BEST Life™
BEST Life and Health Insurance Company

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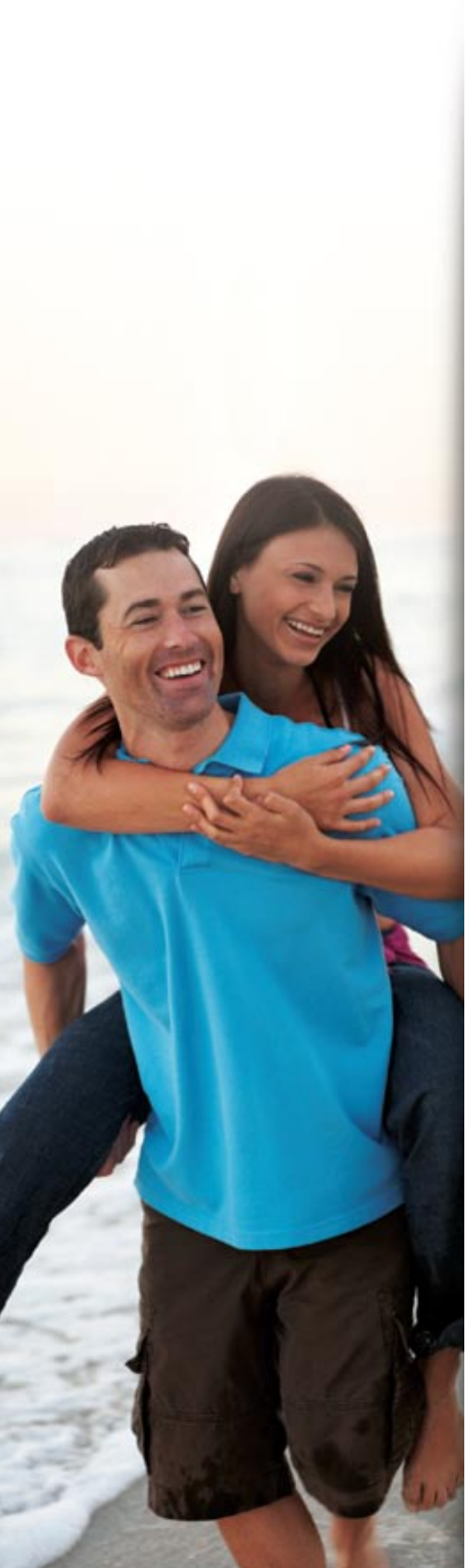
Kentucky's Healthcare Connection



BESTOne

Dental Plus Plan GOLD

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 21 and older.

Adult	In-Network	Out-of-Network
Annual Maximum	$1,500	
Annual Deductible Applies to basic and major services in or out-of-network	Annual deductible of $50 for an individual, $150 per family.	
Diagnostic & Preventive Services Exams, cleanings, x-rays	You pay 0%	You pay 20%
Basic Services Fillings, anterior and posterior composites, emergency palliative treatment, pathology	You pay 30%	You pay 50%
Major Services Crowns and gold fillings, inlays, onlays and pontics, implants, fixed bridges, complete and partial dentures, oral surgery, anesthesia (general or IV sedation), endodontics, periodontics	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 21.

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 diagnostic and preventive services received out-of-network and basic and major services received in or out-of-network.	You pay the first $75 per child	
Diagnostic & Preventive Services Exams, cleanings, sealants, x-rays, space maintainers, palliative treatment	You pay 0%	You pay 20%
Basic Services Fillings	You pay 30%	You pay 40%
Major Services Prefabricated crowns, prosthodontics, maxillofacial prosthodontics, hospital call, oral surgery, IV sedation, periodontics, endodontics	You pay 50%	You pay 70%
Orthodontic Services *(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%	You pay 70%

This document provides a summary of the plan benefits only. For the official plan details and exclusions and limitations, please refer to the plan policy. Plans not available in all areas.

Kentucky

BESTOne GOLD
Dental Plus Plan

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

More Choice. More Savings.

What dentist you see is completely up to you. But you can see additional savings when you see a dentist within network. With BEST Life, members not only have access to their primary network, DenteMax, but they also gain additional access to a secondary, or "wrap-around" network, Connection Dental®. This provides more than 282,000 dental locations nationally with the largest regional and national networks in 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 networks 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 denturist.
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 started and not completed before coverage under this plan.
6. Services not completed on or before the date of termination.
7. Any service or procedure not within the scope of practice by a licensed dentist.
8. Expenses incurred from failure to comply with a professionally prescribed treatment.
9. Expenses incurred for telephone consultations.
10. Charges for failure to keep a scheduled appointment.
11. 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.
12. Periodontal maintenance.
13. Crowns, unless such supplies are defined as a covered expense.
14. Charges in excess of any cost-sharing amounts shown on the schedule of benefits.
15. Orthodontic treatment and orthodontia type procedures unless such procedures are defined as a covered expense.
16. Service provided for temporomandibular joint dysfunction (TMJ), unless such procedures are defined as a covered expense.
17. Congenital or developmental malformations, except as defined as a covered orthodontic expense.
18. Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a covered orthodontic expense.
19. "Safe fees" (gloves, masks, surgical scrubs and sterilization).
20. Charges for copies of records, charts, x-rays and any other costs associated with the forwarding or mailing of these copies, or for completing dental forms.
21. State or territorial taxes associated with dental services performed.
22. 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.
23. Services for which the member would not legally have to pay if there were no insurance, unless mandated by the state.
24. Services or supplies for specialized procedures and techniques, including precision attachments, personalization, and precious metal bases.
25. Duplicate or provisional services or supplies.
26. Plaque control programs, oral hygiene instruction, and dietary instructions.
27. Hospital costs, including charges for treatment at the hospital.
28. Adjustment of a denture or bridgework made within six (6) months after installation, by the same provider who installed it.
29. Home health aides, including toothpaste, fluoride gels, dental floss and teeth whiteners.
30. Replacement of lost, stolen or misplaced dentures.
31. Repair or replacement of damaged lost or missing appliances.
32. Treatments which are experimental or investigational.
33. Veneers and related procedures.
34. Treatment rendered by a family member. For the purpose of this limitation, "family member" includes lawful spouse, domestic partner, child, child of domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law.
35. Expenses that are applied toward satisfaction of a deductible, if any.
36. Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits.
37. Services and supplies not listed as a covered service.
38. 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 denturist.
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 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, except when the installation also replaces a tooth extracted while covered under this plan and commences after continuous coverage for at least three years immediately prior to the date such installation begins.
10. 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 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 year, only one (1) procedure will be allowed.
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 extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.
22. Service provided for temporomandibular joint dysfunction (TMJ).
23. Congenital or developmental malformations.
24. "Safe fees" (gloves, masks, surgical scrubs and sterilization).
25. 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.
26. Chemotherapeutic agents and any other experimental procedures.
27. Charges in excess of any cost-sharing amount shown on the schedule of benefits.
28. Expenses that are applied toward satisfaction of a deductible, if any.
29. Services and supplies performed outside of the US.
30. Services for which the member would not legally have to pay if there were no insurance.
31. Services not completed on or before the date of termination.
32. If care if 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.
33. 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).
34. Treatments which are experimental or investigational.
35. Services and supplies not listed as a covered service.
36. Treatment rendered by a family member. For the purpose of this limitation, "family member" includes Your lawful spouse, domestic partner, child, child of domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law.
37. Services covered on a pediatric only dental plan.