



**SUMMIT COUNTY PUBLIC HEALTH  
CLINIC FEE SCHEDULE<sup>1,2,3</sup>**

SERVICE TYPE		FEE\$ EFFECTIVE July 1, 2017
<b>CLINIC SERVICES</b>		
2000F	Blood Pressure	\$15.00
82551	Hearing Screening	\$25.00
99173	Vision Screening	\$25.00
865801	Mantoux (TB Skin Test)	\$20.00
865802	Two step Mantoux (TB Skin Test)	\$35.00
---	Non-Contractual Professional Consulting Services (hour)	\$50.00
---	Court Ordered STD Testing	\$95.00
---	Documentation HIV Testing	\$20.00
<b>OFFICE VISITS - PHYSICIAN / NURSE PRACTITIONER</b>		
99201	New Patient Office Visit brief	\$30.00
99202	New Patient Office Visit limited (10 min)	\$45.00
99203	New Patient Office Visit medium (20 min)	\$70.00
99204	New Patient Office Visit moderate (30 min)	\$100.00
99205	New Patient Office Visit comprehensive-moderate(45min)	\$120.00
99206	New Patient Office Visit comprehensive-detailed (60 min)	\$110.00
99212	Established Patient Office Visit limited (10 min)	\$40.00
99213	Established Patient Office Visit medium (15 min)	\$50.00
99214	Established Patient Office Visit moderate (25 min)	\$70.00
99215	Established Patient Office Visit high (40 min)	\$90.00
<b>OFFICE VISITS - NURSE</b>		
99211	Brief Assessment	\$20.00
<b>REFUGEE HEALTH SERVICES</b>		
---	Refugee navigator service for new arrivals as per ODJFS contract	\$50.00
---	Examinations and testing as per ODJFS contract	\$796.00
I-693	Completion of immunization section of I-693 form	\$40.00
RI693	Replacement of I- 693	\$25.00

<sup>1</sup>Contractual charges are based on fee schedule in effect at the time contract was signed.

<sup>2</sup>Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.

<sup>3</sup>Sexually Transmitted Disease (STD) Testing and Treatment are provided free of charge to patients under the age of 18.



**SUMMIT COUNTY PUBLIC HEALTH  
IMMUNIZATION FEE SCHEDULE<sup>1,2,5</sup>**

SERVICE TYPE		FEEs EFFECTIVE July 1, 2017
VACCINE		
<b>Vaccines marked with the <sup>VFC</sup> symbol are available to VFC eligible children at no cost. See VFC Eligibility Criteria below<sup>3</sup>. Vaccine administration fees still apply.</b>		
90472 90473 90474 G0008 G0009	Vaccine Administration Fee (per vaccine)	\$21.00
90748	Comvax Vaccine - HIB/Hep B (Pediatric) <sup>VFC</sup>	\$39.00
90649	Gardasil <sup>VFC</sup>	\$199.00
90651	Gardasil 9	\$244.00
90632	Hepatitis A Vaccine (Adult)	\$54.00
90633	Hepatitis A Vaccine (Pediatric) <sup>VFC</sup>	\$64.00
90746	Hepatitis B Vaccine (Adult)	\$74.00
90744	Hepatitis B Vaccine (Pediatric) <sup>VFC</sup>	\$24.00
90636	Hepatitis A/B Combined Vaccine	\$104.00
90647 90648	HIB Vaccine <sup>VFC</sup>	\$29.00
90672 90686 90687	Quadrivalent Influenza Vaccine (includes vaccine administration fee) <sup>4</sup> <sup>VFC</sup>	\$45.00
90734	Meningococcal Conjugate Menactra <sup>VFC</sup>	\$134.00
90733	Meningococcal Polysaccharide Menomune <sup>VFC</sup>	\$184.00
90620 90621	Meningococcal Group B	\$204.00
90707	MMR Vaccine <sup>VFC</sup>	\$79.00
90732	Pneumococcal Vaccine (Adult)	\$104.00
90713	Polio <sup>VFC</sup>	\$29.00
90675	Rabies Vaccine	\$349.00
90680	Rotarix <sup>VFC</sup>	\$139.00
90680	Rotateq <sup>VFC</sup>	\$94.00
90714	Td - Decavac or Tenivac <sup>VFC</sup>	\$44.00
90715	Tdap-Adacel or Boostrix <sup>VFC</sup>	\$49.00
90716	Varicella (Chicken Pox) <sup>VFC</sup>	\$139.00
90736	Zostavax	\$224.00
90698	Pentacel (Dtap & Polio) (Pediatric) <sup>VFC</sup>	\$89.00
90699 90670	Prevnar (Pediatric) <sup>VFC</sup>	\$219.00
90700	Daptacel (Dtap) (Pediatric) <sup>VFC</sup>	\$34.00
90696	Kinrix (Dtap & Polio ages 4 -6 yrs) (Pediatric) <sup>VFC</sup>	\$64.00
90723	Pediarix (Dtap, Polio, Hep B) (Pediatric) <sup>VFC</sup>	\$89.00
---	Vaccination Site Fee (for off-site clinics)	\$50.00
---	Yellow travel book replacement and documentation	\$10.00

