Filing at a Glance

Company: Health Insurance Plan of Greater New York

Product Name: 2012 HIP LG Prior Approval Rate Filing

SERFF Tr Num: HPHP-127306459

State: New York

TOI: H21 Health - Other

SERFF Status: Closed-APPR Approved

State Tr Num: 2011070115

Sub-TOI: H21.000 Health - Other

Co Tr Num: 2011 0715 HIP LG 2012 RATE FILING

State Status:

Filing Type: Rate Adjustment pursuant to Section 4308(c)

Reviewer(s): [redacted]

Authors: [redacted]

Disposition Date: 10/13/2011

Date Submitted: 07/18/2011

Disposition Status: APPR Approved

Implementation Date Requested: 01/01/2012

Implementation Date: 01/01/2012

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 10/13/2011

State Status Changed:

Created By: [redacted]

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

This is the filing for HIP's Large Group Community rated rates.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: [redacted]

Company and Contact

Filing Contact Information

[redacted]
55 Water Street
New York, NY 10041
[redacted]

Filing Company Information

Health Insurance Plan of Greater New York	CoCode: 55247	State of Domicile: New York
55 Water Street	Group Code: 91	Company Type: HEALTH
New York, NY 10041	Group Name:	State ID Number:
(646) 447-5000 ext. [Phone]	FEIN Number: 13-1828429	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

State Specific

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Group Remittance
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, "File and Use" Rate Adjustment, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: Yes. Prior Approval Rate Adjustment
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter

the state tracking number assigned and the effective date of coverage.): No

8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No

9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No

Rate Information

Rate data applies to filing.

Filing Method:	Prior Approval
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	9.100%
Effective Date of Last Rate Revision:	10/01/2011
Filing Method of Last Filing:	Prior Approval

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Health Insurance Plan of Greater New York	Increase	8.600%	8.600%	$157,803,133	968	$1,843,356,172	8.600%	8.600%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	332,150			925				
Policy Holders:	891			77				

Rate Review Details

COMPANY:

Company Name:	Health Insurance Plan of Greater New York
HHS Issuer Id:	88582
Product Names:	HIP Prime HMO, HIP Access I, HIP Prime POS, HIP Access II, Vytra HMO
Trend Factors:	

FORMS:

New Policy Forms:	
Affected Forms:	VHLI-LGRP-01
Other Affected Forms:	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Annual
Member Months:	4,548,159
Benefit Change:	None
Percent Change Requested:	Min: 8.6 Max: 8.6 Avg: 8.6

PRIOR RATE:

Total Earned Premium:	1,756,826,306.00
Total Incurred Claims:	1,525,884,480.00
Annual $:	Min: 295.71 Max: 831.94 Avg: 436.92

REQUESTED RATE:

Projected Earned Premium:	1,776,986,802.00
Projected Incurred Claims:	1,591,229,363.00
Annual $:	Min: 321.02 Max: 903.16 Avg: 474.33

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
	2012 HIP LG Rate Manual	VHLI-LGRP-01, 155-23-grphmo, 155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa	New		2012 HIP LG 1Q Rate Manual 071411.pdf 2012 HIP LG 2Q Rate Manual 071411.pdf 2012 HIP LG 3Q Rate Manual 071411.pdf 2012 HIP LG 4Q Rate Manual 071411.pdf 2012 HIP LG 1Q Rate Manual Rate Change 071411.pdf 2012 HIP LG 2Q Rate Manual Rate Change 0714111.pdf 2012 HIP LG 3Q Rate Manual Rate Change 071411.pdf 2012 HIP LG 4Q Rate Manual Rate Change 071411.pdf

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
Rate Calculation

Prime and Access Rate Formula

Large groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor

Example: Large Group HMO Individual Employee Rate Example

=	490.00	1st QUARTER	(Base Rate
+	(4.95)	$10 Specialist visit copay	Optional Base Benefit Variables (exlcuding Mental Health)
+	8.71	Unlimited days	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	9.60	$10 copay, Unlimited visits	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	1.09	Standard Coverage	Network Area Factor
	513.43		

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	490.00	1,200.50	894.74	1,424.43	911.40	980.00	1,498.91

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.28)	(8.04)	(5.99)	(9.53)	(6.10)	(6.56)	(10.03)
$10	(6.89)	(16.88)	(12.58)	(20.03)	(12.82)	(13.78)	(21.08)
$15	(11.46)	(28.08)	(20.93)	(33.31)	(21.32)	(22.92)	(35.06)
$20	(17.69)	(43.34)	(32.30)	(51.42)	(32.90)	(35.38)	(54.11)
$25	(23.29)	(57.06)	(42.53)	(67.70)	(43.32)	(46.58)	(71.24)
$30	(29.46)	(72.18)	(53.79)	(85.64)	(54.80)	(58.92)	(90.12)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.87)	(4.58)	(3.41)	(5.44)	(3.48)	(3.74)	(5.72)
$10	(3.95)	(9.68)	(7.21)	(11.48)	(7.35)	(7.90)	(12.08)
$15	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$20	(10.13)	(24.82)	(18.50)	(29.45)	(18.84)	(20.26)	(30.99)
$25	(13.35)	(32.71)	(24.38)	(38.81)	(24.83)	(26.70)	(40.84)
$30	(16.90)	(41.41)	(30.86)	(49.13)	(31.43)	(33.80)	(51.70)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$10	(4.95)	(12.13)	(9.04)	(14.39)	(9.21)	(9.90)	(15.14)
$15	(7.76)	(19.01)	(14.17)	(22.56)	(14.43)	(15.52)	(23.74)
$20	(10.95)	(26.83)	(19.99)	(31.83)	(20.37)	(21.90)	(33.50)
$25	(14.45)	(35.40)	(26.39)	(42.01)	(26.88)	(28.90)	(44.20)
$30	(18.41)	(45.10)	(33.62)	(53.52)	(34.24)	(36.82)	(56.32)
$35	(22.12)	(54.19)	(40.39)	(64.30)	(41.14)	(44.24)	(67.67)
$40	(25.98)	(63.65)	(47.44)	(75.52)	(48.32)	(51.96)	(79.47)
$45	(30.02)	(73.55)	(54.82)	(87.27)	(55.84)	(60.04)	(91.83)
$50	(34.28)	(83.99)	(62.60)	(99.65)	(63.76)	(68.56)	(104.86)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$10	(4.20)	(10.29)	(7.67)	(12.21)	(7.81)	(8.40)	(12.85)
$15	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$20	(9.27)	(22.71)	(16.93)	(26.95)	(17.24)	(18.54)	(28.36)
$25	(12.22)	(29.94)	(22.31)	(35.52)	(22.73)	(24.44)	(37.38)
$30	(15.57)	(38.15)	(28.43)	(45.26)	(28.96)	(31.14)	(47.63)
$35	(18.73)	(45.89)	(34.20)	(54.45)	(34.84)	(37.46)	(57.30)
$40	(21.97)	(53.83)	(40.12)	(63.87)	(40.86)	(43.94)	(67.21)
$45	(25.39)	(62.21)	(46.36)	(73.81)	(47.23)	(50.78)	(77.67)
$50	(28.98)	(71.00)	(52.92)	(84.24)	(53.90)	(57.96)	(88.65)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
$150	(1.98)	(4.85)	(3.62)	(5.76)	(3.68)	(3.96)	(6.06)
$200	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$250	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$500	(9.66)	(23.67)	(17.64)	(28.08)	(17.97)	(19.32)	(29.55)
$750	(16.60)	(40.67)	(30.31)	(48.26)	(30.88)	(33.20)	(50.78)
$1,000	(24.97)	(61.18)	(45.60)	(72.59)	(46.44)	(49.94)	(76.38)
Copay/Day							
$50 w/3 Day Max	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$50 w/5 Day Max	(2.00)	(4.90)	(3.65)	(5.81)	(3.72)	(4.00)	(6.12)
$100 w/3 Day Max	(3.64)	(8.92)	(6.65)	(10.58)	(6.77)	(7.28)	(11.13)
$100 w/5 Day Max	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
$250 w/3 Day Max	(12.02)	(29.45)	(21.95)	(34.94)	(22.36)	(24.04)	(36.77)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
$75	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$100	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$125	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$150	(2.37)	(5.81)	(4.33)	(6.89)	(4.41)	(4.74)	(7.25)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$25	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$35	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$50	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$60	(1.74)	(4.26)	(3.18)	(5.06)	(3.24)	(3.48)	(5.32)
$75	(2.30)	(5.64)	(4.20)	(6.69)	(4.28)	(4.60)	(7.04)
$100	(3.27)	(8.01)	(5.97)	(9.51)	(6.08)	(6.54)	(10.00)
$125	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$150	(4.81)	(11.78)	(8.78)	(13.98)	(8.95)	(9.62)	(14.71)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.56	1.37	1.02	1.63	1.04	1.12	1.71
60	1.10	2.70	2.01	3.20	2.05	2.20	3.36
90	1.65	4.04	3.01	4.80	3.07	3.30	5.05
120	1.93	4.73	3.52	5.61	3.59	3.86	5.90
Unlimited	2.48	6.08	4.53	7.21	4.61	4.96	7.59

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
40/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$20 copay	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
40/$25 copay	(0.82)	(2.01)	(1.50)	(2.38)	(1.53)	(1.64)	(2.51)
60	0.30	0.74	0.55	0.87	0.56	0.60	0.92
100	0.72	1.76	1.31	2.09	1.34	1.44	2.20
200	1.93	4.73	3.52	5.61	3.59	3.86	5.90
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.75	1.84	1.37	2.18	1.40	1.50	2.29
90	1.58	3.87	2.89	4.59	2.94	3.16	4.83
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.67	1.64	1.22	1.95	1.25	1.34	2.05
90	1.23	3.01	2.25	3.58	2.29	2.46	3.76
120	2.00	4.90	3.65	5.81	3.72	4.00	6.12
visits for all other			**(Verizon Benefit)**				
	1.55	3.80	2.83	4.51	2.88	3.10	4.74
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.29	0.71	0.53	0.84	0.54	0.58	0.89
30	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Unlimited	0.67	1.64	1.22	1.95	1.25	1.34	2.05
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.38	8.28	6.17	9.83	6.29	6.76	10.34
60	3.97	9.73	7.25	11.54	7.38	7.94	12.14
90	4.75	11.64	8.67	13.81	8.84	9.50	14.53
Unlimited	4.81	11.78	8.78	13.98	8.95	9.62	14.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
60/$20 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60/$25 copay	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
120/$0 copay	0.59	1.45	1.08	1.72	1.10	1.18	1.80
120/$5 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Unlimited/$0 copay	0.68	1.67	1.24	1.98	1.26	1.36	2.08
Unlimited/$5 copay	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited/$10 copay	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$15	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$20	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$25	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$30	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$35	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.40)	(3.67)
$40	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$45	(1.59)	(3.90)	(2.90)	(4.62)	(2.96)	(3.18)	(4.86)
$50	(1.75)	(4.29)	(3.20)	(5.09)	(3.26)	(3.50)	(5.35)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$25	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$60	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$75	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$100	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$100	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.06)	(7.50)	(5.59)	(8.90)	(5.69)	(6.12)	(9.36)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(4.74)	(11.61)	(8.66)	(13.78)	(8.82)	(9.48)	(14.50)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	7.89	19.33	14.41	22.94	14.68	15.78	24.14
60	8.32	20.38	15.19	24.19	15.48	16.64	25.45
90	8.63	21.14	15.76	25.09	16.05	17.26	26.40
Unlimited	8.71	21.34	15.90	25.32	16.20	17.42	26.64
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.81	21.58	16.09	25.61	16.39	17.62	26.95
30	9.71	23.79	17.73	28.23	18.06	19.42	29.70
40	10.25	25.11	18.72	29.80	19.07	20.50	31.35
60	10.80	26.46	19.72	31.40	20.09	21.60	33.04
Unlimited	10.88	26.66	19.87	31.63	20.24	21.76	33.28
LARGE GROUP			**$5 Copay**				
20	8.29	20.31	15.14	24.10	15.42	16.58	25.36
30	9.12	22.34	16.65	26.51	16.96	18.24	27.90
40	9.70	23.77	17.71	28.20	18.04	19.40	29.67
60	10.15	24.87	18.53	29.51	18.88	20.30	31.05
Unlimited	10.23	25.06	18.68	29.74	19.03	20.46	31.29
LARGE GROUP			**$10 Copay**				
20	7.75	18.99	14.15	22.53	14.42	15.50	23.71
30	8.55	20.95	15.61	24.85	15.90	17.10	26.15
40	9.04	22.15	16.51	26.28	16.81	18.08	27.65
60	9.53	23.35	17.40	27.70	17.73	19.06	29.15
Unlimited	9.60	23.52	17.53	27.91	17.86	19.20	29.37
LARGE GROUP			**$15 Copay**				
20	7.28	17.84	13.29	21.16	13.54	14.56	22.27
30	8.04	19.70	14.68	23.37	14.95	16.08	24.59
40	8.51	20.85	15.54	24.74	15.83	17.02	26.03
60	9.00	22.05	16.43	26.16	16.74	18.00	27.53
Unlimited	9.07	22.22	16.56	26.37	16.87	18.14	27.75
LARGE GROUP			**$20 Copay**				
20	6.86	16.81	12.53	19.94	12.76	13.72	20.98
30	7.52	18.42	13.73	21.86	13.99	15.04	23.00
40	7.93	19.43	14.48	23.05	14.75	15.86	24.26
60	8.43	20.65	15.39	24.51	15.68	16.86	25.79
Unlimited	8.49	20.80	15.50	24.68	15.79	16.98	25.97

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP				**$25 Copay**			
20	6.38	15.63	11.65	18.55	11.87	12.76	19.52
30	7.00	17.15	12.78	20.35	13.02	14.00	21.41
40	7.46	18.28	13.62	21.69	13.88	14.92	22.82
60	7.85	19.23	14.33	22.82	14.60	15.70	24.01
Unlimited	7.92	19.40	14.46	23.02	14.73	15.84	24.23
LARGE GROUP				**$30 Copay**			
20	6.07	14.87	11.08	17.65	11.29	12.14	18.57
30	6.59	16.15	12.03	19.16	12.26	13.18	20.16
40	7.02	17.20	12.82	20.41	13.06	14.04	21.47
60	7.37	18.06	13.46	21.42	13.71	14.74	22.54
Unlimited	7.41	18.15	13.53	21.54	13.78	14.82	22.67
LARGE GROUP				**$35 Copay**			
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.16	15.09	11.25	17.91	11.46	12.32	18.84
40	6.56	16.07	11.98	19.07	12.20	13.12	20.07
60	6.89	16.88	12.58	20.03	12.82	13.78	21.08
Unlimited	6.95	17.03	12.69	20.20	12.93	13.90	21.26
LARGE GROUP				**$40 Copay**			
20	5.61	13.74	10.24	16.31	10.43	11.22	17.16
30	6.00	14.70	10.96	17.44	11.16	12.00	18.35
40	6.40	15.68	11.69	18.60	11.90	12.80	19.58
60	6.74	16.51	12.31	19.59	12.54	13.48	20.62
Unlimited	6.79	16.64	12.40	19.74	12.63	13.58	20.77
LARGE GROUP				**$45 Copay**			
20	5.46	13.38	9.97	15.87	10.16	10.92	16.70
30	5.83	14.28	10.65	16.95	10.84	11.66	17.83
40	6.23	15.26	11.38	18.11	11.59	12.46	19.06
60	6.57	16.10	12.00	19.10	12.22	13.14	20.10
Unlimited	6.61	16.19	12.07	19.22	12.29	13.22	20.22

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP				**$50 Copay**			
20	5.31	13.01	9.70	15.44	9.88	10.62	16.24
30	5.68	13.92	10.37	16.51	10.56	11.36	17.38
40	6.07	14.87	11.08	17.65	11.29	12.14	18.57
60	6.42	15.73	11.72	18.66	11.94	12.84	19.64
Unlimited	6.46	15.83	11.80	18.78	12.02	12.92	19.76

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%

				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
NYSHIP: Three Month Extension							
	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.38	10.73	8.00	12.73	8.15	8.76	13.40
$0/Max $5000	4.17	10.22	7.61	12.12	7.76	8.34	12.76
$0/Max $2500	3.89	9.53	7.10	11.31	7.24	7.78	11.90
$25	4.17	10.22	7.61	12.12	7.76	8.34	12.76
$50	3.89	9.53	7.10	11.31	7.24	7.78	11.90
$100	3.58	8.77	6.54	10.41	6.66	7.16	10.95
$500	1.71	4.19	3.12	4.97	3.18	3.42	5.23
$5,000	0.29	0.71	0.53	0.84	0.54	0.58	0.89
Coinsurance							
80%	3.52	8.62	6.43	10.23	6.55	7.04	10.77
75%	3.30	8.09	6.03	9.59	6.14	6.60	10.09
70%	3.09	7.57	5.64	8.98	5.75	6.18	9.45
Deductible			**Orthotics Riders**				
$0	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$0/Max $5000	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$0/Max $2500	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$25	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$50	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$100	0.61	1.49	1.11	1.77	1.13	1.22	1.87
$500	0.31	0.76	0.57	0.90	0.58	0.62	0.95
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.61	1.49	1.11	1.77	1.13	1.22	1.87
75%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
70%	0.54	1.32	0.99	1.57	1.00	1.08	1.65

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.52	1.27	0.95	1.51	0.97	1.04	1.59
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
			Infertility Rider				
Limit							
2 IVF	9.28	22.74	16.95	26.98	17.26	18.56	28.39
3 IVF	11.22	27.49	20.49	32.62	20.87	22.44	34.32
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.76	6.76	5.04	8.02	5.13	5.52	8.44
			Nurse Advice Line Rider				
	0.30	0.74	0.55	0.87	0.56	0.60	0.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
904.81	2,216.78	1,652.18	2,630.28	1,682.95	1,809.62	2,767.81
80% Coinsurance						
891.23	2,183.51	1,627.39	2,590.81	1,657.69	1,782.46	2,726.27
75% Coinsurance						
848.26	2,078.24	1,548.92	2,465.89	1,577.76	1,696.52	2,594.83
70% Coinsurance						
805.27	1,972.91	1,470.42	2,340.92	1,497.80	1,610.54	2,463.32
50% Coinsurance						
762.30	1,867.64	1,391.96	2,216.01	1,417.88	1,524.60	2,331.88

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**

**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
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Rider	ALL TIERS Individual x 2	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(40.87)	(100.13)	(74.63)	(118.81)	(76.02)	(81.74)	(125.02)
$350	(54.10)	(132.55)	(98.79)	(157.27)	(100.63)	(108.20)	(165.49)
$500	(69.61)	(170.54)	(127.11)	(202.36)	(129.47)	(139.22)	(212.94)
$750	(90.44)	(221.58)	(165.14)	(262.91)	(168.22)	(180.88)	(276.66)
$1,000	(106.39)	(260.66)	(194.27)	(309.28)	(197.89)	(212.78)	(325.45)
$1,500	(130.84)	(320.56)	(238.91)	(380.35)	(243.36)	(261.68)	(400.24)
$2,500	(146.27)	(358.36)	(267.09)	(425.21)	(272.06)	(292.54)	(447.44)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(54.62)	(133.82)	(99.74)	(158.78)	(101.59)	(109.24)	(167.08)
$250	(65.15)	(159.62)	(118.96)	(189.39)	(121.18)	(130.30)	(199.29)
$300	(75.72)	(185.51)	(138.26)	(220.12)	(140.84)	(151.44)	(231.63)
$350	(86.29)	(211.41)	(157.57)	(250.85)	(160.50)	(172.58)	(263.96)
$400	(94.58)	(231.72)	(172.70)	(274.94)	(175.92)	(189.16)	(289.32)
$500	(111.18)	(272.39)	(203.01)	(323.20)	(206.79)	(222.36)	(340.10)
$750	(144.38)	(353.73)	(263.64)	(419.71)	(268.55)	(288.76)	(441.66)
$1,000	(169.95)	(416.38)	(310.33)	(494.04)	(316.11)	(339.90)	(519.88)
$1,500	(209.06)	(512.20)	(381.74)	(607.74)	(388.85)	(418.12)	(639.51)
$2,000	(225.05)	(551.37)	(410.94)	(654.22)	(418.59)	(450.10)	(688.43)
$2,500	(241.10)	(590.70)	(440.25)	(700.88)	(448.45)	(482.20)	(737.52)
$5,000	(283.43)	(694.40)	(517.54)	(823.93)	(527.18)	(566.86)	(867.01)
$10,000	(318.41)	(780.10)	(581.42)	(925.62)	(592.24)	(636.82)	(974.02)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(44.75)	(109.64)	(81.71)	(130.09)	(83.24)	(89.50)	(136.89)
$250	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$300	(62.05)	(152.02)	(113.30)	(180.38)	(115.41)	(124.10)	(189.81)
$350	(70.68)	(173.17)	(129.06)	(205.47)	(131.46)	(141.36)	(216.21)
$400	(77.63)	(190.19)	(141.75)	(225.67)	(144.39)	(155.26)	(237.47)
$500	(91.56)	(224.32)	(167.19)	(266.16)	(170.30)	(183.12)	(280.08)
$750	(119.09)	(291.77)	(217.46)	(346.19)	(221.51)	(238.18)	(364.30)
$1,000	(140.52)	(344.27)	(256.59)	(408.49)	(261.37)	(281.04)	(429.85)
$1,500	(173.01)	(423.87)	(315.92)	(502.94)	(321.80)	(346.02)	(529.24)
$2,000	(187.73)	(459.94)	(342.79)	(545.73)	(349.18)	(375.46)	(574.27)
$2,500	(202.47)	(496.05)	(369.71)	(588.58)	(376.59)	(404.94)	(619.36)
$5,000	(244.61)	(599.29)	(446.66)	(711.08)	(454.97)	(489.22)	(748.26)
$10,000	(279.40)	(684.53)	(510.18)	(812.22)	(519.68)	(558.80)	(854.68)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(34.89)	(85.48)	(63.71)	(101.43)	(64.90)	(69.78)	(106.73)
$250	(41.63)	(101.99)	(76.02)	(121.02)	(77.43)	(83.26)	(127.35)
$300	(48.35)	(118.46)	(88.29)	(140.55)	(89.93)	(96.70)	(147.90)
$350	(55.07)	(134.92)	(100.56)	(160.09)	(102.43)	(110.14)	(168.46)
$400	(60.72)	(148.76)	(110.87)	(176.51)	(112.94)	(121.44)	(185.74)
$500	(71.87)	(176.08)	(131.23)	(208.93)	(133.68)	(143.74)	(219.85)
$750	(93.77)	(229.74)	(171.22)	(272.59)	(174.41)	(187.54)	(286.84)
$1,000	(111.04)	(272.05)	(202.76)	(322.79)	(206.53)	(222.08)	(339.67)
$1,500	(136.96)	(335.55)	(250.09)	(398.14)	(254.75)	(273.92)	(418.96)
$2,000	(150.42)	(368.53)	(274.67)	(437.27)	(279.78)	(300.84)	(460.13)
$2,500	(163.88)	(401.51)	(299.24)	(476.40)	(304.82)	(327.76)	(501.31)
$5,000	(205.80)	(504.21)	(375.79)	(598.26)	(382.79)	(411.60)	(629.54)
$10,000	(240.41)	(589.00)	(438.99)	(698.87)	(447.16)	(480.82)	(735.41)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(23.98)	(58.75)	(43.79)	(69.71)	(44.60)	(47.96)	(73.35)
$250	(28.74)	(70.41)	(52.48)	(83.55)	(53.46)	(57.48)	(87.92)
$300	(33.54)	(82.17)	(61.24)	(97.50)	(62.38)	(67.08)	(102.60)
$350	(38.27)	(93.76)	(69.88)	(111.25)	(71.18)	(76.54)	(117.07)
$400	(42.41)	(103.90)	(77.44)	(123.29)	(78.88)	(84.82)	(129.73)
$500	(50.67)	(124.14)	(92.52)	(147.30)	(94.25)	(101.34)	(155.00)
$750	(66.48)	(162.88)	(121.39)	(193.26)	(123.65)	(132.96)	(203.36)
$1,000	(79.34)	(194.38)	(144.87)	(230.64)	(147.57)	(158.68)	(242.70)
$1,500	(99.14)	(242.89)	(181.03)	(288.20)	(184.40)	(198.28)	(303.27)
$2,000	(109.69)	(268.74)	(200.29)	(318.87)	(204.02)	(219.38)	(335.54)
$2,500	(120.27)	(294.66)	(219.61)	(349.62)	(223.70)	(240.54)	(367.91)
$5,000	(161.61)	(395.94)	(295.10)	(469.80)	(300.59)	(323.22)	(494.36)
$10,000	(195.74)	(479.56)	(357.42)	(569.02)	(364.08)	(391.48)	(598.77)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
			LARGE GROUP				
Maximum	**Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance**						
$1,000	(31.77)	(77.84)	(58.01)	(92.36)	(59.09)	(63.54)	(97.18)
$1,500	(34.65)	(84.89)	(63.27)	(100.73)	(64.45)	(69.30)	(105.99)
$2,000	(36.16)	(88.59)	(66.03)	(105.12)	(67.26)	(72.32)	(110.61)
$3,000	(37.48)	(91.83)	(68.44)	(108.95)	(69.71)	(74.96)	(114.65)
$4,000	(38.07)	(93.27)	(69.52)	(110.67)	(70.81)	(76.14)	(116.46)
$5,000	(38.38)	(94.03)	(70.08)	(111.57)	(71.39)	(76.76)	(117.40)
$7,000	(38.73)	(94.89)	(70.72)	(112.59)	(72.04)	(77.46)	(118.48)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(50.56)	(123.87)	(92.32)	(146.98)	(94.04)	(101.12)	(154.66)
$1,500	(55.17)	(135.17)	(100.74)	(160.38)	(102.62)	(110.34)	(168.77)
$2,000	(57.52)	(140.92)	(105.03)	(167.21)	(106.99)	(115.04)	(175.95)
$3,000	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$4,000	(60.64)	(148.57)	(110.73)	(176.28)	(112.79)	(121.28)	(185.50)
$5,000	(61.12)	(149.74)	(111.61)	(177.68)	(113.68)	(122.24)	(186.97)
$7,000	(61.71)	(151.19)	(112.68)	(179.39)	(114.78)	(123.42)	(188.77)
$7,500	(62.21)	(152.41)	(113.60)	(180.84)	(115.71)	(124.42)	(190.30)
$10,000	(64.03)	(156.87)	(116.92)	(186.14)	(119.10)	(128.06)	(195.87)
$20,000	(66.62)	(163.22)	(121.65)	(193.66)	(123.91)	(133.24)	(203.79)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(48.86)	(119.71)	(89.22)	(142.04)	(90.88)	(97.72)	(149.46)
$1,500	(54.31)	(133.06)	(99.17)	(157.88)	(101.02)	(108.62)	(166.13)
$2,000	(57.34)	(140.48)	(104.70)	(166.69)	(106.65)	(114.68)	(175.40)
$3,000	(60.30)	(147.74)	(110.11)	(175.29)	(112.16)	(120.60)	(184.46)
$4,000	(61.66)	(151.07)	(112.59)	(179.25)	(114.69)	(123.32)	(188.62)
$5,000	(62.40)	(152.88)	(113.94)	(181.40)	(116.06)	(124.80)	(190.88)
$7,000	(63.13)	(154.67)	(115.28)	(183.52)	(117.42)	(126.26)	(193.11)
$7,500	(63.67)	(155.99)	(116.26)	(185.09)	(118.43)	(127.34)	(194.77)
$10,000	(65.90)	(161.46)	(120.33)	(191.57)	(122.57)	(131.80)	(201.59)
$20,000	(69.35)	(169.91)	(126.63)	(201.60)	(128.99)	(138.70)	(212.14)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(47.17)	(115.57)	(86.13)	(137.12)	(87.74)	(94.34)	(144.29)
$1,500	(53.50)	(131.08)	(97.69)	(155.52)	(99.51)	(107.00)	(163.66)
$2,000	(57.14)	(139.99)	(104.34)	(166.11)	(106.28)	(114.28)	(174.79)
$3,000	(60.92)	(149.25)	(111.24)	(177.09)	(113.31)	(121.84)	(186.35)
$4,000	(62.64)	(153.47)	(114.38)	(182.09)	(116.51)	(125.28)	(191.62)
$5,000	(63.65)	(155.94)	(116.22)	(185.03)	(118.39)	(127.30)	(194.71)
$7,000	(64.54)	(158.12)	(117.85)	(187.62)	(120.04)	(129.08)	(197.43)
$7,500	(65.11)	(159.52)	(118.89)	(189.27)	(121.10)	(130.22)	(199.17)
$10,000	(67.58)	(165.57)	(123.40)	(196.46)	(125.70)	(135.16)	(206.73)
$20,000	(71.97)	(176.33)	(131.42)	(209.22)	(133.86)	(143.94)	(220.16)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$1,500	(63.61)	(155.84)	(116.15)	(184.91)	(118.31)	(127.22)	(194.58)
$2,000	(70.20)	(171.99)	(128.19)	(204.07)	(130.57)	(140.40)	(214.74)
$3,000	(78.19)	(191.57)	(142.77)	(227.30)	(145.43)	(156.38)	(239.18)
$4,000	(82.57)	(202.30)	(150.77)	(240.03)	(153.58)	(165.14)	(252.58)
$5,000	(85.27)	(208.91)	(155.70)	(247.88)	(158.60)	(170.54)	(260.84)
$7,000	(88.06)	(215.75)	(160.80)	(255.99)	(163.79)	(176.12)	(269.38)
$7,500	(89.09)	(218.27)	(162.68)	(258.98)	(165.71)	(178.18)	(272.53)
$10,000	(93.24)	(228.44)	(170.26)	(271.05)	(173.43)	(186.48)	(285.22)
$20,000	(101.96)	(249.80)	(186.18)	(296.40)	(189.65)	(203.92)	(311.90)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.40	0.98	0.73	1.16	0.74	0.80	1.22
$1,000,000	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$50,000	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
75%	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
70%	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.39)	(4.02)	(6.40)	(4.09)	(4.40)	(6.73)
$10	(4.62)	(11.32)	(8.44)	(13.43)	(8.59)	(9.24)	(14.13)
$15	(7.68)	(18.82)	(14.02)	(22.33)	(14.28)	(15.36)	(23.49)
$20	(11.86)	(29.06)	(21.66)	(34.48)	(22.06)	(23.72)	(36.28)
$25	(15.61)	(38.24)	(28.50)	(45.38)	(29.03)	(31.22)	(47.75)
$30	(19.75)	(48.39)	(36.06)	(57.41)	(36.74)	(39.50)	(60.42)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$10	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$15	(4.40)	(10.78)	(8.03)	(12.79)	(8.18)	(8.80)	(13.46)
$20	(6.79)	(16.64)	(12.40)	(19.74)	(12.63)	(13.58)	(20.77)
$25	(8.94)	(21.90)	(16.32)	(25.99)	(16.63)	(17.88)	(27.35)
$30	(11.30)	(27.69)	(20.63)	(32.85)	(21.02)	(22.60)	(34.57)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$10	(3.32)	(8.13)	(6.06)	(9.65)	(6.18)	(6.64)	(10.16)
$15	(5.21)	(12.76)	(9.51)	(15.15)	(9.69)	(10.42)	(15.94)
$20	(7.34)	(17.98)	(13.40)	(21.34)	(13.65)	(14.68)	(22.45)
$25	(9.67)	(23.69)	(17.66)	(28.11)	(17.99)	(19.34)	(29.58)
$30	(12.34)	(30.23)	(22.53)	(35.87)	(22.95)	(24.68)	(37.75)
$35	(14.82)	(36.31)	(27.06)	(43.08)	(27.57)	(29.64)	(45.33)
$40	(17.39)	(42.61)	(31.75)	(50.55)	(32.35)	(34.78)	(53.20)
$45	(20.12)	(49.29)	(36.74)	(58.49)	(37.42)	(40.24)	(61.55)
$50	(22.96)	(56.25)	(41.92)	(66.74)	(42.71)	(45.92)	(70.23)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$10	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$15	(4.40)	(10.78)	(8.03)	(12.79)	(8.18)	(8.80)	(13.46)
$20	(6.20)	(15.19)	(11.32)	(18.02)	(11.53)	(12.40)	(18.97)
$25	(8.18)	(20.04)	(14.94)	(23.78)	(15.21)	(16.36)	(25.02)
$30	(10.43)	(25.55)	(19.05)	(30.32)	(19.40)	(20.86)	(31.91)
$35	(12.54)	(30.72)	(22.90)	(36.45)	(23.32)	(25.08)	(38.36)
$40	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$45	(17.01)	(41.67)	(31.06)	(49.45)	(31.64)	(34.02)	(52.03)
$50	(19.42)	(47.58)	(35.46)	(56.45)	(36.12)	(38.84)	(59.41)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$150	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$200	(1.87)	(4.58)	(3.41)	(5.44)	(3.48)	(3.74)	(5.72)
$250	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$500	(6.48)	(15.88)	(11.83)	(18.84)	(12.05)	(12.96)	(19.82)
$750	(11.11)	(27.22)	(20.29)	(32.30)	(20.66)	(22.22)	(33.99)
$1,000	(16.72)	(40.96)	(30.53)	(48.61)	(31.10)	(33.44)	(51.15)
Copay/Day							
$50 w/3 Day Max	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$50 w/5 Day Max	(1.33)	(3.26)	(2.43)	(3.87)	(2.47)	(2.66)	(4.07)
$100 w/3 Day Max	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$100 w/5 Day Max	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$250 w/3 Day Max	(8.07)	(19.77)	(14.74)	(23.46)	(15.01)	(16.14)	(24.69)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$100	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$125	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$150	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$35	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$50	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
$60	(1.16)	(2.84)	(2.12)	(3.37)	(2.16)	(2.32)	(3.55)
$75	(1.54)	(3.77)	(2.81)	(4.48)	(2.86)	(3.08)	(4.71)
$100	(2.19)	(5.37)	(4.00)	(6.37)	(4.07)	(4.38)	(6.70)
$125	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$150	(3.22)	(7.89)	(5.88)	(9.36)	(5.99)	(6.44)	(9.85)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.44	1.08	0.80	1.28	0.82	0.88	1.35
60	0.86	2.11	1.57	2.50	1.60	1.72	2.63
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
120	1.48	3.63	2.70	4.30	2.75	2.96	4.53
Unlimited	1.91	4.68	3.49	5.55	3.55	3.82	5.84
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$20 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
40/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.49	1.20	0.89	1.42	0.91	0.98	1.50
200	1.28	3.14	2.34	3.72	2.38	2.56	3.92

