Keystone Point-of-Service

POS Plus 7B

Keystone HEALTH PLAN EAST
POINT-OF-SERVICE

Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non emergency or elective hospital admissions and procedures prior to the admission or procedure. For in-network (referred) services, your participating provider will contact IBC for authorization. For out-of-network (self-referred) services, you are responsible for obtaining approval for certain services. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefits limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Referred	Self-Referred*
BENEFIT PERIOD	Calendar Year[2]	Calendar Year[2]
DEDUCTIBLE		
Individual	$3,500	$5,000
Family	$10,500	$15,000
AFTER DEDUCTIBLE, PLAN PAYS	70%	50%
LIFETIME MAXIMUM	Unlimited	Unlimited
OUT-OF-POCKET MAXIMUM[3]		
Individual	$6,600	$30,000[4]
Family	$13,200	$90,000[4]
DOCTOR'S OFFICE VISITS		
Primary Care Services	$20 Copayment, NO deductible	50%, after deductible
Specialist Services	$40 Copayment, NO deductible	50%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

2 A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year on January 1.

3 The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible. The out-of-network out-of-pocket maximum includes coinsurance only.

4 Copayments, coinsurance and deductible applied to self-referred participating providers will accumulate toward the referred/in-network out-of-pocket maximum.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

Independence

Referred benefits are underwritten or administered by Keystone Health Plan East;
Self-Referred benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

05/15 - PA - 51+ POS Plus 7B - OOPM 2015
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Benefit	Referred	Self-Referred*
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%	50%, NO deductible
ROUTINE EYE EXAM	$40 Copayment (once every two years), NO deductible	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age (no referral required)*	100%, NO deductible	50%, NO deductible
MAMMOGRAM (no referral required)	100%, NO deductible	50%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*	100%, NO deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, NO deductible	50%, after deductible
MATERNITY		
First OB visit	$20 Copayment, NO deductible	50%, after deductible
Hospital	70%, after deductible	50%, after deductible[1]
INPATIENT HOSPITAL SERVICES		
Facility	70%, after deductible	50%, after deductible[1]
Physician/Surgeon	70%, after deductible	50%, after deductible[1]
INPATIENT HOSPITAL DAYS	Unlimited	70[1]
OUTPATIENT SURGERY		
Facility	70%, after deductible	50%, after deductible
Physician/Surgeon	70%, after deductible	50%, after deductible
EMERGENCY ROOM	70%, after deductible	70%, after in-network deductible
URGENT CARE CENTER	70%, after deductible	50%, after deductible
AMBULANCE		
Emergency	70%, after deductible	70%, after in-network deductible
Non-Emergency	70%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY**		
Routine Radiology/Diagnostic	$40 Copayment, no deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment, NO deductible	50%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 total visits per year for PT/OT combined	$40 Copayment, NO deductible	50%, after deductible
Cardiac Rehabilitation 36 visits per year	$40 Copayment, NO deductible	50%, after deductible
Pulmonary Rehabilitation 36 visits per year	$40 Copayment, NO deductible	50%, after deductible
Speech 20 visits per year	$40 Copayment, NO deductible	50%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	$40 Copayment, NO deductible	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year*	$40 Copayment, NO deductible	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%, NO deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables**	100%, NO deductible	50%, after deductible
Biotech/Specialty Injectables	$100 Copayment, NO deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	70%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*	70%, after deductible	50%, after deductible
SKILLED NURSING FACILITY	70%, after deductible 120 days per year	50%, after deductible; 60 days per year
HOSPICE AND HOME HEALTH CARE	70%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%, after deductible	50%, after deductible
PROSTHETICS	50%, after deductible	50%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

** Office visits subject to copayment.

**** Copayment not applicable when service performed in Emergency Room or office setting.

1 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

Benefit	Referred	Self-Referred*
MENTAL HEALTH CARE		
Outpatient	$40 Copayment, NO deductible	50%, after deductible
Inpatient	70%, after deductible	50%, after deductible[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$40 Copayment, NO deductible	50%, after deductible
Inpatient	70%, after deductible	50%, after deductible[1]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$40 Copayment, NO deductible	50%, after deductible
Inpatient Rehabilitation	70%, after deductible	50%, after deductible[1]
Detoxification	70%, after deductible	50%, after deductible[1]

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

1 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

What Is Not Covered?