<sup>1</sup>Contractual charges are based on fee schedule in effect at the time contract was signed.

<sup>2</sup>Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs. Sliding fee scale does not apply to international travel vaccines

<sup>3</sup>VFC (Vaccines for Children Program) Eligibility Criteria- Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccine:

- Medicaid eligible: A child who is eligible for the Medicaid program.
- Uninsured: A child who has no health insurance coverage.
- American Indian or Alaskan Native
- Underinsured: A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured

<sup>4</sup>Influenza vaccine fees are waived for Board of Health members and Township Association members.

<sup>5</sup>Fees may be waived in response to a communicable disease outbreak.



**SUMMIT COUNTY PUBLIC HEALTH  
LABORATORY FEE SCHEDULE<sup>1,2,3,4,5</sup>**

SERVICE TYPE		FEE EFFECTIVE July 1, 2017
<b>LABORATORY SERVICES</b>		
36415	Specimen Collection Venous	\$10.00
36416	Specimen Collection Capillary	\$10.00
82962	Glucose Blood Stick	\$10.00
<b>LABORATORY TESTS</b>		
87081	Strep Culture	\$9.00
87077	Gonorrhea	\$12.00
86592	RPR	\$7.00
83655	Blood Lead	\$18.00
87270	Chlamydia - antigen detection by DFA	\$18.00
81025	Pregnancy Test	\$10.00
87210	Wet Mount	\$7.00
87274	Herpes Type 1	\$18.00
87273	Herpes Type 2	\$18.00
81002	Urine Dipstick	\$4.00
81000	Urine Dipstick/Micro	\$5.00
82947	Glucose Serum	\$6.00
87340	Hepatitis B (HBsAg)	\$14.00
86704	Hepatitis B (HBcAb)	\$18.00
86706	Hepatitis B (HBsAb)	\$16.00
86803	Hepatitis C	\$30.00
86703 87390	HIV	\$25.00
85018	Hemoglobin	\$4.00
87205	Gram Stain	\$7.00
86787	Varicella Titer	\$18.00
G0434QW	Urine Drug Screen	\$19.42
86480	Quantiferon Gold TB	\$86.00
87491	Chlamydia, amplified probe technique (Urine or Swab)	\$50.00
87591	Gonorrhoeae, amplified probe technique (Urine or Swab)	\$50.00

<sup>1</sup>Contractual charges are based on fee schedule in effect at the time contract was signed.

<sup>2</sup>Other laboratory tests (send outs) are charged according to current fee schedule from laboratory performing the

<sup>3</sup>Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.

<sup>4</sup>Sexually Transmitted Disease (STD) Testing and Treatment are provided free of charge to patients under the age of

<sup>5</sup>Laboratory tests are only performed on patients receiving other health district services.



