BEST Life™
BEST Life and Health Insurance Company

NEVADA

BEST Life Essential Basic
Adult Dental Plan

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 Benefit	In-Network	Out-of-Network
Annual Maximum	$1,000	
Annual Deductible Applies to Basic and Major Services (3 per family)	You pay the first $50 for individual, up to $150 for family.	You pay the first $75 for individual, up to $225 for family.
Diagnostic & Preventive Services Exams, cleanings, x-rays	You pay 0%	You pay 30%
Basic Services Fillings (amalgam, porcelain & plastic), anterior & 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 & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures, oral surgery, anesthesia (general or IV sedation), endodontics, periodontics	You pay 100%	You pay 100%
Dental Accident Benefit	Plan pays up to $100	
Vision Discount Plan**	Included	

New Benefits This Year!

BEST Life has been providing great dental benefits for ***over 50 years*** *with* **quality plans, affordable rates** *and* **superior personal customer service!**

PO Box 19721
Irvine, CA 92623

(877) 205-8767
www.bestlife.com

* U.S. Surgeon General Report on Oral Health 2000

** The Vision discount plan is not insurance, but a discount plan for supplies and eligible services

Rev1 7-23-24

NEVADA

BEST Life Essential Basic Child Dental Plan

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

Pediatric Benefit	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, Basic and Major services received in-network or out-of-network	You pay the first **$75** per child	You pay the first **$100** per child
Diagnostic & Preventive Services Exams, cleanings, sealants, fluoride treatment, x-rays, space maintainers, emergency palliative treatment	You pay **0%**	You pay **20%**
Basic Services Fillings	You pay **40%**	You pay **70%**
Major Services Crowns, prosthodontics, endodontics, periodontics, maxillofacial prosthetics, oral surgery, TMJ treatment, anesthesia, IV sedation, nitrous oxide, analgesia, occlusal guard	You pay **50%**	You pay **70%**
Orthodontics (medically necessary)	You pay **50%**	You pay **70%**

MORE CHOICE. MORE SAVINGS.

What dentist you see is completely up to you. However, you can achieve additional savings when you see a dentist within network.

As a BEST Life member, you will have access to the some of the largest national networks available and with rigorous credentialing criteria for providers, you're assured the highest-quality network available.

It's easy to find the best dentists in your area with our Provider Look-Up at: **www.bestlife.com.**

When you choose BEST Life, you can rest easy.
Your smiles are safe with us.

BEST Life™
BEST Life and Health Insurance Company

eyeMed

EyeMed Discount
Plan Details
(Plan #9242264)

As a BEST Life customer, you and your dependents receive access to value-added discount programs that can help provide cost savings on vision care, eyewear, and more. These programs are automatically available to all members that are not currently enrolled on a fully-insured vision plan with BEST Life.

Vision Care Services	In-Network	Out-of-Network
Exam Services	**$50**	Not covered
Contact Lens Fit and Follow-Up		
• Fit and Follow-up - Standard	Up to **$10** off retail price	Not covered
• Fit and Follow-up - Premium	**100%** of retail price	Not covered
Frame	**40%** off retail price	Not covered
Lenses		
• Single Vision	**$55**	Not covered
• Bifocal	**$75**	Not covered
• Trifocal	**$85**	Not covered
• Lenticular	**$85**	Not covered
• Progressive - Standard	**$140**	Not covered
• Progressive - Premium	**30%** off retail price	Not covered
Lens Options		
• Anti Reflective Coating - Standard	**$40**	Not covered
• Anti Reflective Coating - Premium	**30%** off retail price	Not covered
• Polycarbonate - Standard	**$35**	Not covered
• Scratch Coating - Standard Plastic	**$0**	Not covered
• Tint - Solid and Gradient	**$12**	Not covered
• UV Treatment	**$12**	Not covered
• All Other Lens Options	**30%** off retail price	Not covered
Contact Lenses		
• Contacts - Conventional	**15%** off retail price	Not covered
• Contacts - Disposable	**100%** of retail price	Not covered

To access these vision plan discounts, members will need **a copy of the discount ID card below** and **locate an EyeMed Advantage network provider** from our website at https://eyedoclocator.eyemedvisioncare.com/bestlife/en.

For any other questions, please call **(866) 723-0514**.

BEST Life™
BEST Life and Health Insurance Company

eyeMed

Member Name:
Plan #: **9242264**
Network: **EyeMed Advantage Network**

EyeMed Vision Care® Discount Plan
Discounts on eye exams, eyewear and eye correction surgery.
To locate a provider, use our Provider Lookup at **www.bestlife.com** or call **866.723.0514**.

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

This Policy excludes and will not reimburse for the following services or charges.