- Services not medically necessary
- Service or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses, including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Self-injectable drugs
- Alternative therapies/complementary medicine

This summary represents only a partial listing of benefits and exclusions of the Keystone Point-of-Service program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your HMO group contract/member handbook and self-referred group health benefits booklet/certificate carefully to determine which health care services are covered. If you need more information, please call 215-241-2240 (if calling within Philadelphia) or 1-800-227-3115 (outside Philadelphia).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Select Drug Program

$20/$40/$60

Personal CHOICE®

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program® is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing *(Participating Pharmacy)*	
Generic Formulary	$20 Copayment
Brand Formulary	$40 Copayment
Non-Formulary Brand	$60 Copayment
Mail Order Pharmacy - Member Cost Sharing *(Participating Pharmacy) Available for maintenance drugs*	
Generic Formulary	$20 Copayment (1-30 days supply); $40 Copayment (31-90 days supply)
Brand Formulary	$40 Copayment (1-30 days supply); $80 Copayment (31-90 days supply)
Non-Formulary Brand	$60 Copayment (1-30 days supply); $120 Copayment (31-90 days supply)
Total Out-of-Pocket Maximum	Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan.
Out-of-Network Reimbursement	30% of drugs retail cost for the total amount dispensed. For an emergency, you will only be responsible for the applicable copayments listed above. Member must submit for reimbursement.
Network	FutureScripts® network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 30 days supply
Mail order for maintenance drugs	Up to 90 days supply
Formulary	IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**.

Independence

11/14 - PA - PC Select RX Rider $20/$40/$60 w Orals OOPM 2015
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Benefit	Coverage
Specialty Pharmacy Program *Mandatory for Self-Administered Specialty Drugs*	All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply. If your doctor wants you to start the drug immediately, an initial 30-day supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through the Specialty Pharmacy Program.
Covered Prescription Drugs[1]	Compound medications of which at least one ingredient is a prescription drug Contraceptives Prescribed smoking cessation drugs Self-injectable drugs Retin-A through age 35 Insulin Insulin needles and syringes Lancets (no copayment required at participating pharmacies) Glucometers (no copayment required at participating pharmacies) Diabetic supplies (i.e., test strips)

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Experimental drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)

$100 Eyewear Benefit

Biennial Benefit

Keystone HEALTH PLAN EAST

The Keystone Health Plan East $100 HMO/POS Vision Rider program, administered by Davis Vision, offers members corrective eyewear, including eyeglasses or contact lenses. The vision rider program is easy to use. Benefits are maximized by using Davis Vision providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from a select grouping known as the Davis Collection of Frames.

Benefit	Coverage
Eyeglasses, including spectacle lenses and frames, at participating providers	
Spectacle lenses	Spectacle lenses covered at no extra cost include: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal or lenticular lenses
Additional lens options	Additional spectacle lens options covered at no cost include: glass grey #3 prescription sunglass lenses, tinting, polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters
Frames **Two options** are available for selecting frames:	Choose from participating provider's own frame collection and member receives allowance of $65[1] OR Choose from the Davis Collection of Frames that is available at most participating providers and frames are covered in full.
Eyeglasses including spectacle lenses and frames at non-participating providers	Eyeglasses (spectacle lenses and frames) are available up to a $100 reimbursement to member[2]
Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses and evaluation and fitting	
Participating providers	Member receives allowance up to $100[1]
Non-participating providers	Up to $100 reimbursement to member[2]
Total Out-of-Pocket Maximum	Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan.
Benefit frequency	Once every two calendar years
Network	Davis Vision Network To locate a participating provider, go to www.ibx.com and click on the 'Find a Doctor' feature.