### COUNSELING FEE SCHEDULE<sup>1</sup>

SERVICE TYPE		FEE EFFECTIVE July 1, 2017
<b>COUNSELING</b>		
H0001	Assessment, 60 minutes	\$96.24
H0004	Individual Counseling, 15 minutes	\$21.82
H0005	Group Counseling, 15 minutes	\$9.52
H0006	Case Management, hour	\$78.17
H0015	Intensive Outpatient-Unlicensed Clinician	\$136.90
H0015	Intensive Outpatient-Licensed Clinician	\$136.90
H0022	Intervention (Community Services)	\$76.39
H0038	Peer Recovery (Individual)	\$35.00
H0038-HQ	Peer Recovery (Group)	--
A0630	Community-Based Process (Prevention)	\$84.96
A0620	Education (Prevention)	\$85.04
A0610	Information Dissemination (Prevention)	\$85.33
H0023	Behavioral Health Outreach Services (QRT)	\$25.00
A0780 / H0048	Urine Drug Screen	\$19.42
82075	Alcohol Breath	\$15.08
90785	Interactive Complexity	\$11.74
90791	Psychiatric diagnostic evaluation.	\$111.11
90832	Psychotherapy, 30 minutes	\$53.64
90834	Psychotherapy, 45 minutes	\$69.74
90837	Psychotherapy, 60 minutes	\$102.31
90839	Psychotherapy for crisis; first 60 minutes.	\$112.27
90840	Psychotherapy for crisis; each additional 30 minutes.	\$53.58
90846	Family psychotherapy without patient present	\$86.94
90847	Family psychotherapy with patient present	\$85.61
90853	Group psychotherapy	\$21.63
99354	Prolonged Service; first 60 minutes	\$76.42
99355	Prolonged Service; each additional 30 minutes	\$75.85
G0396	AOD screening and brief intervention 15-30 minutes	\$25.05
G0397	AOD screening and brief intervention over 30 minutes	\$47.68

<sup>1</sup>Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.



**SUMMIT COUNTY PUBLIC HEALTH  
DENTAL FEE SCHEDULE<sup>1, \*\*, \*\*</sup>**

<b>DENTAL SERVICES</b>		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE July 1, 2017
D0120	Periodic Oral Exam	\$35.00
D0140	Limited Oral Exam	\$40.00
D0145	Oral Evaluation under age 3	\$35.00
D0150	Comprehensive Oral Evaluation over age 3	\$55.00
D0210	Intraoral-complete series of x-rays	\$90.00
D0220	Periapical X-ray	\$20.00
D0230	Additional Periapical X-ray	\$15.00
D0240	Intraoral occlusal x-ray	\$30.00
D0270	Single Bitewing X-ray	\$20.00
D0272	Two Bitewing X-rays	\$30.00
D0273	Three Bitewing X-rays	\$35.00
D0274	Four Bitewing X-rays	\$40.00
D0330	Panoramic Film X-ray	\$85.00
D0460	Pulp Vitality Test	\$30.00
D0470	Diagnostic casts	\$60.00
D1110	Prophylaxis – age 14 through Adult	\$55.00
D1120	Prophylaxis – age 13 and Younger	\$40.00
D1204	Flouride Treatment only-14 through Adult	\$20.00
D1206	Topical application of flouride varnish	\$25.00
D1208	Topical application of fluoride-Child	\$25.00
D1351	Sealant (per tooth)	\$35.00
D1353	Sealant Repair (per tooth)	\$35.00
D1510	Space Maintainer-Fixed-Unilateral	\$195.00
D1515	Space Maintainer-Fixed-Bilateral	\$265.00
D1550	Recementor-Re-Bond Space Maintainer	\$45.00
D1555	Removal of Fixed Space Maintainer	\$45.00
D2140	Amalgam 1 Surface (primary or permanent)	\$90.00
D2150	Amalgam 2 Surfaces (primary or permanent)	\$105.00
D2160	Amalgam 3 Surfaces (primary or permanent)	\$130.00
D2161	Amalgam 4 or More Surfaces (primary or permanent)	\$150.00
D2330	Composite 1 Surface Anterior	\$105.00
D2331	Composite 2 Surface Anterior	\$150.00
D2332	Composite 3 Surface Anterior	\$165.00
D2335	Composite /Incisal Angle/ or 4 surfaces	\$190.00
D2391	Resin Composite 1 Surface Posterior	\$110.00
D2392	Resin Composite 2 Surface Posterior	\$130.00
D2393	Resin Composite 3 Surface Posterior	\$150.00
D2394	Resin Composite 4 Surface Posterior	\$205.00
D2740	Crown- Porcelain/Ceramic Substrate*	\$800.00
D2750	Crown-Porcelain Fused to High Noble Metal*	\$820.00
D2751	Crown- Porcelain Fused to Predominantly Base Metal*	\$770.00