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.58	1.42	1.06	1.69	1.08	1.16	1.77
90	1.19	2.92	2.17	3.46	2.21	2.38	3.64
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.51	1.25	0.93	1.48	0.95	1.02	1.56
90	0.95	2.33	1.73	2.76	1.77	1.90	2.91
120	1.53	3.75	2.79	4.45	2.85	3.06	4.68
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited	0.51	1.25	0.93	1.48	0.95	1.02	1.56
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.26	5.54	4.13	6.57	4.20	4.52	6.91
60	2.67	6.54	4.88	7.76	4.97	5.34	8.17
90	3.18	7.79	5.81	9.24	5.91	6.36	9.73
Unlimited	3.22	7.89	5.88	9.36	5.99	6.44	9.85
			Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
60/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
120/$0 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
120/$5 copay	0.35	0.86	0.64	1.02	0.65	0.70	1.07
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copay	0.53	1.30	0.97	1.54	0.99	1.06	1.62
Unlimited/$5 copay	0.41	1.00	0.75	1.19	0.76	0.82	1.25
Unlimited/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$20	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$25	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$30	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$35	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$40	(0.94)	(2.30)	(1.72)	(2.73)	(1.75)	(1.88)	(2.88)
$45	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$50	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$25	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$75	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$100	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)

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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)

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HIP POS GROUP CONTRACT
MENTAL HEALTH
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.28	20.29	15.12	24.07	15.40	16.56	25.33
60	8.74	21.41	15.96	25.41	16.26	17.48	26.74
90	9.06	22.20	16.54	26.34	16.85	18.12	27.71
Unlimited	9.15	22.42	16.71	26.60	17.02	18.30	27.99
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.26	22.69	16.91	26.92	17.22	18.52	28.33
30	10.19	24.97	18.61	29.62	18.95	20.38	31.17
40	10.75	26.34	19.63	31.25	20.00	21.50	32.88
60	11.33	27.76	20.69	32.94	21.07	22.66	34.66
Unlimited	11.43	28.00	20.87	33.23	21.26	22.86	34.96
LARGE GROUP				**$5 Copay**			
20	8.70	21.32	15.89	25.29	16.18	17.40	26.61
30	9.58	23.47	17.49	27.85	17.82	19.16	29.31
40	10.18	24.94	18.59	29.59	18.93	20.36	31.14
60	10.67	26.14	19.48	31.02	19.85	21.34	32.64
Unlimited	10.74	26.31	19.61	31.22	19.98	21.48	32.85
LARGE GROUP				**$10 Copay**			
20	8.15	19.97	14.88	23.69	15.16	16.30	24.93
30	8.99	22.03	16.42	26.13	16.72	17.98	27.50
40	9.49	23.25	17.33	27.59	17.65	18.98	29.03
60	10.00	24.50	18.26	29.07	18.60	20.00	30.59
Unlimited	10.08	24.70	18.41	29.30	18.75	20.16	30.83
LARGE GROUP				**$15 Copay**			
20	7.65	18.74	13.97	22.24	14.23	15.30	23.40
30	8.43	20.65	15.39	24.51	15.68	16.86	25.79
40	8.92	21.85	16.29	25.93	16.59	17.84	27.29
60	9.44	23.13	17.24	27.44	17.56	18.88	28.88
Unlimited	9.53	23.35	17.40	27.70	17.73	19.06	29.15

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
LARGE GROUP				**$20 Copay**			
20	7.19	17.62	13.13	20.90	13.37	14.38	21.99
30	7.90	19.36	14.43	22.97	14.69	15.80	24.17
40	8.33	20.41	15.21	24.22	15.49	16.66	25.48
60	8.84	21.66	16.14	25.70	16.44	17.68	27.04
Unlimited	8.91	21.83	16.27	25.90	16.57	17.82	27.26
LARGE GROUP				**$25 Copay**			
20	6.68	16.37	12.20	19.42	12.42	13.36	20.43
30	7.36	18.03	13.44	21.40	13.69	14.72	22.51
40	7.84	19.21	14.32	22.79	14.58	15.68	23.98
60	8.23	20.16	15.03	23.92	15.31	16.46	25.18
Unlimited	8.32	20.38	15.19	24.19	15.48	16.64	25.45
LARGE GROUP				**$30 Copay**			
20	6.39	15.66	11.67	18.58	11.89	12.78	19.55
30	6.93	16.98	12.65	20.15	12.89	13.86	21.20
40	7.38	18.08	13.48	21.45	13.73	14.76	22.58
60	7.72	18.91	14.10	22.44	14.36	15.44	23.62
Unlimited	7.76	19.01	14.17	22.56	14.43	15.52	23.74

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
LARGE GROUP				**$35 Copay**			
20	6.06	14.85	11.07	17.62	11.27	12.12	18.54
30	6.48	15.88	11.83	18.84	12.05	12.96	19.82
40	6.90	16.91	12.60	20.06	12.83	13.80	21.11
60	7.22	17.69	13.18	20.99	13.43	14.44	22.09
Unlimited	7.28	17.84	13.29	21.16	13.54	14.56	22.27
LARGE GROUP				**$40 Copay**			
20	5.91	14.48	10.79	17.18	10.99	11.82	18.08
30	6.30	15.44	11.50	18.31	11.72	12.60	19.27
40	6.71	16.44	12.25	19.51	12.48	13.42	20.53
60	7.08	17.35	12.93	20.58	13.17	14.16	21.66
Unlimited	7.13	17.47	13.02	20.73	13.26	14.26	21.81
LARGE GROUP				**$45 Copay**			
20	5.74	14.06	10.48	16.69	10.68	11.48	17.56
30	6.11	14.97	11.16	17.76	11.36	12.22	18.69
40	6.54	16.02	11.94	19.01	12.16	13.08	20.01
60	6.91	16.93	12.62	20.09	12.85	13.82	21.14
Unlimited	6.95	17.03	12.69	20.20	12.93	13.90	21.26
LARGE GROUP				**$50 Copay**			
20	5.56	13.62	10.15	16.16	10.34	11.12	17.01
30	5.97	14.63	10.90	17.35	11.10	11.94	18.26
40	6.39	15.66	11.67	18.58	11.89	12.78	19.55
60	6.73	16.49	12.29	19.56	12.52	13.46	20.59
Unlimited	6.77	16.59	12.36	19.68	12.59	13.54	20.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.56	16.07	11.98	19.07	12.20	13.12	20.07
$0/Max $5000	6.15	15.07	11.23	17.88	11.44	12.30	18.81
$0/Max $2500	5.80	14.21	10.59	16.86	10.79	11.60	17.74
$25	6.15	15.07	11.23	17.88	11.44	12.30	18.81
$50	5.80	14.21	10.59	16.86	10.79	11.60	17.74
$100	5.21	12.76	9.51	15.15	9.69	10.42	15.94
$500	2.57	6.30	4.69	7.47	4.78	5.14	7.86
$5,000	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Coinsurance							
80%	5.22	12.79	9.53	15.17	9.71	10.44	15.97
75%	4.92	12.05	8.98	14.30	9.15	9.84	15.05
70%	4.57	11.20	8.34	13.28	8.50	9.14	13.98
			Orthotics Riders				
$0/Max $5000	6.81	16.68	12.44	19.80	12.67	13.62	20.83
$0/Max $2500	6.31	15.46	11.52	18.34	11.74	12.62	19.30
Deductible							
$0	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$0/Max $5000	1.07	2.62	1.95	3.11	1.99	2.14	3.27
$0/Max $2500	1.02	2.50	1.86	2.97	1.90	2.04	3.12
$25	1.07	2.62	1.95	3.11	1.99	2.14	3.27
$50	1.02	2.50	1.86	2.97	1.90	2.04	3.12
$100	0.93	2.28	1.70	2.70	1.73	1.86	2.84
$500	0.45	1.10	0.82	1.31	0.84	0.90	1.38
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.93	2.28	1.70	2.70	1.73	1.86	2.84
75%	0.87	2.13	1.59	2.53	1.62	1.74	2.66
70%	0.78	1.91	1.42	2.27	1.45	1.56	2.39

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.76	1.86	1.39	2.21	1.41	1.52	2.32
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	14.34	35.13	26.18	41.69	26.67	28.68	43.87
3 IVF	17.23	42.21	31.46	50.09	32.05	34.46	52.71
			Nurse Advice Line Rider				
	0.30	0.74	0.55	0.87	0.56	0.60	0.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFITS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Large Group*	511.05	1,252.07	933.18	1,485.62	950.55	1,022.10	1,563.30

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.41)	(8.35)	(6.23)	(9.91)	(6.34)	(6.82)	(10.43)
$10	(7.18)	(17.59)	(13.11)	(20.87)	(13.35)	(14.36)	(21.96)
$15	(11.96)	(29.30)	(21.84)	(34.77)	(22.25)	(23.92)	(36.59)
$20	(18.44)	(45.18)	(33.67)	(53.61)	(34.30)	(36.88)	(56.41)
$25	(24.30)	(59.54)	(44.37)	(70.64)	(45.20)	(48.60)	(74.33)
$30	(30.73)	(75.29)	(56.11)	(89.33)	(57.16)	(61.46)	(94.00)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.97)	(4.83)	(3.60)	(5.73)	(3.66)	(3.94)	(6.03)
$10	(4.12)	(10.09)	(7.52)	(11.98)	(7.66)	(8.24)	(12.60)
$15	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$20	(10.56)	(25.87)	(19.28)	(30.70)	(19.64)	(21.12)	(32.30)
$25	(13.92)	(34.10)	(25.42)	(40.47)	(25.89)	(27.84)	(42.58)
$30	(17.62)	(43.17)	(32.17)	(51.22)	(32.77)	(35.24)	(53.90)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.50)	(6.13)	(4.57)	(7.27)	(4.65)	(5.00)	(7.65)
$10	(5.17)	(12.67)	(9.44)	(15.03)	(9.62)	(10.34)	(15.82)
$15	(8.11)	(19.87)	(14.81)	(23.58)	(15.08)	(16.22)	(24.81)
$20	(11.43)	(28.00)	(20.87)	(33.23)	(21.26)	(22.86)	(34.96)
$25	(15.07)	(36.92)	(27.52)	(43.81)	(28.03)	(30.14)	(46.10)
$30	(19.21)	(47.06)	(35.08)	(55.84)	(35.73)	(38.42)	(58.76)
$35	(23.08)	(56.55)	(42.14)	(67.09)	(42.93)	(46.16)	(70.60)
$40	(27.10)	(66.40)	(49.48)	(78.78)	(50.41)	(54.20)	(82.90)
$45	(31.33)	(76.76)	(57.21)	(91.08)	(58.27)	(62.66)	(95.84)
$50	(35.76)	(87.61)	(65.30)	(103.95)	(66.51)	(71.52)	(109.39)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.12)	(5.19)	(3.87)	(6.16)	(3.94)	(4.24)	(6.49)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$20	(9.66)	(23.67)	(17.64)	(28.08)	(17.97)	(19.32)	(29.55)
$25	(12.73)	(31.19)	(23.24)	(37.01)	(23.68)	(25.46)	(38.94)
$30	(16.23)	(39.76)	(29.64)	(47.18)	(30.19)	(32.46)	(49.65)
$35	(19.53)	(47.85)	(35.66)	(56.77)	(36.33)	(39.06)	(59.74)
$40	(22.91)	(56.13)	(41.83)	(66.60)	(42.61)	(45.82)	(70.08)
$45	(26.49)	(64.90)	(48.37)	(77.01)	(49.27)	(52.98)	(81.03)
$50	(30.24)	(74.09)	(55.22)	(87.91)	(56.25)	(60.48)	(92.50)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$150	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$200	(2.92)	(7.15)	(5.33)	(8.49)	(5.43)	(5.84)	(8.93)
$250	(4.22)	(10.34)	(7.71)	(12.27)	(7.85)	(8.44)	(12.91)
$500	(10.09)	(24.72)	(18.42)	(29.33)	(18.77)	(20.18)	(30.87)
$750	(17.30)	(42.39)	(31.59)	(50.29)	(32.18)	(34.60)	(52.92)
$1,000	(26.05)	(63.82)	(47.57)	(75.73)	(48.45)	(52.10)	(79.69)
Copay/Day							
$50 w/3 Day Max	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$50 w/5 Day Max	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$100 w/3 Day Max	(3.79)	(9.29)	(6.92)	(11.02)	(7.05)	(7.58)	(11.59)
$100 w/5 Day Max	(5.46)	(13.38)	(9.97)	(15.87)	(10.16)	(10.92)	(16.70)
$250 w/3 Day Max	(12.54)	(30.72)	(22.90)	(36.45)	(23.32)	(25.08)	(38.36)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$75	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$100	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$125	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$150	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$25	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$35	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$50	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$60	(1.82)	(4.46)	(3.32)	(5.29)	(3.39)	(3.64)	(5.57)
$75	(2.39)	(5.86)	(4.36)	(6.95)	(4.45)	(4.78)	(7.31)
$100	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
$125	(4.22)	(10.34)	(7.71)	(12.27)	(7.85)	(8.44)	(12.91)
$150	(5.01)	(12.27)	(9.15)	(14.56)	(9.32)	(10.02)	(15.33)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.58	1.42	1.06	1.69	1.08	1.16	1.77
60	1.14	2.79	2.08	3.31	2.12	2.28	3.49
90	1.71	4.19	3.12	4.97	3.18	3.42	5.23
120	2.01	4.92	3.67	5.84	3.74	4.02	6.15
Unlimited	2.60	6.37	4.75	7.56	4.84	5.20	7.95
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$20 copay	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
40/$25 copay	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
60	0.31	0.76	0.57	0.90	0.58	0.62	0.95
100	0.75	1.84	1.37	2.18	1.40	1.50	2.29
200	2.01	4.92	3.67	5.84	3.74	4.02	6.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.78	1.91	1.42	2.27	1.45	1.56	2.39
90	1.64	4.02	2.99	4.77	3.05	3.28	5.02

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.70	1.72	1.28	2.03	1.30	1.40	2.14
90	1.28	3.14	2.34	3.72	2.38	2.56	3.92
120	2.09	5.12	3.82	6.08	3.89	4.18	6.39
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.30	0.74	0.55	0.87	0.56	0.60	0.92
30	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Unlimited	0.70	1.72	1.28	2.03	1.30	1.40	2.14
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.54	8.67	6.46	10.29	6.58	7.08	10.83
60	4.14	10.14	7.56	12.03	7.70	8.28	12.66
90	4.94	12.10	9.02	14.36	9.19	9.88	15.11
Unlimited	5.01	12.27	9.15	14.56	9.32	10.02	15.33
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
60/$15 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
60/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60/$25 copay	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
120/$0 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
120/$5 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$10 copay	0.29	0.71	0.53	0.84	0.54	0.58	0.89
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.71	1.74	1.30	2.06	1.32	1.42	2.17
Unlimited/$5 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$10 copa	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$20	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$25	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
$30	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$35	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
$40	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$45	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
$50	(1.83)	(4.48)	(3.34)	(5.32)	(3.40)	(3.66)	(5.60)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
$25	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$60	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$100	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(4.93)	(12.08)	(9.00)	(14.33)	(9.17)	(9.86)	(15.08)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.22	20.14	15.01	23.90	15.29	16.44	25.14
60	8.67	21.24	15.83	25.20	16.13	17.34	26.52
90	9.00	22.05	16.43	26.16	16.74	18.00	27.53
Unlimited	9.09	22.27	16.60	26.42	16.91	18.18	27.81
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.19	22.52	16.78	26.72	17.09	18.38	28.11
30	10.12	24.79	18.48	29.42	18.82	20.24	30.96
40	10.69	26.19	19.52	31.08	19.88	21.38	32.70
60	11.26	27.59	20.56	32.73	20.94	22.52	34.44
Unlimited	11.35	27.81	20.73	32.99	21.11	22.70	34.72
LARGE GROUP				**$5 Copay**			
20	8.65	21.19	15.79	25.15	16.09	17.30	26.46
30	9.52	23.32	17.38	27.67	17.71	19.04	29.12
40	10.11	24.77	18.46	29.39	18.80	20.22	30.93
60	10.59	25.95	19.34	30.79	19.70	21.18	32.39
Unlimited	10.68	26.17	19.50	31.05	19.86	21.36	32.67
LARGE GROUP				**$10 Copay**			
20	8.10	19.85	14.79	23.55	15.07	16.20	24.78
30	8.91	21.83	16.27	25.90	16.57	17.82	27.26
40	9.42	23.08	17.20	27.38	17.52	18.84	28.82
60	9.93	24.33	18.13	28.87	18.47	19.86	30.38
Unlimited	10.01	24.52	18.28	29.10	18.62	20.02	30.62
LARGE GROUP				**$15 Copay**			
20	7.60	18.62	13.88	22.09	14.14	15.20	23.25
30	8.37	20.51	15.28	24.33	15.57	16.74	25.60
40	8.87	21.73	16.20	25.79	16.50	17.74	27.13
60	9.37	22.96	17.11	27.24	17.43	18.74	28.66
Unlimited	9.45	23.15	17.26	27.47	17.58	18.90	28.91
LARGE GROUP				**$20 Copay**			
20	7.15	17.52	13.06	20.79	13.30	14.30	21.87
30	7.84	19.21	14.32	22.79	14.58	15.68	23.98
40	8.27	20.26	15.10	24.04	15.38	16.54	25.30

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	8.79	21.54	16.05	25.55	16.35	17.58	26.89
Unlimited	8.86	21.71	16.18	25.76	16.48	17.72	27.10
LARGE GROUP				$25 Copay			
20	6.64	16.27	12.12	19.30	12.35	13.28	20.31
30	7.29	17.86	13.31	21.19	13.56	14.58	22.30
40	7.79	19.09	14.22	22.65	14.49	15.58	23.83
60	8.18	20.04	14.94	23.78	15.21	16.36	25.02
Unlimited	8.26	20.24	15.08	24.01	15.36	16.52	25.27
LARGE GROUP				$30 Copay			
20	6.35	15.56	11.60	18.46	11.81	12.70	19.42
30	6.88	16.86	12.56	20.00	12.80	13.76	21.05
40	7.32	17.93	13.37	21.28	13.62	14.64	22.39
60	7.68	18.82	14.02	22.33	14.28	15.36	23.49
Unlimited	7.72	18.91	14.10	22.44	14.36	15.44	23.62
LARGE GROUP				$35 Copay			
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.44	15.78	11.76	18.72	11.98	12.88	19.70
40	6.85	16.78	12.51	19.91	12.74	13.70	20.95
60	7.18	17.59	13.11	20.87	13.35	14.36	21.96
Unlimited	7.23	17.71	13.20	21.02	13.45	14.46	22.12
LARGE GROUP				$40 Copay			
20	5.88	14.41	10.74	17.09	10.94	11.76	17.99
30	6.26	15.34	11.43	18.20	11.64	12.52	19.15
40	6.66	16.32	12.16	19.36	12.39	13.32	20.37
60	7.03	17.22	12.84	20.44	13.08	14.06	21.50
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP				$45 Copay			
20	5.69	13.94	10.39	16.54	10.58	11.38	17.41
30	6.07	14.87	11.08	17.65	11.29	12.14	18.57
40	6.50	15.93	11.87	18.90	12.09	13.00	19.88
60	6.87	16.83	12.54	19.97	12.78	13.74	21.02
Unlimited	6.90	16.91	12.60	20.06	12.83	13.80	21.11
LARGE GROUP				$50 Copay			
20	5.53	13.55	10.10	16.08	10.29	11.06	16.92
30	5.93	14.53	10.83	17.24	11.03	11.86	18.14
40	6.35	15.56	11.60	18.46	11.81	12.70	19.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
60	6.68	16.37	12.20	19.42	12.42	13.36	20.43
Unlimited	6.73	16.49	12.29	19.56	12.52	13.46	20.59

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.57	11.20	8.34	13.28	8.50	9.14	13.98
$25	4.34	10.63	7.92	12.62	8.07	8.68	13.28
$50	4.06	9.95	7.41	11.80	7.55	8.12	12.42
$100	3.74	9.16	6.83	10.87	6.96	7.48	11.44
$500	1.78	4.36	3.25	5.17	3.31	3.56	5.45
Coinsurance							
80%	3.68	9.02	6.72	10.70	6.84	7.36	11.26
75%	3.43	8.40	6.26	9.97	6.38	6.86	10.49
70%	3.21	7.86	5.86	9.33	5.97	6.42	9.82
Deductible			**Orthotics Riders**				
$0	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$25	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$50	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$100	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$500	0.32	0.78	0.58	0.93	0.60	0.64	0.98
Coinsurance							
80%	0.63	1.54	1.15	1.83	1.17	1.26	1.93
75%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
70%	0.56	1.37	1.02	1.63	1.04	1.12	1.71
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.54	1.32	0.99	1.57	1.00	1.08	1.65
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49

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HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	9.67	23.69	17.66	28.11	17.99	19.34	29.58
3 IVF	11.71	28.69	21.38	34.04	21.78	23.42	35.82
			Nurse Advice Line Rider				
	0.30	0.74	0.55	0.87	0.56	0.60	0.92

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HIPaccess ll POS LARGE GROUP CONTRACT - BASE BENEFITS *
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
929.97	2,278.43	1,698.13	2,703.42	1,729.74	1,859.94	2,844.78
75% Coinsurance						
884.52	2,167.07	1,615.13	2,571.30	1,645.21	1,769.04	2,705.75
70% Coinsurance						
840.19	2,058.47	1,534.19	2,442.43	1,562.75	1,680.38	2,570.14
50% Coinsurance						
794.75	1,947.14	1,451.21	2,310.34	1,478.24	1,589.50	2,431.14

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max

** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			LARGE GROUP				
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(56.96)	(139.55)	(104.01)	(165.58)	(105.95)	(113.92)	(174.24)
$250	(67.96)	(166.50)	(124.09)	(197.56)	(126.41)	(135.92)	(207.89)
$300	(78.98)	(193.50)	(144.22)	(229.59)	(146.90)	(157.96)	(241.60)
$350	(90.00)	(220.50)	(164.34)	(261.63)	(167.40)	(180.00)	(275.31)
$400	(98.65)	(241.69)	(180.13)	(286.78)	(183.49)	(197.30)	(301.77)
$500	(115.96)	(284.10)	(211.74)	(337.10)	(215.69)	(231.92)	(354.72)
$750	(150.59)	(368.95)	(274.98)	(437.77)	(280.10)	(301.18)	(460.65)
$1,000	(177.27)	(434.31)	(323.70)	(515.32)	(329.72)	(354.54)	(542.27)
$1,500	(218.05)	(534.22)	(398.16)	(633.87)	(405.57)	(436.10)	(667.01)
$2,000	(234.73)	(575.09)	(428.62)	(682.36)	(436.60)	(469.46)	(718.04)
$2,500	(251.47)	(616.10)	(459.18)	(731.02)	(467.73)	(502.94)	(769.25)
$5,000	(295.63)	(724.29)	(539.82)	(859.40)	(549.87)	(591.26)	(904.33)
$10,000	(332.09)	(813.62)	(606.40)	(965.39)	(617.69)	(664.18)	(1,015.86)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(46.68)	(114.37)	(85.24)	(135.70)	(86.82)	(93.36)	(142.79)
$250	(55.69)	(136.44)	(101.69)	(161.89)	(103.58)	(111.38)	(170.36)
$300	(64.72)	(158.56)	(118.18)	(188.14)	(120.38)	(129.44)	(197.98)
$350	(73.71)	(180.59)	(134.59)	(214.27)	(137.10)	(147.42)	(225.48)
$400	(80.96)	(198.35)	(147.83)	(235.35)	(150.59)	(161.92)	(247.66)
$500	(95.49)	(233.95)	(174.36)	(277.59)	(177.61)	(190.98)	(292.10)
$750	(124.21)	(304.31)	(226.81)	(361.08)	(231.03)	(248.42)	(379.96)
$1,000	(146.56)	(359.07)	(267.62)	(426.05)	(272.60)	(293.12)	(448.33)
$1,500	(180.44)	(442.08)	(329.48)	(524.54)	(335.62)	(360.88)	(551.97)
$2,000	(195.81)	(479.73)	(357.55)	(569.22)	(364.21)	(391.62)	(598.98)
$2,500	(211.16)	(517.34)	(385.58)	(613.84)	(392.76)	(422.32)	(645.94)
$5,000	(255.13)	(625.07)	(465.87)	(741.66)	(474.54)	(510.26)	(780.44)
$10,000	(291.40)	(713.93)	(532.10)	(847.10)	(542.00)	(582.80)	(891.39)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(36.39)	(89.16)	(66.45)	(105.79)	(67.69)	(72.78)	(111.32)
$250	(43.41)	(106.35)	(79.27)	(126.19)	(80.74)	(86.82)	(132.79)
$300	(50.44)	(123.58)	(92.10)	(146.63)	(93.82)	(100.88)	(154.30)
$350	(57.45)	(140.75)	(104.90)	(167.01)	(106.86)	(114.90)	(175.74)
$400	(63.33)	(155.16)	(115.64)	(184.10)	(117.79)	(126.66)	(193.73)
$500	(74.96)	(183.65)	(136.88)	(217.91)	(139.43)	(149.92)	(229.30)
$750	(97.80)	(239.61)	(178.58)	(284.30)	(181.91)	(195.60)	(299.17)
$1,000	(115.80)	(283.71)	(211.45)	(336.63)	(215.39)	(231.60)	(354.23)
$1,500	(142.86)	(350.01)	(260.86)	(415.29)	(265.72)	(285.72)	(437.01)
$2,000	(156.89)	(384.38)	(286.48)	(456.08)	(291.82)	(313.78)	(479.93)
$2,500	(170.92)	(418.75)	(312.10)	(496.86)	(317.91)	(341.84)	(522.84)
$5,000	(214.64)	(525.87)	(391.93)	(623.96)	(399.23)	(429.28)	(656.58)
$10,000	(250.76)	(614.36)	(457.89)	(728.96)	(466.41)	(501.52)	(767.07)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(25.02)	(61.30)	(45.69)	(72.73)	(46.54)	(50.04)	(76.54)
$250	(29.97)	(73.43)	(54.73)	(87.12)	(55.74)	(59.94)	(91.68)
$300	(34.96)	(85.65)	(63.84)	(101.63)	(65.03)	(69.92)	(106.94)
$350	(39.92)	(97.80)	(72.89)	(116.05)	(74.25)	(79.84)	(122.12)
$400	(44.24)	(108.39)	(80.78)	(128.61)	(82.29)	(88.48)	(135.33)
$500	(52.85)	(129.48)	(96.50)	(153.63)	(98.30)	(105.70)	(161.67)
$750	(69.34)	(169.88)	(126.61)	(201.57)	(128.97)	(138.68)	(212.11)
$1,000	(82.74)	(202.71)	(151.08)	(240.53)	(153.90)	(165.48)	(253.10)
$1,500	(103.41)	(253.35)	(188.83)	(300.61)	(192.34)	(206.82)	(316.33)
$2,000	(114.41)	(280.30)	(208.91)	(332.59)	(212.80)	(228.82)	(349.98)
$2,500	(125.44)	(307.33)	(229.05)	(364.65)	(233.32)	(250.88)	(383.72)
$5,000	(168.56)	(412.97)	(307.79)	(490.00)	(313.52)	(337.12)	(515.63)
$10,000	(204.15)	(500.17)	(372.78)	(593.46)	(379.72)	(408.30)	(624.49)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(52.73)	(129.19)	(96.28)	(153.29)	(98.08)	(105.46)	(161.30)
$1,500	(57.52)	(140.92)	(105.03)	(167.21)	(106.99)	(115.04)	(175.95)
$2,000	(60.00)	(147.00)	(109.56)	(174.42)	(111.60)	(120.00)	(183.54)
$3,000	(62.29)	(152.61)	(113.74)	(181.08)	(115.86)	(124.58)	(190.55)
$4,000	(63.24)	(154.94)	(115.48)	(183.84)	(117.63)	(126.48)	(193.45)
$5,000	(63.74)	(156.16)	(116.39)	(185.29)	(118.56)	(127.48)	(194.98)
$7,000	(64.37)	(157.71)	(117.54)	(187.12)	(119.73)	(128.74)	(196.91)
$7,500	(64.89)	(158.98)	(118.49)	(188.64)	(120.70)	(129.78)	(198.50)
$10,000	(66.79)	(163.64)	(121.96)	(194.16)	(124.23)	(133.58)	(204.31)
$20,000	(69.50)	(170.28)	(126.91)	(202.04)	(129.27)	(139.00)	(212.60)
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(50.97)	(124.88)	(93.07)	(148.17)	(94.80)	(101.94)	(155.92)
$1,500	(56.65)	(138.79)	(103.44)	(164.68)	(105.37)	(113.30)	(173.29)
$2,000	(59.79)	(146.49)	(109.18)	(173.81)	(111.21)	(119.58)	(182.90)
$3,000	(62.90)	(154.11)	(114.86)	(182.85)	(116.99)	(125.80)	(192.41)
$4,000	(64.30)	(157.54)	(117.41)	(186.92)	(119.60)	(128.60)	(196.69)
$5,000	(65.08)	(159.45)	(118.84)	(189.19)	(121.05)	(130.16)	(199.08)
$7,000	(65.84)	(161.31)	(120.22)	(191.40)	(122.46)	(131.68)	(201.40)
$7,500	(66.40)	(162.68)	(121.25)	(193.02)	(123.50)	(132.80)	(203.12)
$10,000	(68.74)	(168.41)	(125.52)	(199.83)	(127.86)	(137.48)	(210.28)
$20,000	(72.33)	(177.21)	(132.07)	(210.26)	(134.53)	(144.66)	(221.26)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(49.21)	(120.56)	(89.86)	(143.05)	(91.53)	(98.42)	(150.53)
$1,500	(55.79)	(136.69)	(101.87)	(162.18)	(103.77)	(111.58)	(170.66)
$2,000	(59.60)	(146.02)	(108.83)	(173.26)	(110.86)	(119.20)	(182.32)
$3,000	(63.54)	(155.67)	(116.02)	(184.71)	(118.18)	(127.08)	(194.37)
$4,000	(65.33)	(160.06)	(119.29)	(189.91)	(121.51)	(130.66)	(199.84)
$5,000	(66.38)	(162.63)	(121.21)	(192.97)	(123.47)	(132.76)	(203.06)
$7,000	(67.32)	(164.93)	(122.93)	(195.70)	(125.22)	(134.64)	(205.93)
$7,500	(67.92)	(166.40)	(124.02)	(197.44)	(126.33)	(135.84)	(207.77)
$10,000	(70.48)	(172.68)	(128.70)	(204.89)	(131.09)	(140.96)	(215.60)
$20,000	(75.06)	(183.90)	(137.06)	(218.20)	(139.61)	(150.12)	(229.61)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(55.69)	(136.44)	(101.69)	(161.89)	(103.58)	(111.38)	(170.36)
$1,500	(66.34)	(162.53)	(121.14)	(192.85)	(123.39)	(132.68)	(202.93)
$2,000	(73.23)	(179.41)	(133.72)	(212.88)	(136.21)	(146.46)	(224.01)
$3,000	(81.55)	(199.80)	(148.91)	(237.07)	(151.68)	(163.10)	(249.46)
$4,000	(86.14)	(211.04)	(157.29)	(250.41)	(160.22)	(172.28)	(263.50)
$5,000	(88.95)	(217.93)	(162.42)	(258.58)	(165.45)	(177.90)	(272.10)
$7,000	(91.85)	(225.03)	(167.72)	(267.01)	(170.84)	(183.70)	(280.97)
$7,500	(92.92)	(227.65)	(169.67)	(270.12)	(172.83)	(185.84)	(284.24)
$10,000	(97.24)	(238.24)	(177.56)	(282.68)	(180.87)	(194.48)	(297.46)
$20,000	(106.34)	(260.53)	(194.18)	(309.13)	(197.79)	(212.68)	(325.29)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$1,000,000	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$50,000	(5.46)	(13.38)	(9.97)	(15.87)	(10.16)	(10.92)	(16.70)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
75%	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
70%	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.30)	(5.64)	(4.20)	(6.69)	(4.28)	(4.60)	(7.04)
$10	(4.82)	(11.81)	(8.80)	(14.01)	(8.97)	(9.64)	(14.74)
$15	(8.01)	(19.62)	(14.63)	(23.29)	(14.90)	(16.02)	(24.50)
$20	(12.37)	(30.31)	(22.59)	(35.96)	(23.01)	(24.74)	(37.84)
$25	(16.28)	(39.89)	(29.73)	(47.33)	(30.28)	(32.56)	(49.80)
$30	(20.59)	(50.45)	(37.60)	(59.86)	(38.30)	(41.18)	(62.98)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$10	(2.76)	(6.76)	(5.04)	(8.02)	(5.13)	(5.52)	(8.44)
$15	(4.59)	(11.25)	(8.38)	(13.34)	(8.54)	(9.18)	(14.04)
$20	(7.08)	(17.35)	(12.93)	(20.58)	(13.17)	(14.16)	(21.66)
$25	(9.33)	(22.86)	(17.04)	(27.12)	(17.35)	(18.66)	(28.54)
$30	(11.79)	(28.89)	(21.53)	(34.27)	(21.93)	(23.58)	(36.07)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$10	(3.45)	(8.45)	(6.30)	(10.03)	(6.42)	(6.90)	(10.55)
$15	(5.43)	(13.30)	(9.92)	(15.79)	(10.10)	(10.86)	(16.61)
$20	(7.64)	(18.72)	(13.95)	(22.21)	(14.21)	(15.28)	(23.37)
$25	(10.10)	(24.75)	(18.44)	(29.36)	(18.79)	(20.20)	(30.90)
$30	(12.87)	(31.53)	(23.50)	(37.41)	(23.94)	(25.74)	(39.37)
$35	(15.46)	(37.88)	(28.23)	(44.94)	(28.76)	(30.92)	(47.29)
$40	(18.15)	(44.47)	(33.14)	(52.76)	(33.76)	(36.30)	(55.52)
$45	(20.99)	(51.43)	(38.33)	(61.02)	(39.04)	(41.98)	(64.21)
$50	(23.95)	(58.68)	(43.73)	(69.62)	(44.55)	(47.90)	(73.26)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$10	(2.92)	(7.15)	(5.33)	(8.49)	(5.43)	(5.84)	(8.93)
$15	(4.59)	(11.25)	(8.38)	(13.34)	(8.54)	(9.18)	(14.04)
$20	(6.47)	(15.85)	(11.81)	(18.81)	(12.03)	(12.94)	(19.79)
$25	(8.54)	(20.92)	(15.59)	(24.83)	(15.88)	(17.08)	(26.12)
$30	(10.88)	(26.66)	(19.87)	(31.63)	(20.24)	(21.76)	(33.28)
$35	(13.09)	(32.07)	(23.90)	(38.05)	(24.35)	(26.18)	(40.04)
$40	(15.35)	(37.61)	(28.03)	(44.62)	(28.55)	(30.70)	(46.96)
$45	(17.74)	(43.46)	(32.39)	(51.57)	(33.00)	(35.48)	(54.27)
$50	(20.26)	(49.64)	(36.99)	(58.90)	(37.68)	(40.52)	(61.98)
Copay/Admit	Inpatient Facility Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$150	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$200	(1.97)	(4.83)	(3.60)	(5.73)	(3.66)	(3.94)	(6.03)
$250	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$500	(6.75)	(16.54)	(12.33)	(19.62)	(12.56)	(13.50)	(20.65)
$750	(11.59)	(28.40)	(21.16)	(33.69)	(21.56)	(23.18)	(35.45)
$1,000	(17.45)	(42.75)	(31.86)	(50.73)	(32.46)	(34.90)	(53.38)
Copay/Day							
$50 w/3 Day Max	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$50 w/5 Day Max	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$100 w/3 Day Max	(2.55)	(6.25)	(4.66)	(7.41)	(4.74)	(5.10)	(7.80)
$100 w/5 Day Max	(3.67)	(8.99)	(6.70)	(10.67)	(6.83)	(7.34)	(11.23)
$250 w/3 Day Max	(8.40)	(20.58)	(15.34)	(24.42)	(15.62)	(16.80)	(25.70)
Copay	Ambulatory Surgery Facility Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$100	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$125	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$150	(1.66)	(4.07)	(3.03)	(4.83)	(3.09)	(3.32)	(5.08)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$35	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$50	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
$60	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
$75	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$100	(2.29)	(5.61)	(4.18)	(6.66)	(4.26)	(4.58)	(7.01)
$125	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$150	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.46	1.13	0.84	1.34	0.86	0.92	1.41
60	0.89	2.18	1.63	2.59	1.66	1.78	2.72
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98
120	1.54	3.77	2.81	4.48	2.86	3.08	4.71
Unlimited	1.99	4.88	3.63	5.78	3.70	3.98	6.09
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.51	1.25	0.93	1.48	0.95	1.02	1.56
200	1.35	3.31	2.47	3.92	2.51	2.70	4.13
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.61	1.49	1.11	1.77	1.13	1.22	1.87
90	1.24	3.04	2.26	3.60	2.31	2.48	3.79

