



BEST HEALTH PLANS



Advantage Plus In-Network Only Dental Plans

Group Sizes 2 or more

Plan is underwritten by UnitedHealthcare Insurance Company.
Marketed and Distributed by BEST Health Plans, LLC.

Bringing Value with Affordable Dental Care

Dental plans are the second benefit most asked for by employees. With BEST Health Plans Advantage Plus dental plans, employer groups as small as 2 employees enrolling can now offer these valuable benefits to their organizations.

Voluntary Dental Plans

All of the Advantage Plus dental plans are offered on a voluntary basis and provide a low-cost option for employers. Voluntary rates are available for groups with a minimum of 5 employees enrolling and 20% participation. Employers may contribute less than 50% of the employee's single rate to qualify for a voluntary plan.



Advantage Plus In-Network Only Dental Plans



Advantage Plus In-Network Only Dental Plans



Offer your clients the advantage of affordability with an In-Network Only dental plan. Individuals and families enrolled on the Advantage Plus plans receive quality care without the hassle of provider pre-selection at enrollment or a referral process for specialty care.

With Advantage Plus In-Network Only Dental there are:

- ✔ No preauthorized referrals for specialty care
- ✔ No claim forms required for in-network services
- ✔ No waiting periods
- ✔ Over 109,000 dental network locations nationally
- ✔ Deductibles, Calendar Year Maximums and Coinsurance
- ✔ Carryover Calendar Year Maximums (through MAXimizer plan feature)
- ✔ Orthodontic options available

The BEST Health Plans Network

Members on the Advantage Plus Dental Plans can select any primary care dentist from our national PPO network, and each family member may choose a different primary care dentist. Because no pre-selection is required at enrollment, members can change dentists without having to call Member Services.

My Dental Health Web Portal

The Advantage Plus In-Network Only Dental Plans provide members an online portal where they can logon for:

- **Dentist Locator** enables members to find general dentists and specialists close to their home or office, including maps and printable driving directions to the dentist's office. Members can also Nominate a Dentist to join the PPO network.
- **Plan Information** for verifying eligibility for family members, request ID cards and review benefit plan summaries which detail the amount the plan pays for procedures. The treatment cost calculator allows for members to determine their out of pocket costs prior to seeing a dentist. A Frequently Asked Questions provides answers to commonly asked questions about the dental plan, including Member Service and Claims information.
- **Claims Information** provides details on submitted claims including date of service, procedure code, description of services, patient responsibility, amount paid and more. Customers can also download a Claim Form.
- **The Dental Education** section offers little-known facts about the dental industry, dental articles, brushing and flossing techniques, an A-Z guide of frequently used dental words, and more.



Advantage Plus In-Network Only Dental Plan Overview

Benefits	D8372 & D8373*	D8374 & D8375*	D8376 & D8377*	D8378 & D8379*	D8380 & D8381*	D8382 & D8383*	D8368 & D8369*	D8370 & D8371*
Calendar Year Maximum:	\$1,000	\$1,000	\$1,500	\$1,500	\$1,000	\$1,000	\$1,500	\$1,500
Calendar Year Deductible:	\$50 per person \$150 per family Applies to Basic and Major Services							
Preventive & Diagnostic Services Routine oral exam, cleanings, fluoride treatment for children, X-rays, sealants, oral cancer screening (if ortho is elected)	100%	100%	100%	100%	100%	100%	100%	100%
Basic Services Fillings (amalgam, porcelain & plastic), general anesthesia, emergency palliative treatment, space maintainers for children, pathology, endodontics, periodontics, and oral surgery	80%	80%	80%	80%	50%	50%	50%	50%
Major Services Crowns & gold fillings, inlays, onlays and pontics, fixed bridges, complete and partial dentures	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontia	Incl.	Not Incl.	Incl.	Not Incl.	Incl.	Not Incl.	Incl.	Not Incl.
Waiting Periods	None							
MAXimizer (CYM Carryover)	Included							
Child & Adult Orthodontics Benefits	50%							
Maximum Lifetime	\$1,000 Lifetime Maximum available to eligible children up to age 19 and adults							

* These plans are offered on a voluntary basis

Specialty Care

When a member requires treatment by a dental specialist, members may self-refer to any participating dental specialist (Oral Surgeon, Endodontist, Orthodontist, Periodontist, Prosthodontist or Pedodontist).

The following is a summarized list of exclusions and limitations. For a complete list, please refer to the plan's Summary of Benefits.

Limitations

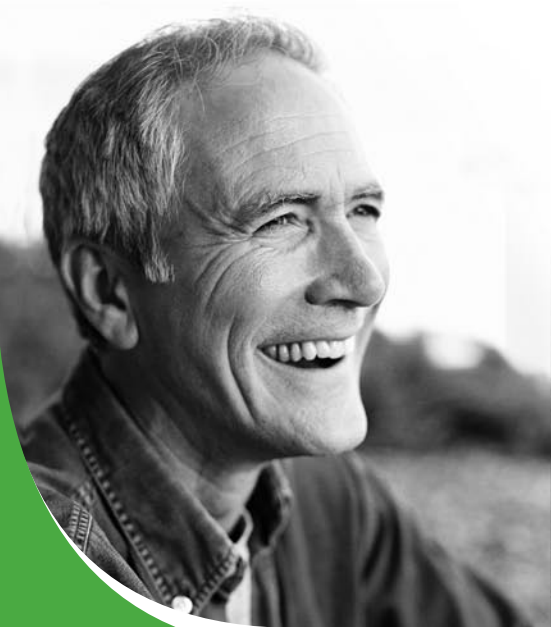
- 1. PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
- 2. COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.
- 3. BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
- 4. EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
- 5. DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.
- 6. FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
- 7. SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8. SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9. RESTORATIONS** Multiple restorations on one surface will be treated as a single filling.
- 10. PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11. INLAYS AND ONLAYS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 12. CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 13. POST AND CORES** Covered only for teeth that have had root canal therapy.
- 14. SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15. SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.
- 16. PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
- 17. FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 18. PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19. RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
- 20. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- 21. PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 22. OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.
- 23. FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.
- 24. GENERAL ANESTHESIA** Covered only where clinically necessary.
- 25. OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.
- 26. PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area.
- 27. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

Exclusions

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage (if a covered benefit under the plan) does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

This brochure is for marketing purposes only and provides a summary of the plan's benefits. For the official plan details, please refer to the plan's Schedule of Benefits and Evidence of Coverage, which is available upon request. The accuracy of this summary is not guaranteed and is subject to change without notice.



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