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86360	T cell absolute count/ratio	No	\$ 67.25	\$ 42.28	\$ 100.00	\$46.98	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86361	T cell absolute count	No	\$ 137.38	\$ 24.10	\$ 204.28	\$26.78	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86431	Rheumatoid factor quant	No	\$ 54.53	\$ 5.10	\$ 81.08	\$5.67	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 39.12	\$ 3.84	\$ 58.18	\$4.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86592	Syphilis test non-trep qual	No	\$ 39.12	\$ 3.84	\$ 58.18	\$4.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86611	Bartonella antibody	No	\$ 59.36	\$ 9.16	\$ 88.26	\$10.18	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86677	Helicobacter pylori antibody	No	\$ 29.29	\$ 15.13	\$ 47.20	\$16.85	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	86692	Hepatitis delta agent antbdy	No	\$ 30.17	\$ 15.44	\$ 44.86	\$17.16	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86698	Histoplasma antibody	No	\$ 33.21	\$ 12.41	\$ 122.54	\$13.79	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86704	HEP B CORE ANTIBODY TOTAL	No	\$ 89.09	\$ 10.85	\$ 132.48	\$12.05	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86705	HEP B CORE ANTIBODY IGM	No	\$ 23.77	\$ 10.59	\$ 35.35	\$11.77	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86706	HEP B SURFACE ANTIBODY	No	\$ 102.41	\$ 9.67	\$ 152.28	\$10.74	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86708	Hepatitis a antibody	No	\$ 23.49	\$ 11.15	\$ 34.94	\$12.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86762	Rubella antibody	No	\$ 65.86	\$ 12.95	\$ 120.30	\$14.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86765	Rubeola antibody	No	\$ 26.01	\$ 11.59	\$ 38.68	\$12.88	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86769	86769 - SARS-COV-2 COVID-19 ANTIBODY	No	\$ 53.26	\$ -	\$ 79.20	\$42.13	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86790	Virus antibody nos	No	\$ 26.01	\$ 11.59	\$ 38.68	\$12.88	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86850	Rbc antibody screen	No	\$ 21.03	\$ 5.00	\$ 31.26	\$45.32	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86885	Coombs test indirect qual	No	\$ 253.19	\$ 5.65	\$ 376.50	\$136.01	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>
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 205.88	\$ 3.78	\$ 306.14	\$102.83	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86900	Blood typing serologic abo	No	\$ 205.88	\$ 3.78	\$ 306.14	\$102.83	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 62.33	\$ 3.78	\$ 92.68	\$30.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86901	Blood typing serologic rh(d)	No	\$ 62.33	\$ 3.78	\$ 92.68	\$30.87	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86902	BLOOD TYPE ANTIGEN DONOR EA	No	\$ 6.02	\$ 4.84	\$ 8.95	\$265.60	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86920	COMPATIBILITY TEST SPIN	No	\$ 253.19	\$ 13.44	\$ 376.50	\$136.01	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87040	Blood culture for bacteria	No	\$ 138.54	\$ 9.29	\$ 206.00	\$10.32	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87110	Chlamydia culture	No	\$ 135.26	\$ 17.64	\$ 201.14	\$19.60	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87340	Lab Test - Detection test for Hepatitis B Surface Antigen	No	\$ 65.75	\$ 9.30	\$ 97.77	\$10.33	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87389	Lab Test - Detection test for HIV-1 and HIV-2	No	\$ 114.26	\$ 21.67	\$ 169.90	\$24.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87425	Rotavirus ag ia	No	\$ 38.74	\$ 10.78	\$ 9.58	\$11.98	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	\$ 138.66	\$35.09	Per Unit	
Laboratory & Pathology Services	Hospital Outpatient	CPT	87635	87635 - SARS-COV-2 COVID-19 AMP PRB	No	\$ 55.21	\$ -	\$ 82.10	\$51.31	Per Unit	