1 Member is responsible for balance

2 In lieu of participating provider benefit, member is responsible for balance

This summary is intended to highlight the benefits available to you. For a complete description, including benefits and exclusions, refer to your benefit booklet.

Administered by:

DAVISVISION

SEE LIFE

www.ibx.com

12/14 - PA - $100 Eyewear Benefit- Fully Insured - OOPM 2015
10002502

Value-added Services*

Spectacle lens options available at most participating providers, MEMBER PAYS fixed discounted prices:

Spectacle Lens Option	Fixed Discounted Price
Blended invisible bifocals	$10
Ultraviolet (UV) coating	$12
Scratch-resistant coating - single vision	$15
Scratch-resistant coating - multifocal	$25
Intermediate vision lenses	$30
Anti-reflective coating - standard	$33
Anti-reflective coating - premium	$48
Anti-reflective coating - ultra	$60
Progressive additional multifocal lenses - standard	$50
Progressive additional multifocal lenses - premium	$90
Polarized lenses	$60
Polycarbonate[3]	$30
High index	$55
Photochromic glass - single vision	$15
Photochromic glass - multifocal	$25
Photochromic plastic - single vision	$60
Photochromic plastic - multifocal	$70

Warranty - Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

Replacement Contact Lenses - Through Lens 123, a free mail order program, member may receive replacement contact lenses offered at guaranteed, discounted prices.

Laser Vision Correction Services - Discount on Laser Vision Correction Services at Davis Vision Participating Laser Vision Correction Providers: Up to 25% off the participating provider's usual and customary fees or 5% off any participating provider's advertised specials, whichever is less.

Additional Eyewear Discount - Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

* Not available at non-participating providers

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters are covered at no cost.

Frequently Asked Questions

Below find answers to some frequently asked questions about how your IBC Vision benefit program works.

Who are the participating providers in the IBC Vision network?

Our administrator, Davis Vision, contracts with a national network of providers including ophthalmologists, optometrists and opticians. They are primarily licensed providers in private practice and in some retail locations, such as Wal-Mart Vision Center and For Eyes. Please go to www.ibx.com to locate a participating 'Vision Provider' through the 'Find a Doctor' feature, or once enrolled, call the number on your Identification card.

If a retail location such as Wal-Mart Vision Center is in the network, does that mean the doctor located in that store is in the network?

No. When going to a retail location such as Wal-Mart Vision Center for eyewear purchases, you should always confirm the participation status of the on-site doctor who provides the eye exam, since each provider contracts separately with Davis Vision. Please Note: Coverage for routine eye exam, if available, would be included under your medical benefit.

What are the advantages of using a participating provider?

- Quality service standards: all participating providers have been extensively reviewed and credentialed to NCQA standards to ensure that stringent standards for quality service are maintained.
- Paid-in-full benefit available: in addition to their own selection of frames, most participating providers have available the Davis Collection of Frames. This allows you to utilize the paid-in-full benefit available through your IBC Vision Program when frames are selected from the Collection with standard lenses - single, bifocal, trifocal or lenticular.
- Spectacle lens options discount: additional services such as anti-reflective coating and Transitions® lenses (photochromic) are available at a discounted price.
- Eyewear quality and value: most eyewear (lenses, coatings, and frames) is fabricated on site at one of Davis Vision's Regional Fabrication Centers. This allows Davis to monitor quality assurance and costs associated with the fabrication process, thereby creating the most value for you, our member.
- Warranty: Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

Will I need a claim form to receive services from a participating provider?

No, you will not need a claim form for in-network services. The process is simple. Here's what to do:

- Call the participating provider of your choice and schedule an appointment.
- Identify yourself as a member of IBC Vision, administered by Davis Vision.
- Provide the office with your ID number located on your Identification card and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and no claim forms are required!

Will I be able to choose any frame available at a participating provider?

Yes, you may apply the amount of your frame benefit toward any available frame that you choose. You can maximize your benefit by selecting frames from the Davis Collection of Frames, which offers you the ability to have a paid in full pair of frames. The Collection is available at most participating providers. The 'Find a Doctor' feature on www.ibx.com also indicates the participating doctors that have the Davis Collection of Frames available.