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Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.53	1.30	0.97	1.54	0.99	1.06	1.62
90	0.99	2.43	1.81	2.88	1.84	1.98	3.03
120	1.60	3.92	2.92	4.65	2.98	3.20	4.89
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.62
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.36	5.78	4.31	6.86	4.39	4.72	7.22
60	2.78	6.81	5.08	8.08	5.17	5.56	8.50
90	3.31	8.11	6.04	9.62	6.16	6.62	10.13
Unlimited	3.36	8.23	6.14	9.77	6.25	6.72	10.28
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
60/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
120/$0 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$5 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$5 copay	0.43	1.05	0.79	1.25	0.80	0.86	1.32
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$25	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$30	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$35	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$40	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$45	(1.11)	(2.72)	(2.03)	(3.23)	(2.06)	(2.22)	(3.40)
$50	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$25	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)

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Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.31)	(8.11)	(6.04)	(9.62)	(6.16)	(6.62)	(10.13)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

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MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.64	21.17	15.78	25.12	16.07	17.28	26.43
60	9.11	22.32	16.63	26.48	16.94	18.22	27.87
90	9.44	23.13	17.24	27.44	17.56	18.88	28.88
Unlimited	9.55	23.40	17.44	27.76	17.76	19.10	29.21
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.65	23.64	17.62	28.05	17.95	19.30	29.52
30	10.63	26.04	19.41	30.90	19.77	21.26	32.52
40	11.22	27.49	20.49	32.62	20.87	22.44	34.32
60	11.82	28.96	21.58	34.36	21.99	23.64	36.16
Unlimited	11.92	29.20	21.77	34.65	22.17	23.84	36.46
LARGE GROUP				**$5 Copay**			
20	9.08	22.25	16.58	26.40	16.89	18.16	27.78
30	9.99	24.48	18.24	29.04	18.58	19.98	30.56
40	10.62	26.02	19.39	30.87	19.75	21.24	32.49
60	11.11	27.22	20.29	32.30	20.66	22.22	33.99
Unlimited	11.21	27.46	20.47	32.59	20.85	22.42	34.29
LARGE GROUP				**$10 Copay**			
20	8.51	20.85	15.54	24.74	15.83	17.02	26.03
30	9.36	22.93	17.09	27.21	17.41	18.72	28.63
40	9.89	24.23	18.06	28.75	18.40	19.78	30.25
60	10.43	25.55	19.05	30.32	19.40	20.86	31.91
Unlimited	10.51	25.75	19.19	30.55	19.55	21.02	32.15
LARGE GROUP				**$15 Copay**			
20	7.98	19.55	14.57	23.20	14.84	15.96	24.41
30	8.79	21.54	16.05	25.55	16.35	17.58	26.89
40	9.31	22.81	17.00	27.06	17.32	18.62	28.48
60	9.85	24.13	17.99	28.63	18.32	19.70	30.13
Unlimited	9.93	24.33	18.13	28.87	18.47	19.86	30.38

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.51	18.40	13.71	21.83	13.97	15.02	22.97
30	8.23	20.16	15.03	23.92	15.31	16.46	25.18
40	8.68	21.27	15.85	25.23	16.14	17.36	26.55
60	9.23	22.61	16.85	26.83	17.17	18.46	28.23
Unlimited	9.30	22.79	16.98	27.04	17.30	18.60	28.45
LARGE GROUP				**$25 Copay**			
20	6.98	17.10	12.75	20.29	12.98	13.96	21.35
30	7.67	18.79	14.01	22.30	14.27	15.34	23.46
40	8.17	20.02	14.92	23.75	15.20	16.34	24.99
60	8.60	21.07	15.70	25.00	16.00	17.20	26.31
Unlimited	8.67	21.24	15.83	25.20	16.13	17.34	26.52
LARGE GROUP				**$30 Copay**			
20	6.65	16.29	12.14	19.33	12.37	13.30	20.34
30	7.21	17.66	13.17	20.96	13.41	14.42	22.06
40	7.69	18.84	14.04	22.35	14.30	15.38	23.52
60	8.07	19.77	14.74	23.46	15.01	16.14	24.69
Unlimited	8.11	19.87	14.81	23.58	15.08	16.22	24.81
LARGE GROUP				**$35 Copay**			
20	6.33	15.51	11.56	18.40	11.77	12.66	19.36
30	6.75	16.54	12.33	19.62	12.56	13.50	20.65
40	7.19	17.62	13.13	20.90	13.37	14.38	21.99
60	7.55	18.50	13.79	21.95	14.04	15.10	23.10
Unlimited	7.60	18.62	13.88	22.09	14.14	15.20	23.25

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$40 Copay**			
20	6.15	15.07	11.23	17.88	11.44	12.30	18.81
30	6.56	16.07	11.98	19.07	12.20	13.12	20.07
40	7.00	17.15	12.78	20.35	13.02	14.00	21.41
60	7.38	18.08	13.48	21.45	13.73	14.76	22.58
Unlimited	7.44	18.23	13.59	21.63	13.84	14.88	22.76
LARGE GROUP				**$45 Copay**			
20	5.98	14.65	10.92	17.38	11.12	11.96	18.29
30	6.39	15.66	11.67	18.58	11.89	12.78	19.55
40	6.83	16.73	12.47	19.85	12.70	13.66	20.89
60	7.20	17.64	13.15	20.93	13.39	14.40	22.02
Unlimited	7.23	17.71	13.20	21.02	13.45	14.46	22.12
LARGE GROUP				**$50 Copay**			
20	5.82	14.26	10.63	16.92	10.83	11.64	17.80
30	6.22	15.24	11.36	18.08	11.57	12.44	19.03
40	6.65	16.29	12.14	19.33	12.37	13.30	20.34
60	7.02	17.20	12.82	20.41	13.06	14.04	21.47
Unlimited	7.07	17.32	12.91	20.55	13.15	14.14	21.63

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

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HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	6.85	16.78	12.51	19.91	12.74	13.70	20.95
$25	6.43	15.75	11.74	18.69	11.96	12.86	19.67
$50	6.05	14.82	11.05	17.59	11.25	12.10	18.51
$100	5.43	13.30	9.92	15.79	10.10	10.86	16.61
$500	2.67	6.54	4.88	7.76	4.97	5.34	8.17
Coinsurance							
80%	5.44	13.33	9.93	15.81	10.12	10.88	16.64
75%	5.12	12.54	9.35	14.88	9.52	10.24	15.66
70%	4.78	11.71	8.73	13.90	8.89	9.56	14.62
Deductible			**Orthotics Riders**				
$0	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$25	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$50	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$100	0.97	2.38	1.77	2.82	1.80	1.94	2.97
$500	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Coinsurance							
80%	0.97	2.38	1.77	2.82	1.80	1.94	2.97
75%	0.90	2.21	1.64	2.62	1.67	1.80	2.75
70%	0.85	2.08	1.55	2.47	1.58	1.70	2.60
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.79	1.94	1.44	2.30	1.47	1.58	2.42
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	14.97	36.68	27.34	43.52	27.84	29.94	45.79
3 IVF	17.96	44.00	32.79	52.21	33.41	35.92	54.94
			Nurse Advice Line Rider				
	0.30	0.74	0.55	0.87	0.56	0.60	0.92

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LARGE GROUP HMO
VHLI - LGRP - 01
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	561.17	1,460.28
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.11	5.17
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.31	3.21
Outpatient Mental Health: 20 Visits	5.83	14.30
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.07	2.61
Other Riders		
Durable Medical Equipment	1.55	3.66
Chiropractic: $5 Copay	4.12	10.82
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	137.46	357.40
Infertility Drug Coverage: $7 Brand Copay	3.21	8.40
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.48
Inpatient Substance Abuse Rehab: Unlimited days	4.42	10.83
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.62	1.52
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.48	1.17

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

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HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
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NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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Table 1: Drug Rider Base Values pmpm			
Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm				
Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm				
Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjusti Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	2.5%
3Q2011	1.9%
4Q2011	1.9%
1Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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Rate Calculation

Prime and Access Rate Formula

Large groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor

Example: Large Group HMO Individual Employee Rate Example

=	499.31	2nd QUARTER	(Base Rate
+	(5.04)	$10 Specialist visit copay	Optional Base Benefit Variables (exlcuding Mental Health)
+	8.88	Unlimited days	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	9.78	$10 copay, Unlimited visits	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	1.09	Standard Coverage	Network Area Factor
	523.19		

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	499.31	1,223.31	911.74	1,451.49	928.72	998.62	1,527.39

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.34)	(8.18)	(6.10)	(9.71)	(6.21)	(6.68)	(10.22)
$10	(7.02)	(17.20)	(12.82)	(20.41)	(13.06)	(14.04)	(21.47)
$15	(11.68)	(28.62)	(21.33)	(33.95)	(21.72)	(23.36)	(35.73)
$20	(18.03)	(44.17)	(32.92)	(52.41)	(33.54)	(36.06)	(55.15)
$25	(23.73)	(58.14)	(43.33)	(68.98)	(44.14)	(47.46)	(72.59)
$30	(30.02)	(73.55)	(54.82)	(87.27)	(55.84)	(60.04)	(91.83)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$10	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$15	(6.68)	(16.37)	(12.20)	(19.42)	(12.42)	(13.36)	(20.43)
$20	(10.32)	(25.28)	(18.84)	(30.00)	(19.20)	(20.64)	(31.57)
$25	(13.60)	(33.32)	(24.83)	(39.54)	(25.30)	(27.20)	(41.60)
$30	(17.22)	(42.19)	(31.44)	(50.06)	(32.03)	(34.44)	(52.68)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$10	(5.04)	(12.35)	(9.20)	(14.65)	(9.37)	(10.08)	(15.42)
$15	(7.91)	(19.38)	(14.44)	(22.99)	(14.71)	(15.82)	(24.20)
$20	(11.16)	(27.34)	(20.38)	(32.44)	(20.76)	(22.32)	(34.14)
$25	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$30	(18.76)	(45.96)	(34.26)	(54.54)	(34.89)	(37.52)	(57.39)
$35	(22.54)	(55.22)	(41.16)	(65.52)	(41.92)	(45.08)	(68.95)
$40	(26.47)	(64.85)	(48.33)	(76.95)	(49.23)	(52.94)	(80.97)
$45	(30.59)	(74.95)	(55.86)	(88.93)	(56.90)	(61.18)	(93.57)
$50	(34.93)	(85.58)	(63.78)	(101.54)	(64.97)	(69.86)	(106.85)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$10	(4.28)	(10.49)	(7.82)	(12.44)	(7.96)	(8.56)	(13.09)
$15	(6.68)	(16.37)	(12.20)	(19.42)	(12.42)	(13.36)	(20.43)
$20	(9.45)	(23.15)	(17.26)	(27.47)	(17.58)	(18.90)	(28.91)
$25	(12.45)	(30.50)	(22.73)	(36.19)	(23.16)	(24.90)	(38.08)
$30	(15.87)	(38.88)	(28.98)	(46.13)	(29.52)	(31.74)	(48.55)
$35	(19.09)	(46.77)	(34.86)	(55.49)	(35.51)	(38.18)	(58.40)
$40	(22.39)	(54.86)	(40.88)	(65.09)	(41.65)	(44.78)	(68.49)
$45	(25.87)	(63.38)	(47.24)	(75.20)	(48.12)	(51.74)	(79.14)
$50	(29.53)	(72.35)	(53.92)	(85.84)	(54.93)	(59.06)	(90.33)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
$150	(2.02)	(4.95)	(3.69)	(5.87)	(3.76)	(4.04)	(6.18)
$200	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$250	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$500	(9.84)	(24.11)	(17.97)	(28.60)	(18.30)	(19.68)	(30.10)
$750	(16.92)	(41.45)	(30.90)	(49.19)	(31.47)	(33.84)	(51.76)
$1,000	(25.44)	(62.33)	(46.45)	(73.95)	(47.32)	(50.88)	(77.82)
Copay/Day							
$50 w/3 Day Max	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$50 w/5 Day Max	(2.04)	(5.00)	(3.73)	(5.93)	(3.79)	(4.08)	(6.24)
$100 w/3 Day Max	(3.71)	(9.09)	(6.77)	(10.78)	(6.90)	(7.42)	(11.35)
$100 w/5 Day Max	(5.34)	(13.08)	(9.75)	(15.52)	(9.93)	(10.68)	(16.34)
$250 w/3 Day Max	(12.25)	(30.01)	(22.37)	(35.61)	(22.79)	(24.50)	(37.47)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$75	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$100	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$125	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$150	(2.42)	(5.93)	(4.42)	(7.03)	(4.50)	(4.84)	(7.40)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$25	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$35	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$50	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$60	(1.77)	(4.34)	(3.23)	(5.15)	(3.29)	(3.54)	(5.41)
$75	(2.34)	(5.73)	(4.27)	(6.80)	(4.35)	(4.68)	(7.16)
$100	(3.33)	(8.16)	(6.08)	(9.68)	(6.19)	(6.66)	(10.19)
$125	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$150	(4.90)	(12.01)	(8.95)	(14.24)	(9.11)	(9.80)	(14.99)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.57	1.40	1.04	1.66	1.06	1.14	1.74
60	1.12	2.74	2.05	3.26	2.08	2.24	3.43
90	1.68	4.12	3.07	4.88	3.12	3.36	5.14
120	1.97	4.83	3.60	5.73	3.66	3.94	6.03
Unlimited	2.53	6.20	4.62	7.35	4.71	5.06	7.74

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$15 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$20 copay	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
40/$25 copay	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
60	0.31	0.76	0.57	0.90	0.58	0.62	0.95
100	0.73	1.79	1.33	2.12	1.36	1.46	2.23
200	1.97	4.83	3.60	5.73	3.66	3.94	6.03
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.76	1.86	1.39	2.21	1.41	1.52	2.32
90	1.61	3.94	2.94	4.68	2.99	3.22	4.92
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.68	1.67	1.24	1.98	1.26	1.36	2.08
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
120	2.04	5.00	3.73	5.93	3.79	4.08	6.24
visits for all other			**(Verizon Benefit)**				
	1.58	3.87	2.89	4.59	2.94	3.16	4.83
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.30	0.74	0.55	0.87	0.56	0.60	0.92
30	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Unlimited	0.68	1.67	1.24	1.98	1.26	1.36	2.08
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.44	8.43	6.28	10.00	6.40	6.88	10.52
60	4.05	9.92	7.40	11.77	7.53	8.10	12.39
90	4.84	11.86	8.84	14.07	9.00	9.68	14.81
Unlimited	4.90	12.01	8.95	14.24	9.11	9.80	14.99

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
60/$20 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
60/$25 copay	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
120/$0 copay	0.60	1.47	1.10	1.74	1.12	1.20	1.84
120/$5 copay	0.47	1.15	0.86	1.37	0.87	0.94	1.44
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
Unlimited/$0 copay	0.69	1.69	1.26	2.01	1.28	1.38	2.11
Unlimited/$5 copay	0.53	1.30	0.97	1.54	0.99	1.06	1.62
Unlimited/$10 copay	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$15	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$20	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$25	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$30	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$35	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$40	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$45	(1.62)	(3.97)	(2.96)	(4.71)	(3.01)	(3.24)	(4.96)
$50	(1.78)	(4.36)	(3.25)	(5.17)	(3.31)	(3.56)	(5.45)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$15	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$20	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$25	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$60	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$75	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$100	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.12)	(7.64)	(5.70)	(9.07)	(5.80)	(6.24)	(9.54)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(4.83)	(11.83)	(8.82)	(14.04)	(8.98)	(9.66)	(14.77)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.04	19.70	14.68	23.37	14.95	16.08	24.59
60	8.48	20.78	15.48	24.65	15.77	16.96	25.94
90	8.79	21.54	16.05	25.55	16.35	17.58	26.89
Unlimited	8.88	21.76	16.21	25.81	16.52	17.76	27.16
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.98	22.00	16.40	26.10	16.70	17.96	27.47
30	9.89	24.23	18.06	28.75	18.40	19.78	30.25
40	10.44	25.58	19.06	30.35	19.42	20.88	31.94
60	11.01	26.97	20.10	32.01	20.48	22.02	33.68
Unlimited	11.09	27.17	20.25	32.24	20.63	22.18	33.92
LARGE GROUP			**$5 Copay**				
20	8.45	20.70	15.43	24.56	15.72	16.90	25.85
30	9.29	22.76	16.96	27.01	17.28	18.58	28.42
40	9.88	24.21	18.04	28.72	18.38	19.76	30.22
60	10.34	25.33	18.88	30.06	19.23	20.68	31.63
Unlimited	10.42	25.53	19.03	30.29	19.38	20.84	31.87
LARGE GROUP			**$10 Copay**				
20	7.90	19.36	14.43	22.97	14.69	15.80	24.17
30	8.71	21.34	15.90	25.32	16.20	17.42	26.64
40	9.21	22.56	16.82	26.77	17.13	18.42	28.17
60	9.71	23.79	17.73	28.23	18.06	19.42	29.70
Unlimited	9.78	23.96	17.86	28.43	18.19	19.56	29.92
LARGE GROUP			**$15 Copay**				
20	7.42	18.18	13.55	21.57	13.80	14.84	22.70
30	8.19	20.07	14.95	23.81	15.23	16.38	25.05
40	8.67	21.24	15.83	25.20	16.13	17.34	26.52
60	9.17	22.47	16.74	26.66	17.06	18.34	28.05
Unlimited	9.24	22.64	16.87	26.86	17.19	18.48	28.27
LARGE GROUP			**$20 Copay**				
20	6.99	17.13	12.76	20.32	13.00	13.98	21.38
30	7.66	18.77	13.99	22.27	14.25	15.32	23.43
40	8.08	19.80	14.75	23.49	15.03	16.16	24.72
60	8.59	21.05	15.69	24.97	15.98	17.18	26.28
Unlimited	8.65	21.19	15.79	25.15	16.09	17.30	26.46

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP			**$25 Copay**				
20	6.50	15.93	11.87	18.90	12.09	13.00	19.88
30	7.13	17.47	13.02	20.73	13.26	14.26	21.81
40	7.60	18.62	13.88	22.09	14.14	15.20	23.25
60	8.00	19.60	14.61	23.26	14.88	16.00	24.47
Unlimited	8.07	19.77	14.74	23.46	15.01	16.14	24.69
LARGE GROUP			**$30 Copay**				
20	6.19	15.17	11.30	17.99	11.51	12.38	18.94
30	6.72	16.46	12.27	19.54	12.50	13.44	20.56
40	7.15	17.52	13.06	20.79	13.30	14.30	21.87
60	7.51	18.40	13.71	21.83	13.97	15.02	22.97
Unlimited	7.55	18.50	13.79	21.95	14.04	15.10	23.10
LARGE GROUP			**$35 Copay**				
20	5.89	14.43	10.76	17.12	10.96	11.78	18.02
30	6.28	15.39	11.47	18.26	11.68	12.56	19.21
40	6.68	16.37	12.20	19.42	12.42	13.36	20.43
60	7.02	17.20	12.82	20.41	13.06	14.04	21.47
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP			**$40 Copay**				
20	5.72	14.01	10.44	16.63	10.64	11.44	17.50
30	6.11	14.97	11.16	17.76	11.36	12.22	18.69
40	6.52	15.97	11.91	18.95	12.13	13.04	19.94
60	6.87	16.83	12.54	19.97	12.78	13.74	21.02
Unlimited	6.92	16.95	12.64	20.12	12.87	13.84	21.17
LARGE GROUP			**$45 Copay**				
20	5.56	13.62	10.15	16.16	10.34	11.12	17.01
30	5.94	14.55	10.85	17.27	11.05	11.88	18.17
40	6.35	15.56	11.60	18.46	11.81	12.70	19.42
60	6.69	16.39	12.22	19.45	12.44	13.38	20.46
Unlimited	6.74	16.51	12.31	19.59	12.54	13.48	20.62

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$50 Copay**			
20	5.41	13.25	9.88	15.73	10.06	10.82	16.55
30	5.79	14.19	10.57	16.83	10.77	11.58	17.71
40	6.19	15.17	11.30	17.99	11.51	12.38	18.94
60	6.54	16.02	11.94	19.01	12.16	13.08	20.01
Unlimited	6.58	16.12	12.02	19.13	12.24	13.16	20.13

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%

				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
NYSHIP: Three Month Extension							
	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.46	10.93	8.14	12.97	8.30	8.92	13.64
$0/Max $5000	4.25	10.41	7.76	12.35	7.91	8.50	13.00
$0/Max $2500	3.96	9.70	7.23	11.51	7.37	7.92	12.11
$25	4.25	10.41	7.76	12.35	7.91	8.50	13.00
$50	3.96	9.70	7.23	11.51	7.37	7.92	12.11
$100	3.65	8.94	6.66	10.61	6.79	7.30	11.17
$500	1.74	4.26	3.18	5.06	3.24	3.48	5.32
$5,000	0.30	0.74	0.55	0.87	0.56	0.60	0.92
Coinsurance							
80%	3.59	8.80	6.56	10.44	6.68	7.18	10.98
75%	3.36	8.23	6.14	9.77	6.25	6.72	10.28
70%	3.15	7.72	5.75	9.16	5.86	6.30	9.64
Deductible			**Orthotics Riders**				
$0	0.75	1.84	1.37	2.18	1.40	1.50	2.29
$0/Max $5000	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$0/Max $2500	0.68	1.67	1.24	1.98	1.26	1.36	2.08
$25	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$50	0.68	1.67	1.24	1.98	1.26	1.36	2.08
$100	0.62	1.52	1.13	1.80	1.15	1.24	1.90
$500	0.32	0.78	0.58	0.93	0.60	0.64	0.98
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.62	1.52	1.13	1.80	1.15	1.24	1.90
75%	0.58	1.42	1.06	1.69	1.08	1.16	1.77
70%	0.55	1.35	1.00	1.60	1.02	1.10	1.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.53	1.30	0.97	1.54	0.99	1.06	1.62
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
			Infertility Rider				
Limit							
2 IVF	9.46	23.18	17.27	27.50	17.60	18.92	28.94
3 IVF	11.43	28.00	20.87	33.23	21.26	22.86	34.96
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.81	6.88	5.13	8.17	5.23	5.62	8.60
			Nurse Advice Line Rider				
	0.31	0.76	0.57	0.90	0.58	0.62	0.95

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
922.00	2,258.90	1,683.57	2,680.25	1,714.92	1,844.00	2,820.40
80% Coinsurance						
908.16	2,224.99	1,658.30	2,640.02	1,689.18	1,816.32	2,778.06
75% Coinsurance						
864.38	2,117.73	1,578.36	2,512.75	1,607.75	1,728.76	2,644.14
70% Coinsurance						
820.57	2,010.40	1,498.36	2,385.40	1,526.26	1,641.14	2,510.12
50% Coinsurance						
776.78	1,903.11	1,418.40	2,258.10	1,444.81	1,553.56	2,376.17

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**

**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual x 2	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(41.65)	(102.04)	(76.05)	(121.08)	(77.47)	(83.30)	(127.41)
$350	(55.13)	(135.07)	(100.67)	(160.26)	(102.54)	(110.26)	(168.64)
$500	(70.93)	(173.78)	(129.52)	(206.19)	(131.93)	(141.86)	(216.97)
$750	(92.16)	(225.79)	(168.28)	(267.91)	(171.42)	(184.32)	(281.92)
$1,000	(108.41)	(265.60)	(197.96)	(315.15)	(201.64)	(216.82)	(331.63)
$1,500	(133.33)	(326.66)	(243.46)	(387.59)	(247.99)	(266.66)	(407.86)
$2,500	(149.05)	(365.17)	(272.17)	(433.29)	(277.23)	(298.10)	(455.94)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(55.66)	(136.37)	(101.64)	(161.80)	(103.53)	(111.32)	(170.26)
$250	(66.39)	(162.66)	(121.23)	(193.00)	(123.49)	(132.78)	(203.09)
$300	(77.16)	(189.04)	(140.89)	(224.30)	(143.52)	(154.32)	(236.03)
$350	(87.93)	(215.43)	(160.56)	(255.61)	(163.55)	(175.86)	(268.98)
$400	(96.38)	(236.13)	(175.99)	(280.18)	(179.27)	(192.76)	(294.83)
$500	(113.29)	(277.56)	(206.87)	(329.33)	(210.72)	(226.58)	(346.55)
$750	(147.12)	(360.44)	(268.64)	(427.68)	(273.64)	(294.24)	(450.04)
$1,000	(173.18)	(424.29)	(316.23)	(503.43)	(322.11)	(346.36)	(529.76)
$1,500	(213.03)	(521.92)	(388.99)	(619.28)	(396.24)	(426.06)	(651.66)
$2,000	(229.33)	(561.86)	(418.76)	(666.66)	(426.55)	(458.66)	(701.52)
$2,500	(245.68)	(601.92)	(448.61)	(714.19)	(456.96)	(491.36)	(751.54)
$5,000	(288.82)	(707.61)	(527.39)	(839.60)	(537.21)	(577.64)	(883.50)
$10,000	(324.46)	(794.93)	(592.46)	(943.21)	(603.50)	(648.92)	(992.52)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(45.60)	(111.72)	(83.27)	(132.56)	(84.82)	(91.20)	(139.49)
$250	(54.39)	(133.26)	(99.32)	(158.11)	(101.17)	(108.78)	(166.38)
$300	(63.23)	(154.91)	(115.46)	(183.81)	(117.61)	(126.46)	(193.42)
$350	(72.02)	(176.45)	(131.51)	(209.36)	(133.96)	(144.04)	(220.31)
$400	(79.10)	(193.80)	(144.44)	(229.94)	(147.13)	(158.20)	(241.97)
$500	(93.30)	(228.59)	(170.37)	(271.22)	(173.54)	(186.60)	(285.40)
$750	(121.35)	(297.31)	(221.59)	(352.76)	(225.71)	(242.70)	(371.21)
$1,000	(143.19)	(350.82)	(261.46)	(416.25)	(266.33)	(286.38)	(438.02)
$1,500	(176.30)	(431.94)	(321.92)	(512.50)	(327.92)	(352.60)	(539.30)
$2,000	(191.30)	(468.69)	(349.31)	(556.11)	(355.82)	(382.60)	(585.19)
$2,500	(206.32)	(505.48)	(376.74)	(599.77)	(383.76)	(412.64)	(631.13)
$5,000	(249.26)	(610.69)	(455.15)	(724.60)	(463.62)	(498.52)	(762.49)
$10,000	(284.71)	(697.54)	(519.88)	(827.65)	(529.56)	(569.42)	(870.93)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(35.55)	(87.10)	(64.91)	(103.34)	(66.12)	(71.10)	(108.75)
$250	(42.42)	(103.93)	(77.46)	(123.31)	(78.90)	(84.84)	(129.76)
$300	(49.27)	(120.71)	(89.97)	(143.23)	(91.64)	(98.54)	(150.72)
$350	(56.12)	(137.49)	(102.48)	(163.14)	(104.38)	(112.24)	(171.67)
$400	(61.87)	(151.58)	(112.97)	(179.86)	(115.08)	(123.74)	(189.26)
$500	(73.24)	(179.44)	(133.74)	(212.91)	(136.23)	(146.48)	(224.04)
$750	(95.55)	(234.10)	(174.47)	(277.76)	(177.72)	(191.10)	(292.29)
$1,000	(113.15)	(277.22)	(206.61)	(328.93)	(210.46)	(226.30)	(346.13)
$1,500	(139.56)	(341.92)	(254.84)	(405.70)	(259.58)	(279.12)	(426.91)
$2,000	(153.28)	(375.54)	(279.89)	(445.58)	(285.10)	(306.56)	(468.88)
$2,500	(166.99)	(409.13)	(304.92)	(485.44)	(310.60)	(333.98)	(510.82)
$5,000	(209.71)	(513.79)	(382.93)	(609.63)	(390.06)	(419.42)	(641.50)
$10,000	(244.98)	(600.20)	(447.33)	(712.16)	(455.66)	(489.96)	(749.39)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(24.44)	(59.88)	(44.63)	(71.05)	(45.46)	(48.88)	(74.76)
$250	(29.29)	(71.76)	(53.48)	(85.15)	(54.48)	(58.58)	(89.60)
$300	(34.18)	(83.74)	(62.41)	(99.36)	(63.57)	(68.36)	(104.56)
$350	(39.00)	(95.55)	(71.21)	(113.37)	(72.54)	(78.00)	(119.30)
$400	(43.22)	(105.89)	(78.92)	(125.64)	(80.39)	(86.44)	(132.21)
$500	(51.63)	(126.49)	(94.28)	(150.09)	(96.03)	(103.26)	(157.94)
$750	(67.74)	(165.96)	(123.69)	(196.92)	(126.00)	(135.48)	(207.22)
$1,000	(80.85)	(198.08)	(147.63)	(235.03)	(150.38)	(161.70)	(247.32)
$1,500	(101.02)	(247.50)	(184.46)	(293.67)	(187.90)	(202.04)	(309.02)
$2,000	(111.77)	(273.84)	(204.09)	(324.92)	(207.89)	(223.54)	(341.90)
$2,500	(122.56)	(300.27)	(223.79)	(356.28)	(227.96)	(245.12)	(374.91)
$5,000	(164.68)	(403.47)	(300.71)	(478.72)	(306.30)	(329.36)	(503.76)
$10,000	(199.46)	(488.68)	(364.21)	(579.83)	(371.00)	(398.92)	(610.15)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
			LARGE GROUP				
Maximum	**Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance**						
$1,000	(32.37)	(79.31)	(59.11)	(94.10)	(60.21)	(64.74)	(99.02)
$1,500	(35.31)	(86.51)	(64.48)	(102.65)	(65.68)	(70.62)	(108.01)
$2,000	(36.85)	(90.28)	(67.29)	(107.12)	(68.54)	(73.70)	(112.72)
$3,000	(38.19)	(93.57)	(69.73)	(111.02)	(71.03)	(76.38)	(116.82)
$4,000	(38.79)	(95.04)	(70.83)	(112.76)	(72.15)	(77.58)	(118.66)
$5,000	(39.11)	(95.82)	(71.41)	(113.69)	(72.74)	(78.22)	(119.64)
$7,000	(39.47)	(96.70)	(72.07)	(114.74)	(73.41)	(78.94)	(120.74)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(51.52)	(126.22)	(94.08)	(149.77)	(95.83)	(103.04)	(157.60)
$1,500	(56.22)	(137.74)	(102.66)	(163.43)	(104.57)	(112.44)	(171.98)
$2,000	(58.61)	(143.59)	(107.02)	(170.38)	(109.01)	(117.22)	(179.29)
$3,000	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$4,000	(61.79)	(151.39)	(112.83)	(179.62)	(114.93)	(123.58)	(189.02)
$5,000	(62.28)	(152.59)	(113.72)	(181.05)	(115.84)	(124.56)	(190.51)
$7,000	(62.88)	(154.06)	(114.82)	(182.79)	(116.96)	(125.76)	(192.35)
$7,500	(63.39)	(155.31)	(115.75)	(184.27)	(117.91)	(126.78)	(193.91)
$10,000	(65.25)	(159.86)	(119.15)	(189.68)	(121.37)	(130.50)	(199.60)
$20,000	(67.89)	(166.33)	(123.97)	(197.36)	(126.28)	(135.78)	(207.68)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(49.79)	(121.99)	(90.92)	(144.74)	(92.61)	(99.58)	(152.31)
$1,500	(55.34)	(135.58)	(101.05)	(160.87)	(102.93)	(110.68)	(169.29)
$2,000	(58.43)	(143.15)	(106.69)	(169.86)	(108.68)	(116.86)	(178.74)
$3,000	(61.45)	(150.55)	(112.21)	(178.64)	(114.30)	(122.90)	(187.98)
$4,000	(62.83)	(153.93)	(114.73)	(182.65)	(116.86)	(125.66)	(192.20)
$5,000	(63.59)	(155.80)	(116.12)	(184.86)	(118.28)	(127.18)	(194.52)
$7,000	(64.33)	(157.61)	(117.47)	(187.01)	(119.65)	(128.66)	(196.79)
$7,500	(64.88)	(158.96)	(118.47)	(188.61)	(120.68)	(129.76)	(198.47)
$10,000	(67.15)	(164.52)	(122.62)	(195.21)	(124.90)	(134.30)	(205.41)
$20,000	(70.67)	(173.14)	(129.04)	(205.44)	(131.45)	(141.34)	(216.18)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(48.07)	(117.77)	(87.78)	(139.74)	(89.41)	(96.14)	(147.05)
$1,500	(54.52)	(133.57)	(99.55)	(158.49)	(101.41)	(109.04)	(166.78)
$2,000	(58.23)	(142.66)	(106.33)	(169.27)	(108.31)	(116.46)	(178.13)
$3,000	(62.08)	(152.10)	(113.36)	(180.47)	(115.47)	(124.16)	(189.90)
$4,000	(63.83)	(156.38)	(116.55)	(185.55)	(118.72)	(127.66)	(195.26)
$5,000	(64.86)	(158.91)	(118.43)	(188.55)	(120.64)	(129.72)	(198.41)
$7,000	(65.77)	(161.14)	(120.10)	(191.19)	(122.33)	(131.54)	(201.19)
$7,500	(66.35)	(162.56)	(121.16)	(192.88)	(123.41)	(132.70)	(202.96)
$10,000	(68.86)	(168.71)	(125.74)	(200.18)	(128.08)	(137.72)	(210.64)
$20,000	(73.34)	(179.68)	(133.92)	(213.20)	(136.41)	(146.68)	(224.35)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(54.39)	(133.26)	(99.32)	(158.11)	(101.17)	(108.78)	(166.38)
$1,500	(64.82)	(158.81)	(118.36)	(188.43)	(120.57)	(129.64)	(198.28)
$2,000	(71.53)	(175.25)	(130.61)	(207.94)	(133.05)	(143.06)	(218.81)
$3,000	(79.68)	(195.22)	(145.50)	(231.63)	(148.20)	(159.36)	(243.74)
$4,000	(84.14)	(206.14)	(153.64)	(244.59)	(156.50)	(168.28)	(257.38)
$5,000	(86.89)	(212.88)	(158.66)	(252.59)	(161.62)	(173.78)	(265.80)
$7,000	(89.73)	(219.84)	(163.85)	(260.85)	(166.90)	(179.46)	(274.48)
$7,500	(90.78)	(222.41)	(165.76)	(263.90)	(168.85)	(181.56)	(277.70)
$10,000	(95.01)	(232.77)	(173.49)	(276.19)	(176.72)	(190.02)	(290.64)
$20,000	(103.90)	(254.56)	(189.72)	(302.04)	(193.25)	(207.80)	(317.83)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.41	1.00	0.75	1.19	0.76	0.82	1.25
$1,000,000	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$50,000	(5.34)	(13.08)	(9.75)	(15.52)	(9.93)	(10.68)	(16.34)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
75%	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
70%	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