Laboratory & Pathology Services	Hospital Outpatient	CPT	87798	Detect agent nos dna amp	No	\$ 93.25	\$ 31.58	\$ 138.66	\$35.09	Per Unit	
Laboratory & Pathology Services	Hospital Outpatient	CPT	87880	Strep Test (Streptococcus, group A)	No	\$ 89.94	\$ 19.87	\$ 148.06	\$16.53	Per Unit	
Laboratory & Pathology Services	Hospital Outpatient	CPT	88185	Flowcytometry/tc add-on	No	\$ 71.19	\$ -	\$ 105.86	\$0.00	Per Unit	
Vaccinations	Hospital Outpatient	CPT	90471	Immunization Administration	No	\$ 44.49	\$ 7.02	\$ 80.64	\$56.54	Per Unit	
Vaccinations	Hospital Outpatient	CPT	90472	Immunization Administration Each Additional Component	No	\$ 12.56	\$ -	\$ 31.53	\$0.00	Per Unit	
Chemotherapy	Hospital Outpatient	CPT	96413	Chemo iv infusion 1 hr	No	\$ 583.25		\$ 867.28	\$290.77	Per Unit	
Chemotherapy	Hospital Outpatient	CPT	96415	Chemo iv infusion addl hr	No	\$ 114.07		\$ 169.62	\$56.54	Per Unit	
Chemotherapy	Hospital Outpatient	CPT	96417	Chemo iv infus each addl seq	No	\$ 114.07		\$ 169.62	\$56.54	Per Unit	
Radiology Services	Hospital Outpatient	CPT	70491	Ct soft tissue neck w/dye	No	\$ 1,069.80		\$ 1,590.78	\$162.89	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		\$ 226.31	\$99.28	Per Unit
Injections	Hospital Outpatient	CPT	96402	Chemo hormon antineopl sq/im	No	\$ 123.61	\$ 66.86	\$ 169.62	\$56.54	Case Rate
Pet Scan	Hospital Outpatient	CPT	78815	Pet image w/ct skull-thigh	No	\$ 3,017.62		\$ 4,487.17	\$1,349.70	Per Unit
Pet Scan	Hospital Outpatient	CPT	78816	Pet image w/ct full body	No	\$ 3,017.62		\$ 4,487.17	\$1,349.70	Per Unit
Medicine Hyberbaric	Hospital Outpatient	CPT	G0277	Hbot, full body chamber, 30m	No	\$ 111.89	\$ 46.24	\$ 1,080.34	\$108.76	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97116	GAIT TRAINING THERAPY	No	\$ 80.30	\$ 22.90	\$ 119.40	\$28.26	Per Unit
Exablate	Hospital Outpatient	CPT	0398T	Focused Ultrasound	No	\$ 32,139.56	\$ 11,272.90	Service Not Covered by Payer	\$10,253.71	Case Rate
Vaccinations	Hospital Outpatient	CPT	G0008	Admin influenza virus vaccine	No	\$ 70.15	\$ -	\$ 115.23	\$36.49	Per Unit
Vaccinations	Hospital Outpatient	CPT	G0009	Admin pneumococcal vaccine	No	\$ 27.43	\$ -	\$ 49.50	\$36.49	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97530	Physical Therapy - Therapeutic Activities	No	\$ 83.07	\$ 17.40	\$ 142.23	\$35.32	Per Unit
Medicine Occupational Therapy	Hospital Outpatient	CPT	97165	OT EVAL LOW COMPLEX 30 MIN	No	\$ 187.14	\$ 77.05	\$ 278.27	\$96.78	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	\$ 96.00	\$96.78	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	G0480	Drug test def 1-7 classes	No	\$ 492.51	\$ -	\$ 732.35	\$114.43	Per Unit
Injections	Hospital Outpatient	HCPCS	J1071	Inj testosterone cypionate	No	\$ 0.18	\$ 0.03	\$ 0.34	\$0.03	Per Unit
Injections	Hospital Outpatient	HCPCS	J1815	Insulin injection	No	\$ 2.35	\$ 0.78	\$ 3.28	\$0.87	Per Unit
Injections	Hospital Outpatient	HCPCS	J7325	Synvisc or synvisc-one	No	\$ 30.80	\$ -	\$ 41.47	\$10.22	Per Unit
Injections	Hospital Outpatient	CPT	J9217	Eligard	No	\$ 816.35	\$ -	\$ 4,336.21	\$176.46	Per Unit
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11102	Biopsy - Tangential Biopsy of Skin	No	\$ 447.50	\$ 161.58	\$ 614.06	\$163.76	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	11104	Biopsy - Punch Biopsy of Skin	No	\$ 804.56	\$ 167.15	\$ 1,104.03	\$315.20	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	17000	Destruction of Lesion (outpatient)	No	\$ 781.92	\$ 157.92	\$ 1,072.96	\$163.76	Case Rate