What types of frames are included in the Davis Collection of Frames?

The Davis Collection includes frames for men and women, adults and children. The collection includes many notable designer name frames that have passed rigorous inspections, such as Perry Ellis, Steve Madden, Alfred Sung, Converse, Bongo, Club Med, Catherine Deneuve, Scooby-Doo!, Garfield and Harley-Davidson. This frame collection is typically updated twice a year.

How soon will I receive my glasses after they are ordered?

Your provider will advise you when to return to his/her office to pick up your new prescription eyeglasses. Delivery of your new eyeglasses to your participating provider from the fabrication center is generally within two to five business days of the doctor's submission of your order. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coatings), specialized prescriptions or a participating provider's frame is selected.

What if my vision care provider does not participate in the network?

You may receive covered services from a non-participating provider, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose a non-participating provider, you pay the provider directly for all charges and then submit a Direct Reimbursement Claim Form. Covered services will be paid directly to you based on your out-of-network benefits. You are responsible for any balances.

Where do I send the Direct Reimbursement Claim Form?

Mail your completed Direct Reimbursement Claim Form with receipts attached to:

Vision Care Processing Unit

P. O. Box 1525

Latham, NY 12110

To obtain a claim form, please visit www.ibx.com and click on 'Forms'. The IBC Vision Direct Reimbursement Claim Form is located on this Forms page under the Claims section.

How do I purchase replacement contact lenses through the Lens 123 Program?

Enrolled members who have utilized their covered benefit may call 1-800-LENS 123 (1-800-536-7123) to register and set up your Lens 123 account. The Customer Service Representative will explain to you how to order replacement contact lenses and receive them in the mail. Lens 123 is an easy and convenient way to order replacement contact lenses. For additional information, go to www.lens123.com.

Pediatric Dental Program

Keystone HEALTH PLAN EAST

Program Benefits

Included as part of your Keystone Health Plan East Benefits package is a preventive Dental Program for children under age 12. The Keystone's Pediatric Dental Program provides 100% coverage for the following services:

- Oral Examinations (once in six months)
- Cleanings (once in six months)
- Fluoride Treatments (once in six months)

With Keystone's Pediatric Dental Program, there are no deductibles and no annual maximums. Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan.

How the Program Works

You must select one of Keystone's participating primary dental offices for your children under age 12 from the Primary Dental Office Network listed in the Dental Directory. All children under age 12 in your family must receive treatment from the same primary dental office. Once coverage is effective, you may call the primary dental office you have selected for your children for an appointment.

How to Receive Your Dental Benefits

Be sure to indicate the name and number of the primary dental office you have selected from the network on the lower portion of the Keystone Enrollment Form. Return the completed Keystone enrollment form to your benefits office.

Please note:
This is intended only to be a summary to the services provided under the Pediatric Dental Program. For a complete listing of benefits refer to the Group Master Contract provided to your employer. As with Keystone's Medical Certificate of Coverage, there are specific exclusions and limitations under this Dental Program, including but not limited to: Services of dentists who are neither participating general dentists nor participating specialists; Services obtained from a specialist without written authorization from a participating primary dentist; Dental services or supplies that are cosmetic in nature, including personalized or specialized techniques; Dental services performed or initiated prior to the effective date of coverage or completed after the termination date of coverage; Dental services or supplies which are unnecessary or experimental according to accepted standards of dental practice; Surgical implants; Periodontal splinting; Services related to the treatment of temporomandibular joint dysfunction; General anesthesia; Any dental service for which the member is eligible under worker's compensation, under federal, state or local government programs, or dental services for which, in the absence of any health services or insurance program, no charge would be made to the individual; Services, the costs of which has been or is later recovered in any action at law or in compromise or settlement of any claim; Dental services performed in a hospital; Charges for broken appointments; Charges for additional treatment necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan; Treatment required as a result of an accidental injury, except for emergency treatment to relieve pain, and Services other than those specifically listed on the schedule.

Independence

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