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Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.24)	(5.49)	(4.09)	(6.51)	(4.17)	(4.48)	(6.85)
$10	(4.71)	(11.54)	(8.60)	(13.69)	(8.76)	(9.42)	(14.41)
$15	(7.83)	(19.18)	(14.30)	(22.76)	(14.56)	(15.66)	(23.95)
$20	(12.09)	(29.62)	(22.08)	(35.15)	(22.49)	(24.18)	(36.98)
$25	(15.91)	(38.98)	(29.05)	(46.25)	(29.59)	(31.82)	(48.67)
$30	(20.13)	(49.32)	(36.76)	(58.52)	(37.44)	(40.26)	(61.58)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$10	(2.70)	(6.62)	(4.93)	(7.85)	(5.02)	(5.40)	(8.26)
$15	(4.48)	(10.98)	(8.18)	(13.02)	(8.33)	(8.96)	(13.70)
$20	(6.92)	(16.95)	(12.64)	(20.12)	(12.87)	(13.84)	(21.17)
$25	(9.11)	(22.32)	(16.63)	(26.48)	(16.94)	(18.22)	(27.87)
$30	(11.51)	(28.20)	(21.02)	(33.46)	(21.41)	(23.02)	(35.21)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$10	(3.38)	(8.28)	(6.17)	(9.83)	(6.29)	(6.76)	(10.34)
$15	(5.31)	(13.01)	(9.70)	(15.44)	(9.88)	(10.62)	(16.24)
$20	(7.48)	(18.33)	(13.66)	(21.74)	(13.91)	(14.96)	(22.88)
$25	(9.85)	(24.13)	(17.99)	(28.63)	(18.32)	(19.70)	(30.13)
$30	(12.57)	(30.80)	(22.95)	(36.54)	(23.38)	(25.14)	(38.45)
$35	(15.10)	(37.00)	(27.57)	(43.90)	(28.09)	(30.20)	(46.19)
$40	(17.72)	(43.41)	(32.36)	(51.51)	(32.96)	(35.44)	(54.21)
$45	(20.50)	(50.23)	(37.43)	(59.59)	(38.13)	(41.00)	(62.71)
$50	(23.40)	(57.33)	(42.73)	(68.02)	(43.52)	(46.80)	(71.58)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.40)	(3.43)	(2.56)	(4.07)	(2.60)	(2.80)	(4.28)
$10	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$15	(4.48)	(10.98)	(8.18)	(13.02)	(8.33)	(8.96)	(13.70)
$20	(6.32)	(15.48)	(11.54)	(18.37)	(11.76)	(12.64)	(19.33)
$25	(8.34)	(20.43)	(15.23)	(24.24)	(15.51)	(16.68)	(25.51)
$30	(10.63)	(26.04)	(19.41)	(30.90)	(19.77)	(21.26)	(32.52)
$35	(12.78)	(31.31)	(23.34)	(37.15)	(23.77)	(25.56)	(39.09)
$40	(15.00)	(36.75)	(27.39)	(43.61)	(27.90)	(30.00)	(45.89)
$45	(17.33)	(42.46)	(31.64)	(50.38)	(32.23)	(34.66)	(53.01)
$50	(19.79)	(48.49)	(36.14)	(57.53)	(36.81)	(39.58)	(60.54)

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Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$150	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$200	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$250	(2.74)	(6.71)	(5.00)	(7.97)	(5.10)	(5.48)	(8.38)
$500	(6.60)	(16.17)	(12.05)	(19.19)	(12.28)	(13.20)	(20.19)
$750	(11.32)	(27.73)	(20.67)	(32.91)	(21.06)	(22.64)	(34.63)
$1,000	(17.04)	(41.75)	(31.12)	(49.54)	(31.69)	(34.08)	(52.13)
Copay/Day							
$50 w/3 Day Max	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$50 w/5 Day Max	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$100 w/3 Day Max	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)
$100 w/5 Day Max	(3.58)	(8.77)	(6.54)	(10.41)	(6.66)	(7.16)	(10.95)
$250 w/3 Day Max	(8.22)	(20.14)	(15.01)	(23.90)	(15.29)	(16.44)	(25.14)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$100	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$125	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$150	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$35	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$50	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$60	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$75	(1.57)	(3.85)	(2.87)	(4.56)	(2.92)	(3.14)	(4.80)
$100	(2.23)	(5.46)	(4.07)	(6.48)	(4.15)	(4.46)	(6.82)
$125	(2.74)	(6.71)	(5.00)	(7.97)	(5.10)	(5.48)	(8.38)
$150	(3.28)	(8.04)	(5.99)	(9.53)	(6.10)	(6.56)	(10.03)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.45	1.10	0.82	1.31	0.84	0.90	1.38
60	0.88	2.16	1.61	2.56	1.64	1.76	2.69
90	1.27	3.11	2.32	3.69	2.36	2.54	3.88
120	1.51	3.70	2.76	4.39	2.81	3.02	4.62
Unlimited	1.95	4.78	3.56	5.67	3.63	3.90	5.97
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$20 copay	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
40/$25 copay	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.50	1.23	0.91	1.45	0.93	1.00	1.53
200	1.30	3.19	2.37	3.78	2.42	2.60	3.98

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.59	1.45	1.08	1.72	1.10	1.18	1.80
90	1.21	2.96	2.21	3.52	2.25	2.42	3.70
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.52	1.27	0.95	1.51	0.97	1.04	1.59
90	0.97	2.38	1.77	2.82	1.80	1.94	2.97
120	1.56	3.82	2.85	4.53	2.90	3.12	4.77
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited	0.52	1.27	0.95	1.51	0.97	1.04	1.59
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.30	5.64	4.20	6.69	4.28	4.60	7.04
60	2.72	6.66	4.97	7.91	5.06	5.44	8.32
90	3.24	7.94	5.92	9.42	6.03	6.48	9.91
Unlimited	3.28	8.04	5.99	9.53	6.10	6.56	10.03
			Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
60/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$25 copay	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
120/$0 copay	0.47	1.15	0.86	1.37	0.87	0.94	1.44
120/$5 copay	0.36	0.88	0.66	1.05	0.67	0.72	1.10
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$5 copay	0.42	1.03	0.77	1.22	0.78	0.84	1.28
Unlimited/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$20	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$25	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$30	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$35	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$40	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$45	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$50	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$25	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

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Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.44	20.68	15.41	24.54	15.70	16.88	25.82
60	8.91	21.83	16.27	25.90	16.57	17.82	27.26
90	9.23	22.61	16.85	26.83	17.17	18.46	28.23
Unlimited	9.32	22.83	17.02	27.09	17.34	18.64	28.51
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.44	23.13	17.24	27.44	17.56	18.88	28.88
30	10.38	25.43	18.95	30.17	19.31	20.76	31.75
40	10.95	26.83	19.99	31.83	20.37	21.90	33.50
60	11.55	28.30	21.09	33.58	21.48	23.10	35.33
Unlimited	11.65	28.54	21.27	33.87	21.67	23.30	35.64
LARGE GROUP				**$5 Copay**			
20	8.87	21.73	16.20	25.79	16.50	17.74	27.13
30	9.76	23.91	17.82	28.37	18.15	19.52	29.86
40	10.37	25.41	18.94	30.15	19.29	20.74	31.72
60	10.87	26.63	19.85	31.60	20.22	21.74	33.25
Unlimited	10.94	26.80	19.98	31.80	20.35	21.88	33.47
LARGE GROUP				**$10 Copay**			
20	8.30	20.34	15.16	24.13	15.44	16.60	25.39
30	9.16	22.44	16.73	26.63	17.04	18.32	28.02
40	9.67	23.69	17.66	28.11	17.99	19.34	29.58
60	10.19	24.97	18.61	29.62	18.95	20.38	31.17
Unlimited	10.27	25.16	18.75	29.85	19.10	20.54	31.42
LARGE GROUP				**$15 Copay**			
20	7.80	19.11	14.24	22.67	14.51	15.60	23.86
30	8.59	21.05	15.69	24.97	15.98	17.18	26.28
40	9.09	22.27	16.60	26.42	16.91	18.18	27.81
60	9.62	23.57	17.57	27.97	17.89	19.24	29.43
Unlimited	9.71	23.79	17.73	28.23	18.06	19.42	29.70

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.33	17.96	13.38	21.31	13.63	14.66	22.42
30	8.05	19.72	14.70	23.40	14.97	16.10	24.62
40	8.49	20.80	15.50	24.68	15.79	16.98	25.97
60	9.01	22.07	16.45	26.19	16.76	18.02	27.56
Unlimited	9.08	22.25	16.58	26.40	16.89	18.16	27.78
LARGE GROUP				**$25 Copay**			
20	6.81	16.68	12.44	19.80	12.67	13.62	20.83
30	7.50	18.38	13.70	21.80	13.95	15.00	22.94
40	7.99	19.58	14.59	23.23	14.86	15.98	24.44
60	8.39	20.56	15.32	24.39	15.61	16.78	25.67
Unlimited	8.48	20.78	15.48	24.65	15.77	16.96	25.94
LARGE GROUP				**$30 Copay**			
20	6.51	15.95	11.89	18.92	12.11	13.02	19.91
30	7.06	17.30	12.89	20.52	13.13	14.12	21.60
40	7.52	18.42	13.73	21.86	13.99	15.04	23.00
60	7.87	19.28	14.37	22.88	14.64	15.74	24.07
Unlimited	7.91	19.38	14.44	22.99	14.71	15.82	24.20

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$35 Copay**			
20	6.18	15.14	11.28	17.97	11.49	12.36	18.90
30	6.60	16.17	12.05	19.19	12.28	13.20	20.19
40	7.03	17.22	12.84	20.44	13.08	14.06	21.50
60	7.36	18.03	13.44	21.40	13.69	14.72	22.51
Unlimited	7.42	18.18	13.55	21.57	13.80	14.84	22.70
LARGE GROUP				**$40 Copay**			
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.42	15.73	11.72	18.66	11.94	12.84	19.64
40	6.84	16.76	12.49	19.88	12.72	13.68	20.92
60	7.21	17.66	13.17	20.96	13.41	14.42	22.06
Unlimited	7.27	17.81	13.28	21.13	13.52	14.54	22.24
LARGE GROUP				**$45 Copay**			
20	5.85	14.33	10.68	17.01	10.88	11.70	17.90
30	6.23	15.26	11.38	18.11	11.59	12.46	19.06
40	6.66	16.32	12.16	19.36	12.39	13.32	20.37
60	7.04	17.25	12.86	20.47	13.09	14.08	21.54
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP				**$50 Copay**			
20	5.67	13.89	10.35	16.48	10.55	11.34	17.34
30	6.08	14.90	11.10	17.67	11.31	12.16	18.60
40	6.51	15.95	11.89	18.92	12.11	13.02	19.91
60	6.86	16.81	12.53	19.94	12.76	13.72	20.98
Unlimited	6.90	16.91	12.60	20.06	12.83	13.80	21.11

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DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	6.68	16.37	12.20	19.42	12.42	13.36	20.43
$0/Max $5000	6.27	15.36	11.45	18.23	11.66	12.54	19.18
$0/Max $2500	5.91	14.48	10.79	17.18	10.99	11.82	18.08
$25	6.27	15.36	11.45	18.23	11.66	12.54	19.18
$50	5.91	14.48	10.79	17.18	10.99	11.82	18.08
$100	5.31	13.01	9.70	15.44	9.88	10.62	16.24
$500	2.62	6.42	4.78	7.62	4.87	5.24	8.01
$5,000	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Coinsurance							
80%	5.32	13.03	9.71	15.47	9.90	10.64	16.27
75%	5.01	12.27	9.15	14.56	9.32	10.02	15.33
70%	4.66	11.42	8.51	13.55	8.67	9.32	14.25
			Orthotics Riders				
$0/Max $5000	6.94	17.00	12.67	20.17	12.91	13.88	21.23
$0/Max $2500	6.43	15.75	11.74	18.69	11.96	12.86	19.67
Deductible							
$0	1.14	2.79	2.08	3.31	2.12	2.28	3.49
$0/Max $5000	1.09	2.67	1.99	3.17	2.03	2.18	3.33
$0/Max $2500	1.04	2.55	1.90	3.02	1.93	2.08	3.18
$25	1.09	2.67	1.99	3.17	2.03	2.18	3.33
$50	1.04	2.55	1.90	3.02	1.93	2.08	3.18
$100	0.95	2.33	1.73	2.76	1.77	1.90	2.91
$500	0.46	1.13	0.84	1.34	0.86	0.92	1.41
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.95	2.33	1.73	2.76	1.77	1.90	2.91
75%	0.89	2.18	1.63	2.59	1.66	1.78	2.72
70%	0.79	1.94	1.44	2.30	1.47	1.58	2.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.77	1.89	1.41	2.24	1.43	1.54	2.36
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	14.61	35.79	26.68	42.47	27.17	29.22	44.69
3 IVF	17.56	43.02	32.06	51.05	32.66	35.12	53.72
			Nurse Advice Line Rider				
	0.31	0.76	0.57	0.90	0.58	0.62	0.95

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFITS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Large Group*	520.76	1,275.86	950.91	1,513.85	968.61	1,041.52	1,593.00

* ***Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.47)	(8.50)	(6.34)	(10.09)	(6.45)	(6.94)	(10.61)
$10	(7.32)	(17.93)	(13.37)	(21.28)	(13.62)	(14.64)	(22.39)
$15	(12.19)	(29.87)	(22.26)	(35.44)	(22.67)	(24.38)	(37.29)
$20	(18.79)	(46.04)	(34.31)	(54.62)	(34.95)	(37.58)	(57.48)
$25	(24.76)	(60.66)	(45.21)	(71.98)	(46.05)	(49.52)	(75.74)
$30	(31.31)	(76.71)	(57.17)	(91.02)	(58.24)	(62.62)	(95.78)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$10	(4.20)	(10.29)	(7.67)	(12.21)	(7.81)	(8.40)	(12.85)
$15	(6.98)	(17.10)	(12.75)	(20.29)	(12.98)	(13.96)	(21.35)
$20	(10.76)	(26.36)	(19.65)	(31.28)	(20.01)	(21.52)	(32.91)
$25	(14.18)	(34.74)	(25.89)	(41.22)	(26.37)	(28.36)	(43.38)
$30	(17.95)	(43.98)	(32.78)	(52.18)	(33.39)	(35.90)	(54.91)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.55)	(6.25)	(4.66)	(7.41)	(4.74)	(5.10)	(7.80)
$10	(5.27)	(12.91)	(9.62)	(15.32)	(9.80)	(10.54)	(16.12)
$15	(8.26)	(20.24)	(15.08)	(24.01)	(15.36)	(16.52)	(25.27)
$20	(11.65)	(28.54)	(21.27)	(33.87)	(21.67)	(23.30)	(35.64)
$25	(15.36)	(37.63)	(28.05)	(44.65)	(28.57)	(30.72)	(46.99)
$30	(19.57)	(47.95)	(35.73)	(56.89)	(36.40)	(39.14)	(59.86)
$35	(23.52)	(57.62)	(42.95)	(68.37)	(43.75)	(47.04)	(71.95)
$40	(27.61)	(67.64)	(50.42)	(80.26)	(51.35)	(55.22)	(84.46)
$45	(31.93)	(78.23)	(58.30)	(92.82)	(59.39)	(63.86)	(97.67)
$50	(36.44)	(89.28)	(66.54)	(105.93)	(67.78)	(72.88)	(111.47)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.16)	(5.29)	(3.94)	(6.28)	(4.02)	(4.32)	(6.61)
$10	(4.44)	(10.88)	(8.11)	(12.91)	(8.26)	(8.88)	(13.58)
$15	(6.98)	(17.10)	(12.75)	(20.29)	(12.98)	(13.96)	(21.35)
$20	(9.84)	(24.11)	(17.97)	(28.60)	(18.30)	(19.68)	(30.10)
$25	(12.97)	(31.78)	(23.68)	(37.70)	(24.12)	(25.94)	(39.68)
$30	(16.54)	(40.52)	(30.20)	(48.08)	(30.76)	(33.08)	(50.60)
$35	(19.90)	(48.76)	(36.34)	(57.85)	(37.01)	(39.80)	(60.87)
$40	(23.35)	(57.21)	(42.64)	(67.88)	(43.43)	(46.70)	(71.43)
$45	(26.99)	(66.13)	(49.28)	(78.46)	(50.20)	(53.98)	(82.56)
$50	(30.81)	(75.48)	(56.26)	(89.56)	(57.31)	(61.62)	(94.25)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$150	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$200	(2.98)	(7.30)	(5.44)	(8.66)	(5.54)	(5.96)	(9.12)
$250	(4.30)	(10.54)	(7.85)	(12.50)	(8.00)	(8.60)	(13.15)
$500	(10.28)	(25.19)	(18.77)	(29.88)	(19.12)	(20.56)	(31.45)
$750	(17.63)	(43.19)	(32.19)	(51.25)	(32.79)	(35.26)	(53.93)
$1,000	(26.54)	(65.02)	(48.46)	(77.15)	(49.36)	(53.08)	(81.19)
Copay/Day							
$50 w/3 Day Max	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$50 w/5 Day Max	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
$100 w/3 Day Max	(3.86)	(9.46)	(7.05)	(11.22)	(7.18)	(7.72)	(11.81)
$100 w/5 Day Max	(5.56)	(13.62)	(10.15)	(16.16)	(10.34)	(11.12)	(17.01)
$250 w/3 Day Max	(12.78)	(31.31)	(23.34)	(37.15)	(23.77)	(25.56)	(39.09)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$75	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$100	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$125	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$150	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$25	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$35	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$50	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$60	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$75	(2.44)	(5.98)	(4.46)	(7.09)	(4.54)	(4.88)	(7.46)
$100	(3.46)	(8.48)	(6.32)	(10.06)	(6.44)	(6.92)	(10.58)
$125	(4.30)	(10.54)	(7.85)	(12.50)	(8.00)	(8.60)	(13.15)
$150	(5.11)	(12.52)	(9.33)	(14.85)	(9.50)	(10.22)	(15.63)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.59	1.45	1.08	1.72	1.10	1.18	1.80
60	1.16	2.84	2.12	3.37	2.16	2.32	3.55
90	1.74	4.26	3.18	5.06	3.24	3.48	5.32
120	2.05	5.02	3.74	5.96	3.81	4.10	6.27
Unlimited	2.65	6.49	4.84	7.70	4.93	5.30	8.11
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$15 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
40/$20 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
40/$25 copay	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
60	0.32	0.78	0.58	0.93	0.60	0.64	0.98
100	0.76	1.86	1.39	2.21	1.41	1.52	2.32
200	2.05	5.02	3.74	5.96	3.81	4.10	6.27
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.79	1.94	1.44	2.30	1.47	1.58	2.42
90	1.67	4.09	3.05	4.85	3.11	3.34	5.11

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.71	1.74	1.30	2.06	1.32	1.42	2.17
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98
120	2.13	5.22	3.89	6.19	3.96	4.26	6.52
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.31	0.76	0.57	0.90	0.58	0.62	0.95
30	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Unlimited	0.71	1.74	1.30	2.06	1.32	1.42	2.17
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.61	8.84	6.59	10.49	6.71	7.22	11.04
60	4.22	10.34	7.71	12.27	7.85	8.44	12.91
90	5.03	12.32	9.18	14.62	9.36	10.06	15.39
Unlimited	5.11	12.52	9.33	14.85	9.50	10.22	15.63
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
60/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$20 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
60/$25 copay	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
120/$0 copay	0.63	1.54	1.15	1.83	1.17	1.26	1.93
120/$5 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$10 copay	0.30	0.74	0.55	0.87	0.56	0.60	0.92
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.72	1.76	1.31	2.09	1.34	1.44	2.20
Unlimited/$5 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$10 copa	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$25	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
$30	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$35	(1.27)	(3.11)	(2.32)	(3.69)	(2.36)	(2.54)	(3.88)
$40	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$45	(1.68)	(4.12)	(3.07)	(4.88)	(3.12)	(3.36)	(5.14)
$50	(1.86)	(4.56)	(3.40)	(5.41)	(3.46)	(3.72)	(5.69)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$15	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$20	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$25	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$60	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$100	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.02)	(12.30)	(9.17)	(14.59)	(9.34)	(10.04)	(15.36)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.38	20.53	15.30	24.36	15.59	16.76	25.63
60	8.83	21.63	16.12	25.67	16.42	17.66	27.01
90	9.17	22.47	16.74	26.66	17.06	18.34	28.05
Unlimited	9.26	22.69	16.91	26.92	17.22	18.52	28.33
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.36	22.93	17.09	27.21	17.41	18.72	28.63
30	10.31	25.26	18.83	29.97	19.18	20.62	31.54
40	10.89	26.68	19.89	31.66	20.26	21.78	33.31
60	11.47	28.10	20.94	33.34	21.33	22.94	35.09
Unlimited	11.57	28.35	21.13	33.63	21.52	23.14	35.39
LARGE GROUP				**$5 Copay**			
20	8.81	21.58	16.09	25.61	16.39	17.62	26.95
30	9.70	23.77	17.71	28.20	18.04	19.40	29.67
40	10.30	25.24	18.81	29.94	19.16	20.60	31.51
60	10.79	26.44	19.70	31.37	20.07	21.58	33.01
Unlimited	10.88	26.66	19.87	31.63	20.24	21.76	33.28
LARGE GROUP				**$10 Copay**			
20	8.25	20.21	15.06	23.98	15.35	16.50	25.24
30	9.08	22.25	16.58	26.40	16.89	18.16	27.78
40	9.60	23.52	17.53	27.91	17.86	19.20	29.37
60	10.12	24.79	18.48	29.42	18.82	20.24	30.96
Unlimited	10.20	24.99	18.63	29.65	18.97	20.40	31.20
LARGE GROUP				**$15 Copay**			
20	7.74	18.96	14.13	22.50	14.40	15.48	23.68
30	8.53	20.90	15.58	24.80	15.87	17.06	26.09
40	9.04	22.15	16.51	26.28	16.81	18.08	27.65
60	9.55	23.40	17.44	27.76	17.76	19.10	29.21
Unlimited	9.63	23.59	17.58	27.99	17.91	19.26	29.46
LARGE GROUP				**$20 Copay**			
20	7.29	17.86	13.31	21.19	13.56	14.58	22.30
30	7.99	19.58	14.59	23.23	14.86	15.98	24.44
40	8.43	20.65	15.39	24.51	15.68	16.86	25.79

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	8.96	21.95	16.36	26.05	16.67	17.92	27.41
Unlimited	9.03	22.12	16.49	26.25	16.80	18.06	27.62
LARGE GROUP				$25 Copay			
20	6.77	16.59	12.36	19.68	12.59	13.54	20.71
30	7.43	18.20	13.57	21.60	13.82	14.86	22.73
40	7.94	19.45	14.50	23.08	14.77	15.88	24.29
60	8.34	20.43	15.23	24.24	15.51	16.68	25.51
Unlimited	8.42	20.63	15.37	24.48	15.66	16.84	25.76
LARGE GROUP				$30 Copay			
20	6.47	15.85	11.81	18.81	12.03	12.94	19.79
30	7.01	17.17	12.80	20.38	13.04	14.02	21.44
40	7.46	18.28	13.62	21.69	13.88	14.92	22.82
60	7.83	19.18	14.30	22.76	14.56	15.66	23.95
Unlimited	7.87	19.28	14.37	22.88	14.64	15.74	24.07
LARGE GROUP				$35 Copay			
20	6.13	15.02	11.19	17.82	11.40	12.26	18.75
30	6.56	16.07	11.98	19.07	12.20	13.12	20.07
40	6.98	17.10	12.75	20.29	12.98	13.96	21.35
60	7.32	17.93	13.37	21.28	13.62	14.64	22.39
Unlimited	7.37	18.06	13.46	21.42	13.71	14.74	22.54
LARGE GROUP				$40 Copay			
20	5.99	14.68	10.94	17.41	11.14	11.98	18.32
30	6.38	15.63	11.65	18.55	11.87	12.76	19.52
40	6.79	16.64	12.40	19.74	12.63	13.58	20.77
60	7.16	17.54	13.07	20.81	13.32	14.32	21.90
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP				$45 Copay			
20	5.80	14.21	10.59	16.86	10.79	11.60	17.74
30	6.19	15.17	11.30	17.99	11.51	12.38	18.94
40	6.62	16.22	12.09	19.24	12.31	13.24	20.25
60	7.00	17.15	12.78	20.35	13.02	14.00	21.41
Unlimited	7.03	17.22	12.84	20.44	13.08	14.06	21.50
LARGE GROUP				$50 Copay			
20	5.64	13.82	10.30	16.40	10.49	11.28	17.25
30	6.04	14.80	11.03	17.56	11.23	12.08	18.48
40	6.47	15.85	11.81	18.81	12.03	12.94	19.79

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
60	6.81	16.68	12.44	19.80	12.67	13.62	20.83
Unlimited	6.86	16.81	12.53	19.94	12.76	13.72	20.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.66	11.42	8.51	13.55	8.67	9.32	14.25
$25	4.42	10.83	8.07	12.85	8.22	8.84	13.52
$50	4.14	10.14	7.56	12.03	7.70	8.28	12.66
$100	3.81	9.33	6.96	11.08	7.09	7.62	11.65
$500	1.81	4.43	3.31	5.26	3.37	3.62	5.54
Coinsurance							
80%	3.75	9.19	6.85	10.90	6.98	7.50	11.47
75%	3.50	8.58	6.39	10.17	6.51	7.00	10.71
70%	3.27	8.01	5.97	9.51	6.08	6.54	10.00
Deductible			**Orthotics Riders**				
$0	0.78	1.91	1.42	2.27	1.45	1.56	2.39
$25	0.75	1.84	1.37	2.18	1.40	1.50	2.29
$50	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$100	0.64	1.57	1.17	1.86	1.19	1.28	1.96
$500	0.33	0.81	0.60	0.96	0.61	0.66	1.01
Coinsurance							
80%	0.64	1.57	1.17	1.86	1.19	1.28	1.96
75%	0.60	1.47	1.10	1.74	1.12	1.20	1.84
70%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.55	1.35	1.00	1.60	1.02	1.10	1.68
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	9.85	24.13	17.99	28.63	18.32	19.70	30.13
3 IVF	11.93	29.23	21.78	34.68	22.19	23.86	36.49
			Nurse Advice Line Rider				
	0.31	0.76	0.57	0.90	0.58	0.62	0.95

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess ll POS LARGE GROUP CONTRACT - BASE BENEFITS *
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
947.64	2,321.72	1,730.39	2,754.79	1,762.61	1,895.28	2,898.83
75% Coinsurance						
901.33	2,208.26	1,645.83	2,620.17	1,676.47	1,802.66	2,757.17
70% Coinsurance						
856.15	2,097.57	1,563.33	2,488.83	1,592.44	1,712.30	2,618.96
50% Coinsurance						
809.85	1,984.13	1,478.79	2,354.23	1,506.32	1,619.70	2,477.33