Injections	Hospital Outpatient	CPT	20610	Arthrocentesis (outpatient)	No	\$ 1,185.82	\$ 182.39	\$ 1,627.20	\$238.26	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	31575	Laryngoscopy - Diagnostic	No	\$ 377.88	\$ 135.86	\$ 518.54	\$150.12	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	43235	Upper Gastrointestinal Endoscopy - Diagnostic	Yes	\$ 2,532.81	\$ 61.00	\$ 3,475.56	\$737.90	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	\$ 5,364.18	\$737.90	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45378	Colonoscopy - Diagnostic (outpatient)	Yes	\$ 2,399.03	\$ 335.79	\$ 3,291.98	\$723.69	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45380	Colonoscopy - With Biopsy (outpatient)	Yes	\$ 2,423.51	\$ 343.06	\$ 3,325.57	\$945.65	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	45385	Colonoscopy - With Polyp Removal (outpatient)	Yes	\$ 2,553.22	\$ 354.50	\$ 3,503.56	\$945.65	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	51798	Urine Capacity Measurement	No	\$ 248.09	\$ -	\$ 340.43	\$50.76	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	52000	Cystoscopy	No	\$ 948.42	\$ 282.78	\$ 1,301.43	\$524.64	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	55700	Biopsy of prostate gland	Yes	\$ 702.11	\$ 284.76	\$ 963.45	\$1,632.83	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58100	Biopsy - Endometrial (Uterus)	No	\$ 354.58	\$ 144.00	\$ 486.56	\$155.36	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58300	Insert intrauterine device	No	\$ 536.76	\$ 48.93	\$ 736.54	\$0.00	Case Rate
Hospital Outpatient Procedure	Hospital Outpatient	CPT	58301	Remove intrauterine device	No	\$ 669.25	\$ 32.34	\$ 918.35	\$257.20	Case Rate
Medicine Speech Therapy	Hospital Outpatient	CPT	92507	SPEECH/HEARING THERAPY	No	\$ 163.49	\$ 17.40	\$ 80.00	\$73.93	Per Unit
Radiology Services	Hospital Outpatient	CPT	72125	Ct neck spine w/o dye	No	\$ 1,075.17	\$ 136.86	\$ 1,739.13	\$99.28	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	\$ 194.76	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	72070	X-Ray - Middle Back, Thoracic Spine	No	\$ 224.35	\$ 33.93	\$ 347.31	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	72110	X-Ray, lower back, minimum four views	Yes	\$ 168.26	\$ 52.80	\$ 269.38	\$99.28	Per Unit
Medicine Cardiac Stress Test	Hospital Outpatient	CPT	93017	CARDIOVASCULAR STRESS TEST	No	\$ 487.71	\$ 61.00	\$ 725.22	\$241.35	Per Unit
Radiology Services	Hospital Outpatient	CPT	72170	X-Ray - Pelvis	No	\$ 224.35	\$ 28.72	\$ 344.26	\$99.28	Per Unit
Medicine Other	Hospital Outpatient	CPT	93306	Tte w/doppler complete	No	\$ 953.92	\$ 322.26	\$ 1,508.46	\$440.64	Per Unit
Hospital Observation Per Hour	Hospital Outpatient	CPT	G0378	Hospital observation per hr	No	\$ 255.22	\$ 605.00	\$ 24,131.86	\$-	Per Unit
Radiology Services	Hospital Outpatient	CPT	73030	X-Ray - Shoulder (outpatient)	No	\$ 121.75	\$ 28.33	\$ 192.56	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73110	X-Ray - Wrist (outpatient)	No	\$ 121.75	\$ 30.72	\$ 191.71	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	70551	MRI BRAIN STEM W/O DYE	No	\$ 1,344.67	\$ 252.20	\$ 2,104.42	\$209.84	Per Unit
Radiology Services	Hospital Outpatient	CPT	73502	X-Ray - Hip	No	\$ 121.75	\$ 37.77	\$ 194.76	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	73562	X-Ray - Knee (outpatient)	No	\$ 233.07	\$ 36.52	\$ 358.09	\$73.76	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	\$ 3,179.47	\$335.82	Per Unit
Radiology Services	Hospital Outpatient	CPT	74018	X-Ray - Abdomen	No	\$ 121.75	\$ 28.31	\$ 192.16	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	72197	MRI - Pelvis (outpatient)	No	\$ 2,065.91	\$ 402.71	\$ 3,059.51	\$335.82	Per Unit
Radiology Services	Hospital Outpatient	CPT	76536	Ultrasound - Head and Neck	No	\$ 224.35	\$ 78.79	\$ 367.82	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76642	Ultrasound - Breast (outpatient)	No	\$ 121.75	\$ 78.52	\$ 222.48	\$73.76	Per Unit