<b>DENTAL SERVICES (CONTINUED)</b>		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE July 1, 2017
D2752	Crown- Porcelain Fused to Noble Metal*	\$770.00
D2790	Crown- Full Cast High Noble Metal*	\$800.00
D2791	Crown- Full Cast Predominantly Base Metal*	\$745.00
D2792	Crown- Full Cast Noble Metal*	\$745.00
D2915	Recement Cast or Prefabricated Post and Core	\$60.00
D2920	Recement or Re-bond Crown	\$60.00
D2930	Prefab Stainless Steel Crown-Primary Tooth	\$195.00
D2931	Prefab Stainless Steel Crown-Permanent Tooth	\$225.00
D2932	Prefabricated Resin Crown	\$175.00
D2933	Prefabricated Stainless Steel Crown	\$235.00
D2934	Prefabricated Stainless Steel Crown with Resin Window	\$200.00
D2940	Dental Sedative Filling	\$75.00
D2950	Core Buildup Including Pins When Required	\$150.00
D2951	Pin Retention (per tooth)	\$30.00
D2952	Post and Core in Addition to Crown- Indirectly Fabricated*	\$240.00
D2954	Prefabricated Post and Core in Addition to Crown	\$235.00
D2960	Labial veneer (resin laminate) Chairside	\$300.00
D2961	Labial veneer (resin laminate) Lab	\$500.00
D2962	Labial veneer (porcelain laminate) Lab	\$675.00
D2970	Temporary crown (fractured tooth)	\$145.00
D2971	Procedures to Construct New Crown Under Denture*	\$150.00
D3110	Pulp cap- direct (excluding final restoration)	\$45.00
D3120	Pulp cap- indirect (excluding final restoration)	\$45.00
D3220	Pulpotomy	\$115.00
D3240	Pulpal Therapy -Posterior Primary Tooth	\$120.00
D4341	Periodontal Scaling and Root Planing- 4 or more teeth	\$140.00
D4342	Periodontal Scaling and Root Planing - 1 to 3 teeth	\$115.00
D4355	Full Mouth Debridement	\$125.00
D4910	Peridontal Maintainance	\$80.00
D5110	Complete Denture - Maxillary*	\$925.00
D5120	Complete Denture - Mandibular*	\$925.00
D5130	Immediate Denture- Maxillary*	\$975.00
D5140	Immediate Denture- Mandibular*	\$975.00
D5211	Maxillary Partial Denture -Resin Base*	\$650.00
D5212	Mandibular Partial Denture - Resin Base*	\$650.00
D5213	Maxillary Partial Denture Cast Metal Framework*	\$1,310.00
D5214	Mandibular Partial Denture Cast Metal Framework*	\$1,310.00
D5225	Maxillary Partial Denture, Flexible Base*	\$1,450.00
D5226	Mandibular Partial Denture, Flexible Base*	\$1,450.00
D5410	Adjust Complete Denture - Maxillary	\$65.00
D5411	Adjust Complete Denture - Mandibular	\$65.00
D5421	Adjust Partial Denture - Maxillary	\$65.00
D5422	Adjust Partial Denture - Mandibular	\$65.00
D5510	Repair Broken Complete Denture Base	\$125.00
D5520	Replace Missing/Broken Denture Teeth (each tooth)	\$125.00