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max

** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			LARGE GROUP				
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(58.04)	(142.20)	(105.98)	(168.72)	(107.95)	(116.08)	(177.54)
$250	(69.25)	(169.66)	(126.45)	(201.31)	(128.81)	(138.50)	(211.84)
$300	(80.48)	(197.18)	(146.96)	(233.96)	(149.69)	(160.96)	(246.19)
$350	(91.71)	(224.69)	(167.46)	(266.60)	(170.58)	(183.42)	(280.54)
$400	(100.52)	(246.27)	(183.55)	(292.21)	(186.97)	(201.04)	(307.49)
$500	(118.16)	(289.49)	(215.76)	(343.49)	(219.78)	(236.32)	(361.45)
$750	(153.45)	(375.95)	(280.20)	(446.08)	(285.42)	(306.90)	(469.40)
$1,000	(180.64)	(442.57)	(329.85)	(525.12)	(335.99)	(361.28)	(552.58)
$1,500	(222.19)	(544.37)	(405.72)	(645.91)	(413.27)	(444.38)	(679.68)
$2,000	(239.19)	(586.02)	(436.76)	(695.33)	(444.89)	(478.38)	(731.68)
$2,500	(256.25)	(627.81)	(467.91)	(744.92)	(476.63)	(512.50)	(783.87)
$5,000	(301.25)	(738.06)	(550.08)	(875.73)	(560.33)	(602.50)	(921.52)
$10,000	(338.40)	(829.08)	(617.92)	(983.73)	(629.42)	(676.80)	(1,035.17)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(47.57)	(116.55)	(86.86)	(138.29)	(88.48)	(95.14)	(145.52)
$250	(56.75)	(139.04)	(103.63)	(164.97)	(105.56)	(113.50)	(173.60)
$300	(65.95)	(161.58)	(120.42)	(191.72)	(122.67)	(131.90)	(201.74)
$350	(75.11)	(184.02)	(137.15)	(218.34)	(139.70)	(150.22)	(229.76)
$400	(82.50)	(202.13)	(150.65)	(239.83)	(153.45)	(165.00)	(252.37)
$500	(97.30)	(238.39)	(177.67)	(282.85)	(180.98)	(194.60)	(297.64)
$750	(126.57)	(310.10)	(231.12)	(367.94)	(235.42)	(253.14)	(387.18)
$1,000	(149.34)	(365.88)	(272.69)	(434.13)	(277.77)	(298.68)	(456.83)
$1,500	(183.87)	(450.48)	(335.75)	(534.51)	(342.00)	(367.74)	(562.46)
$2,000	(199.53)	(488.85)	(364.34)	(580.03)	(371.13)	(399.06)	(610.36)
$2,500	(215.17)	(527.17)	(392.90)	(625.50)	(400.22)	(430.34)	(658.21)
$5,000	(259.98)	(636.95)	(474.72)	(755.76)	(483.56)	(519.96)	(795.28)
$10,000	(296.94)	(727.50)	(542.21)	(863.20)	(552.31)	(593.88)	(908.34)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(37.08)	(90.85)	(67.71)	(107.79)	(68.97)	(74.16)	(113.43)
$250	(44.23)	(108.36)	(80.76)	(128.58)	(82.27)	(88.46)	(135.30)
$300	(51.40)	(125.93)	(93.86)	(149.42)	(95.60)	(102.80)	(157.23)
$350	(58.54)	(143.42)	(106.89)	(170.18)	(108.88)	(117.08)	(179.07)
$400	(64.53)	(158.10)	(117.83)	(187.59)	(120.03)	(129.06)	(197.40)
$500	(76.38)	(187.13)	(139.47)	(222.04)	(142.07)	(152.76)	(233.65)
$750	(99.66)	(244.17)	(181.98)	(289.71)	(185.37)	(199.32)	(304.86)
$1,000	(118.00)	(289.10)	(215.47)	(343.03)	(219.48)	(236.00)	(360.96)
$1,500	(145.57)	(356.65)	(265.81)	(423.17)	(270.76)	(291.14)	(445.30)
$2,000	(159.87)	(391.68)	(291.92)	(464.74)	(297.36)	(319.74)	(489.04)
$2,500	(174.17)	(426.72)	(318.03)	(506.31)	(323.96)	(348.34)	(532.79)
$5,000	(218.72)	(535.86)	(399.38)	(635.82)	(406.82)	(437.44)	(669.06)
$10,000	(255.52)	(626.02)	(466.58)	(742.80)	(475.27)	(511.04)	(781.64)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(25.50)	(62.48)	(46.56)	(74.13)	(47.43)	(51.00)	(78.00)
$250	(30.54)	(74.82)	(55.77)	(88.78)	(56.80)	(61.08)	(93.42)
$300	(35.62)	(87.27)	(65.04)	(103.55)	(66.25)	(71.24)	(108.96)
$350	(40.68)	(99.67)	(74.28)	(118.26)	(75.66)	(81.36)	(124.44)
$400	(45.08)	(110.45)	(82.32)	(131.05)	(83.85)	(90.16)	(137.90)
$500	(53.85)	(131.93)	(98.33)	(156.54)	(100.16)	(107.70)	(164.73)
$750	(70.66)	(173.12)	(129.03)	(205.41)	(131.43)	(141.32)	(216.15)
$1,000	(84.31)	(206.56)	(153.95)	(245.09)	(156.82)	(168.62)	(257.90)
$1,500	(105.37)	(258.16)	(192.41)	(306.31)	(195.99)	(210.74)	(322.33)
$2,000	(116.58)	(285.62)	(212.88)	(338.90)	(216.84)	(233.16)	(356.62)
$2,500	(127.82)	(313.16)	(233.40)	(371.57)	(237.75)	(255.64)	(391.00)
$5,000	(171.76)	(420.81)	(313.63)	(499.31)	(319.47)	(343.52)	(525.41)
$10,000	(208.03)	(509.67)	(379.86)	(604.74)	(386.94)	(416.06)	(636.36)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(53.73)	(131.64)	(98.11)	(156.19)	(99.94)	(107.46)	(164.36)
$1,500	(58.61)	(143.59)	(107.02)	(170.38)	(109.01)	(117.22)	(179.29)
$2,000	(61.14)	(149.79)	(111.64)	(177.73)	(113.72)	(122.28)	(187.03)
$3,000	(63.47)	(155.50)	(115.90)	(184.51)	(118.05)	(126.94)	(194.15)
$4,000	(64.44)	(157.88)	(117.67)	(187.33)	(119.86)	(128.88)	(197.12)
$5,000	(64.95)	(159.13)	(118.60)	(188.81)	(120.81)	(129.90)	(198.68)
$7,000	(65.59)	(160.70)	(119.77)	(190.67)	(122.00)	(131.18)	(200.64)
$7,500	(66.12)	(161.99)	(120.74)	(192.21)	(122.98)	(132.24)	(202.26)
$10,000	(68.06)	(166.75)	(124.28)	(197.85)	(126.59)	(136.12)	(208.20)
$20,000	(70.82)	(173.51)	(129.32)	(205.87)	(131.73)	(141.64)	(216.64)
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(51.94)	(127.25)	(94.84)	(150.99)	(96.61)	(103.88)	(158.88)
$1,500	(57.73)	(141.44)	(105.41)	(167.82)	(107.38)	(115.46)	(176.60)
$2,000	(60.93)	(149.28)	(111.26)	(177.12)	(113.33)	(121.86)	(186.38)
$3,000	(64.10)	(157.05)	(117.05)	(186.34)	(119.23)	(128.20)	(196.08)
$4,000	(65.52)	(160.52)	(119.64)	(190.47)	(121.87)	(131.04)	(200.43)
$5,000	(66.32)	(162.48)	(121.10)	(192.79)	(123.36)	(132.64)	(202.87)
$7,000	(67.09)	(164.37)	(122.51)	(195.03)	(124.79)	(134.18)	(205.23)
$7,500	(67.66)	(165.77)	(123.55)	(196.69)	(125.85)	(135.32)	(206.97)
$10,000	(70.05)	(171.62)	(127.91)	(203.64)	(130.29)	(140.10)	(214.28)
$20,000	(73.70)	(180.57)	(134.58)	(214.25)	(137.08)	(147.40)	(225.45)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(50.14)	(122.84)	(91.56)	(145.76)	(93.26)	(100.28)	(153.38)
$1,500	(56.85)	(139.28)	(103.81)	(165.26)	(105.74)	(113.70)	(173.90)
$2,000	(60.73)	(148.79)	(110.89)	(176.54)	(112.96)	(121.46)	(185.77)
$3,000	(64.75)	(158.64)	(118.23)	(188.23)	(120.44)	(129.50)	(198.07)
$4,000	(66.57)	(163.10)	(121.56)	(193.52)	(123.82)	(133.14)	(203.64)
$5,000	(67.64)	(165.72)	(123.51)	(196.63)	(125.81)	(135.28)	(206.91)
$7,000	(68.60)	(168.07)	(125.26)	(199.42)	(127.60)	(137.20)	(209.85)
$7,500	(69.21)	(169.56)	(126.38)	(201.19)	(128.73)	(138.42)	(211.71)
$10,000	(71.82)	(175.96)	(131.14)	(208.78)	(133.59)	(143.64)	(219.70)
$20,000	(76.49)	(187.40)	(139.67)	(222.36)	(142.27)	(152.98)	(233.98)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(56.75)	(139.04)	(103.63)	(164.97)	(105.56)	(113.50)	(173.60)
$1,500	(67.60)	(165.62)	(123.44)	(196.51)	(125.74)	(135.20)	(206.79)
$2,000	(74.62)	(182.82)	(136.26)	(216.92)	(138.79)	(149.24)	(228.26)
$3,000	(83.10)	(203.60)	(151.74)	(241.57)	(154.57)	(166.20)	(254.20)
$4,000	(87.78)	(215.06)	(160.29)	(255.18)	(163.27)	(175.56)	(268.52)
$5,000	(90.64)	(222.07)	(165.51)	(263.49)	(168.59)	(181.28)	(277.27)
$7,000	(93.60)	(229.32)	(170.91)	(272.10)	(174.10)	(187.20)	(286.32)
$7,500	(94.69)	(231.99)	(172.90)	(275.26)	(176.12)	(189.38)	(289.66)
$10,000	(99.09)	(242.77)	(180.94)	(288.05)	(184.31)	(198.18)	(303.12)
$20,000	(108.36)	(265.48)	(197.87)	(315.00)	(201.55)	(216.72)	(331.47)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.43	1.05	0.79	1.25	0.80	0.86	1.32
$1,000,000	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$50,000	(5.56)	(13.62)	(10.15)	(16.16)	(10.34)	(11.12)	(17.01)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
75%	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
70%	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.34)	(5.73)	(4.27)	(6.80)	(4.35)	(4.68)	(7.16)
$10	(4.91)	(12.03)	(8.97)	(14.27)	(9.13)	(9.82)	(15.02)
$15	(8.16)	(19.99)	(14.90)	(23.72)	(15.18)	(16.32)	(24.96)
$20	(12.61)	(30.89)	(23.03)	(36.66)	(23.45)	(25.22)	(38.57)
$25	(16.59)	(40.65)	(30.29)	(48.23)	(30.86)	(33.18)	(50.75)
$30	(20.98)	(51.40)	(38.31)	(60.99)	(39.02)	(41.96)	(64.18)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.01)
$10	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$15	(4.68)	(11.47)	(8.55)	(13.60)	(8.70)	(9.36)	(14.32)
$20	(7.21)	(17.66)	(13.17)	(20.96)	(13.41)	(14.42)	(22.06)
$25	(9.51)	(23.30)	(17.37)	(27.65)	(17.69)	(19.02)	(29.09)
$30	(12.01)	(29.42)	(21.93)	(34.91)	(22.34)	(24.02)	(36.74)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$10	(3.52)	(8.62)	(6.43)	(10.23)	(6.55)	(7.04)	(10.77)
$15	(5.53)	(13.55)	(10.10)	(16.08)	(10.29)	(11.06)	(16.92)
$20	(7.79)	(19.09)	(14.22)	(22.65)	(14.49)	(15.58)	(23.83)
$25	(10.29)	(25.21)	(18.79)	(29.91)	(19.14)	(20.58)	(31.48)
$30	(13.11)	(32.12)	(23.94)	(38.11)	(24.38)	(26.22)	(40.10)
$35	(15.75)	(38.59)	(28.76)	(45.79)	(29.30)	(31.50)	(48.18)
$40	(18.49)	(45.30)	(33.76)	(53.75)	(34.39)	(36.98)	(56.56)
$45	(21.39)	(52.41)	(39.06)	(62.18)	(39.79)	(42.78)	(65.43)
$50	(24.41)	(59.80)	(44.57)	(70.96)	(45.40)	(48.82)	(74.67)

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Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$10	(2.98)	(7.30)	(5.44)	(8.66)	(5.54)	(5.96)	(9.12)
$15	(4.68)	(11.47)	(8.55)	(13.60)	(8.70)	(9.36)	(14.32)
$20	(6.59)	(16.15)	(12.03)	(19.16)	(12.26)	(13.18)	(20.16)
$25	(8.70)	(21.32)	(15.89)	(25.29)	(16.18)	(17.40)	(26.61)
$30	(11.09)	(27.17)	(20.25)	(32.24)	(20.63)	(22.18)	(33.92)
$35	(13.34)	(32.68)	(24.36)	(38.78)	(24.81)	(26.68)	(40.81)
$40	(15.64)	(38.32)	(28.56)	(45.47)	(29.09)	(31.28)	(47.84)
$45	(18.08)	(44.30)	(33.01)	(52.56)	(33.63)	(36.16)	(55.31)
$50	(20.64)	(50.57)	(37.69)	(60.00)	(38.39)	(41.28)	(63.14)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$150	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$200	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$250	(2.85)	(6.98)	(5.20)	(8.28)	(5.30)	(5.70)	(8.72)
$500	(6.88)	(16.86)	(12.56)	(20.00)	(12.80)	(13.76)	(21.05)
$750	(11.81)	(28.93)	(21.57)	(34.33)	(21.97)	(23.62)	(36.13)
$1,000	(17.78)	(43.56)	(32.47)	(51.69)	(33.07)	(35.56)	(54.39)
Copay/Day							
$50 w/3 Day Max	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$50 w/5 Day Max	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$100 w/3 Day Max	(2.60)	(6.37)	(4.75)	(7.56)	(4.84)	(5.20)	(7.95)
$100 w/5 Day Max	(3.74)	(9.16)	(6.83)	(10.87)	(6.96)	(7.48)	(11.44)
$250 w/3 Day Max	(8.56)	(20.97)	(15.63)	(24.88)	(15.92)	(17.12)	(26.19)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$100	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$125	(1.35)	(3.31)	(2.47)	(3.92)	(2.51)	(2.70)	(4.13)
$150	(1.69)	(4.14)	(3.09)	(4.91)	(3.14)	(3.38)	(5.17)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$35	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$50	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$60	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$75	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$100	(2.33)	(5.71)	(4.25)	(6.77)	(4.33)	(4.66)	(7.13)
$125	(2.85)	(6.98)	(5.20)	(8.28)	(5.30)	(5.70)	(8.72)
$150	(3.42)	(8.38)	(6.24)	(9.94)	(6.36)	(6.84)	(10.46)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.47	1.15	0.86	1.37	0.87	0.94	1.44
60	0.91	2.23	1.66	2.65	1.69	1.82	2.78
90	1.32	3.23	2.41	3.84	2.46	2.64	4.04
120	1.57	3.85	2.87	4.56	2.92	3.14	4.80
Unlimited	2.03	4.97	3.71	5.90	3.78	4.06	6.21
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.52	1.27	0.95	1.51	0.97	1.04	1.59
200	1.38	3.38	2.52	4.01	2.57	2.76	4.22
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.62	1.52	1.13	1.80	1.15	1.24	1.90
90	1.26	3.09	2.30	3.66	2.34	2.52	3.85

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.54	1.32	0.99	1.57	1.00	1.08	1.65
90	1.01	2.47	1.84	2.94	1.88	2.02	3.09
120	1.63	3.99	2.98	4.74	3.03	3.26	4.99
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited	0.54	1.32	0.99	1.57	1.00	1.08	1.65
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.40	5.88	4.38	6.98	4.46	4.80	7.34
60	2.83	6.93	5.17	8.23	5.26	5.66	8.66
90	3.37	8.26	6.15	9.80	6.27	6.74	10.31
Unlimited	3.42	8.38	6.24	9.94	6.36	6.84	10.46
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
60/$20 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
60/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
120/$0 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$5 copay	0.38	0.93	0.69	1.10	0.71	0.76	1.16
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$5 copay	0.44	1.08	0.80	1.28	0.82	0.88	1.35
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$30	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$35	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$40	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$45	(1.13)	(2.77)	(2.06)	(3.28)	(2.10)	(2.26)	(3.46)
$50	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$25	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.37)	(8.26)	(6.15)	(9.80)	(6.27)	(6.74)	(10.31)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

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Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.80	21.56	16.07	25.58	16.37	17.60	26.92
60	9.28	22.74	16.95	26.98	17.26	18.56	28.39
90	9.62	23.57	17.57	27.97	17.89	19.24	29.43
Unlimited	9.73	23.84	17.77	28.29	18.10	19.46	29.76
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.83	24.08	17.95	28.58	18.28	19.66	30.07
30	10.83	26.53	19.78	31.48	20.14	21.66	33.13
40	11.43	28.00	20.87	33.23	21.26	22.86	34.96
60	12.04	29.50	21.99	35.00	22.39	24.08	36.83
Unlimited	12.15	29.77	22.19	35.32	22.60	24.30	37.17
LARGE GROUP				**$5 Copay**			
20	9.25	22.66	16.89	26.89	17.21	18.50	28.30
30	10.18	24.94	18.59	29.59	18.93	20.36	31.14
40	10.82	26.51	19.76	31.45	20.13	21.64	33.10
60	11.32	27.73	20.67	32.91	21.06	22.64	34.63
Unlimited	11.42	27.98	20.85	33.20	21.24	22.84	34.93
LARGE GROUP				**$10 Copay**			
20	8.67	21.24	15.83	25.20	16.13	17.34	26.52
30	9.54	23.37	17.42	27.73	17.74	19.08	29.18
40	10.08	24.70	18.41	29.30	18.75	20.16	30.83
60	10.63	26.04	19.41	30.90	19.77	21.26	32.52
Unlimited	10.71	26.24	19.56	31.13	19.92	21.42	32.76
LARGE GROUP				**$15 Copay**			
20	8.13	19.92	14.85	23.63	15.12	16.26	24.87
30	8.96	21.95	16.36	26.05	16.67	17.92	27.41
40	9.49	23.25	17.33	27.59	17.65	18.98	29.03
60	10.04	24.60	18.33	29.19	18.67	20.08	30.71
Unlimited	10.12	24.79	18.48	29.42	18.82	20.24	30.96

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.65	18.74	13.97	22.24	14.23	15.30	23.40
30	8.39	20.56	15.32	24.39	15.61	16.78	25.67
40	8.84	21.66	16.14	25.70	16.44	17.68	27.04
60	9.41	23.05	17.18	27.35	17.50	18.82	28.79
Unlimited	9.48	23.23	17.31	27.56	17.63	18.96	29.00
LARGE GROUP				**$25 Copay**			
20	7.11	17.42	12.98	20.67	13.22	14.22	21.75
30	7.82	19.16	14.28	22.73	14.55	15.64	23.92
40	8.33	20.41	15.21	24.22	15.49	16.66	25.48
60	8.76	21.46	16.00	25.47	16.29	17.52	26.80
Unlimited	8.83	21.63	16.12	25.67	16.42	17.66	27.01
LARGE GROUP				**$30 Copay**			
20	6.78	16.61	12.38	19.71	12.61	13.56	20.74
30	7.35	18.01	13.42	21.37	13.67	14.70	22.48
40	7.84	19.21	14.32	22.79	14.58	15.68	23.98
60	8.22	20.14	15.01	23.90	15.29	16.44	25.14
Unlimited	8.26	20.24	15.08	24.01	15.36	16.52	25.27
LARGE GROUP				**$35 Copay**			
20	6.45	15.80	11.78	18.75	12.00	12.90	19.73
30	6.88	16.86	12.56	20.00	12.80	13.76	21.05
40	7.33	17.96	13.38	21.31	13.63	14.66	22.42
60	7.69	18.84	14.04	22.35	14.30	15.38	23.52
Unlimited	7.74	18.96	14.13	22.50	14.40	15.48	23.68

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MENTAL HEALTH
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP				**$40 Copay**			
20	6.27	15.36	11.45	18.23	11.66	12.54	19.18
30	6.68	16.37	12.20	19.42	12.42	13.36	20.43
40	7.13	17.47	13.02	20.73	13.26	14.26	21.81
60	7.52	18.42	13.73	21.86	13.99	15.04	23.00
Unlimited	7.58	18.57	13.84	22.04	14.10	15.16	23.19
LARGE GROUP				**$45 Copay**			
20	6.09	14.92	11.12	17.70	11.33	12.18	18.63
30	6.51	15.95	11.89	18.92	12.11	13.02	19.91
40	6.96	17.05	12.71	20.23	12.95	13.92	21.29
60	7.34	17.98	13.40	21.34	13.65	14.68	22.45
Unlimited	7.37	18.06	13.46	21.42	13.71	14.74	22.54
LARGE GROUP				**$50 Copay**			
20	5.93	14.53	10.83	17.24	11.03	11.86	18.14
30	6.34	15.53	11.58	18.43	11.79	12.68	19.39
40	6.78	16.61	12.38	19.71	12.61	13.56	20.74
60	7.15	17.52	13.06	20.79	13.30	14.30	21.87
Unlimited	7.20	17.64	13.15	20.93	13.39	14.40	22.02

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	6.98	17.10	12.75	20.29	12.98	13.96	21.35
$25	6.55	16.05	11.96	19.04	12.18	13.10	20.04
$50	6.16	15.09	11.25	17.91	11.46	12.32	18.84
$100	5.53	13.55	10.10	16.08	10.29	11.06	16.92
$500	2.72	6.66	4.97	7.91	5.06	5.44	8.32
Coinsurance							
80%	5.54	13.57	10.12	16.10	10.30	11.08	16.95
75%	5.22	12.79	9.53	15.17	9.71	10.44	15.97
70%	4.87	11.93	8.89	14.16	9.06	9.74	14.90
Deductible			**Orthotics Riders**				
$0	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$25	1.14	2.79	2.08	3.31	2.12	2.28	3.49
$50	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$100	0.99	2.43	1.81	2.88	1.84	1.98	3.03
$500	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Coinsurance							
80%	0.99	2.43	1.81	2.88	1.84	1.98	3.03
75%	0.92	2.25	1.68	2.67	1.71	1.84	2.81
70%	0.87	2.13	1.59	2.53	1.62	1.74	2.66
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.81	1.98	1.48	2.35	1.51	1.62	2.48
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	15.25	37.36	27.85	44.33	28.37	30.50	46.65
3 IVF	18.30	44.84	33.42	53.20	34.04	36.60	55.98
			Nurse Advice Line Rider				
	0.31	0.76	0.57	0.90	0.58	0.62	0.95

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LARGE GROUP HMO
VHLI - LGRP - 01
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	571.83	1,488.03
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.15	5.27
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.33	3.27
Outpatient Mental Health: 20 Visits	5.94	14.57
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.09	2.66
Other Riders		
Durable Medical Equipment	1.58	3.73
Chiropractic: $5 Copay	4.20	11.03
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	140.07	364.19
Infertility Drug Coverage: $7 Brand Copay	3.27	8.56
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.89
Inpatient Substance Abuse Rehab: Unlimited days	4.50	11.04
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.63	1.55
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.49	1.19

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

Table 1: Drug Rider Base Values pmpm			
Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm				
Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm				
Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjusti Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	2.5%
3Q2011	1.9%
4Q2011	1.9%
1Q2012-2Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
Rate Calculation

Prime and Access Rate Formula

Large groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor

Example: Large Group HMO Individual Employee Rate Example

=	508.80	3rd QUARTER	(Base Rate
+	(5.14)	$10 Specialist visit copay	Optional Base Benefit Variables (exlcuding Mental Health)
+	9.05	Unlimited days	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	9.97	$10 copay, Unlimited visits	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	1.09	Standard Coverage	Network Area Factor
	533.13		

HEALTH INSURANCE PLAN OF GREATER NEW YORK

3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	508.80	1,246.56	929.07	1,479.08	946.37	1,017.60	1,556.42

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
$10	(7.15)	(17.52)	(13.06)	(20.79)	(13.30)	(14.30)	(21.87)
$15	(11.90)	(29.16)	(21.73)	(34.59)	(22.13)	(23.80)	(36.40)
$20	(18.37)	(45.01)	(33.54)	(53.40)	(34.17)	(36.74)	(56.19)
$25	(24.18)	(59.24)	(44.15)	(70.29)	(44.97)	(48.36)	(73.97)
$30	(30.59)	(74.95)	(55.86)	(88.93)	(56.90)	(61.18)	(93.57)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$10	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$15	(6.81)	(16.68)	(12.44)	(19.80)	(12.67)	(13.62)	(20.83)
$20	(10.52)	(25.77)	(19.21)	(30.58)	(19.57)	(21.04)	(32.18)
$25	(13.86)	(33.96)	(25.31)	(40.29)	(25.78)	(27.72)	(42.40)
$30	(17.55)	(43.00)	(32.05)	(51.02)	(32.64)	(35.10)	(53.69)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)
$10	(5.14)	(12.59)	(9.39)	(14.94)	(9.56)	(10.28)	(15.72)
$15	(8.06)	(19.75)	(14.72)	(23.43)	(14.99)	(16.12)	(24.66)
$20	(11.37)	(27.86)	(20.76)	(33.05)	(21.15)	(22.74)	(34.78)
$25	(15.00)	(36.75)	(27.39)	(43.61)	(27.90)	(30.00)	(45.89)
$30	(19.12)	(46.84)	(34.91)	(55.58)	(35.56)	(38.24)	(58.49)
$35	(22.97)	(56.28)	(41.94)	(66.77)	(42.72)	(45.94)	(70.27)
$40	(26.97)	(66.08)	(49.25)	(78.40)	(50.16)	(53.94)	(82.50)
$45	(31.17)	(76.37)	(56.92)	(90.61)	(57.98)	(62.34)	(95.35)
$50	(35.59)	(87.20)	(64.99)	(103.46)	(66.20)	(71.18)	(108.87)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(6.81)	(16.68)	(12.44)	(19.80)	(12.67)	(13.62)	(20.83)
$20	(9.63)	(23.59)	(17.58)	(27.99)	(17.91)	(19.26)	(29.46)
$25	(12.69)	(31.09)	(23.17)	(36.89)	(23.60)	(25.38)	(38.82)
$30	(16.17)	(39.62)	(29.53)	(47.01)	(30.08)	(32.34)	(49.46)
$35	(19.45)	(47.65)	(35.52)	(56.54)	(36.18)	(38.90)	(59.50)
$40	(22.82)	(55.91)	(41.67)	(66.34)	(42.45)	(45.64)	(69.81)
$45	(26.36)	(64.58)	(48.13)	(76.63)	(49.03)	(52.72)	(80.64)
$50	(30.09)	(73.72)	(54.94)	(87.47)	(55.97)	(60.18)	(92.05)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$150	(2.06)	(5.05)	(3.76)	(5.99)	(3.83)	(4.12)	(6.30)
$200	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$250	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$500	(10.03)	(24.57)	(18.31)	(29.16)	(18.66)	(20.06)	(30.68)
$750	(17.24)	(42.24)	(31.48)	(50.12)	(32.07)	(34.48)	(52.74)
$1,000	(25.92)	(63.50)	(47.33)	(75.35)	(48.21)	(51.84)	(79.29)
Copay/Day							
$50 w/3 Day Max	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$50 w/5 Day Max	(2.08)	(5.10)	(3.80)	(6.05)	(3.87)	(4.16)	(6.36)
$100 w/3 Day Max	(3.78)	(9.26)	(6.90)	(10.99)	(7.03)	(7.56)	(11.56)
$100 w/5 Day Max	(5.44)	(13.33)	(9.93)	(15.81)	(10.12)	(10.88)	(16.64)
$250 w/3 Day Max	(12.48)	(30.58)	(22.79)	(36.28)	(23.21)	(24.96)	(38.18)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$75	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$100	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$125	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$150	(2.47)	(6.05)	(4.51)	(7.18)	(4.59)	(4.94)	(7.56)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$25	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$35	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$50	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$60	(1.80)	(4.41)	(3.29)	(5.23)	(3.35)	(3.60)	(5.51)
$75	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$100	(3.39)	(8.31)	(6.19)	(9.85)	(6.31)	(6.78)	(10.37)
$125	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$150	(4.99)	(12.23)	(9.11)	(14.51)	(9.28)	(9.98)	(15.26)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.58	1.42	1.06	1.69	1.08	1.16	1.77
60	1.14	2.79	2.08	3.31	2.12	2.28	3.49
90	1.71	4.19	3.12	4.97	3.18	3.42	5.23
120	2.01	4.92	3.67	5.84	3.74	4.02	6.15
Unlimited	2.58	6.32	4.71	7.50	4.80	5.16	7.89

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$20 copay	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
40/$25 copay	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
60	0.32	0.78	0.58	0.93	0.60	0.64	0.98
100	0.74	1.81	1.35	2.15	1.38	1.48	2.26
200	2.01	4.92	3.67	5.84	3.74	4.02	6.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.77	1.89	1.41	2.24	1.43	1.54	2.36
90	1.64	4.02	2.99	4.77	3.05	3.28	5.02
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.69	1.69	1.26	2.01	1.28	1.38	2.11
90	1.27	3.11	2.32	3.69	2.36	2.54	3.88
120	2.08	5.10	3.80	6.05	3.87	4.16	6.36
visits for all other			**(Verizon Benefit)**				
	1.61	3.94	2.94	4.68	2.99	3.22	4.92
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.31	0.76	0.57	0.90	0.58	0.62	0.95
30	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Unlimited	0.69	1.69	1.26	2.01	1.28	1.38	2.11
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.51	8.60	6.41	10.20	6.53	7.02	10.74
60	4.13	10.12	7.54	12.01	7.68	8.26	12.63
90	4.93	12.08	9.00	14.33	9.17	9.86	15.08
Unlimited	4.99	12.23	9.11	14.51	9.28	9.98	15.26

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HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
60/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60/$25 copay	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
120/$0 copay	0.61	1.49	1.11	1.77	1.13	1.22	1.87
120/$5 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
Unlimited/$0 copay	0.70	1.72	1.28	2.03	1.30	1.40	2.14
Unlimited/$5 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$10 copay	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$20	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$25	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$30	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$35	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$40	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$45	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
$50	(1.81)	(4.43)	(3.31)	(5.26)	(3.37)	(3.62)	(5.54)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$25	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$60	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$100	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP HMO GROUP CONTRACT - MENTAL HEALTH
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Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.19	20.07	14.95	23.81	15.23	16.38	25.05
60	8.64	21.17	15.78	25.12	16.07	17.28	26.43
90	8.96	21.95	16.36	26.05	16.67	17.92	27.41
Unlimited	9.05	22.17	16.53	26.31	16.83	18.10	27.68
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.15	22.42	16.71	26.60	17.02	18.30	27.99
30	10.08	24.70	18.41	29.30	18.75	20.16	30.83
40	10.64	26.07	19.43	30.93	19.79	21.28	32.55
60	11.22	27.49	20.49	32.62	20.87	22.44	34.32
Unlimited	11.30	27.69	20.63	32.85	21.02	22.60	34.57
LARGE GROUP			**$5 Copay**				
20	8.61	21.09	15.72	25.03	16.01	17.22	26.34
30	9.47	23.20	17.29	27.53	17.61	18.94	28.97
40	10.07	24.67	18.39	29.27	18.73	20.14	30.80
60	10.54	25.82	19.25	30.64	19.60	21.08	32.24
Unlimited	10.62	26.02	19.39	30.87	19.75	21.24	32.49
LARGE GROUP			**$10 Copay**				
20	8.05	19.72	14.70	23.40	14.97	16.10	24.62
30	8.88	21.76	16.21	25.81	16.52	17.76	27.16
40	9.38	22.98	17.13	27.27	17.45	18.76	28.69
60	9.89	24.23	18.06	28.75	18.40	19.78	30.25
Unlimited	9.97	24.43	18.21	28.98	18.54	19.94	30.50
LARGE GROUP			**$15 Copay**				
20	7.56	18.52	13.80	21.98	14.06	15.12	23.13
30	8.35	20.46	15.25	24.27	15.53	16.70	25.54
40	8.83	21.63	16.12	25.67	16.42	17.66	27.01
60	9.34	22.88	17.05	27.15	17.37	18.68	28.57
Unlimited	9.42	23.08	17.20	27.38	17.52	18.84	28.82
LARGE GROUP			**$20 Copay**				
20	7.12	17.44	13.00	20.70	13.24	14.24	21.78
30	7.81	19.13	14.26	22.70	14.53	15.62	23.89
40	8.23	20.16	15.03	23.92	15.31	16.46	25.18
60	8.75	21.44	15.98	25.44	16.28	17.50	26.77
Unlimited	8.81	21.58	16.09	25.61	16.39	17.62	26.95

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP			**$25 Copay**				
20	6.62	16.22	12.09	19.24	12.31	13.24	20.25
30	7.27	17.81	13.28	21.13	13.52	14.54	22.24
40	7.74	18.96	14.13	22.50	14.40	15.48	23.68
60	8.15	19.97	14.88	23.69	15.16	16.30	24.93
Unlimited	8.22	20.14	15.01	23.90	15.29	16.44	25.14
LARGE GROUP			**$30 Copay**				
20	6.31	15.46	11.52	18.34	11.74	12.62	19.30
30	6.85	16.78	12.51	19.91	12.74	13.70	20.95
40	7.29	17.86	13.31	21.19	13.56	14.58	22.30
60	7.65	18.74	13.97	22.24	14.23	15.30	23.40
Unlimited	7.69	18.84	14.04	22.35	14.30	15.38	23.52
LARGE GROUP			**$35 Copay**				
20	6.00	14.70	10.96	17.44	11.16	12.00	18.35
30	6.40	15.68	11.69	18.60	11.90	12.80	19.58
40	6.81	16.68	12.44	19.80	12.67	13.62	20.83
60	7.15	17.52	13.06	20.79	13.30	14.30	21.87
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP			**$40 Copay**				
20	5.83	14.28	10.65	16.95	10.84	11.66	17.83
30	6.23	15.26	11.38	18.11	11.59	12.46	19.06
40	6.64	16.27	12.12	19.30	12.35	13.28	20.31
60	7.00	17.15	12.78	20.35	13.02	14.00	21.41
Unlimited	7.05	17.27	12.87	20.49	13.11	14.10	21.57
LARGE GROUP			**$45 Copay**				
20	5.67	13.89	10.35	16.48	10.55	11.34	17.34
30	6.05	14.82	11.05	17.59	11.25	12.10	18.51
40	6.47	15.85	11.81	18.81	12.03	12.94	19.79
60	6.82	16.71	12.45	19.83	12.69	13.64	20.86
Unlimited	6.87	16.83	12.54	19.97	12.78	13.74	21.02

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$50 Copay**			
20	5.51	13.50	10.06	16.02	10.25	11.02	16.86
30	5.90	14.46	10.77	17.15	10.97	11.80	18.05
40	6.31	15.46	11.52	18.34	11.74	12.62	19.30
60	6.66	16.32	12.16	19.36	12.39	13.32	20.37
Unlimited	6.71	16.44	12.25	19.51	12.48	13.42	20.53