Radiology Services	Hospital Outpatient	CPT	76700	Ultrasound - Abdominal, Complete	Yes	\$ 224.35	\$ 91.69	\$ 382.85	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76705	Ultrasound - Abdominal, Limited	No	\$ 224.35	\$ 46.05	\$ 369.56	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76805	Ultrasound - Pregnancy (outpatient)	Yes	\$ 224.35	\$ 100.36	\$ 394.84	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76830	Ultrasound - Transvaginal (non-maternity)	Yes	\$ 224.35	\$ 98.63	\$ 375.88	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	76856	Ultrasound - Pelvic (outpatient)	No	\$ 224.35	\$ 70.34	\$ 375.48	\$99.28	Per Unit
Radiology Services	Hospital Outpatient	CPT	77065	Mammography of one breast	Yes	\$ 271.82	\$ 107.57	\$ 453.69	\$80.74	Per Unit
Radiology Services	Hospital Outpatient	CPT	77066	Mammography of both breasts	Yes	\$ 343.48	\$ 135.81	\$ 571.80	\$102.96	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	77067	Mammogram (outpatient)	Yes	\$ 276.60	\$ 109.22	\$ 457.52	\$85.06	Per Unit
Radiology Services	Hospital Outpatient	CPT	78452	Myocardial Imaging (outpatient)	No	\$ 539.40	\$ 336.74	\$ 898.75	\$1,191.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80048	Blood Test - Basic Metabolic Panel	Yes	\$ 159.70	\$ 11.84	\$ 246.51	\$8.46	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80053	Blood Test - Comprehensive Metabolic Panel	Yes	\$ 92.22	\$ 14.78	\$ 148.44	\$10.56	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80061	Blood Test - Cholesterol Test, Lipid Panel	Yes	\$ 48.09	\$ 12.05	\$ 71.51	\$13.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80069	Blood Test - Renal (Kidney) Function Panel	Yes	\$ 13.92	\$ 8.68	\$ 29.98	\$8.68	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	80076	Blood Test - Hepatic (Liver) Function Panel	Yes	\$ 148.16	\$ 11.44	\$ 229.05	\$8.17	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81001	Urine Test - Automated with Microscope Examination	Yes	\$ 5.22	\$ 4.44	\$ 36.99	\$3.17	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	81003	Urine Test - Automated without Microscope	Yes	\$ 22.60	\$ 3.16	\$ 10.16	\$2.25	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82607	Blood Test - Vitamin B-12 (Cyanocobalamin) Level	No	\$ 30.42	\$ 13.57	\$ 45.23	\$15.08	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	82728	Blood Test - Ferritin (Blood Protein) Level	No	\$ 27.50	\$ 19.09	\$ 55.48	\$13.63	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	\$ 58.08	\$14.70	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83036	Blood Test - Blood Glucose Control (Hemoglobin A1C)	No	\$ 73.74	\$ 8.74	\$ 109.65	\$9.71	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83540	Blood Test - Iron Level	No	\$ 50.28	\$ 9.06	\$ 81.69	\$6.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	83690	Blood Test - Lipase (fat enzyme) Level	No	\$ 71.87	\$ 6.20	\$ 106.87	\$6.89	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84153	Blood Test - Prostate Specific Antigen (PSA) Level	Yes	\$ 67.06	\$ 25.75	\$ 119.39	\$18.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84154	PSA (prostate specific antigen)	Yes	\$ 110.02	\$ 16.55	\$ 163.60	\$18.39	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84439	Blood Test - Thyroxine (Thyroid Chemical) Level, Free	No	\$ 68.50	\$ 8.12	\$ 101.86	\$9.02	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	84443	Blood Test - Thyroid Stimulating Hormone (TSH) Level	Yes	\$ 56.72	\$ 23.52	\$ 102.31	\$16.80	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85025	Blood Test - Complete Blood Cell Count and Automated WBC	Yes	\$ 76.57	\$ 10.88	\$ 122.17	\$7.77	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85027	Blood Test - Complete Blood Cell Count (Hemoglobin)	Yes	\$ 62.89	\$ 5.82	\$ 93.52	\$6.47	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	85610	Blood Test - Clotting Time	Yes	\$ 44.12	\$ 6.01	\$ 69.81	\$4.29	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	\$ 70.78	\$6.01	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	86803	Blood Test - Hepatitis C Antibody Level	No	\$ 69.98	\$ 12.84	\$ 104.06	\$14.