05-204 DOH PCNCP 9/14

PCN Primary Care Network Co-Pay Summary

Services*	Co-Pay Amount
Visits to Primary Care Provider	$3 per visit
Prescriptions (Limit: 4 per month)	$3 for generic and OTC
Dental exams, cleanings, fillings, routine x-rays, tooth extractions	No co-pay
Immunizations	$3
Eye exam (one per year)*	Optometrist - No co-pay for annual exam Ophthalmologist - No co-pay for annual exam ***(eyeglasses not covered)***
Laboratory services	No co-pay
X-rays	No co-pay
Medical equipment and supplies	No co-pay
Emergency room visits (Restrictions apply. Not all emergencies are covered. See PCN Member Guide.)	No co-pay for diagnosed emergency ***(non-emergent use of ER is not covered)***
Ambulance ride	No co-pay
Birth Control	No co-pay

This is only a summary of PCN services and co-pay amounts. Plan restrictions may apply. (American Indians/Alaska Natives do not have a co-pay when getting services at Indian Health Services or tribal facilities.)

*Services that are not covered include prescription eyeglasses, contact lenses, MRI's, CT Scans, Dexa Scans, outpatient hospital services, specialty care, pregnancy related services, mental health services, occupational therapy, physical therapy, chiropractic services. See the PCN Member Guide for details.