

Horizon Dental PPO \$50/\$1000 (100/80/50) D2643

A six-month waiting period applies to major services. Annual maximum benefit is \$1000.

	In-Network Coverage	Out-of-Network Coverage
Network	Horizon Dental PPO, National GRID	—
Deductible Does not apply to in-network preventive/diagnostics services		
Individual	\$50	\$50
Family	\$150	\$150
Orthodontia	Not covered	Not covered
Class I: Preventive & Diagnostic		
Adult prophylaxis	100%	100%
Fluoride treatment	100%	100%
Periodic oral exam	100%	100%
Sealants application	100%	100%
X-rays	100%	100%
Class II: Basic		
Space maintainers	80%	80%
Oral surgery	80%	80%
Impacted teeth	80%	80%
Simple extractions	80%	80%
Surgical extractions	80%	80%
Anthesthesia	80%	80%
Amalgam Restorations	80%	80%
Composite Restorations	80%	80%
Gingivectomy	80%, once every 3 years	80%, once every 3 years
Osseous Surgery	80%, once every 2 years	80%, once every 2 years
Periodontal Maintenance	80%, once every 6 months	80%, once every 6 months
Root Canal Therapy: anterior and bicuspid	80%	80%
Root Canal Therapy: molar	80%	80%
Scaling & Root Planing	80%, once every 12 months	80%, once every 12 months
Class III: Major		
Bridges	50%, once every 5 years	50%, once every 5 years
Dentures	50%, once every 5 years	50%, once every 5 years
Adjustments	50%	50%
Inlays/Onlays/Crowns	50%, once every 5 years	50%, once every 5 years

Effective date varies based on contract.

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Spanish (Español): Para recibir ayuda en español, llame al **1-800-4DENTAL (433-6825)**.

Chinese: 如需中文協助，請致電 **1-800-4DENTAL (433-6825)**。