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87070	Bacterial Culture - Swab	No	\$ 143.43	\$ 7.76	\$ 213.27	\$8.62	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87077	Bacterial Culture - Aerobic Isolates	No	\$ 62.53	\$ 7.27	\$ 92.98	\$8.08	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	\$ 124.87	\$6.63	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87086	Urine Test - Bacterial Culture, Quantitative Colony Count	No	\$ 85.00	\$ 7.26	\$ 126.40	\$8.07	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87088	Urine Test - Bacterial Culture	No	\$ 16.35	\$ 7.28	\$ 24.31	\$8.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87186	Evaluation of Antimicrobial Drug (antibiotic, antifungal, antiviral)	No	\$ 71.55	\$ 7.79	\$ 106.40	\$8.65	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87205	Lab Test - Smear for Microorganism	No	\$ 51.65	\$ 3.84	\$ 76.81	\$4.27	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87491	Urine Test - Chlamydia	No	\$ 112.18	\$ 31.58	\$ 166.82	\$35.09	Per Unit
Laboratory & Pathology Services	Hospital Outpatient	CPT	87804	Lab Test - Detection test for Influenza Virus	No	\$ 35.62	\$ 19.82	\$ 62.34	\$16.55	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	\$ 439.37	\$257.99	Per Unit
Vaccination	Hospital Outpatient	CPT	90715	Vaccine - Tetanus, Diphtheria Toxoids, and Acellular Pertussis (Whooping Cough) for Injection into Muscle	No	\$ 57.74	\$ -	\$ 139.46	\$38.28	Per Unit
Medicine Other	Hospital Outpatient	CPT	93005	Electrocardiogram (ECG or EKG)	No	\$ 109.68	\$ -	\$ 172.64	\$50.76	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97032	Physical Therapy - Manual Electrical Stimulation Therapy, 15 minutes	No	\$ 32.34	\$ 12.56	\$ 48.10	\$14.07	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97035	Physical Therapy - Ultrasound Therapy	No	\$ 27.85	\$ 11.95	\$ 41.41	\$13.61	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97110	Physical Therapy - Therapeutic Exercises	Yes	\$ 91.82	\$ 17.40	\$ 136.53	\$28.26	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97112	Physical Therapy - Neuromuscular Reeducation	No	\$ 72.35	\$ 26.14	\$ 107.58	\$32.77	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97140	Physical Therapy - Manual Therapy	No	\$ 58.15	\$ 23.73	\$ 108.21	\$26.03	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97161	Physical Therapy - Low Complexity Evaluation	No	\$ 173.88	\$ 71.97	\$ 258.56	\$96.16	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	\$ 96.00	\$96.16	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97163	Physical Therapy - High Complexity Evaluation	No	\$ 173.88	\$ 71.97	\$ 258.56	\$96.16	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97164	Physical Therapy - Re-Evaluation	No	\$ 117.26	\$ 48.67	\$ 174.37	\$66.01	Per Unit
Medicine Physical Medicine and Rehabilitation	Hospital Outpatient	CPT	97535	Physical Therapy - Self-care or Home Management Training	No	\$ 71.27	\$ -	\$ 132.65	\$31.35	Per Unit
Emergency Room Visit	Hospital Outpatient	CPT	99281	Emergency Department Visit - Minor (outpatient)	No	\$ 218.75	\$ 74.98	\$ 300.17	\$66.15	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99282	Emergency Department Visit - Low Complexity (outpatient)	No	\$ 404.82	\$ 93.52	\$ 555.50	\$119.78	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99283	Emergency Department Visit - Moderate Complexity (outpatient)	No	\$ 929.87	\$ 182.62	\$ 1,275.98	\$211.04	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99284	Emergency Department Visit - Higher Complexity (outpatient)	No	\$ 2,470.23	\$ 270.43	\$ 3,389.68	\$331.74	Case Rate
Emergency Room Visit	Hospital Outpatient	CPT	99285	Emergency Department Visit - High Complexity (outpatient)	No	\$ 3,326.63	\$ 458.20	\$ 4,564.84	\$476.17	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	\$ 27,050.24	\$679.28	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%.