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%

				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
NYSHIP: Three Month Extension							
	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.54	11.12	8.29	13.20	8.44	9.08	13.89
$0/Max $5000	4.33	10.61	7.91	12.59	8.05	8.66	13.25
$0/Max $2500	4.04	9.90	7.38	11.74	7.51	8.08	12.36
$25	4.33	10.61	7.91	12.59	8.05	8.66	13.25
$50	4.04	9.90	7.38	11.74	7.51	8.08	12.36
$100	3.72	9.11	6.79	10.81	6.92	7.44	11.38
$500	1.77	4.34	3.23	5.15	3.29	3.54	5.41
$5,000	0.31	0.76	0.57	0.90	0.58	0.62	0.95
Coinsurance							
80%	3.66	8.97	6.68	10.64	6.81	7.32	11.20
75%	3.42	8.38	6.24	9.94	6.36	6.84	10.46
70%	3.21	7.86	5.86	9.33	5.97	6.42	9.82
Deductible			**Orthotics Riders**				
$0	0.76	1.86	1.39	2.21	1.41	1.52	2.32
$0/Max $5000	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$0/Max $2500	0.69	1.69	1.26	2.01	1.28	1.38	2.11
$25	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$50	0.69	1.69	1.26	2.01	1.28	1.38	2.11
$100	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$500	0.33	0.81	0.60	0.96	0.61	0.66	1.01
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.63	1.54	1.15	1.83	1.17	1.26	1.93
75%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
70%	0.56	1.37	1.02	1.63	1.04	1.12	1.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.54	1.32	0.99	1.57	1.00	1.08	1.65
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
			Infertility Rider				
Limit							
2 IVF	9.64	23.62	17.60	28.02	17.93	19.28	29.49
3 IVF	11.65	28.54	21.27	33.87	21.67	23.30	35.64
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.86	7.01	5.22	8.31	5.32	5.72	8.75
			Nurse Advice Line Rider				
	0.32	0.78	0.58	0.93	0.60	0.64	0.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
939.52	2,301.82	1,715.56	2,731.18	1,747.51	1,879.04	2,873.99
80% Coinsurance						
925.42	2,267.28	1,689.82	2,690.20	1,721.28	1,850.84	2,830.86
75% Coinsurance						
880.80	2,157.96	1,608.34	2,560.49	1,638.29	1,761.60	2,694.37
70% Coinsurance						
836.16	2,048.59	1,526.83	2,430.72	1,555.26	1,672.32	2,557.81
50% Coinsurance						
791.54	1,939.27	1,445.35	2,301.01	1,472.26	1,583.08	2,421.32

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**

**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual x 2	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(42.44)	(103.98)	(77.50)	(123.37)	(78.94)	(84.88)	(129.82)
$350	(56.18)	(137.64)	(102.58)	(163.32)	(104.49)	(112.36)	(171.85)
$500	(72.28)	(177.09)	(131.98)	(210.12)	(134.44)	(144.56)	(221.10)
$750	(93.91)	(230.08)	(171.48)	(273.00)	(174.67)	(187.82)	(287.27)
$1,000	(110.47)	(270.65)	(201.72)	(321.14)	(205.47)	(220.94)	(337.93)
$1,500	(135.86)	(332.86)	(248.08)	(394.95)	(252.70)	(271.72)	(415.60)
$2,500	(151.88)	(372.11)	(277.33)	(441.52)	(282.50)	(303.76)	(464.60)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(56.72)	(138.96)	(103.57)	(164.89)	(105.50)	(113.44)	(173.51)
$250	(67.65)	(165.74)	(123.53)	(196.66)	(125.83)	(135.30)	(206.94)
$300	(78.63)	(192.64)	(143.58)	(228.58)	(146.25)	(157.26)	(240.53)
$350	(89.60)	(219.52)	(163.61)	(260.47)	(166.66)	(179.20)	(274.09)
$400	(98.21)	(240.61)	(179.33)	(285.50)	(182.67)	(196.42)	(300.42)
$500	(115.44)	(282.83)	(210.79)	(335.58)	(214.72)	(230.88)	(353.13)
$750	(149.92)	(367.30)	(273.75)	(435.82)	(278.85)	(299.84)	(458.61)
$1,000	(176.47)	(432.35)	(322.23)	(513.00)	(328.23)	(352.94)	(539.82)
$1,500	(217.08)	(531.85)	(396.39)	(631.05)	(403.77)	(434.16)	(664.05)
$2,000	(233.69)	(572.54)	(426.72)	(679.34)	(434.66)	(467.38)	(714.86)
$2,500	(250.35)	(613.36)	(457.14)	(727.77)	(465.65)	(500.70)	(765.82)
$5,000	(294.31)	(721.06)	(537.41)	(855.56)	(547.42)	(588.62)	(900.29)
$10,000	(330.62)	(810.02)	(603.71)	(961.11)	(614.95)	(661.24)	(1,011.37)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(46.47)	(113.85)	(84.85)	(135.09)	(86.43)	(92.94)	(142.15)
$250	(55.42)	(135.78)	(101.20)	(161.11)	(103.08)	(110.84)	(169.53)
$300	(64.43)	(157.85)	(117.65)	(187.30)	(119.84)	(128.86)	(197.09)
$350	(73.39)	(179.81)	(134.01)	(213.34)	(136.51)	(146.78)	(224.50)
$400	(80.60)	(197.47)	(147.18)	(234.30)	(149.92)	(161.20)	(246.56)
$500	(95.07)	(232.92)	(173.60)	(276.37)	(176.83)	(190.14)	(290.82)
$750	(123.66)	(302.97)	(225.80)	(359.48)	(230.01)	(247.32)	(378.28)
$1,000	(145.91)	(357.48)	(266.43)	(424.16)	(271.39)	(291.82)	(446.34)
$1,500	(179.65)	(440.14)	(328.04)	(522.24)	(334.15)	(359.30)	(549.55)
$2,000	(194.93)	(477.58)	(355.94)	(566.66)	(362.57)	(389.86)	(596.29)
$2,500	(210.24)	(515.09)	(383.90)	(611.17)	(391.05)	(420.48)	(643.12)
$5,000	(254.00)	(622.30)	(463.80)	(738.38)	(472.44)	(508.00)	(776.99)
$10,000	(290.12)	(710.79)	(529.76)	(843.38)	(539.62)	(580.24)	(887.48)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(36.23)	(88.76)	(66.16)	(105.32)	(67.39)	(72.46)	(110.83)
$250	(43.23)	(105.91)	(78.94)	(125.67)	(80.41)	(86.46)	(132.24)
$300	(50.21)	(123.01)	(91.68)	(145.96)	(93.39)	(100.42)	(153.59)
$350	(57.19)	(140.12)	(104.43)	(166.25)	(106.37)	(114.38)	(174.94)
$400	(63.05)	(154.47)	(115.13)	(183.29)	(117.27)	(126.10)	(192.87)
$500	(74.63)	(182.84)	(136.27)	(216.95)	(138.81)	(149.26)	(228.29)
$750	(97.37)	(238.56)	(177.80)	(283.05)	(181.11)	(194.74)	(297.85)
$1,000	(115.30)	(282.49)	(210.54)	(335.18)	(214.46)	(230.60)	(352.70)
$1,500	(142.21)	(348.41)	(259.68)	(413.40)	(264.51)	(284.42)	(435.02)
$2,000	(156.19)	(382.67)	(285.20)	(454.04)	(290.51)	(312.38)	(477.79)
$2,500	(170.16)	(416.89)	(310.71)	(494.66)	(316.50)	(340.32)	(520.52)
$5,000	(213.69)	(523.54)	(390.20)	(621.20)	(397.46)	(427.38)	(653.68)
$10,000	(249.63)	(611.59)	(455.82)	(725.67)	(464.31)	(499.26)	(763.62)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(24.90)	(61.01)	(45.47)	(72.38)	(46.31)	(49.80)	(76.17)
$250	(29.85)	(73.13)	(54.51)	(86.77)	(55.52)	(59.70)	(91.31)
$300	(34.83)	(85.33)	(63.60)	(101.25)	(64.78)	(69.66)	(106.54)
$350	(39.74)	(97.36)	(72.57)	(115.52)	(73.92)	(79.48)	(121.56)
$400	(44.04)	(107.90)	(80.42)	(128.02)	(81.91)	(88.08)	(134.72)
$500	(52.61)	(128.89)	(96.07)	(152.94)	(97.85)	(105.22)	(160.93)
$750	(69.03)	(169.12)	(126.05)	(200.67)	(128.40)	(138.06)	(211.16)
$1,000	(82.39)	(201.86)	(150.44)	(239.51)	(153.25)	(164.78)	(252.03)
$1,500	(102.94)	(252.20)	(187.97)	(299.25)	(191.47)	(205.88)	(314.89)
$2,000	(113.89)	(279.03)	(207.96)	(331.08)	(211.84)	(227.78)	(348.39)
$2,500	(124.89)	(305.98)	(228.05)	(363.06)	(232.30)	(249.78)	(382.04)
$5,000	(167.81)	(411.13)	(306.42)	(487.82)	(312.13)	(335.62)	(513.33)
$10,000	(203.25)	(497.96)	(371.13)	(590.85)	(378.05)	(406.50)	(621.74)

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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
			LARGE GROUP				
Maximum	**Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance**						
$1,000	(32.99)	(80.83)	(60.24)	(95.90)	(61.36)	(65.98)	(100.92)
$1,500	(35.98)	(88.15)	(65.70)	(104.59)	(66.92)	(71.96)	(110.06)
$2,000	(37.55)	(92.00)	(68.57)	(109.16)	(69.84)	(75.10)	(114.87)
$3,000	(38.92)	(95.35)	(71.07)	(113.14)	(72.39)	(77.84)	(119.06)
$4,000	(39.53)	(96.85)	(72.18)	(114.91)	(73.53)	(79.06)	(120.92)
$5,000	(39.85)	(97.63)	(72.77)	(115.84)	(74.12)	(79.70)	(121.90)
$7,000	(40.22)	(98.54)	(73.44)	(116.92)	(74.81)	(80.44)	(123.03)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(52.50)	(128.63)	(95.87)	(152.62)	(97.65)	(105.00)	(160.60)
$1,500	(57.29)	(140.36)	(104.61)	(166.54)	(106.56)	(114.58)	(175.25)
$2,000	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$3,000	(62.01)	(151.92)	(113.23)	(180.26)	(115.34)	(124.02)	(189.69)
$4,000	(62.96)	(154.25)	(114.96)	(183.02)	(117.11)	(125.92)	(192.59)
$5,000	(63.46)	(155.48)	(115.88)	(184.48)	(118.04)	(126.92)	(194.12)
$7,000	(64.07)	(156.97)	(116.99)	(186.25)	(119.17)	(128.14)	(195.99)
$7,500	(64.59)	(158.25)	(117.94)	(187.76)	(120.14)	(129.18)	(197.58)
$10,000	(66.49)	(162.90)	(121.41)	(193.29)	(123.67)	(132.98)	(203.39)
$20,000	(69.18)	(169.49)	(126.32)	(201.11)	(128.67)	(138.36)	(211.62)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(50.74)	(124.31)	(92.65)	(147.50)	(94.38)	(101.48)	(155.21)
$1,500	(56.39)	(138.16)	(102.97)	(163.93)	(104.89)	(112.78)	(172.50)
$2,000	(59.54)	(145.87)	(108.72)	(173.08)	(110.74)	(119.08)	(182.13)
$3,000	(62.62)	(153.42)	(114.34)	(182.04)	(116.47)	(125.24)	(191.55)
$4,000	(64.02)	(156.85)	(116.90)	(186.11)	(119.08)	(128.04)	(195.84)
$5,000	(64.80)	(158.76)	(118.32)	(188.37)	(120.53)	(129.60)	(198.22)
$7,000	(65.55)	(160.60)	(119.69)	(190.55)	(121.92)	(131.10)	(200.52)
$7,500	(66.11)	(161.97)	(120.72)	(192.18)	(122.96)	(132.22)	(202.23)
$10,000	(68.43)	(167.65)	(124.95)	(198.93)	(127.28)	(136.86)	(209.33)
$20,000	(72.01)	(176.42)	(131.49)	(209.33)	(133.94)	(144.02)	(220.28)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(48.98)	(120.00)	(89.44)	(142.38)	(91.10)	(97.96)	(149.83)
$1,500	(55.56)	(136.12)	(101.45)	(161.51)	(103.34)	(111.12)	(169.96)
$2,000	(59.34)	(145.38)	(108.35)	(172.50)	(110.37)	(118.68)	(181.52)
$3,000	(63.26)	(154.99)	(115.51)	(183.90)	(117.66)	(126.52)	(193.51)
$4,000	(65.04)	(159.35)	(118.76)	(189.07)	(120.97)	(130.08)	(198.96)
$5,000	(66.09)	(161.92)	(120.68)	(192.12)	(122.93)	(132.18)	(202.17)
$7,000	(67.02)	(164.20)	(122.38)	(194.83)	(124.66)	(134.04)	(205.01)
$7,500	(67.61)	(165.64)	(123.46)	(196.54)	(125.75)	(135.22)	(206.82)
$10,000	(70.17)	(171.92)	(128.13)	(203.98)	(130.52)	(140.34)	(214.65)
$20,000	(74.73)	(183.09)	(136.46)	(217.24)	(139.00)	(149.46)	(228.60)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(55.42)	(135.78)	(101.20)	(161.11)	(103.08)	(110.84)	(169.53)
$1,500	(66.05)	(161.82)	(120.61)	(192.01)	(122.85)	(132.10)	(202.05)
$2,000	(72.89)	(178.58)	(133.10)	(211.89)	(135.58)	(145.78)	(222.97)
$3,000	(81.19)	(198.92)	(148.25)	(236.02)	(151.01)	(162.38)	(248.36)
$4,000	(85.74)	(210.06)	(156.56)	(249.25)	(159.48)	(171.48)	(262.28)
$5,000	(88.54)	(216.92)	(161.67)	(257.39)	(164.68)	(177.08)	(270.84)
$7,000	(91.43)	(224.00)	(166.95)	(265.79)	(170.06)	(182.86)	(279.68)
$7,500	(92.50)	(226.63)	(168.91)	(268.90)	(172.05)	(185.00)	(282.96)
$10,000	(96.82)	(237.21)	(176.79)	(281.46)	(180.09)	(193.64)	(296.17)
$20,000	(105.87)	(259.38)	(193.32)	(307.76)	(196.92)	(211.74)	(323.86)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$1,000,000	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$50,000	(5.44)	(13.33)	(9.93)	(15.81)	(10.12)	(10.88)	(16.64)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
75%	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
70%	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

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Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.28)	(5.59)	(4.16)	(6.63)	(4.24)	(4.56)	(6.97)
$10	(4.80)	(11.76)	(8.76)	(13.95)	(8.93)	(9.60)	(14.68)
$15	(7.98)	(19.55)	(14.57)	(23.20)	(14.84)	(15.96)	(24.41)
$20	(12.32)	(30.18)	(22.50)	(35.81)	(22.92)	(24.64)	(37.69)
$25	(16.21)	(39.71)	(29.60)	(47.12)	(30.15)	(32.42)	(49.59)
$30	(20.51)	(50.25)	(37.45)	(59.62)	(38.15)	(41.02)	(62.74)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$10	(2.75)	(6.74)	(5.02)	(7.99)	(5.12)	(5.50)	(8.41)
$15	(4.57)	(11.20)	(8.34)	(13.28)	(8.50)	(9.14)	(13.98)
$20	(7.05)	(17.27)	(12.87)	(20.49)	(13.11)	(14.10)	(21.57)
$25	(9.28)	(22.74)	(16.95)	(26.98)	(17.26)	(18.56)	(28.39)
$30	(11.73)	(28.74)	(21.42)	(34.10)	(21.82)	(23.46)	(35.88)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$10	(3.44)	(8.43)	(6.28)	(10.00)	(6.40)	(6.88)	(10.52)
$15	(5.41)	(13.25)	(9.88)	(15.73)	(10.06)	(10.82)	(16.55)
$20	(7.62)	(18.67)	(13.91)	(22.15)	(14.17)	(15.24)	(23.31)
$25	(10.04)	(24.60)	(18.33)	(29.19)	(18.67)	(20.08)	(30.71)
$30	(12.81)	(31.38)	(23.39)	(37.24)	(23.83)	(25.62)	(39.19)
$35	(15.39)	(37.71)	(28.10)	(44.74)	(28.63)	(30.78)	(47.08)
$40	(18.06)	(44.25)	(32.98)	(52.50)	(33.59)	(36.12)	(55.25)
$45	(20.89)	(51.18)	(38.15)	(60.73)	(38.86)	(41.78)	(63.90)
$50	(23.84)	(58.41)	(43.53)	(69.30)	(44.34)	(47.68)	(72.93)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$10	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$15	(4.57)	(11.20)	(8.34)	(13.28)	(8.50)	(9.14)	(13.98)
$20	(6.44)	(15.78)	(11.76)	(18.72)	(11.98)	(12.88)	(19.70)
$25	(8.50)	(20.83)	(15.52)	(24.71)	(15.81)	(17.00)	(26.00)
$30	(10.83)	(26.53)	(19.78)	(31.48)	(20.14)	(21.66)	(33.13)
$35	(13.02)	(31.90)	(23.77)	(37.85)	(24.22)	(26.04)	(39.83)
$40	(15.29)	(37.46)	(27.92)	(44.45)	(28.44)	(30.58)	(46.77)
$45	(17.66)	(43.27)	(32.25)	(51.34)	(32.85)	(35.32)	(54.02)
$50	(20.17)	(49.42)	(36.83)	(58.63)	(37.52)	(40.34)	(61.70)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$150	(1.35)	(3.31)	(2.47)	(3.92)	(2.51)	(2.70)	(4.13)
$200	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$250	(2.79)	(6.84)	(5.09)	(8.11)	(5.19)	(5.58)	(8.53)
$500	(6.73)	(16.49)	(12.29)	(19.56)	(12.52)	(13.46)	(20.59)
$750	(11.54)	(28.27)	(21.07)	(33.55)	(21.46)	(23.08)	(35.30)
$1,000	(17.36)	(42.53)	(31.70)	(50.47)	(32.29)	(34.72)	(53.10)
Copay/Day							
$50 w/3 Day Max	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$50 w/5 Day Max	(1.39)	(3.41)	(2.54)	(4.04)	(2.59)	(2.78)	(4.25)
$100 w/3 Day Max	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$100 w/5 Day Max	(3.65)	(8.94)	(6.66)	(10.61)	(6.79)	(7.30)	(11.17)
$250 w/3 Day Max	(8.38)	(20.53)	(15.30)	(24.36)	(15.59)	(16.76)	(25.63)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$100	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$125	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$150	(1.66)	(4.07)	(3.03)	(4.83)	(3.09)	(3.32)	(5.08)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$35	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$50	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
$60	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.40)	(3.67)
$75	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
$100	(2.27)	(5.56)	(4.15)	(6.60)	(4.22)	(4.54)	(6.94)
$125	(2.79)	(6.84)	(5.09)	(8.11)	(5.19)	(5.58)	(8.53)
$150	(3.34)	(8.18)	(6.10)	(9.71)	(6.21)	(6.68)	(10.22)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.46	1.13	0.84	1.34	0.86	0.92	1.41
60	0.90	2.21	1.64	2.62	1.67	1.80	2.75
90	1.29	3.16	2.36	3.75	2.40	2.58	3.95
120	1.54	3.77	2.81	4.48	2.86	3.08	4.71
Unlimited	1.99	4.88	3.63	5.78	3.70	3.98	6.09
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.51	1.25	0.93	1.48	0.95	1.02	1.56
200	1.32	3.23	2.41	3.84	2.46	2.64	4.04

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

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Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.94)	(2.30)	(1.72)	(2.73)	(1.75)	(1.88)	(2.88)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.60	1.47	1.10	1.74	1.12	1.20	1.84
90	1.23	3.01	2.25	3.58	2.29	2.46	3.76
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.53	1.30	0.97	1.54	0.99	1.06	1.62
90	0.99	2.43	1.81	2.88	1.84	1.98	3.03
120	1.59	3.90	2.90	4.62	2.96	3.18	4.86
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.62
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.34	5.73	4.27	6.80	4.35	4.68	7.16
60	2.77	6.79	5.06	8.05	5.15	5.54	8.47
90	3.30	8.09	6.03	9.59	6.14	6.60	10.09
Unlimited	3.34	8.18	6.10	9.71	6.21	6.68	10.22
			Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
60/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
120/$0 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$5 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Jnlimited/$0 copa	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Jnlimited/$5 copa	0.43	1.05	0.79	1.25	0.80	0.86	1.32
nlimited/$10 copa	0.24	0.59	0.44	0.70	0.45	0.48	0.73
nlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
nlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
nlimited/$25 copa	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

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Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$25	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$30	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$35	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$40	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$45	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$50	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$25	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.30)	(8.09)	(6.03)	(9.59)	(6.14)	(6.60)	(10.09)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.60	21.07	15.70	25.00	16.00	17.20	26.31
60	9.08	22.25	16.58	26.40	16.89	18.16	27.78
90	9.41	23.05	17.18	27.35	17.50	18.82	28.79
Unlimited	9.50	23.28	17.35	27.62	17.67	19.00	29.06
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.62	23.57	17.57	27.97	17.89	19.24	29.43
30	10.58	25.92	19.32	30.76	19.68	21.16	32.36
40	11.16	27.34	20.38	32.44	20.76	22.32	34.14
60	11.77	28.84	21.49	34.22	21.89	23.54	36.00
Unlimited	11.87	29.08	21.67	34.51	22.08	23.74	36.31
LARGE GROUP				**$5 Copay**			
20	9.04	22.15	16.51	26.28	16.81	18.08	27.65
30	9.95	24.38	18.17	28.92	18.51	19.90	30.44
40	10.57	25.90	19.30	30.73	19.66	21.14	32.33
60	11.08	27.15	20.23	32.21	20.61	22.16	33.89
Unlimited	11.15	27.32	20.36	32.41	20.74	22.30	34.11
LARGE GROUP				**$10 Copay**			
20	8.46	20.73	15.45	24.59	15.74	16.92	25.88
30	9.33	22.86	17.04	27.12	17.35	18.66	28.54
40	9.85	24.13	17.99	28.63	18.32	19.70	30.13
60	10.38	25.43	18.95	30.17	19.31	20.76	31.75
Unlimited	10.47	25.65	19.12	30.44	19.47	20.94	32.03
LARGE GROUP				**$15 Copay**			
20	7.95	19.48	14.52	23.11	14.79	15.90	24.32
30	8.75	21.44	15.98	25.44	16.28	17.50	26.77
40	9.26	22.69	16.91	26.92	17.22	18.52	28.33
60	9.80	24.01	17.89	28.49	18.23	19.60	29.98
Unlimited	9.89	24.23	18.06	28.75	18.40	19.78	30.25

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.47	18.30	13.64	21.72	13.89	14.94	22.85
30	8.20	20.09	14.97	23.84	15.25	16.40	25.08
40	8.65	21.19	15.79	25.15	16.09	17.30	26.46
60	9.18	22.49	16.76	26.69	17.07	18.36	28.08
Unlimited	9.25	22.66	16.89	26.89	17.21	18.50	28.30
LARGE GROUP				**$25 Copay**			
20	6.94	17.00	12.67	20.17	12.91	13.88	21.23
30	7.64	18.72	13.95	22.21	14.21	15.28	23.37
40	8.14	19.94	14.86	23.66	15.14	16.28	24.90
60	8.55	20.95	15.61	24.85	15.90	17.10	26.15
Unlimited	8.64	21.17	15.78	25.12	16.07	17.28	26.43
LARGE GROUP				**$30 Copay**			
20	6.63	16.24	12.11	19.27	12.33	13.26	20.28
30	7.19	17.62	13.13	20.90	13.37	14.38	21.99
40	7.66	18.77	13.99	22.27	14.25	15.32	23.43
60	8.02	19.65	14.64	23.31	14.92	16.04	24.53
Unlimited	8.06	19.75	14.72	23.43	14.99	16.12	24.66

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
LARGE GROUP				**$35 Copay**			
20	6.30	15.44	11.50	18.31	11.72	12.60	19.27
30	6.73	16.49	12.29	19.56	12.52	13.46	20.59
40	7.16	17.54	13.07	20.81	13.32	14.32	21.90
60	7.50	18.38	13.70	21.80	13.95	15.00	22.94
Unlimited	7.56	18.52	13.80	21.98	14.06	15.12	23.13
LARGE GROUP				**$40 Copay**			
20	6.13	15.02	11.19	17.82	11.40	12.26	18.75
30	6.54	16.02	11.94	19.01	12.16	13.08	20.01
40	6.97	17.08	12.73	20.26	12.96	13.94	21.32
60	7.35	18.01	13.42	21.37	13.67	14.70	22.48
Unlimited	7.41	18.15	13.53	21.54	13.78	14.82	22.67
LARGE GROUP				**$45 Copay**			
20	5.96	14.60	10.88	17.33	11.09	11.92	18.23
30	6.35	15.56	11.60	18.46	11.81	12.70	19.42
40	6.79	16.64	12.40	19.74	12.63	13.58	20.77
60	7.17	17.57	13.09	20.84	13.34	14.34	21.93
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP				**$50 Copay**			
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.20	15.19	11.32	18.02	11.53	12.40	18.97
40	6.63	16.24	12.11	19.27	12.33	13.26	20.28
60	6.99	17.13	12.76	20.32	13.00	13.98	21.38
Unlimited	7.03	17.22	12.84	20.44	13.08	14.06	21.50

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	6.81	16.68	12.44	19.80	12.67	13.62	20.83
$0/Max $5000	6.39	15.66	11.67	18.58	11.89	12.78	19.55
$0/Max $2500	6.02	14.75	10.99	17.50	11.20	12.04	18.42
$25	6.39	15.66	11.67	18.58	11.89	12.78	19.55
$50	6.02	14.75	10.99	17.50	11.20	12.04	18.42
$100	5.41	13.25	9.88	15.73	10.06	10.82	16.55
$500	2.67	6.54	4.88	7.76	4.97	5.34	8.17
$5,000	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Coinsurance							
80%	5.42	13.28	9.90	15.76	10.08	10.84	16.58
75%	5.11	12.52	9.33	14.85	9.50	10.22	15.63
70%	4.75	11.64	8.67	13.81	8.84	9.50	14.53
			Orthotics Riders				
$0/Max $5000	7.07	17.32	12.91	20.55	13.15	14.14	21.63
$0/Max $2500	6.55	16.05	11.96	19.04	12.18	13.10	20.04
Deductible							
$0	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$0/Max $5000	1.11	2.72	2.03	3.23	2.06	2.22	3.40
$0/Max $2500	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$25	1.11	2.72	2.03	3.23	2.06	2.22	3.40
$50	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$100	0.97	2.38	1.77	2.82	1.80	1.94	2.97
$500	0.47	1.15	0.86	1.37	0.87	0.94	1.44
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.97	2.38	1.77	2.82	1.80	1.94	2.97
75%	0.91	2.23	1.66	2.65	1.69	1.82	2.78
70%	0.81	1.98	1.48	2.35	1.51	1.62	2.48

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.78	1.91	1.42	2.27	1.45	1.56	2.39
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	14.89	36.48	27.19	43.29	27.70	29.78	45.55
3 IVF	17.89	43.83	32.67	52.01	33.28	35.78	54.73
			Nurse Advice Line Rider				
	0.32	0.78	0.58	0.93	0.60	0.64	0.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFITS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Large Group*	530.65	1,300.09	968.97	1,542.60	987.01	1,061.30	1,623.26

** Base rates exclude premium component for mandatory mental health coverage*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.54)	(8.67)	(6.46)	(10.29)	(6.58)	(7.08)	(10.83)
$10	(7.46)	(18.28)	(13.62)	(21.69)	(13.88)	(14.92)	(22.82)
$15	(12.42)	(30.43)	(22.68)	(36.10)	(23.10)	(24.84)	(37.99)
$20	(19.15)	(46.92)	(34.97)	(55.67)	(35.62)	(38.30)	(58.58)
$25	(25.23)	(61.81)	(46.07)	(73.34)	(46.93)	(50.46)	(77.18)
$30	(31.90)	(78.16)	(58.25)	(92.73)	(59.33)	(63.80)	(97.58)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
$10	(4.28)	(10.49)	(7.82)	(12.44)	(7.96)	(8.56)	(13.09)
$15	(7.11)	(17.42)	(12.98)	(20.67)	(13.22)	(14.22)	(21.75)
$20	(10.96)	(26.85)	(20.01)	(31.86)	(20.39)	(21.92)	(33.53)
$25	(14.45)	(35.40)	(26.39)	(42.01)	(26.88)	(28.90)	(44.20)
$30	(18.29)	(44.81)	(33.40)	(53.17)	(34.02)	(36.58)	(55.95)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.60)	(6.37)	(4.75)	(7.56)	(4.84)	(5.20)	(7.95)
$10	(5.37)	(13.16)	(9.81)	(15.61)	(9.99)	(10.74)	(16.43)
$15	(8.42)	(20.63)	(15.37)	(24.48)	(15.66)	(16.84)	(25.76)
$20	(11.87)	(29.08)	(21.67)	(34.51)	(22.08)	(23.74)	(36.31)
$25	(15.65)	(38.34)	(28.58)	(45.49)	(29.11)	(31.30)	(47.87)
$30	(19.94)	(48.85)	(36.41)	(57.97)	(37.09)	(39.88)	(61.00)
$35	(23.97)	(58.73)	(43.77)	(69.68)	(44.58)	(47.94)	(73.32)
$40	(28.13)	(68.92)	(51.37)	(81.77)	(52.32)	(56.26)	(86.05)
$45	(32.54)	(79.72)	(59.42)	(94.59)	(60.52)	(65.08)	(99.54)
$50	(37.13)	(90.97)	(67.80)	(107.94)	(69.06)	(74.26)	(113.58)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.39)	(4.02)	(6.40)	(4.09)	(4.40)	(6.73)
$10	(4.52)	(11.07)	(8.25)	(13.14)	(8.41)	(9.04)	(13.83)
$15	(7.11)	(17.42)	(12.98)	(20.67)	(13.22)	(14.22)	(21.75)
$20	(10.03)	(24.57)	(18.31)	(29.16)	(18.66)	(20.06)	(30.68)
$25	(13.22)	(32.39)	(24.14)	(38.43)	(24.59)	(26.44)	(40.44)
$30	(16.85)	(41.28)	(30.77)	(48.98)	(31.34)	(33.70)	(51.54)
$35	(20.28)	(49.69)	(37.03)	(58.95)	(37.72)	(40.56)	(62.04)
$40	(23.79)	(58.29)	(43.44)	(69.16)	(44.25)	(47.58)	(72.77)
$45	(27.50)	(67.38)	(50.22)	(79.94)	(51.15)	(55.00)	(84.12)
$50	(31.40)	(76.93)	(57.34)	(91.28)	(58.40)	(62.80)	(96.05)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$150	(2.15)	(5.27)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$200	(3.04)	(7.45)	(5.55)	(8.84)	(5.65)	(6.08)	(9.30)
$250	(4.38)	(10.73)	(8.00)	(12.73)	(8.15)	(8.76)	(13.40)
$500	(10.48)	(25.68)	(19.14)	(30.47)	(19.49)	(20.96)	(32.06)
$750	(17.96)	(44.00)	(32.79)	(52.21)	(33.41)	(35.92)	(54.94)
$1,000	(27.04)	(66.25)	(49.38)	(78.61)	(50.29)	(54.08)	(82.72)
Copay/Day							
$50 w/3 Day Max	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
$50 w/5 Day Max	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
$100 w/3 Day Max	(3.93)	(9.63)	(7.18)	(11.42)	(7.31)	(7.86)	(12.02)
$100 w/5 Day Max	(5.67)	(13.89)	(10.35)	(16.48)	(10.55)	(11.34)	(17.34)
$250 w/3 Day Max	(13.02)	(31.90)	(23.77)	(37.85)	(24.22)	(26.04)	(39.83)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$75	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$100	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
$125	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$150	(2.58)	(6.32)	(4.71)	(7.50)	(4.80)	(5.16)	(7.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$25	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$35	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$50	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
$60	(1.89)	(4.63)	(3.45)	(5.49)	(3.52)	(3.78)	(5.78)
$75	(2.49)	(6.10)	(4.55)	(7.24)	(4.63)	(4.98)	(7.62)
$100	(3.53)	(8.65)	(6.45)	(10.26)	(6.57)	(7.06)	(10.80)
$125	(4.38)	(10.73)	(8.00)	(12.73)	(8.15)	(8.76)	(13.40)
$150	(5.21)	(12.76)	(9.51)	(15.15)	(9.69)	(10.42)	(15.94)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.60	1.47	1.10	1.74	1.12	1.20	1.84
60	1.18	2.89	2.15	3.43	2.19	2.36	3.61
90	1.77	4.34	3.23	5.15	3.29	3.54	5.41
120	2.09	5.12	3.82	6.08	3.89	4.18	6.39
Unlimited	2.70	6.62	4.93	7.85	5.02	5.40	8.26
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$15 copay	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
40/$20 copay	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
40/$25 copay	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
60	0.33	0.81	0.60	0.96	0.61	0.66	1.01
100	0.77	1.89	1.41	2.24	1.43	1.54	2.36
200	2.09	5.12	3.82	6.08	3.89	4.18	6.39
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.81	1.98	1.48	2.35	1.51	1.62	2.48
90	1.70	4.17	3.10	4.94	3.16	3.40	5.20

