## Summary of Benefits: Horizon Dental PPO $25/$1500 100/80/50 with waiting period D580

A six-month waiting period applies to major services. Annual maximum benefit is $1500.

<table>
<thead>
<tr>
<th>Network</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Horizon Dental PPO &amp; National GRID</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Deductible:**

Does not apply to in-network preventive/diagnostics services.

- **Individual:**
  - Deductible: $25
  - Benefits: $25 (100%)
  - Benefits: $25 (100%)

- **Family:**
  - Deductible: $75
  - Benefits: $75 (100%)
  - Benefits: $75 (100%)

**Orthodontia**:

- Not covered
  - Not covered

**Class I: Preventive & Diagnostic**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult prophylaxis</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride treatment</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants application</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>X-rays</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Class II: Basic**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space maintainers</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Impacted Teeth</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Simple extractions</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Surgical extractions</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Amalgam Restorations</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Composite Restorations</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Gingivectomy</td>
<td>80%, once every 3 years</td>
<td>80%, once every 3 years</td>
</tr>
<tr>
<td>Osseous Surgery</td>
<td>80%, once every 2 years</td>
<td>80%, once every 2 years</td>
</tr>
<tr>
<td>Periodontal Maintenance</td>
<td>80%, once every 6 months</td>
<td>80%, once every 6 months</td>
</tr>
<tr>
<td>Root Canal Therapy: anterior and bicuspid</td>
<td>80%, once every year</td>
<td>80%, once every year</td>
</tr>
<tr>
<td>Root Canal Therapy: molar</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Scaling &amp; Root Planing</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Class III: Major**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridges</td>
<td>50%, once every 5 years</td>
<td>50%, once every 5 years</td>
</tr>
<tr>
<td>Dentures</td>
<td>50%, once every 5 years</td>
<td>50%, once every 5 years</td>
</tr>
<tr>
<td>Adjustments</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns</td>
<td>50%, once every 5 years</td>
<td>50%, once every 5 years</td>
</tr>
</tbody>
</table>

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)**。