HASTINGS TEACHERS ASSOCIATION BENEFIT FUND
HASTINGS TEACHERS PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	• All employees who are eligible for benefits according to the provisions of the Rules of Eligibility of the Hastings Teachers Association Benefit Fund • **Eligible dependents** include the lawful spouse and each unmarried child who has not attained his 19th birthday, or 26th birthday if attending an accredited school or college on a full time basis, or unmarried child who was mentally retarded before the age of 19, and is dependent on parents for support.
PLAN YEAR	• September 1 st through August 31 st
PLAN MAXIMUM	• **First year member -** $2,000 individual and/or family maximum • **Family Coverage -** $2,000 per person not to exceed $3,500 per family • **Individual Coverage -** $2,000 year maximum, after first year of coverage
DEDUCTIBLE	• $100 per covered individual with a $200 family maximum in a plan year. The deductible is waived on preventive and diagnostic services.
PLAN LIMITATIONS	• **Examination** – two in plan year • **Prophylaxis** – two in a plan year • **X-rays** – **panoramic or full mouth series –** one in thirty six months • **Replacement of crowns, bridge, dentures** – not more than once in five years • **Palliative treatment** – no other treatment rendered that same visit • **Fluoride treatment** – one per twelve months • **Sealant –** 2 applications per lifetime of the tooth, to age 16 • **Root Scaling, curettage, bite correction; any combination, including prophylaxis** – maximum $436 per member, per plan year, not included in deductible • **Orthodontic treatment – one year waiting period for Orthodontic services – Orthodontic Services are not included in the annual maximum -** Fixed appliance, 24 months of active treatment, 8 months of passive treatment • **Osseous surgery, grafts or localized delivery of chemotherapeutic agent –** maximum per quadrant once in 36 months • **Limited Implant coverage –** maximum one per calendar year, two per lifetime per jaw; the allowance for an implant is intended to reduce the patients out of pocket expense and you are not required to accept the allowance as payment in full.
PRE-TREATMENT REVIEW	• This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. **Please note-** a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible • Pre-op periapical x-rays required for crowns, veneers, inlays and extractions • Periodontal charting and x-rays are required for surgical periodontal procedures • Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework
PERMISSIBLE CHARGES	• **20% co-payment applies to spouse and children only** • **Covered and reimbursable services, no co-payment:** None • **Covered and reimbursable services, with co-payment –** only established co-payments • **Covered but not reimbursable services:** Schedule allowance • **Non-covered services:** Your usual charge for that service
COORDINATION OF BENEFITS	• If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate charges for co-payments, plan maximums or frequency limitations.
HOW TO FILE A CLAIM	• **As a participating provider, you must complete all necessary paper work and accept assignment of benefits.** • Complete a Claim Form **(computer generated, ADA, and universal claim forms are accepted)** and provide an itemized bill of services rendered. **Signature on file is accepted.** • Enclose, when appropriate, x-rays, tooth charting, periodontal charting Mail claims to Self-Insured Dental Services, Dept. 029 P.O Box 9005 Lynbrook, NY 11563-9005 516-396-5500 For claims electronically: **PAYOR ID CX076**

If you have any questions regarding the operation of this program please contact S.I.D.S. at:
(516) 396-5500 or (718) 204-7172