DENTAL SERVICES (CONTINUED)		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE July 1, 2017
D5610	Repair Resin Denture Base	\$125.00
D5620	Repair Cast Framework	\$145.00
D5630	Repair or Replace Broken Clasp	\$145.00
D5640	Replace Broken Teeth (per tooth)	\$160.00
D5650	Add Tooth to Existing Partial Denture	\$160.00
D5660	Add Clasp to Existing Partial Denture	\$160.00
D5730	Reline Complete Maxillary Denture (chairside)	\$200.00
D5731	Reline Complete Mandibular Denture (chairside)	\$200.00
D5740	Reline Partial Maxillary Denture (chairside)	\$200.00
D5741	Reline Partial Mandibular Denture (chairside)	\$200.00
D5750	Reline Complete Maxillary Denture (lab)	\$300.00
D5751	Reline Complete Mandibular Denture (lab)	\$300.00
D5760	Reline Partial Maxillary Denture (lab)	\$300.00
D5761	Reline Partial Mandibular Denture (lab)	\$300.00
D6056	Prefabricated Abutment (Modification and Placement)	\$475.00
D6057	Implant Custom Abutment	\$565.00
D6058	Abutment Supported Porcelain/Ceramic Crown*	\$1,010.00
D6059	Abut Supp Porcelain to Mtl Crown Hi Nob*	\$990.00
D6060	Abut Supp Porcelain to Mtl Crown Predom*	\$875.00
D6061	Abut Supp Porcelain to Mtl Crown Nob Mtl*	\$935.00
D6065	Implant Supported Porcelain/Ceramic Crown*	\$1,010.00
D6066	Implant Supported Porcelain Fused to Metal Crown*	\$990.00
D6110	Implant Supported Removable Full Denture -Maxillary*	\$1,700.00
D6111	Implant Supported Removable Full Denture -Mandible*	\$1,700.00
D6112	Implant Supported Removeable Partial -Maxillary*	\$2,300.00
D6113	Implant Supported Removeable Partial -Mandible*	\$2,300.00
D6240	Pontic- Porcelain Fused to High Noble Metal*	\$820.00
D6241	Pontic- Porcelain Fused to Predominantly Base Metal*	\$700.00
D6242	Pontic- Porcelain Fused to Noble Metal*	\$700.00
D6245	Pontic - Porcelain/Ceramic*	\$950.00
D6545	Retainer- Cast Metal for Resin Bonded Fixed Prothesis*	\$250.00
D6740	Crown - Porcelain/Ceramic Substrate*	\$950.00
D6750	Crown - Porcelain Fused to High Noble Metal*	\$820.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal*	\$750.00
D6752	Crown - Porcelain Fused to Noble Metal*	\$750.00
D6930	Recement or Re-bond Fixed Partial Denture	\$50.00
D7111	Extract, Coronal Remnants - Deciduous Tooth	\$85.00
D7140	Basic Extraction (per tooth)	\$105.00
D7210	Surgical Extraction (per tooth)	\$200.00
D7220	Soft Tissue Extraction (per tooth)	\$305.00
D7230	Part Bony Impact w/Remov Bone, Tooth Sect	\$305.00
D7270	Tooth Reimplantation or Stabilization	\$250.00
D7510	Incision & Drainage of Absceses - Intraoral Soft Tissue	\$125.00
---	MI Paste Treatment	\$20.00
D9110	Palliative (emergency) Tx of Dental Pain	\$65.00

<b>DENTAL SERVICES (CONTINUED)</b>		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE July 1, 2017
D9120	Fixed Partial Denture Sectioning	\$105.00
D9910	Application of Desensitizing Medicaments	\$35.00
D9911	Application of Desensitizing Resin (per tooth)	\$75.00
D9940	Occlusal Guard	\$400.00
D9941	Fabrication of Athletic Mouthguard	\$100.00

<sup>1</sup>Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs. Exclusions and discount limits may apply. See Summit County Public Health Medical and Dental Fee Policy for details.

\*Exclusions: The following services will be billed at 60% of actual charges regardless of discount eligibility due to associated lab costs.

- Dentures
- Crowns
- Bridge Work

\*\*The services listed below may not be discounted any lower than the fee to the right regardless of income:

- Extractions non-surgical (per tooth) \$30.00
- Cleaning, exam and diagnostic x-rays (bitewings only) \$50.00
- Emergency walk-in exam, x-ray and extraction \$65.00