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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.72	1.76	1.31	2.09	1.34	1.44	2.20
90	1.32	3.23	2.41	3.84	2.46	2.64	4.04
120	2.17	5.32	3.96	6.31	4.04	4.34	6.64
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.32	0.78	0.58	0.93	0.60	0.64	0.98
30	0.50	1.23	0.91	1.45	0.93	1.00	1.53
Unlimited	0.72	1.76	1.31	2.09	1.34	1.44	2.20
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.68	9.02	6.72	10.70	6.84	7.36	11.26
60	4.30	10.54	7.85	12.50	8.00	8.60	13.15
90	5.13	12.57	9.37	14.91	9.54	10.26	15.69
Unlimited	5.21	12.76	9.51	15.15	9.69	10.42	15.94
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
60/$15 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$20 copay	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
60/$25 copay	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
120/$0 copay	0.64	1.57	1.17	1.86	1.19	1.28	1.96
120/$5 copay	0.50	1.23	0.91	1.45	0.93	1.00	1.53
120/$10 copay	0.31	0.76	0.57	0.90	0.58	0.62	0.95
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
Unlimited/$5 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$10 copa	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$20	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$25	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
$30	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$35	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$40	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$45	(1.71)	(4.19)	(3.12)	(4.97)	(3.18)	(3.42)	(5.23)
$50	(1.90)	(4.66)	(3.47)	(5.52)	(3.53)	(3.80)	(5.81)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$15	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$20	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
$25	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$60	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$100	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.30)	(8.09)	(6.03)	(9.59)	(6.14)	(6.60)	(10.09)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.12)	(12.54)	(9.35)	(14.88)	(9.52)	(10.24)	(15.66)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)

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HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
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Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.54	20.92	15.59	24.83	15.88	17.08	26.12
60	9.00	22.05	16.43	26.16	16.74	18.00	27.53
90	9.34	22.88	17.05	27.15	17.37	18.68	28.57
Unlimited	9.44	23.13	17.24	27.44	17.56	18.88	28.88
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.54	23.37	17.42	27.73	17.74	19.08	29.18
30	10.51	25.75	19.19	30.55	19.55	21.02	32.15
40	11.10	27.20	20.27	32.27	20.65	22.20	33.95
60	11.69	28.64	21.35	33.98	21.74	23.38	35.76
Unlimited	11.79	28.89	21.53	34.27	21.93	23.58	36.07
LARGE GROUP				**$5 Copay**			
20	8.98	22.00	16.40	26.10	16.70	17.96	27.47
30	9.88	24.21	18.04	28.72	18.38	19.76	30.22
40	10.50	25.73	19.17	30.52	19.53	21.00	32.12
60	11.00	26.95	20.09	31.98	20.46	22.00	33.65
Unlimited	11.09	27.17	20.25	32.24	20.63	22.18	33.92
LARGE GROUP				**$10 Copay**			
20	8.41	20.60	15.36	24.45	15.64	16.82	25.73
30	9.25	22.66	16.89	26.89	17.21	18.50	28.30
40	9.78	23.96	17.86	28.43	18.19	19.56	29.92
60	10.31	25.26	18.83	29.97	19.18	20.62	31.54
Unlimited	10.39	25.46	18.97	30.20	19.33	20.78	31.78
LARGE GROUP				**$15 Copay**			
20	7.89	19.33	14.41	22.94	14.68	15.78	24.14
30	8.69	21.29	15.87	25.26	16.16	17.38	26.58
40	9.21	22.56	16.82	26.77	17.13	18.42	28.17
60	9.73	23.84	17.77	28.29	18.10	19.46	29.76
Unlimited	9.81	24.03	17.91	28.52	18.25	19.62	30.01
LARGE GROUP				**$20 Copay**			
20	7.43	18.20	13.57	21.60	13.82	14.86	22.73
30	8.14	19.94	14.86	23.66	15.14	16.28	24.90
40	8.59	21.05	15.69	24.97	15.98	17.18	26.28

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	9.13	22.37	16.67	26.54	16.98	18.26	27.93
Unlimited	9.20	22.54	16.80	26.74	17.11	18.40	28.14
LARGE GROUP				$25 Copay			
20	6.90	16.91	12.60	20.06	12.83	13.80	21.11
30	7.57	18.55	13.82	22.01	14.08	15.14	23.16
40	8.09	19.82	14.77	23.52	15.05	16.18	24.75
60	8.50	20.83	15.52	24.71	15.81	17.00	26.00
Unlimited	8.58	21.02	15.67	24.94	15.96	17.16	26.25
LARGE GROUP				$30 Copay			
20	6.59	16.15	12.03	19.16	12.26	13.18	20.16
30	7.14	17.49	13.04	20.76	13.28	14.28	21.84
40	7.60	18.62	13.88	22.09	14.14	15.20	23.25
60	7.98	19.55	14.57	23.20	14.84	15.96	24.41
Unlimited	8.02	19.65	14.64	23.31	14.92	16.04	24.53
LARGE GROUP				$35 Copay			
20	6.25	15.31	11.41	18.17	11.63	12.50	19.12
30	6.68	16.37	12.20	19.42	12.42	13.36	20.43
40	7.11	17.42	12.98	20.67	13.22	14.22	21.75
60	7.46	18.28	13.62	21.69	13.88	14.92	22.82
Unlimited	7.51	18.40	13.71	21.83	13.97	15.02	22.97
LARGE GROUP				$40 Copay			
20	6.10	14.95	11.14	17.73	11.35	12.20	18.66
30	6.50	15.93	11.87	18.90	12.09	13.00	19.88
40	6.92	16.95	12.64	20.12	12.87	13.84	21.17
60	7.30	17.89	13.33	21.22	13.58	14.60	22.33
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP				$45 Copay			
20	5.91	14.48	10.79	17.18	10.99	11.82	18.08
30	6.31	15.46	11.52	18.34	11.74	12.62	19.30
40	6.75	16.54	12.33	19.62	12.56	13.50	20.65
60	7.13	17.47	13.02	20.73	13.26	14.26	21.81
Unlimited	7.16	17.54	13.07	20.81	13.32	14.32	21.90
LARGE GROUP				$50 Copay			
20	5.75	14.09	10.50	16.72	10.70	11.50	17.59
30	6.15	15.07	11.23	17.88	11.44	12.30	18.81
40	6.59	16.15	12.03	19.16	12.26	13.18	20.16

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
60	6.94	17.00	12.67	20.17	12.91	13.88	21.23
Unlimited	6.99	17.13	12.76	20.32	13.00	13.98	21.38

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.75	11.64	8.67	13.81	8.84	9.50	14.53
$25	4.50	11.03	8.22	13.08	8.37	9.00	13.77
$50	4.22	10.34	7.71	12.27	7.85	8.44	12.91
$100	3.88	9.51	7.08	11.28	7.22	7.76	11.87
$500	1.84	4.51	3.36	5.35	3.42	3.68	5.63
Coinsurance							
80%	3.82	9.36	6.98	11.10	7.11	7.64	11.69
75%	3.57	8.75	6.52	10.38	6.64	7.14	10.92
70%	3.33	8.16	6.08	9.68	6.19	6.66	10.19
Deductible			**Orthotics Riders**				
$0	0.79	1.94	1.44	2.30	1.47	1.58	2.42
$25	0.76	1.86	1.39	2.21	1.41	1.52	2.32
$50	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$100	0.65	1.59	1.19	1.89	1.21	1.30	1.99
$500	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Coinsurance							
80%	0.65	1.59	1.19	1.89	1.21	1.30	1.99
75%	0.61	1.49	1.11	1.77	1.13	1.22	1.87
70%	0.58	1.42	1.06	1.69	1.08	1.16	1.77
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.56	1.37	1.02	1.63	1.04	1.12	1.71
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	10.04	24.60	18.33	29.19	18.67	20.08	30.71
3 IVF	12.16	29.79	22.20	35.35	22.62	24.32	37.20
			Nurse Advice Line Rider				
	0.32	0.78	0.58	0.93	0.60	0.64	0.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess ll POS LARGE GROUP CONTRACT - BASE BENEFITS *
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
965.65	2,365.84	1,763.28	2,807.14	1,796.11	1,931.30	2,953.92
75% Coinsurance						
918.46	2,250.23	1,677.11	2,669.96	1,708.34	1,836.92	2,809.57
70% Coinsurance						
872.42	2,137.43	1,593.04	2,536.12	1,622.70	1,744.84	2,668.73
50% Coinsurance						
825.24	2,021.84	1,506.89	2,398.97	1,534.95	1,650.48	2,524.41

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max

** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			LARGE GROUP				
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(59.14)	(144.89)	(107.99)	(171.92)	(110.00)	(118.28)	(180.91)
$250	(70.57)	(172.90)	(128.86)	(205.15)	(131.26)	(141.14)	(215.87)
$300	(82.01)	(200.92)	(149.75)	(238.40)	(152.54)	(164.02)	(250.87)
$350	(93.45)	(228.95)	(170.64)	(271.66)	(173.82)	(186.90)	(285.86)
$400	(102.43)	(250.95)	(187.04)	(297.76)	(190.52)	(204.86)	(313.33)
$500	(120.41)	(295.00)	(219.87)	(350.03)	(223.96)	(240.82)	(368.33)
$750	(156.37)	(383.11)	(285.53)	(454.57)	(290.85)	(312.74)	(478.34)
$1,000	(184.07)	(450.97)	(336.11)	(535.09)	(342.37)	(368.14)	(563.07)
$1,500	(226.41)	(554.70)	(413.42)	(658.17)	(421.12)	(452.82)	(692.59)
$2,000	(243.73)	(597.14)	(445.05)	(708.52)	(453.34)	(487.46)	(745.57)
$2,500	(261.12)	(639.74)	(476.81)	(759.08)	(485.68)	(522.24)	(798.77)
$5,000	(306.97)	(752.08)	(560.53)	(892.36)	(570.96)	(613.94)	(939.02)
$10,000	(344.83)	(844.83)	(629.66)	(1,002.42)	(641.38)	(689.66)	(1,054.83)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(48.47)	(118.75)	(88.51)	(140.90)	(90.15)	(96.94)	(148.27)
$250	(57.83)	(141.68)	(105.60)	(168.11)	(107.56)	(115.66)	(176.90)
$300	(67.20)	(164.64)	(122.71)	(195.35)	(124.99)	(134.40)	(205.56)
$350	(76.54)	(187.52)	(139.76)	(222.50)	(142.36)	(153.08)	(234.14)
$400	(84.07)	(205.97)	(153.51)	(244.39)	(156.37)	(168.14)	(257.17)
$500	(99.15)	(242.92)	(181.05)	(288.23)	(184.42)	(198.30)	(303.30)
$750	(128.97)	(315.98)	(235.50)	(374.92)	(239.88)	(257.94)	(394.52)
$1,000	(152.18)	(372.84)	(277.88)	(442.39)	(283.05)	(304.36)	(465.52)
$1,500	(187.36)	(459.03)	(342.12)	(544.66)	(348.49)	(374.72)	(573.13)
$2,000	(203.32)	(498.13)	(371.26)	(591.05)	(378.18)	(406.64)	(621.96)
$2,500	(219.26)	(537.19)	(400.37)	(637.39)	(407.82)	(438.52)	(670.72)
$5,000	(264.92)	(649.05)	(483.74)	(770.12)	(492.75)	(529.84)	(810.39)
$10,000	(302.58)	(741.32)	(552.51)	(879.60)	(562.80)	(605.16)	(925.59)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(37.78)	(92.56)	(68.99)	(109.83)	(70.27)	(75.56)	(115.57)
$250	(45.07)	(110.42)	(82.30)	(131.02)	(83.83)	(90.14)	(137.87)
$300	(52.38)	(128.33)	(95.65)	(152.27)	(97.43)	(104.76)	(160.23)
$350	(59.65)	(146.14)	(108.92)	(173.40)	(110.95)	(119.30)	(182.47)
$400	(65.76)	(161.11)	(120.08)	(191.16)	(122.31)	(131.52)	(201.16)
$500	(77.83)	(190.68)	(142.12)	(226.25)	(144.76)	(155.66)	(238.08)
$750	(101.55)	(248.80)	(185.43)	(295.21)	(188.88)	(203.10)	(310.64)
$1,000	(120.24)	(294.59)	(219.56)	(349.54)	(223.65)	(240.48)	(367.81)
$1,500	(148.34)	(363.43)	(270.87)	(431.22)	(275.91)	(296.68)	(453.77)
$2,000	(162.91)	(399.13)	(297.47)	(473.58)	(303.01)	(325.82)	(498.34)
$2,500	(177.48)	(434.83)	(324.08)	(515.93)	(330.11)	(354.96)	(542.91)
$5,000	(222.88)	(546.06)	(406.98)	(647.91)	(414.56)	(445.76)	(681.79)
$10,000	(260.37)	(637.91)	(475.44)	(756.90)	(484.29)	(520.74)	(796.47)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(25.98)	(63.65)	(47.44)	(75.52)	(48.32)	(51.96)	(79.47)
$250	(31.12)	(76.24)	(56.83)	(90.47)	(57.88)	(62.24)	(95.20)
$300	(36.30)	(88.94)	(66.28)	(105.52)	(67.52)	(72.60)	(111.04)
$350	(41.45)	(101.55)	(75.69)	(120.50)	(77.10)	(82.90)	(126.80)
$400	(45.94)	(112.55)	(83.89)	(133.55)	(85.45)	(91.88)	(140.53)
$500	(54.87)	(134.43)	(100.19)	(159.51)	(102.06)	(109.74)	(167.85)
$750	(72.00)	(176.40)	(131.47)	(209.30)	(133.92)	(144.00)	(220.25)
$1,000	(85.91)	(210.48)	(156.87)	(249.74)	(159.79)	(171.82)	(262.80)
$1,500	(107.37)	(263.06)	(196.06)	(312.12)	(199.71)	(214.74)	(328.44)
$2,000	(118.80)	(291.06)	(216.93)	(345.35)	(220.97)	(237.60)	(363.41)
$2,500	(130.25)	(319.11)	(237.84)	(378.64)	(242.27)	(260.50)	(398.43)
$5,000	(175.02)	(428.80)	(319.59)	(508.78)	(325.54)	(350.04)	(535.39)
$10,000	(211.98)	(519.35)	(387.08)	(616.23)	(394.28)	(423.96)	(648.45)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(54.75)	(134.14)	(99.97)	(159.16)	(101.84)	(109.50)	(167.48)
$1,500	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$2,000	(62.30)	(152.64)	(113.76)	(181.11)	(115.88)	(124.60)	(190.58)
$3,000	(64.68)	(158.47)	(118.11)	(188.02)	(120.30)	(129.36)	(197.86)
$4,000	(65.66)	(160.87)	(119.90)	(190.87)	(122.13)	(131.32)	(200.85)
$5,000	(66.18)	(162.14)	(120.84)	(192.39)	(123.09)	(132.36)	(202.44)
$7,000	(66.84)	(163.76)	(122.05)	(194.30)	(124.32)	(133.68)	(204.46)
$7,500	(67.38)	(165.08)	(123.04)	(195.87)	(125.33)	(134.76)	(206.12)
$10,000	(69.35)	(169.91)	(126.63)	(201.60)	(128.99)	(138.70)	(212.14)
$20,000	(72.17)	(176.82)	(131.78)	(209.80)	(134.24)	(144.34)	(220.77)
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(52.93)	(129.68)	(96.65)	(153.87)	(98.45)	(105.86)	(161.91)
$1,500	(58.83)	(144.13)	(107.42)	(171.02)	(109.42)	(117.66)	(179.96)
$2,000	(62.09)	(152.12)	(113.38)	(180.50)	(115.49)	(124.18)	(189.93)
$3,000	(65.32)	(160.03)	(119.27)	(189.89)	(121.50)	(130.64)	(199.81)
$4,000	(66.76)	(163.56)	(121.90)	(194.07)	(124.17)	(133.52)	(204.22)
$5,000	(67.58)	(165.57)	(123.40)	(196.46)	(125.70)	(135.16)	(206.73)
$7,000	(68.36)	(167.48)	(124.83)	(198.72)	(127.15)	(136.72)	(209.11)
$7,500	(68.95)	(168.93)	(125.90)	(200.44)	(128.25)	(137.90)	(210.92)
$10,000	(71.38)	(174.88)	(130.34)	(207.50)	(132.77)	(142.76)	(218.35)
$20,000	(75.10)	(184.00)	(137.13)	(218.32)	(139.69)	(150.20)	(229.73)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(51.09)	(125.17)	(93.29)	(148.52)	(95.03)	(102.18)	(156.28)
$1,500	(57.93)	(141.93)	(105.78)	(168.40)	(107.75)	(115.86)	(177.21)
$2,000	(61.88)	(151.61)	(112.99)	(179.89)	(115.10)	(123.76)	(189.29)
$3,000	(65.98)	(161.65)	(120.48)	(191.80)	(122.72)	(131.96)	(201.83)
$4,000	(67.83)	(166.18)	(123.86)	(197.18)	(126.16)	(135.66)	(207.49)
$5,000	(68.93)	(168.88)	(125.87)	(200.38)	(128.21)	(137.86)	(210.86)
$7,000	(69.90)	(171.26)	(127.64)	(203.20)	(130.01)	(139.80)	(213.82)
$7,500	(70.52)	(172.77)	(128.77)	(205.00)	(131.17)	(141.04)	(215.72)
$10,000	(73.18)	(179.29)	(133.63)	(212.73)	(136.11)	(146.36)	(223.86)
$20,000	(77.94)	(190.95)	(142.32)	(226.57)	(144.97)	(155.88)	(238.42)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(57.83)	(141.68)	(105.60)	(168.11)	(107.56)	(115.66)	(176.90)
$1,500	(68.88)	(168.76)	(125.77)	(200.23)	(128.12)	(137.76)	(210.70)
$2,000	(76.04)	(186.30)	(138.85)	(221.05)	(141.43)	(152.08)	(232.61)
$3,000	(84.68)	(207.47)	(154.63)	(246.16)	(157.50)	(169.36)	(259.04)
$4,000	(89.45)	(219.15)	(163.34)	(260.03)	(166.38)	(178.90)	(273.63)
$5,000	(92.36)	(226.28)	(168.65)	(268.49)	(171.79)	(184.72)	(282.53)
$7,000	(95.38)	(233.68)	(174.16)	(277.27)	(177.41)	(190.76)	(291.77)
$7,500	(96.49)	(236.40)	(176.19)	(280.50)	(179.47)	(192.98)	(295.16)
$10,000	(100.97)	(247.38)	(184.37)	(293.52)	(187.80)	(201.94)	(308.87)
$20,000	(110.42)	(270.53)	(201.63)	(320.99)	(205.38)	(220.84)	(337.77)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.44	1.08	0.80	1.28	0.82	0.88	1.35
$1,000,000	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$50,000	(5.67)	(13.89)	(10.35)	(16.48)	(10.55)	(11.34)	(17.34)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
75%	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
70%	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

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Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$10	(5.00)	(12.25)	(9.13)	(14.54)	(9.30)	(10.00)	(15.30)
$15	(8.32)	(20.38)	(15.19)	(24.19)	(15.48)	(16.64)	(25.45)
$20	(12.85)	(31.48)	(23.46)	(37.35)	(23.90)	(25.70)	(39.31)
$25	(16.91)	(41.43)	(30.88)	(49.16)	(31.45)	(33.82)	(51.73)
$30	(21.38)	(52.38)	(39.04)	(62.15)	(39.77)	(42.76)	(65.40)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.33)	(3.26)	(2.43)	(3.87)	(2.47)	(2.66)	(4.07)
$10	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$15	(4.77)	(11.69)	(8.71)	(13.87)	(8.87)	(9.54)	(14.59)
$20	(7.35)	(18.01)	(13.42)	(21.37)	(13.67)	(14.70)	(22.48)
$25	(9.69)	(23.74)	(17.69)	(28.17)	(18.02)	(19.38)	(29.64)
$30	(12.24)	(29.99)	(22.35)	(35.58)	(22.77)	(24.48)	(37.44)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.73)	(4.24)	(3.16)	(5.03)	(3.22)	(3.46)	(5.29)
$10	(3.59)	(8.80)	(6.56)	(10.44)	(6.68)	(7.18)	(10.98)
$15	(5.64)	(13.82)	(10.30)	(16.40)	(10.49)	(11.28)	(17.25)
$20	(7.94)	(19.45)	(14.50)	(23.08)	(14.77)	(15.88)	(24.29)
$25	(10.49)	(25.70)	(19.15)	(30.49)	(19.51)	(20.98)	(32.09)
$30	(13.36)	(32.73)	(24.40)	(38.84)	(24.85)	(26.72)	(40.87)
$35	(16.05)	(39.32)	(29.31)	(46.66)	(29.85)	(32.10)	(49.10)
$40	(18.84)	(46.16)	(34.40)	(54.77)	(35.04)	(37.68)	(57.63)
$45	(21.80)	(53.41)	(39.81)	(63.37)	(40.55)	(43.60)	(66.69)
$50	(24.87)	(60.93)	(45.41)	(72.30)	(46.26)	(49.74)	(76.08)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$10	(3.04)	(7.45)	(5.55)	(8.84)	(5.65)	(6.08)	(9.30)
$15	(4.77)	(11.69)	(8.71)	(13.87)	(8.87)	(9.54)	(14.59)
$20	(6.72)	(16.46)	(12.27)	(19.54)	(12.50)	(13.44)	(20.56)
$25	(8.87)	(21.73)	(16.20)	(25.79)	(16.50)	(17.74)	(27.13)
$30	(11.30)	(27.69)	(20.63)	(32.85)	(21.02)	(22.60)	(34.57)
$35	(13.59)	(33.30)	(24.82)	(39.51)	(25.28)	(27.18)	(41.57)
$40	(15.94)	(39.05)	(29.11)	(46.34)	(29.65)	(31.88)	(48.76)
$45	(18.42)	(45.13)	(33.63)	(53.55)	(34.26)	(36.84)	(56.35)
$50	(21.03)	(51.52)	(38.40)	(61.13)	(39.12)	(42.06)	(64.33)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$150	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$200	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
$250	(2.90)	(7.11)	(5.30)	(8.43)	(5.39)	(5.80)	(8.87)
$500	(7.01)	(17.17)	(12.80)	(20.38)	(13.04)	(14.02)	(21.44)
$750	(12.03)	(29.47)	(21.97)	(34.97)	(22.38)	(24.06)	(36.80)
$1,000	(18.12)	(44.39)	(33.09)	(52.67)	(33.70)	(36.24)	(55.43)
Copay/Day							
$50 w/3 Day Max	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$50 w/5 Day Max	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$100 w/3 Day Max	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$100 w/5 Day Max	(3.81)	(9.33)	(6.96)	(11.08)	(7.09)	(7.62)	(11.65)
$250 w/3 Day Max	(8.72)	(21.36)	(15.92)	(25.35)	(16.22)	(17.44)	(26.67)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$75	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$100	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$125	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$150	(1.72)	(4.21)	(3.14)	(5.00)	(3.20)	(3.44)	(5.26)

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Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$35	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$50	(1.01)	(2.47)	(1.84)	(2.94)	(1.88)	(2.02)	(3.09)
$60	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
$75	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$100	(2.37)	(5.81)	(4.33)	(6.89)	(4.41)	(4.74)	(7.25)
$125	(2.90)	(7.11)	(5.30)	(8.43)	(5.39)	(5.80)	(8.87)
$150	(3.48)	(8.53)	(6.35)	(10.12)	(6.47)	(6.96)	(10.65)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.48	1.18	0.88	1.40	0.89	0.96	1.47
60	0.93	2.28	1.70	2.70	1.73	1.86	2.84
90	1.35	3.31	2.47	3.92	2.51	2.70	4.13
120	1.60	3.92	2.92	4.65	2.98	3.20	4.89
Unlimited	2.07	5.07	3.78	6.02	3.85	4.14	6.33
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$25 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.53	1.30	0.97	1.54	0.99	1.06	1.62
200	1.41	3.45	2.57	4.10	2.62	2.82	4.31
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.63	1.54	1.15	1.83	1.17	1.26	1.93
90	1.28	3.14	2.34	3.72	2.38	2.56	3.92

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Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.55	1.35	1.00	1.60	1.02	1.10	1.68
90	1.03	2.52	1.88	2.99	1.92	2.06	3.15
120	1.66	4.07	3.03	4.83	3.09	3.32	5.08
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.39	0.96	0.71	1.13	0.73	0.78	1.19
Unlimited	0.55	1.35	1.00	1.60	1.02	1.10	1.68
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.45	6.00	4.47	7.12	4.56	4.90	7.49
60	2.88	7.06	5.26	8.37	5.36	5.76	8.81
90	3.43	8.40	6.26	9.97	6.38	6.86	10.49
Unlimited	3.48	8.53	6.35	10.12	6.47	6.96	10.65
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
60/$20 copay	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
60/$25 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
120/$0 copay	0.50	1.23	0.91	1.45	0.93	1.00	1.53
120/$5 copay	0.39	0.96	0.71	1.13	0.73	0.78	1.19
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess ll POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
Unlimited/$5 copay	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$25	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
$30	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$35	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$40	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$45	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
$50	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$20	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$25	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess ll POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.21)	(5.41)	(4.04)	(6.42)	(4.11)	(4.42)	(6.76)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.43)	(8.40)	(6.26)	(9.97)	(6.38)	(6.86)	(10.49)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

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HIPaccess ll POS LARGE GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.97	21.98	16.38	26.08	16.68	17.94	27.44
60	9.46	23.18	17.27	27.50	17.60	18.92	28.94
90	9.80	24.01	17.89	28.49	18.23	19.60	29.98
Unlimited	9.91	24.28	18.10	28.81	18.43	19.82	30.31
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	10.02	24.55	18.30	29.13	18.64	20.04	30.65
30	11.04	27.05	20.16	32.09	20.53	22.08	33.77
40	11.65	28.54	21.27	33.87	21.67	23.30	35.64
60	12.27	30.06	22.41	35.67	22.82	24.54	37.53
Unlimited	12.38	30.33	22.61	35.99	23.03	24.76	37.87
LARGE GROUP				**$5 Copay**			
20	9.43	23.10	17.22	27.41	17.54	18.86	28.85
30	10.37	25.41	18.94	30.15	19.29	20.74	31.72
40	11.03	27.02	20.14	32.06	20.52	22.06	33.74
60	11.54	28.27	21.07	33.55	21.46	23.08	35.30
Unlimited	11.64	28.52	21.25	33.84	21.65	23.28	35.61
LARGE GROUP				**$10 Copay**			
20	8.83	21.63	16.12	25.67	16.42	17.66	27.01
30	9.72	23.81	17.75	28.26	18.08	19.44	29.73
40	10.27	25.16	18.75	29.85	19.10	20.54	31.42
60	10.83	26.53	19.78	31.48	20.14	21.66	33.13
Unlimited	10.91	26.73	19.92	31.72	20.29	21.82	33.37
LARGE GROUP				**$15 Copay**			
20	8.28	20.29	15.12	24.07	15.40	16.56	25.33
30	9.13	22.37	16.67	26.54	16.98	18.26	27.93
40	9.67	23.69	17.66	28.11	17.99	19.34	29.58
60	10.23	25.06	18.68	29.74	19.03	20.46	31.29
Unlimited	10.31	25.26	18.83	29.97	19.18	20.62	31.54

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HIPaccess ll POS LARGE GROUP CONTRACT
MENTAL HEALTH
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.80	19.11	14.24	22.67	14.51	15.60	23.86
30	8.55	20.95	15.61	24.85	15.90	17.10	26.15
40	9.01	22.07	16.45	26.19	16.76	18.02	27.56
60	9.59	23.50	17.51	27.88	17.84	19.18	29.34
Unlimited	9.66	23.67	17.64	28.08	17.97	19.32	29.55
LARGE GROUP				**$25 Copay**			
20	7.25	17.76	13.24	21.08	13.49	14.50	22.18
30	7.97	19.53	14.55	23.17	14.82	15.94	24.38
40	8.49	20.80	15.50	24.68	15.79	16.98	25.97
60	8.93	21.88	16.31	25.96	16.61	17.86	27.32
Unlimited	9.00	22.05	16.43	26.16	16.74	18.00	27.53
LARGE GROUP				**$30 Copay**			
20	6.91	16.93	12.62	20.09	12.85	13.82	21.14
30	7.49	18.35	13.68	21.77	13.93	14.98	22.91
40	7.99	19.58	14.59	23.23	14.86	15.98	24.44
60	8.38	20.53	15.30	24.36	15.59	16.76	25.63
Unlimited	8.42	20.63	15.37	24.48	15.66	16.84	25.76
LARGE GROUP				**$35 Copay**			
20	6.57	16.10	12.00	19.10	12.22	13.14	20.10
30	7.01	17.17	12.80	20.38	13.04	14.02	21.44
40	7.47	18.30	13.64	21.72	13.89	14.94	22.85
60	7.84	19.21	14.32	22.79	14.58	15.68	23.98
Unlimited	7.89	19.33	14.41	22.94	14.68	15.78	24.14

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess ll POS LARGE GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP				**$40 Copay**			
20	6.39	15.66	11.67	18.58	11.89	12.78	19.55
30	6.81	16.68	12.44	19.80	12.67	13.62	20.83
40	7.27	17.81	13.28	21.13	13.52	14.54	22.24
60	7.66	18.77	13.99	22.27	14.25	15.32	23.43
Unlimited	7.72	18.91	14.10	22.44	14.36	15.44	23.62
LARGE GROUP				**$45 Copay**			
20	6.21	15.21	11.34	18.05	11.55	12.42	19.00
30	6.63	16.24	12.11	19.27	12.33	13.26	20.28
40	7.09	17.37	12.95	20.61	13.19	14.18	21.69
60	7.48	18.33	13.66	21.74	13.91	14.96	22.88
Unlimited	7.51	18.40	13.71	21.83	13.97	15.02	22.97
LARGE GROUP				**$50 Copay**			
20	6.04	14.80	11.03	17.56	11.23	12.08	18.48
30	6.46	15.83	11.80	18.78	12.02	12.92	19.76
40	6.91	16.93	12.62	20.09	12.85	13.82	21.14
60	7.29	17.86	13.31	21.19	13.56	14.58	22.30
Unlimited	7.34	17.98	13.40	21.34	13.65	14.68	22.45

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	7.11	17.42	12.98	20.67	13.22	14.22	21.75
$25	6.67	16.34	12.18	19.39	12.41	13.34	20.40
$50	6.28	15.39	11.47	18.26	11.68	12.56	19.21
$100	5.64	13.82	10.30	16.40	10.49	11.28	17.25
$500	2.77	6.79	5.06	8.05	5.15	5.54	8.47
Coinsurance							
80%	5.65	13.84	10.32	16.42	10.51	11.30	17.28
75%	5.32	13.03	9.71	15.47	9.90	10.64	16.27
70%	4.96	12.15	9.06	14.42	9.23	9.92	15.17
Deductible			**Orthotics Riders**				
$0	1.20	2.94	2.19	3.49	2.23	2.40	3.67
$25	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$50	1.10	2.70	2.01	3.20	2.05	2.20	3.36
$100	1.01	2.47	1.84	2.94	1.88	2.02	3.09
$500	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Coinsurance							
80%	1.01	2.47	1.84	2.94	1.88	2.02	3.09
75%	0.94	2.30	1.72	2.73	1.75	1.88	2.88
70%	0.89	2.18	1.63	2.59	1.66	1.78	2.72
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.83	2.03	1.52	2.41	1.54	1.66	2.54
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	15.54	38.07	28.38	45.17	28.90	31.08	47.54
3 IVF	18.65	45.69	34.05	54.22	34.69	37.30	57.05
			Nurse Advice Line Rider				
	0.32	0.78	0.58	0.93	0.60	0.64	0.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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LARGE GROUP HMO
VHLI - LGRP - 01
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	582.69	1,516.30
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.19	5.37
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.36	3.33
Outpatient Mental Health: 20 Visits	6.05	14.85
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.11	2.71
Other Riders		
Durable Medical Equipment	1.61	3.80
Chiropractic: $5 Copay	4.28	11.24
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	142.73	371.11
Infertility Drug Coverage: $7 Brand Copay	3.33	8.72
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	22.31
Inpatient Substance Abuse Rehab: Unlimited days	4.59	11.25
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.64	1.58
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.50	1.21

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
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NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
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Table 1: Drug Rider Base Values pmpm			
Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm				
Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm				
Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
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GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjusti Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	2.5%
3Q2011	1.9%
4Q2011	1.9%
1Q2012-3Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
Rate Calculation

Prime and Access Rate Formula

Large groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor

Example: Large Group HMO Individual Employee Rate Example

=	518.47	4th QUARTER	(Base Rate
+	(5.24)	$10 Specialist visit copay	Optional Base Benefit Variables (exlcuding Mental Health)
+	9.22	Unlimited days	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	10.16	$10 copay, Unlimited visits	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	1.09	Standard Coverage	Network Area Factor
	543.26		

HEALTH INSURANCE PLAN OF GREATER NEW YORK

4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	518.47	1,270.25	946.73	1,507.19	964.35	1,036.94	1,586.00