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HASTINGS TEACHERS ASSOCIATION
SCHEDULE OF MAXIMUM CHARGES

I-DIAGNOSTIC	
ORAL EXAM	64.00
PERIAPICAL X-RAY (1st FILM)	20.00
PERIAPICAL X-RAY-each additional	14.00
FULL MOUTH X-RAY	152.00
BITEWING-(1st FILM)	20.00
BITEWING-each additional	14.00
TMJ FILM	113.00
CEPHALOMETRIC FILM	134.00
PANORAMIC FILM	134.00
DIAGNOSTIC CASTS	73.00
II-PREVENTIVE	
PROPHYLAXIS-ADULT	113.00
PROPHYLAXIS-CHILD(to age 14)	60.00
SEALANT	55.00
SPACE MAINTAINER	272.00
RECEMENT SPACE MAINTAINER	31.00
FLUORIDE EXCL. PROPHY	70.00
III-RESTORATIVE	
AMALGAM - 1 SRF	120.00
AMALGAM - 2 SRF	144.00
AMALGAM - 3 SRF	160.00
RESIN-1 SURFACE	144.00
RESIN-2 SURFACE	168.00
RESIN-3 SURFACE OR INCISAL ANGLE	184.00
METALLIC INLAY-1 SRF	398.00
METALLIC INLAY-2 SRF	496.00
METALLIC INLAY-3 SRF	590.00
PORCELAIN INLAY-1 SRF	391.00
PORCELAIN INLAY-2 SRF	496.00
PORCELAIN INLAY-3 SRF	598.00
CROWN-PORCELAIN JACKET	598.00
CROWN-PLASTIC WITH METAL	637.00
CROWN-PORCELAIN WITH METAL	910.00
GOLD FULL CAST CROWN	733.00
CROWN-3/4 CAST	686.00
RECEMENT INLAY	71.00
RECEMENT CROWN	80.00
PREFAB SS CROWN-PRIMARY	120.00
CAST POST AND CORE	304.00
PREFAB POST AND CORE	199.00
LABIAL VENEER	486.00
IV-ENDODONTICS	
PULP CAP	80.00
VITAL PULPOTOMY	128.00
ROOT CANAL THERAPY-ANTERIOR	623.00
ROOT CANAL THERAPY-BICUSPID	766.00
ROOT CANAL THERAPY-MOLAR	910.00
APICOECTOMY-PER ROOT	254.00
APICOECTOMY-MAX PER TOOTH	508.00
RETROGRADE FILLING PER ROOT	120.00
ROOT RESECTION/HEMISECTION	398.00
V-ORTHODONTIC TREATMENT	
DIAG. & INITIAL INSERTION-Members	918.00
DIAG. & INITIAL INSERTION-Dependents	826.00
ACTIVE TREATMENT-PER MONTH-Members	144.00
ACTIVE TREATMENT-PER MONTH-Dependents	130.00
PASSIVE TREATMENT- PER THREE MONTHS-member	144.00
PASSIVE TREATMENT- PER THREE MONTHS-Dependents	130.00
REMOVABLE APPLIANCE	558.00

VI-PERIODONTICS	
GINGIVECTOMY-PER QUADRANT	398.00
OSSEOUS SURGERY-PER QUAD	733.00
FREE SOFT TISSUE GRAFTS	575.00
LOCALIZED DEL. OF CHEMOTHERAPEUTIC AGENT-PER SITE	71.00
SCALING AND ROOT PLANING-PER QUAD	80.00
PERIODONTAL MAINTENANCE PROCEDURE	134.00
VII-PROSTHODONTICS	
COMPLETE DENTURE	1116.00
IMMEDIATE DENTURE	958.00
PARTIAL DENTURE-ACRYLIC BASE	1037.00
PARTIAL DENTURE-CAST BASE	1116.00
REMOVABLE UNILATERAL PARTIAL DENTURE	358.00
REPAIR COMP DENT BASE	95.00
REPLACE MISSING/BROKEN TOOTH-COMP DENT	95.00
REPAIR PART ACRYLIC SADDLE/BASE	95.00
REPAIR CAST FRAMEWORK	95.00
REPAIR OR REPLACE BROKEN CLASP	95.00
REPLACE BROKEN TEETH- PER TOOTH	95.00
ADD TOOTH TO EXISTING PARTIAL DENT	95.00
ADD CLASP TO EXISTING PARTIAL DENT	95.00
RELINE COMPLETE DENTURE-CHAIR	184.00
RELINE PARTIAL DENTURE-CHAIR	184.00
RELINE COMPLETE DENTURE-LAB	280.00
RELINE PARTIAL DENTURE-LAB	280.00
PONTIC-CAST GOLD	637.00
PONTIC-PORCELAIN TO METAL	878.00
PONTIC-RESIN WITH METAL	637.00
CROWN-PORCELAIN WITH METAL	878.00
CROWN-FULL CAST	733.00
RECEMENT BRIDGE	95.00
REPLACE FACING	160.00
ENDOSSEOUS IMPLANT	1116.00
SUBPERIOSTEAL IMPLANT	1116.00
VIII-ORAL SURGERY	
SIMPLE EXTRACTION	134.00
SURGICAL EXTRACTION	184.00
IMPACTION-SOFT TISSUE	254.00
IMPACTION-PARTIAL BONY	358.00
IMPACTION-COMPLETE BONY	438.00
EXTRACTION-ROOT REMOVAL	184.00
SURG. EXPOSURE-AID ERUP	319.00
EXCISION OF TUMOR	240.00
CYST REMOVAL	358.00
ALVEOPLASTY-PER JAW	120.00
INCISION AND DRAINAGE	139.00
FRENULECTOMY	287.00
BIOPSY SOFT TISSUE	120.00
IX-ADJUNCTIVE SERVICES	
PALLIATIVE-EMERGENCY TREATMENT	64.00
GENERAL ANESTHESIA- per 15 min max 30 minutes	80.00
CONSULTATION BY A SPECIALIST	95.00

SPOUSES & DEPENDENTS
PAY A 20% CO-PAYMENT
EXCEPT ORTHODONTIC APPLIANCE & ACTIVE VISITS
Shaded services are for children only and do not require a 20% co-payment.

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