



HEALTH INSURANCE PLAN OF GREATER NEW YORK HIP PRIME DENTAL PPO

Group Name _____

ADDITIONAL INFORMATION REQUIRED BY HIP

HIP AFFILIATION

Does your group have existing HIP coverage? Yes No If yes, please provide your HIP Employer Group Number _____

CONTRIBUTIONS, MINIMUM PARTICIPATION AND WAITING PERIODS

The following criteria must be met or the HIP Prime Dental coverage cannot become effective:

The minimum acceptable Group Contribution toward premium, based on the number of Eligible Employees are the following:

# ELIGIBLE EMPLOYEES	MINIMUM CONTRIBUTION
2-9	100%
10-50	75%
51 plus	50%

The minimum acceptable Participation level is 75% of all Eligible Employees from all Dental plans offered.

ELIGIBLE EMPLOYEES

The following requirements must also be met for coverage:

- There must be at least 2 eligible employees in your group.
- An association of Groups or individuals will be limited to Plan 5 only.
- Members of small groups (less than 10 eligible employees) without previous dental coverage, will have Class III service deferred for one year. Class III services for these small groups will only be covered when HIP is taking over dental coverage from a previous carrier and the Employee or Dependent had coverage on the day before HIP's effective date. Proof of coverage must be submitted along with the individual application.

COVERAGE OPTIONS

PLAN OPTIONS (Select One Plan)

	Class I Diagnostic and Preventive (Percentage payable by HIP)	Class II Minor Restorative (Percentage payable by HIP)	Class III Major Restorative (Percentage payable by HIP)	Annual Maximum (Amount payable by HIP)	Deductible All Classes Combined (Amount payable by Member)
<input type="checkbox"/> Plan 1:	100% coinsurance	80% coinsurance	50% coinsurance	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$25 <input type="checkbox"/> \$0 <input type="checkbox"/> Option to waive deductible for Class 1 only
<input type="checkbox"/> Plan 2:	80% coinsurance	80% coinsurance	50% coinsurance	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$25 <input type="checkbox"/> \$0 <input type="checkbox"/> Option to waive deductible for Class 1 only
<input type="checkbox"/> Plan 3:	50% coinsurance	50% coinsurance	50% coinsurance	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	\$0
<input type="checkbox"/> Plan 4:	25% coinsurance	25% coinsurance	25% coinsurance	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	\$0
<input type="checkbox"/> Plan 5:	100% coinsurance	No Coverage	No Coverage	<input type="checkbox"/> \$1,000	\$25

ORTHODONTIA OPTION (Available only to Groups with 10+ Eligible Employees purchasing Plans 1 or 2)

50% coinsurance; \$1,200 Lifetime maximum; \$0 deductible

DEPENDENT AGE LIMITS (No options exist)

Full-Time Students: 23 End of year
 Dependent Children: 19 End of Month

MONTHLY RATES (to be completed by your broker or HIP)

	<u>2 TIER</u>	<u>3 TIER</u>	<u>4 TIER</u>
Individual	\$ _____	\$ _____	\$ _____
Two Persons		\$ _____	
Employee & Child(ren)			\$ _____
Employee & Spouse			\$ _____
Family	\$ _____	\$ _____	\$ _____