

2025

Horizon Dental Expense Plan (DEP)

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Horizon Dental Expense Plan (DEP)| Active Members

5XaX gCXebW	Calendar Year	Calendar Year
Network	Horizon Dental Option	Horizon Dental Option
Deductible	In-Network	Out-of-Network
Individual	\$50	\$75
Family	\$100	\$150
Deductible Applies To	Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays	Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays
\$ G P G , V 2 G T K Q F / C Z K O W O	\$3,000 (per person)	\$2,000 (per person; maximum of \$3,000 E Q O D K P G F + P 1 W V Q H 0 G V Y Q T M
\$ G P G , V 2 G T K Q F / C Z K O W O # R R N K G	Preventive/Diagnostic, Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays	Preventive/Diagnostic, Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays
Orthodontics Eligibility (FT employee for at least 10 months)	Child (To age 19)	Child (To age 19)
Orthodontics	50%	40%
Orthodontics Maximum	\$1,000 (Lifetime Maximum; Not subject to deductible; Maximum not combined with Annual Max)	\$750 (Lifetime Maximum; Maximum of \$1000 combined In/ 1 W V Q H P G V Y Q T M 0 Q V U W D L G E V V Q F G F W E V combined with Annual Max)
Preventative/Diagnostic Services		
Exam (2x per cal yr)	100%	90%
Cleanings (Oral Prophylaxis - 2x per cal yr)	100%	90%
Fluoride Treatment (to age 19; 2x cal yr)	100%	90%
Sealant Application (to age 19; limited once per lifetime for permanent molars)	100%	90%
X-rays (Bitewing & Full Mouth)- Horizontal bitewings NKOKVGF VQ VYQ UGTKGU QH WR VQ H Q W T , N O U K P C E C N [T X G T V K E C N DKVGYKPIU NKOKVGF VQ VYQ UGTKGU QH WR VQ , N O U R G T E C N [T set of full mouth/panoramic limited to once per 36 month K P V G T X C N U 0 Q O Q T G V J C P , N O U R G T U G V Q H H W N N O Q W V J periapical Xrays.	100%	90%
Space Maintainers	80%	70%
Treatment and Therapy		
Amalgam Restorations	80%	70%
Composite Restorations	80%	70%
Simple Extractions	80%	70%
Endodontics		
Root Canal Therapy – Anterior & Bicuspid	80%	70%
Root Canal Therapy – Molar	80%	70%
Periodontics		
Scaling & Root Planing (limited to one procedure per 12 month interval)	50%	40%
Gingivectomy (1 per 36 months)	50%	40%
Periodontal Maintenance (limited to one surgical type procedure every 36 months)	50%	40%
Osseous Surgery (1 per 36 months)	50%	40%
Surgical Extractions	80%	70%
Partial Bony Extractions	80%	70%
Prosthodontics (5 year frequency limitation)		
\$ T K F I G Y Q T M	50%	40%
Full & Partial Dentures	50%	40%
Denture Adjustments	50%	40%
Denture Repairs	80%	70%
Crowns and Onlays		
Crown – porcelain fused to high noble metal (covered only after a 5 yr period measured from the date on which the crown was previously placed)	65%	55%
Eligibility	Dependent children of enrolled employees are covered to age 26.	

This is a brief description of covered services. Consult your Employee Dental Plans Member Handbook for detailed plan descriptions and limitations.

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.

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