

2011 ESTIMATED RANGE OF MEDICARE PATIENT OUT-OF-POCKET COSTS FOR OUTPATIENT HOSPITAL PROCEDURES *WITH DEDUCTIBLE MET

- These estimated out-of-pocket costs are not a guarantee of insurance coverage and are provided for informational purposes only.
- Please check with Medicare (CMS) if you need additional help understanding your benefits for the service chosen.
- Average out-of-pocket costs are estimates; your eventual out-of-pocket expense will depend on your individual coverage (such as co-insurance or deductibles) and the procedure or procedures performed and billed.
- If you have additional questions, please contact AMS Health Care Affairs at 888-865-3373.

Outpatient Hospital Procedure	Physician Portion (co-insurance)	Hospital Portion (co-insurance)	Anesthesia Portion	Total Due By Patient
INFLATABLE PENILE IMPLANT (AMS 700®, AMS AMBICOR®) CPT Codes billed: 54405, 00938	\$151 - \$219	\$1,132	\$46 - \$69	\$1,329 - \$1,420
MALLEABLE PENILE IMPLANT (SPECTRA®) CPT Codes billed: 54400, 00938	\$99 - \$143	\$1,132	\$46 - \$69	\$ 1,277 - \$1,344
ARTIFICIAL URINARY SPHINCTER (AMS 800®) CPT Codes billed: 53445, 00860	\$164 - \$237	\$1,132	\$46 - \$69	\$1,342 - \$1,438
MALE SLING (INVANCE and ADVANCE®) CPT Codes billed: 53440, 00920	\$164 - \$238	\$1,132	\$38 - \$58	\$1,335 - \$1,427
BPH PROSTATE TREATMENT (GREENLIGHT™) CPT Codes billed: 52648, 00914	\$128 - \$186	\$542 - \$999	\$35 - \$52	\$705 - \$1,237
FEMALE INCONTINENCE SLING (MINIARC®, MONARC®) CPT Codes billed: 57288, 00860	\$128 - \$186	\$529 - \$976	\$38 - \$58	\$696 - \$1,220
FEMALE CYSTOCELE PROLAPSE REPAIR WITH MESH CPT Codes billed: 57240, 57267, 00940	\$166 - \$243	\$624 - \$1,132	\$35 - \$52	\$824 - \$1,426

The examples above make the following assumptions:

1. The procedure is medically necessary and billed using the codes listed.
2. Additional billed supplies or procedures can add to the total due by patient.
3. The patient has **met** the Medicare deductible (\$162 for CY2011).
4. Coinsurance range is the calculated minimum and maximum patient coinsurance for a procedure performed in a Medicare approved hospital in the United States.
5. Includes anesthesia provider billing for typical procedure time as determined by Centers for Medicare and Medicaid Services (CMS).
6. The information listed is for traditional Medicare plans only - Medi-gap or Medicare Advantage Plans may differ with regard to benefits.
7. These estimates do not include: pre-procedure office visits, post-procedure office visits, diagnostic testing or additional supplies or procedures.
8. For more information contact **Medicare** at 1-800-MEDICARE [(800) 633-4227] or on their website at Medicare.gov.
9. CPT 2011. Current Procedural Terminology. Professional Edition. CPT is a trademark of the American Medical Association.

DEFINITIONS

Physician Portion Due (Co-insurance)	Estimated amount of co-insurance due to physician (20% of Medicare allowed)
Deductible	Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies (For 2011 it is \$162.00)
ASC Portion (Co-insurance)	Estimated amount of co-insurance due to ASC - 20% of Medicare allowed
Anesthesia Portion	Estimated amount of co-insurance for anesthesia provider services (20% of Medicare allowed)
Total Due By Patient	Estimated net payment due by a Medicare patient for the service as described (includes MD, facility and anesthesia)
Maximum	Estimated maximum payment in the US as calculated by specific ASC or carrier
Minimum	Estimated minimum payment in the US as calculated by specific ASC or carrier

2011 ESTIMATED RANGE OF MEDICARE PATIENT OUT-OF-POCKET COSTS FOR AMBULATORY SURGERY CENTER (ASC) PROCEDURES *WITH DEDUCTIBLE MET

- These estimated out-of-pocket costs are not a guarantee of insurance coverage and are provided for informational purposes only.
- Please check with Medicare (CMS) if you need additional help understanding your benefits for the service chosen.
- Average out-of-pocket costs are estimates; your eventual out-of-pocket expense will depend on your individual coverage (such as co-insurance or deductibles) and the procedure or procedures performed and billed.
- If you have additional questions, please contact AMS Health Care Affairs at 888-865-3373.

Ambulatory Surgery Center Procedure	Physician Portion (co-insurance)	ASC portion (co-insurance)	Anesthesia Portion	Total Due By Patient
INFLATABLE PENILE IMPLANT (AMS 700®, AMS AMBICOR®) CPT Codes billed: 54405, 00938	\$151 - \$219	\$1,697 - \$2,721	\$46 - \$69	\$1,894 - \$3,009
MALLEABLE PENILE IMPLANT (SPECTRA®) CPT Codes billed: 54400, 00938	\$99 - \$143	\$976 - \$1,565	\$46 - \$69	\$1,121 - \$1,777
ARTIFICIAL URINARY SPHINCTER (AMS 800®) CPT Codes billed: 53445, 00860	\$164 - \$237	\$1,697 - \$2,721	\$46 - \$69	\$1,907 - \$3,027
MALE SLING (INVANCE and ADVANCE®) CPT Codes billed: 53440, 00920	\$164 - \$238	\$976 - \$1,565	\$38 - \$58	\$ 1,179 - \$1,860
BPH PROSTATE TREATMENT (GREENLIGHT™) CPT Codes billed: 52648, 00914	\$128 - \$186	\$300 - \$481	\$35 - \$52	\$463 - \$719
FEMALE INCONTINENCE SLING (MINIARC®, MONARC®) CPT Codes billed: 57288, 00860	\$128 - \$186	\$293 - \$470	\$38 - \$58	\$460 - \$714
FEMALE CYSTOCELE PROLAPSE REPAIR WITH MESH CPT Codes billed: 57240, 57267, 00940	\$166 - \$243	\$346 - \$554	\$35 - \$52	\$546 - \$849

The examples above make the following assumptions:

1. The procedure is medically necessary and billed using the codes listed.
2. Additional billed supplies or procedures can add to the total due by patient.
3. The patient has **met** the Medicare deductible (\$162 for CY2011).
4. Coinsurance range is the calculated minimum and maximum patient coinsurance for a procedure performed in a Medicare approved hospital in the United States.
5. Includes anesthesia provider billing for typical procedure time as determined by Centers for Medicare and Medicaid Services (CMS).
6. The information listed is for traditional Medicare plans only - Medi-gap or Medicare Advantage Plans may differ with regard to benefits.
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ASC Portion (Co-insurance)	Estimated amount of co-insurance due to ASC - 20% of Medicare allowed
Anesthesia Portion	Estimated amount of co-insurance for anesthesia provider services (20% of Medicare allowed)
Total Due By Patient	Estimated net payment due by a Medicare patient for the service as described (includes MD, facility and anesthesia)
Maximum	Estimated maximum payment in the US as calculated by specific ASC or carrier
Minimum	Estimated minimum payment in the US as calculated by specific ASC or carrier