

# BEST One

## Dental Plus Plan **SILVER**

For families

Your oral health is an important part of overall health maintenance. In fact, keeping your mouth healthy helps to keep your whole body healthy and can actually reduce your risk for more serious problems. Did you know that more than 120 medical conditions can be detected in early stages by your dentist?

For adults and dependent children 19 and older.

Adult	In-Network	Out-of-Network
<b>Annual Maximum</b>	\$1,500	
<b>Annual Deductible</b> Applies to basic and major services in or out-of-network	You pay the first \$50 for an individual, \$150 per family.	
<b>Diagnostic &amp; Preventive Services</b> Exams, cleanings, x-rays	You pay 0%	You pay 20%
<b>Basic Services</b> Fillings, anterior and posterior composites, emergency palliative treatment, pathology	You pay 30% After 6 month waiting period.	You pay 50% After 6 month waiting period.
<b>Major Services</b> Crowns and gold fillings, inlays, onlays and pontics, implants, fixed bridges, complete and partial dentures, oral surgery, anesthesia (general or IV sedation), periodontics, endodontics	You pay 60% After 12 month waiting period.	You pay 80% After 12 month waiting period.

Satisfies the ACA pediatric dental requirement for children up to age 19.

Pediatric	In-Network	Out-of-Network
<b>Out-of-Pocket Maximum</b>	\$350 for 1 child \$700 for 2 or more children	\$700 for 1 child \$1,400 for 2 or more children
<b>Annual Deductible</b> Applies to diagnostic and preventive, basic and major services received in or out-of-network.	You pay the first \$75 per child	You pay the first \$100 per child
<b>Diagnostic &amp; Preventive Services</b> Exams, cleanings, sealants, fluoride treatment, x-rays, emergency palliative treatment	You pay 0%	You pay 20%
<b>Basic Services</b> Fillings, anesthesia (general or IV sedation)	You pay 40%	You pay 70%
<b>Major Services</b> Crowns and casts, prosthodontics, maxillofacial prosthetics, oral surgery, periodontics, endodontics	You pay 50%	You pay 70%
<b>Orthodontic Services</b> (Medically necessary) Diagnosis and treatment for repair of a disabling malocclusion or cleft palate, severe craniofacial defects or injury impacting function of speech, swallowing or chewing	You pay 50% After 24 month waiting period.	You pay 70% After 24 month waiting period.





BEST Life has been providing great dental benefits for more than 40 years with quality plans, affordable rates and superior customer service.



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## More Choice. More Savings.

What dentist you see is completely up to you. But you can gain additional savings when you see a dentist within network. With BEST Life, members have access to some of the largest national networks available with more than 280,000 dental access locations throughout the country. It's easy to find the best dentists in your area with our Provider Look-up at [www.bestlife.com](http://www.bestlife.com). And with rigorous credentialing criteria for providers, you're assured the highest-quality network available.

When you choose BEST Life, you can rest easy.

**Your smiles are safe with us.™**

## EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not covered.

1. Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist.
2. Treatments which are experimental or investigational.
3. Expenses incurred while on active duty with any military, naval, or air force of any country or international organization.
4. Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony.
5. Services and supplies covered under any Workers' Compensation Act or similar law or incurred due to treatment rendered by the employer.
6. Services and supplies started and not completed before coverage including but not limited to an appliance, or modification of one, where an impression was made before coverage; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before coverage; root canal therapy if the pulp chamber was opened before coverage.
7. Services not completed on or before the date of termination.
8. Any service or procedure not within the scope of practice by a licensed dentist, including but not limited to, those that are not medically necessary or would not meet generally accepted standards of dental practice.
9. Expenses incurred from failure to comply with a professionally prescribed treatment.
10. Expenses incurred for telephone consultations.
11. Charges for failure to keep a scheduled appointment.
12. Services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
13. Fixed bridge work.
14. Plaque control.
15. Gold inlays.
16. Gold crowns, except for permanent first and second molars.
17. Overdentures.
18. Elective tooth extractions.
19. Orthodontic treatment and orthodontia type procedures unless such procedures are defined as a covered expense.
20. Charges in excess of the cost-sharing amounts as shown on the schedule of benefits.
21. Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments.
22. Service provided for temporomandibular joint dysfunction (TMJ).
23. Congenital or developmental malformations, except as defined as a covered expense.
24. Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a covered expense.
25. "Safe fees" (gloves, masks, surgical scrubs and sterilization).
26. Treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, lawful spouse, domestic partner, child, child of domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law.
27. Services for which the member would not legally have to pay if there were no insurance, unless mandated by the state.
28. Services not completed on or before the date of termination.
29. If care is transferred from one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one procedure, payment will only be for the amount that would have been charged had one dentist rendered the services.
30. Expenses that are applied toward satisfaction of a deductible, if any.
31. Any service or procedure not commonly found within the scope of practice by a licensed dentist.
32. Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits.
33. Chemotherapeutic agents and any other experimental procedures.
34. Veneers and related procedures.
35. Services and supplies not listed as a covered service.
36. Services and supplies performed outside of the US.

## EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not covered.

1. Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist.
2. Expenses incurred while on active duty with any military, naval, or air force of any country or international organization.
3. Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony.
4. Services and supplies covered under any Workers' Compensation Act or similar law or incurred due to treatment rendered by the employer.
5. Services and supplies begun and not completed prior to the effective date, including but not limited to an appliance, or modification of one, where an impression was made before coverage; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before coverage; root canal therapy if the pulp chamber was opened before coverage.
6. Services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
7. Tests, examinations, diagnostic casts and oral cancer screenings other than those listed as a covered service.
8. Sedative fillings, prescribed drugs, pre medication or analgesia.
9. The initial installation of a prosthetic device (a fixed bridge, implant, or denture, crowns, inlays and abutments) to replace teeth missing before coverage under the policy, except when the installation also replaces a tooth extracted while covered and commences after continuous coverage for at least three (3) years immediately prior to the date installation begins.
10. Expenses incurred for veneers and related procedures.
11. Replacement of a lost or stolen or discarded prosthetic device.
12. Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan.
13. Core buildup will only be considered in conjunction with a crown.
14. Pulp capping with final restoration. Final restoration is defined as the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations.
15. If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure.
16. X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits.
17. The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions.
18. Gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting.
19. Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits.
20. Orthodontic treatment and orthodontia type procedures unless such procedures are a covered expense.
21. Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.
22. Congenital or developmental malformations.
23. "Safe fees" (gloves, masks, surgical scrubs and sterilization).
24. Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments or night guards or any other appliances for the correction of harmful habits.
25. Chemotherapeutic agents and any other experimental procedures.
26. Charges in excess of the cost-sharing amounts as shown on the schedule of benefits.
27. Expenses that are applied toward satisfaction of a deductible, if any.
28. Treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, lawful spouse, domestic partner, child, child of domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law.
29. Services for which the member would not legally have to be paid if there were no insurance.
30. Services not completed on or before the date of termination.
31. If care is transferred from one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, payment will only be for the amount that would have been charged had one dentist rendered the services.
32. Any service or procedure not within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association (ADA).
33. Treatments which are experimental or investigational.
34. Services and supplies not listed as a covered service.
35. Services and supplies performed outside of the US.
36. Services covered on a pediatric only dental plan.