

BEST One

Dental Basic 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
Annual Maximum	\$1,000	
Annual Deductible Applies to intermediate and major services.	You pay the first \$50 for an individual, \$150 per family.	
Basic Services Exams, cleanings, x-rays	You pay 0%	You pay 30%
Intermediate Services Fillings, anterior and posterior composites, emergency palliative treatment, pathology	You pay 50% After 6 month waiting period.	You pay 70% After 6 month waiting period.
Major Services 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 70% After 12 month waiting period.	Not covered.

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

Pediatric	In-Network	Out-of-Network
Out-of-Pocket Maximum	\$350 for 1 child \$700 for 2 or more children	\$700 for 1 child \$1,400 for 2 or more children
Annual Deductible Applies to basic services received out-of-network and intermediate and major services received in or out-of-network.	You pay the first \$75 per child	You pay the first \$100 per child
Basic Services Exams, cleanings, sealants, fluoride treatment, x-rays, space maintainers, emergency palliative treatment	You pay 0%	You pay 30%
Intermediate Services Minor restorative services, fillings, pulpal treatment, periodontal maintenance, denture adjustment and repair, surgical extractions, anesthesia (general or IV sedation)	You pay 30%	You pay 60%
Major Services Major restorative services, crowns and casts, prosthodontics, implants, endodontics, periodontics, occlusal guard	You pay 50%	You pay 80%
Orthodontic Services <i>(Medically necessary)</i> 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%	



BEST One
Dental Basic Plan **SILVER**

BEST Life has been providing great dental benefits for more than 45 years with quality plans, affordable rates and superior customer service.



17701 Mitchell North
Irvine, CA. 92614-6028
p 800.433.0088
www.bestlife.com

© 2021 BEST Life and Health Insurance Company

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 442,000 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. 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. Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
2. Services and treatment which are experimental or investigational.
3. Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
4. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
5. Services and treatment performed prior to your effective date of coverage.
6. Services and treatment incurred after the termination date of your coverage unless otherwise indicated.
7. Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
8. Services and treatment resulting from your failure to comply with professionally prescribed treatment.
9. Telephone consultations.
10. Any charges for failure to keep a scheduled appointment.
11. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
12. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ).
13. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
14. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
15. Office infection control charges.
16. Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays.
17. State or territorial taxes on dental services performed.
18. Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.
19. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
20. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
21. Those which are for specialized procedures and techniques.
22. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
23. Duplicate, provisional and temporary devices, appliances, and services.
24. Plaque control programs, oral hygiene instruction, and dietary instructions; Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
25. Gold foil restorations.
26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
27. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
28. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
29. Charges by the provider for completing dental forms.
30. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
31. Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners.
32. Sealants for teeth other than permanent molars.
33. Precision attachments, personalization, precious metal bases and other specialized techniques.
34. Replacement of dentures that have been lost, stolen or misplaced.
35. Repair of damaged orthodontic appliances.
36. Replacement of lost or missing appliances.
37. Fabrication of athletic mouth guard.
38. Internal bleaching.
39. Nitrous oxide.
40. Oral sedation.
41. Topical medicament center.
42. Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants.
43. When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service).
44. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), coverage will only be for the service that represents the final treatment.
45. Charges in excess of any cost-sharing amounts shown on the schedule of benefits.
46. Expenses incurred for services and supplies not listed as a covered service.
47. Services and supplies performed outside of the U.S.

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 Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
5. Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
6. Dental 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. Pulp capping with final restoration. Final restoration is defined as the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations;
8. Charges for tests, examinations, diagnostic casts and oral cancer screenings other than those listed as a Covered Service;
9. Expenses incurred for sedative fillings, prescribed drugs, pre medication or analgesia;
10. The initial installation of a prosthetic device (a fixed bridge, implant, or denture, crowns, inlays and abutments) to replace teeth missing before the Insured was covered under the Policy, except when the installation also replaces a tooth extracted while covered under this plan and commences after the Insured has remained continuously covered under this plan for at least three (3) years immediately prior to the date such installation begins;
11. [Implants, implant services and implant supported prosthetics;]
12. Expenses incurred for veneers and related procedures;
13. Replacement of a lost or stolen or discarded prosthetic device;
14. 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;
15. Expenses incurred for a core buildup will only be considered in conjunction with a crown;
16. 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;
17. X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
18. The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
19. Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
20. Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
21. Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
22. 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;
23. Charges for service provided for temporomandibular joint dysfunction (TMJ);
24. Expenses incurred for congenital or developmental malformations;
25. Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
26. 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;
27. Chemotherapeutic agents and any other experimental procedures;
28. Charges in excess of the cost-sharing amounts shown on the Schedule of Benefits;
29. Expenses that are applied toward satisfaction of a Deductible, if any;
30. Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
31. Expenses for services for which You would not legally have to pay if there were no insurance;
32. Services not completed on or before the date of termination;
33. If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
34. 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;
35. Expenses incurred for treatment which are experimental or investigational;
36. Expenses incurred for services and supplies not listed as a Covered Service;
37. Services and supplies performed outside of the United States of America.
38. Expenses incurred for services covered on a pediatric only dental plan.