1. Services provided by anyone other than a doctor of medical dentistry or a doctor of dental surgery, unless a licensed hygienist performs the services under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist.
2. Services received while on active duty with a military service of any country or international organization.
3. Services needed because of participation in a riot or insurrection or the commission of a felony.
4. Services needed as a result of a work related injury or illness, whether or not covered under Worker's Compensation;
5. Services provided by an employer.
6. Services started before Your effective date. Examples of excluded services under this paragraph include but are not limited to the following: obtaining an impression for an appliance, or a modification of one, before Your effective date; preparing a tooth for a crown, bridge or other lab fabricated restorations before Your effective date; opening a pulp chamber for root canal therapy before Your effective date.
7. Services not completed before Your termination date.
8. Services required because You failed to comply with professionally prescribed treatment.
9. Telephone consultation services.
10. Charges for Your failure to keep a scheduled appointment.
11. Services that are primarily for cosmetic reasons. Examples include alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
12. Services for orthodontic treatment and orthodontia type procedures unless this Policy defines those services as Covered Services.
13. Charges in excess of the agreed to coverage amounts, as shown on the Schedule of Benefits.
14. Services 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 Dental Expense.
15. Charges for "safe fees" (e.g., gloves, masks, surgical scrubs and sterilization).
16. 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.
17. Charges for state or territorial taxes associated with dental services.
18. Charges for services received from two or more providers for a single procedure or course of care, if those charges would have been less if received from one provider and You made the decision to transfer Your care during the procedure or course of care.
19. Services that are experimental or investigational.
20. Service that are not within the scope of the treating provider's practice.
21. Services that are not Medically Necessary or that would not meet generally accepted standards of practice.
22. Charges that You would not legally have to pay if You did not have insurance, unless mandated by law.
23. Services for specialized procedures and techniques, including precision attachments, personalization, and precious metal bases.
24. Charges for duplicate or provisional services or supplies.
25. Charges for plaque control programs, oral hygiene instruction, and dietary instructions.
26. Charges for gold foil restorations.
27. Charges for treatment at the hospital.
28. Service to adjust a denture or bridgework within six (6) months after it is installed or adjusted, by the same Provider who installed or adjusted it.
29. Charges for home health aides, including but not limited to toothpaste, fluoride gels, dental floss and teeth whiteners.
30. Services to seal teeth, other than permanent molars.
31. Charges to replace lost, stolen or misplaced dentures.
32. Charges to repair or replace damaged, lost or missing appliances.
33. Services to fabricate an athletic mouth guard;
34. Charges for internal bleaching, nitrous oxide, oral sedation, and/or topical medicament centers.
35. Charges for bone grafts in connection with extractions, apicoectomies or non-covered or non-eligible implants.
36. Services received from a family member. "Family member" includes, but is not limited to, a lawful spouse, domestic partner, child, child of a domestic partner, parent, step-parent, grandparent, brother, sister, cousin of the first degree, or in-law.
37. Charges for a Deductible, Coinsurance, or other cost sharing amount for which You are responsible.
38. Temporary services that are considered an integral part of a final services rather than a separate service.
39. Charges for veneers and related procedures.
40. Services not listed as a Covered Service.
41. Services received outside of the United States of America.

EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

This Policy excludes and will not reimburse for the following services or charges.

1. Services provided by anyone other than a doctor of medical dentistry or a doctor of dental surgery, unless a licensed hygienist performs the services under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist.
2. Services received while on active duty with a military service of any country or international organization.
3. Services needed because of participation in a riot or insurrection or the commission of a felony.
4. Services needed as a result of a work related injury or illness, whether or not covered under Worker's Compensation;
5. Services provided by an employer.
6. Services started before Your effective date. Examples of excluded services under this paragraph include but are not limited to the following: obtaining an impression for an appliance, or a modification of one, before Your effective date; preparing a tooth for a crown, bridge or other lab fabricated restorations before Your effective date; opening a pulp chamber for root canal therapy before Your effective date.
7. Services not completed before Your termination date.
8. Services required because You failed to comply with professionally prescribed treatment.
9. Telephone consultation services.
10. Charges for Your failure to keep a scheduled appointment.
11. Services that are primarily for cosmetic reasons. Examples include alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
12. Services for orthodontic treatment and orthodontia type procedures unless this Policy defines those services as Covered Services.
13. Charges in excess of the agreed to coverage amounts, as shown on the Schedule of Benefits.
14. Services 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 Dental Expense.
15. Charges for "safe fees" (e.g., gloves, masks, surgical scrubs and sterilization).
16. 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.
17. Charges for state or territorial taxes associated with dental services.
18. Charges for services received from two or more providers for a single procedure or course of care, if those charges would have been less if received from one provider and You made the decision to transfer Your care during the procedure or course of care.
19. Services that are experimental or investigational.
20. Service that are not within the scope of the treating provider's practice.
21. Services that are not Medically Necessary or that would not meet generally accepted standards of practice.
22. Charges that You would not legally have to pay if You did not have insurance, unless mandated by law.
23. Services for specialized procedures and techniques, including precision attachments, personalization, and precious metal bases.
24. Charges for duplicate or provisional services or supplies.
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30. Services to seal teeth, other than permanent molars.
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32. Charges to repair or replace damaged, lost or missing appliances.
33. Services to fabricate an athletic mouth guard;
34. Charges for internal bleaching, nitrous oxide, oral sedation, and/or topical medicament centers.
35. Charges for bone grafts in connection with extractions, apicoectomies or non-covered or non-eligible implants.
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37. Charges for a Deductible, Coinsurance, or other cost sharing amount for which You are responsible.
38. Temporary services that are considered an integral part of a final services rather than a separate service.
39. Charges for veneers and related procedures.
40. Services not listed as a Covered Service.
41. Services received outside of the United States of America.

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