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.46)	(8.48)	(6.32)	(10.06)	(6.44)	(6.92)	(10.58)
$10	(7.29)	(17.86)	(13.31)	(21.19)	(13.56)	(14.58)	(22.30)
$15	(12.13)	(29.72)	(22.15)	(35.26)	(22.56)	(24.26)	(37.11)
$20	(18.72)	(45.86)	(34.18)	(54.42)	(34.82)	(37.44)	(57.26)
$25	(24.64)	(60.37)	(44.99)	(71.63)	(45.83)	(49.28)	(75.37)
$30	(31.17)	(76.37)	(56.92)	(90.61)	(57.98)	(62.34)	(95.35)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$10	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$15	(6.94)	(17.00)	(12.67)	(20.17)	(12.91)	(13.88)	(21.23)
$20	(10.72)	(26.26)	(19.57)	(31.16)	(19.94)	(21.44)	(32.79)
$25	(14.12)	(34.59)	(25.78)	(41.05)	(26.26)	(28.24)	(43.19)
$30	(17.88)	(43.81)	(32.65)	(51.98)	(33.26)	(35.76)	(54.69)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$10	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
$15	(8.21)	(20.11)	(14.99)	(23.87)	(15.27)	(16.42)	(25.11)
$20	(11.59)	(28.40)	(21.16)	(33.69)	(21.56)	(23.18)	(35.45)
$25	(15.29)	(37.46)	(27.92)	(44.45)	(28.44)	(30.58)	(46.77)
$30	(19.48)	(47.73)	(35.57)	(56.63)	(36.23)	(38.96)	(59.59)
$35	(23.41)	(57.35)	(42.75)	(68.05)	(43.54)	(46.82)	(71.61)
$40	(27.48)	(67.33)	(50.18)	(79.88)	(51.11)	(54.96)	(84.06)
$45	(31.76)	(77.81)	(57.99)	(92.33)	(59.07)	(63.52)	(97.15)
$50	(36.27)	(88.86)	(66.23)	(105.44)	(67.46)	(72.54)	(110.95)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.15)	(5.27)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$10	(4.44)	(10.88)	(8.11)	(12.91)	(8.26)	(8.88)	(13.58)
$15	(6.94)	(17.00)	(12.67)	(20.17)	(12.91)	(13.88)	(21.23)
$20	(9.81)	(24.03)	(17.91)	(28.52)	(18.25)	(19.62)	(30.01)
$25	(12.93)	(31.68)	(23.61)	(37.59)	(24.05)	(25.86)	(39.55)
$30	(16.48)	(40.38)	(30.09)	(47.91)	(30.65)	(32.96)	(50.41)
$35	(19.82)	(48.56)	(36.19)	(57.62)	(36.87)	(39.64)	(60.63)
$40	(23.25)	(56.96)	(42.45)	(67.59)	(43.25)	(46.50)	(71.12)
$45	(26.86)	(65.81)	(49.05)	(78.08)	(49.96)	(53.72)	(82.16)
$50	(30.66)	(75.12)	(55.99)	(89.13)	(57.03)	(61.32)	(93.79)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
$150	(2.10)	(5.15)	(3.83)	(6.10)	(3.91)	(4.20)	(6.42)
$200	(2.97)	(7.28)	(5.42)	(8.63)	(5.52)	(5.94)	(9.09)
$250	(4.27)	(10.46)	(7.80)	(12.41)	(7.94)	(8.54)	(13.06)
$500	(10.22)	(25.04)	(18.66)	(29.71)	(19.01)	(20.44)	(31.26)
$750	(17.57)	(43.05)	(32.08)	(51.08)	(32.68)	(35.14)	(53.75)
$1,000	(26.41)	(64.70)	(48.22)	(76.77)	(49.12)	(52.82)	(80.79)
Copay/Day							
$50 w/3 Day Max	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$50 w/5 Day Max	(2.12)	(5.19)	(3.87)	(6.16)	(3.94)	(4.24)	(6.49)
$100 w/3 Day Max	(3.85)	(9.43)	(7.03)	(11.19)	(7.16)	(7.70)	(11.78)
$100 w/5 Day Max	(5.54)	(13.57)	(10.12)	(16.10)	(10.30)	(11.08)	(16.95)
$250 w/3 Day Max	(12.72)	(31.16)	(23.23)	(36.98)	(23.66)	(25.44)	(38.91)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$75	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$100	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$125	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$150	(2.52)	(6.17)	(4.60)	(7.33)	(4.69)	(5.04)	(7.71)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$25	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$35	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$50	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$60	(1.83)	(4.48)	(3.34)	(5.32)	(3.40)	(3.66)	(5.60)
$75	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$100	(3.45)	(8.45)	(6.30)	(10.03)	(6.42)	(6.90)	(10.55)
$125	(4.27)	(10.46)	(7.80)	(12.41)	(7.94)	(8.54)	(13.06)
$150	(5.08)	(12.45)	(9.28)	(14.77)	(9.45)	(10.16)	(15.54)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.59	1.45	1.08	1.72	1.10	1.18	1.80
60	1.16	2.84	2.12	3.37	2.16	2.32	3.55
90	1.74	4.26	3.18	5.06	3.24	3.48	5.32
120	2.05	5.02	3.74	5.96	3.81	4.10	6.27
Unlimited	2.63	6.44	4.80	7.65	4.89	5.26	8.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$15 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
40/$20 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
40/$25 copay	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
60	0.33	0.81	0.60	0.96	0.61	0.66	1.01
100	0.75	1.84	1.37	2.18	1.40	1.50	2.29
200	2.05	5.02	3.74	5.96	3.81	4.10	6.27
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.78	1.91	1.42	2.27	1.45	1.56	2.39
90	1.67	4.09	3.05	4.85	3.11	3.34	5.11
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.70	1.72	1.28	2.03	1.30	1.40	2.14
90	1.29	3.16	2.36	3.75	2.40	2.58	3.95
120	2.12	5.19	3.87	6.16	3.94	4.24	6.49
visits for all other			**(Verizon Benefit)**				
	1.64	4.02	2.99	4.77	3.05	3.28	5.02
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.32	0.78	0.58	0.93	0.60	0.64	0.98
30	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Unlimited	0.70	1.72	1.28	2.03	1.30	1.40	2.14
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.58	8.77	6.54	10.41	6.66	7.16	10.95
60	4.21	10.31	7.69	12.24	7.83	8.42	12.88
90	5.02	12.30	9.17	14.59	9.34	10.04	15.36
Unlimited	5.08	12.45	9.28	14.77	9.45	10.16	15.54

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$20 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
60/$25 copay	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
120/$0 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
120/$5 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
Unlimited/$0 copay	0.71	1.74	1.30	2.06	1.32	1.42	2.17
Unlimited/$5 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$10 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$25	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$30	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$35	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$40	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
$45	(1.68)	(4.12)	(3.07)	(4.88)	(3.12)	(3.36)	(5.14)
$50	(1.84)	(4.51)	(3.36)	(5.35)	(3.42)	(3.68)	(5.63)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$15	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$20	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
$25	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$60	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$100	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.01)	(12.27)	(9.15)	(14.56)	(9.32)	(10.02)	(15.33)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.35	20.46	15.25	24.27	15.53	16.70	25.54
60	8.80	21.56	16.07	25.58	16.37	17.60	26.92
90	9.13	22.37	16.67	26.54	16.98	18.26	27.93
Unlimited	9.22	22.59	16.84	26.80	17.15	18.44	28.20
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.32	22.83	17.02	27.09	17.34	18.64	28.51
30	10.27	25.16	18.75	29.85	19.10	20.54	31.42
40	10.84	26.56	19.79	31.51	20.16	21.68	33.16
60	11.43	28.00	20.87	33.23	21.26	22.86	34.96
Unlimited	11.51	28.20	21.02	33.46	21.41	23.02	35.21
LARGE GROUP			**$5 Copay**				
20	8.77	21.49	16.01	25.49	16.31	17.54	26.83
30	9.65	23.64	17.62	28.05	17.95	19.30	29.52
40	10.26	25.14	18.73	29.83	19.08	20.52	31.39
60	10.74	26.31	19.61	31.22	19.98	21.48	32.85
Unlimited	10.82	26.51	19.76	31.45	20.13	21.64	33.10
LARGE GROUP			**$10 Copay**				
20	8.20	20.09	14.97	23.84	15.25	16.40	25.08
30	9.05	22.17	16.53	26.31	16.83	18.10	27.68
40	9.56	23.42	17.46	27.79	17.78	19.12	29.24
60	10.08	24.70	18.41	29.30	18.75	20.16	30.83
Unlimited	10.16	24.89	18.55	29.54	18.90	20.32	31.08
LARGE GROUP			**$15 Copay**				
20	7.70	18.87	14.06	22.38	14.32	15.40	23.55
30	8.51	20.85	15.54	24.74	15.83	17.02	26.03
40	9.00	22.05	16.43	26.16	16.74	18.00	27.53
60	9.52	23.32	17.38	27.67	17.71	19.04	29.12
Unlimited	9.60	23.52	17.53	27.91	17.86	19.20	29.37
LARGE GROUP			**$20 Copay**				
20	7.26	17.79	13.26	21.10	13.50	14.52	22.21
30	7.96	19.50	14.53	23.14	14.81	15.92	24.35
40	8.39	20.56	15.32	24.39	15.61	16.78	25.67
60	8.92	21.85	16.29	25.93	16.59	17.84	27.29
Unlimited	8.98	22.00	16.40	26.10	16.70	17.96	27.47

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP			**$25 Copay**				
20	6.75	16.54	12.33	19.62	12.56	13.50	20.65
30	7.41	18.15	13.53	21.54	13.78	14.82	22.67
40	7.89	19.33	14.41	22.94	14.68	15.78	24.14
60	8.30	20.34	15.16	24.13	15.44	16.60	25.39
Unlimited	8.38	20.53	15.30	24.36	15.59	16.76	25.63
LARGE GROUP			**$30 Copay**				
20	6.43	15.75	11.74	18.69	11.96	12.86	19.67
30	6.98	17.10	12.75	20.29	12.98	13.96	21.35
40	7.43	18.20	13.57	21.60	13.82	14.86	22.73
60	7.80	19.11	14.24	22.67	14.51	15.60	23.86
Unlimited	7.84	19.21	14.32	22.79	14.58	15.68	23.98
LARGE GROUP			**$35 Copay**				
20	6.11	14.97	11.16	17.76	11.36	12.22	18.69
30	6.52	15.97	11.91	18.95	12.13	13.04	19.94
40	6.94	17.00	12.67	20.17	12.91	13.88	21.23
60	7.29	17.86	13.31	21.19	13.56	14.58	22.30
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP			**$40 Copay**				
20	5.94	14.55	10.85	17.27	11.05	11.88	18.17
30	6.35	15.56	11.60	18.46	11.81	12.70	19.42
40	6.77	16.59	12.36	19.68	12.59	13.54	20.71
60	7.13	17.47	13.02	20.73	13.26	14.26	21.81
Unlimited	7.18	17.59	13.11	20.87	13.35	14.36	21.96
LARGE GROUP			**$45 Copay**				
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.16	15.09	11.25	17.91	11.46	12.32	18.84
40	6.59	16.15	12.03	19.16	12.26	13.18	20.16
60	6.95	17.03	12.69	20.20	12.93	13.90	21.26
Unlimited	7.00	17.15	12.78	20.35	13.02	14.00	21.41

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP			**$50 Copay**				
20	5.61	13.74	10.24	16.31	10.43	11.22	17.16
30	6.01	14.72	10.97	17.47	11.18	12.02	18.38
40	6.43	15.75	11.74	18.69	11.96	12.86	19.67
60	6.79	16.64	12.40	19.74	12.63	13.58	20.77
Unlimited	6.84	16.76	12.49	19.88	12.72	13.68	20.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
NYSHIP: Three Month Extension							
	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%	1.05%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.63	11.34	8.45	13.46	8.61	9.26	14.16
$0/Max $5000	4.41	10.80	8.05	12.82	8.20	8.82	13.49
$0/Max $2500	4.12	10.09	7.52	11.98	7.66	8.24	12.60
$25	4.41	10.80	8.05	12.82	8.20	8.82	13.49
$50	4.12	10.09	7.52	11.98	7.66	8.24	12.60
$100	3.79	9.29	6.92	11.02	7.05	7.58	11.59
$500	1.80	4.41	3.29	5.23	3.35	3.60	5.51
$5,000	0.32	0.78	0.58	0.93	0.60	0.64	0.98
Coinsurance							
80%	3.73	9.14	6.81	10.84	6.94	7.46	11.41
75%	3.48	8.53	6.35	10.12	6.47	6.96	10.65
70%	3.27	8.01	5.97	9.51	6.08	6.54	10.00
Deductible			**Orthotics Riders**				
$0	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$0/Max $5000	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$0/Max $2500	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$25	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$50	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$100	0.64	1.57	1.17	1.86	1.19	1.28	1.96
$500	0.34	0.83	0.62	0.99	0.63	0.68	1.04
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.64	1.57	1.17	1.86	1.19	1.28	1.96
75%	0.60	1.47	1.10	1.74	1.12	1.20	1.84
70%	0.57	1.40	1.04	1.66	1.06	1.14	1.74

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.55	1.35	1.00	1.60	1.02	1.10	1.68
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
			Infertility Rider				
Limit							
2 IVF	9.82	24.06	17.93	28.55	18.27	19.64	30.04
3 IVF	11.87	29.08	21.67	34.51	22.08	23.74	36.31
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.91	7.13	5.31	8.46	5.41	5.82	8.90
			Nurse Advice Line Rider				
	0.33	0.81	0.60	0.96	0.61	0.66	1.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
957.37	2,345.56	1,748.16	2,783.07	1,780.71	1,914.74	2,928.59
80% Coinsurance						
943.00	2,310.35	1,721.92	2,741.30	1,753.98	1,886.00	2,884.64
75% Coinsurance						
897.54	2,198.97	1,638.91	2,609.15	1,669.42	1,795.08	2,745.57
70% Coinsurance						
852.05	2,087.52	1,555.84	2,476.91	1,584.81	1,704.10	2,606.42
50% Coinsurance						
806.58	1,976.12	1,472.82	2,344.73	1,500.24	1,613.16	2,467.33

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**

**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual x 2	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(43.25)	(105.96)	(78.97)	(125.73)	(80.45)	(86.50)	(132.30)
$350	(57.25)	(140.26)	(104.54)	(166.43)	(106.49)	(114.50)	(175.13)
$500	(73.65)	(180.44)	(134.48)	(214.10)	(136.99)	(147.30)	(225.30)
$750	(95.69)	(234.44)	(174.73)	(278.17)	(177.98)	(191.38)	(292.72)
$1,000	(112.57)	(275.80)	(205.55)	(327.24)	(209.38)	(225.14)	(344.35)
$1,500	(138.44)	(339.18)	(252.79)	(402.45)	(257.50)	(276.88)	(423.49)
$2,500	(154.77)	(379.19)	(282.61)	(449.92)	(287.87)	(309.54)	(473.44)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(57.80)	(141.61)	(105.54)	(168.02)	(107.51)	(115.60)	(176.81)
$250	(68.94)	(168.90)	(125.88)	(200.41)	(128.23)	(137.88)	(210.89)
$300	(80.12)	(196.29)	(146.30)	(232.91)	(149.02)	(160.24)	(245.09)
$350	(91.30)	(223.69)	(166.71)	(265.41)	(169.82)	(182.60)	(279.29)
$400	(100.08)	(245.20)	(182.75)	(290.93)	(186.15)	(200.16)	(306.14)
$500	(117.63)	(288.19)	(214.79)	(341.95)	(218.79)	(235.26)	(359.83)
$750	(152.77)	(374.29)	(278.96)	(444.10)	(284.15)	(305.54)	(467.32)
$1,000	(179.82)	(440.56)	(328.35)	(522.74)	(334.47)	(359.64)	(550.07)
$1,500	(221.20)	(541.94)	(403.91)	(643.03)	(411.43)	(442.40)	(676.65)
$2,000	(238.13)	(583.42)	(434.83)	(692.24)	(442.92)	(476.26)	(728.44)
$2,500	(255.11)	(625.02)	(465.83)	(741.60)	(474.50)	(510.22)	(780.38)
$5,000	(299.90)	(734.76)	(547.62)	(871.81)	(557.81)	(599.80)	(917.39)
$10,000	(336.90)	(825.41)	(615.18)	(979.37)	(626.63)	(673.80)	(1,030.58)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(47.35)	(116.01)	(86.46)	(137.65)	(88.07)	(94.70)	(144.84)
$250	(56.47)	(138.35)	(103.11)	(164.16)	(105.03)	(112.94)	(172.74)
$300	(65.65)	(160.84)	(119.88)	(190.84)	(122.11)	(131.30)	(200.82)
$350	(74.78)	(183.21)	(136.55)	(217.39)	(139.09)	(149.56)	(228.75)
$400	(82.13)	(201.22)	(149.97)	(238.75)	(152.76)	(164.26)	(251.24)
$500	(96.88)	(237.36)	(176.90)	(281.63)	(180.20)	(193.76)	(296.36)
$750	(126.01)	(308.72)	(230.09)	(366.31)	(234.38)	(252.02)	(385.46)
$1,000	(148.68)	(364.27)	(271.49)	(432.21)	(276.54)	(297.36)	(454.81)
$1,500	(183.06)	(448.50)	(334.27)	(532.16)	(340.49)	(366.12)	(559.98)
$2,000	(198.63)	(486.64)	(362.70)	(577.42)	(369.45)	(397.26)	(607.61)
$2,500	(214.23)	(524.86)	(391.18)	(622.77)	(398.47)	(428.46)	(655.33)
$5,000	(258.83)	(634.13)	(472.62)	(752.42)	(481.42)	(517.66)	(791.76)
$10,000	(295.63)	(724.29)	(539.82)	(859.40)	(549.87)	(591.26)	(904.33)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(36.92)	(90.45)	(67.42)	(107.33)	(68.67)	(73.84)	(112.94)
$250	(44.05)	(107.92)	(80.44)	(128.05)	(81.93)	(88.10)	(134.75)
$300	(51.16)	(125.34)	(93.42)	(148.72)	(95.16)	(102.32)	(156.50)
$350	(58.28)	(142.79)	(106.42)	(169.42)	(108.40)	(116.56)	(178.28)
$400	(64.25)	(157.41)	(117.32)	(186.77)	(119.51)	(128.50)	(196.54)
$500	(76.05)	(186.32)	(138.87)	(221.08)	(141.45)	(152.10)	(232.64)
$750	(99.22)	(243.09)	(181.18)	(288.43)	(184.55)	(198.44)	(303.51)
$1,000	(117.49)	(287.85)	(214.54)	(341.54)	(218.53)	(234.98)	(359.40)
$1,500	(144.91)	(355.03)	(264.61)	(421.25)	(269.53)	(289.82)	(443.28)
$2,000	(159.16)	(389.94)	(290.63)	(462.68)	(296.04)	(318.32)	(486.87)
$2,500	(173.39)	(424.81)	(316.61)	(504.04)	(322.51)	(346.78)	(530.40)
$5,000	(217.75)	(533.49)	(397.61)	(633.00)	(405.02)	(435.50)	(666.10)
$10,000	(254.37)	(623.21)	(464.48)	(739.45)	(473.13)	(508.74)	(778.12)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(25.37)	(62.16)	(46.33)	(73.75)	(47.19)	(50.74)	(77.61)
$250	(30.42)	(74.53)	(55.55)	(88.43)	(56.58)	(60.84)	(93.05)
$300	(35.49)	(86.95)	(64.80)	(103.17)	(66.01)	(70.98)	(108.56)
$350	(40.50)	(99.23)	(73.95)	(117.73)	(75.33)	(81.00)	(123.89)
$400	(44.88)	(109.96)	(81.95)	(130.47)	(83.48)	(89.76)	(137.29)
$500	(53.61)	(131.34)	(97.89)	(155.84)	(99.71)	(107.22)	(163.99)
$750	(70.34)	(172.33)	(128.44)	(204.48)	(130.83)	(140.68)	(215.17)
$1,000	(83.96)	(205.70)	(153.31)	(244.07)	(156.17)	(167.92)	(256.83)
$1,500	(104.90)	(257.01)	(191.55)	(304.94)	(195.11)	(209.80)	(320.89)
$2,000	(116.05)	(284.32)	(211.91)	(337.36)	(215.85)	(232.10)	(355.00)
$2,500	(127.26)	(311.79)	(232.38)	(369.94)	(236.70)	(254.52)	(389.29)
$5,000	(171.00)	(418.95)	(312.25)	(497.10)	(318.06)	(342.00)	(523.09)
$10,000	(207.11)	(507.42)	(378.18)	(602.07)	(385.22)	(414.22)	(633.55)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
			LARGE GROUP				
Maximum	**Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance**						
$1,000	(33.62)	(82.37)	(61.39)	(97.73)	(62.53)	(67.24)	(102.84)
$1,500	(36.66)	(89.82)	(66.94)	(106.57)	(68.19)	(73.32)	(112.14)
$2,000	(38.26)	(93.74)	(69.86)	(111.22)	(71.16)	(76.52)	(117.04)
$3,000	(39.66)	(97.17)	(72.42)	(115.29)	(73.77)	(79.32)	(121.32)
$4,000	(40.28)	(98.69)	(73.55)	(117.09)	(74.92)	(80.56)	(123.22)
$5,000	(40.61)	(99.49)	(74.15)	(118.05)	(75.53)	(81.22)	(124.23)
$7,000	(40.98)	(100.40)	(74.83)	(119.13)	(76.22)	(81.96)	(125.36)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(53.50)	(131.08)	(97.69)	(155.52)	(99.51)	(107.00)	(163.66)
$1,500	(58.38)	(143.03)	(106.60)	(169.71)	(108.59)	(116.76)	(178.58)
$2,000	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$3,000	(63.19)	(154.82)	(115.38)	(183.69)	(117.53)	(126.38)	(193.30)
$4,000	(64.16)	(157.19)	(117.16)	(186.51)	(119.34)	(128.32)	(196.27)
$5,000	(64.67)	(158.44)	(118.09)	(188.00)	(120.29)	(129.34)	(197.83)
$7,000	(65.29)	(159.96)	(119.22)	(189.80)	(121.44)	(130.58)	(199.72)
$7,500	(65.82)	(161.26)	(120.19)	(191.34)	(122.43)	(131.64)	(201.34)
$10,000	(67.75)	(165.99)	(123.71)	(196.95)	(126.02)	(135.50)	(207.25)
$20,000	(70.49)	(172.70)	(128.71)	(204.91)	(131.11)	(140.98)	(215.63)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(51.70)	(126.67)	(94.40)	(150.29)	(96.16)	(103.40)	(158.15)
$1,500	(57.46)	(140.78)	(104.92)	(167.04)	(106.88)	(114.92)	(175.77)
$2,000	(60.67)	(148.64)	(110.78)	(176.37)	(112.85)	(121.34)	(185.59)
$3,000	(63.81)	(156.33)	(116.52)	(185.50)	(118.69)	(127.62)	(195.19)
$4,000	(65.24)	(159.84)	(119.13)	(189.65)	(121.35)	(130.48)	(199.57)
$5,000	(66.03)	(161.77)	(120.57)	(191.95)	(122.82)	(132.06)	(201.99)
$7,000	(66.80)	(163.66)	(121.98)	(194.19)	(124.25)	(133.60)	(204.34)
$7,500	(67.37)	(165.06)	(123.02)	(195.84)	(125.31)	(134.74)	(206.08)
$10,000	(69.73)	(170.84)	(127.33)	(202.71)	(129.70)	(139.46)	(213.30)
$20,000	(73.38)	(179.78)	(133.99)	(213.32)	(136.49)	(146.76)	(224.47)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(49.91)	(122.28)	(91.14)	(145.09)	(92.83)	(99.82)	(152.67)
$1,500	(56.62)	(138.72)	(103.39)	(164.59)	(105.31)	(113.24)	(173.20)
$2,000	(60.47)	(148.15)	(110.42)	(175.79)	(112.47)	(120.94)	(184.98)
$3,000	(64.46)	(157.93)	(117.70)	(187.39)	(119.90)	(128.92)	(197.18)
$4,000	(66.28)	(162.39)	(121.03)	(192.68)	(123.28)	(132.56)	(202.75)
$5,000	(67.35)	(165.01)	(122.98)	(195.79)	(125.27)	(134.70)	(206.02)
$7,000	(68.29)	(167.31)	(124.70)	(198.52)	(127.02)	(136.58)	(208.90)
$7,500	(68.89)	(168.78)	(125.79)	(200.26)	(128.14)	(137.78)	(210.73)
$10,000	(71.50)	(175.18)	(130.56)	(207.85)	(132.99)	(143.00)	(218.72)
$20,000	(76.15)	(186.57)	(139.05)	(221.37)	(141.64)	(152.30)	(232.94)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(56.47)	(138.35)	(103.11)	(164.16)	(105.03)	(112.94)	(172.74)
$1,500	(67.30)	(164.89)	(122.89)	(195.64)	(125.18)	(134.60)	(205.87)
$2,000	(74.27)	(181.96)	(135.62)	(215.90)	(138.14)	(148.54)	(227.19)
$3,000	(82.73)	(202.69)	(151.06)	(240.50)	(153.88)	(165.46)	(253.07)
$4,000	(87.37)	(214.06)	(159.54)	(253.98)	(162.51)	(174.74)	(267.26)
$5,000	(90.22)	(221.04)	(164.74)	(262.27)	(167.81)	(180.44)	(275.98)
$7,000	(93.17)	(228.27)	(170.13)	(270.85)	(173.30)	(186.34)	(285.01)
$7,500	(94.26)	(230.94)	(172.12)	(274.01)	(175.32)	(188.52)	(288.34)
$10,000	(98.66)	(241.72)	(180.15)	(286.80)	(183.51)	(197.32)	(301.80)
$20,000	(107.88)	(264.31)	(196.99)	(313.61)	(200.66)	(215.76)	(330.00)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.43	1.05	0.79	1.25	0.80	0.86	1.32
$1,000,000	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$50,000	(5.54)	(13.57)	(10.12)	(16.10)	(10.30)	(11.08)	(16.95)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
75%	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
70%	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.32)	(5.68)	(4.24)	(6.74)	(4.32)	(4.64)	(7.10)
$10	(4.89)	(11.98)	(8.93)	(14.22)	(9.10)	(9.78)	(14.96)
$15	(8.13)	(19.92)	(14.85)	(23.63)	(15.12)	(16.26)	(24.87)
$20	(12.55)	(30.75)	(22.92)	(36.48)	(23.34)	(25.10)	(38.39)
$25	(16.52)	(40.47)	(30.17)	(48.02)	(30.73)	(33.04)	(50.53)
$30	(20.90)	(51.21)	(38.16)	(60.76)	(38.87)	(41.80)	(63.93)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$10	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$15	(4.66)	(11.42)	(8.51)	(13.55)	(8.67)	(9.32)	(14.25)
$20	(7.18)	(17.59)	(13.11)	(20.87)	(13.35)	(14.36)	(21.96)
$25	(9.46)	(23.18)	(17.27)	(27.50)	(17.60)	(18.92)	(28.94)
$30	(11.95)	(29.28)	(21.82)	(34.74)	(22.23)	(23.90)	(36.56)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$10	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$15	(5.51)	(13.50)	(10.06)	(16.02)	(10.25)	(11.02)	(16.86)
$20	(7.76)	(19.01)	(14.17)	(22.56)	(14.43)	(15.52)	(23.74)
$25	(10.23)	(25.06)	(18.68)	(29.74)	(19.03)	(20.46)	(31.29)
$30	(13.05)	(31.97)	(23.83)	(37.94)	(24.27)	(26.10)	(39.92)
$35	(15.68)	(38.42)	(28.63)	(45.58)	(29.16)	(31.36)	(47.97)
$40	(18.40)	(45.08)	(33.60)	(53.49)	(34.22)	(36.80)	(56.29)
$45	(21.29)	(52.16)	(38.88)	(61.89)	(39.60)	(42.58)	(65.13)
$50	(24.29)	(59.51)	(44.35)	(70.61)	(45.18)	(48.58)	(74.30)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$10	(2.97)	(7.28)	(5.42)	(8.63)	(5.52)	(5.94)	(9.09)
$15	(4.66)	(11.42)	(8.51)	(13.55)	(8.67)	(9.32)	(14.25)
$20	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$25	(8.66)	(21.22)	(15.81)	(25.17)	(16.11)	(17.32)	(26.49)
$30	(11.04)	(27.05)	(20.16)	(32.09)	(20.53)	(22.08)	(33.77)
$35	(13.27)	(32.51)	(24.23)	(38.58)	(24.68)	(26.54)	(40.59)
$40	(15.58)	(38.17)	(28.45)	(45.29)	(28.98)	(31.16)	(47.66)
$45	(18.00)	(44.10)	(32.87)	(52.33)	(33.48)	(36.00)	(55.06)
$50	(20.55)	(50.35)	(37.52)	(59.74)	(38.22)	(41.10)	(62.86)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$150	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$200	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$250	(2.84)	(6.96)	(5.19)	(8.26)	(5.28)	(5.68)	(8.69)
$500	(6.86)	(16.81)	(12.53)	(19.94)	(12.76)	(13.72)	(20.98)
$750	(11.76)	(28.81)	(21.47)	(34.19)	(21.87)	(23.52)	(35.97)
$1,000	(17.69)	(43.34)	(32.30)	(51.42)	(32.90)	(35.38)	(54.11)
Copay/Day							
$50 w/3 Day Max	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$50 w/5 Day Max	(1.42)	(3.48)	(2.59)	(4.13)	(2.64)	(2.84)	(4.34)
$100 w/3 Day Max	(2.58)	(6.32)	(4.71)	(7.50)	(4.80)	(5.16)	(7.89)
$100 w/5 Day Max	(3.72)	(9.11)	(6.79)	(10.81)	(6.92)	(7.44)	(11.38)
$250 w/3 Day Max	(8.54)	(20.92)	(15.59)	(24.83)	(15.88)	(17.08)	(26.12)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$100	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$125	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$150	(1.69)	(4.14)	(3.09)	(4.91)	(3.14)	(3.38)	(5.17)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$35	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$50	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$60	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$75	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
$100	(2.31)	(5.66)	(4.22)	(6.72)	(4.30)	(4.62)	(7.07)
$125	(2.84)	(6.96)	(5.19)	(8.26)	(5.28)	(5.68)	(8.69)
$150	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.47	1.15	0.86	1.37	0.87	0.94	1.44
60	0.92	2.25	1.68	2.67	1.71	1.84	2.81
90	1.31	3.21	2.39	3.81	2.44	2.62	4.01
120	1.57	3.85	2.87	4.56	2.92	3.14	4.80
Unlimited	2.03	4.97	3.71	5.90	3.78	4.06	6.21
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.52	1.27	0.95	1.51	0.97	1.04	1.59
200	1.35	3.31	2.47	3.92	2.51	2.70	4.13

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
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October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.61	1.49	1.11	1.77	1.13	1.22	1.87
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.54	1.32	0.99	1.57	1.00	1.08	1.65
90	1.01	2.47	1.84	2.94	1.88	2.02	3.09
120	1.62	3.97	2.96	4.71	3.01	3.24	4.96
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited	0.54	1.32	0.99	1.57	1.00	1.08	1.65
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.38	5.83	4.35	6.92	4.43	4.76	7.28
60	2.82	6.91	5.15	8.20	5.25	5.64	8.63
90	3.36	8.23	6.14	9.77	6.25	6.72	10.28
Unlimited	3.40	8.33	6.21	9.88	6.32	6.80	10.40
			Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
60/$20 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
60/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
120/$0 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$5 copay	0.38	0.93	0.69	1.10	0.71	0.76	1.16
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$5 copay	0.44	1.08	0.80	1.28	0.82	0.88	1.35
Unlimited/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
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October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$30	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$35	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$40	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$45	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$50	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$20	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$25	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
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October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.76	21.46	16.00	25.47	16.29	17.52	26.80
60	9.25	22.66	16.89	26.89	17.21	18.50	28.30
90	9.59	23.50	17.51	27.88	17.84	19.18	29.34
Unlimited	9.68	23.72	17.68	28.14	18.00	19.36	29.61
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.80	24.01	17.89	28.49	18.23	19.60	29.98
30	10.78	26.41	19.68	31.34	20.05	21.56	32.98
40	11.37	27.86	20.76	33.05	21.15	22.74	34.78
60	11.99	29.38	21.89	34.85	22.30	23.98	36.68
Unlimited	12.10	29.65	22.09	35.17	22.51	24.20	37.01
LARGE GROUP				**$5 Copay**			
20	9.21	22.56	16.82	26.77	17.13	18.42	28.17
30	10.14	24.84	18.52	29.48	18.86	20.28	31.02
40	10.77	26.39	19.67	31.31	20.03	21.54	32.95
60	11.29	27.66	20.62	32.82	21.00	22.58	34.54
Unlimited	11.36	27.83	20.74	33.02	21.13	22.72	34.75
LARGE GROUP				**$10 Copay**			
20	8.62	21.12	15.74	25.06	16.03	17.24	26.37
30	9.51	23.30	17.37	27.65	17.69	19.02	29.09
40	10.04	24.60	18.33	29.19	18.67	20.08	30.71
60	10.58	25.92	19.32	30.76	19.68	21.16	32.36
Unlimited	10.67	26.14	19.48	31.02	19.85	21.34	32.64
LARGE GROUP				**$15 Copay**			
20	8.10	19.85	14.79	23.55	15.07	16.20	24.78
30	8.92	21.85	16.29	25.93	16.59	17.84	27.29
40	9.44	23.13	17.24	27.44	17.56	18.88	28.88
60	9.99	24.48	18.24	29.04	18.58	19.98	30.56
Unlimited	10.08	24.70	18.41	29.30	18.75	20.16	30.83

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.61	18.64	13.90	22.12	14.15	15.22	23.28
30	8.36	20.48	15.27	24.30	15.55	16.72	25.57
40	8.81	21.58	16.09	25.61	16.39	17.62	26.95
60	9.35	22.91	17.07	27.18	17.39	18.70	28.60
Unlimited	9.43	23.10	17.22	27.41	17.54	18.86	28.85
LARGE GROUP				**$25 Copay**			
20	7.07	17.32	12.91	20.55	13.15	14.14	21.63
30	7.79	19.09	14.22	22.65	14.49	15.58	23.83
40	8.29	20.31	15.14	24.10	15.42	16.58	25.36
60	8.71	21.34	15.90	25.32	16.20	17.42	26.64
Unlimited	8.80	21.56	16.07	25.58	16.37	17.60	26.92
LARGE GROUP				**$30 Copay**			
20	6.76	16.56	12.34	19.65	12.57	13.52	20.68
30	7.33	17.96	13.38	21.31	13.63	14.66	22.42
40	7.81	19.13	14.26	22.70	14.53	15.62	23.89
60	8.17	20.02	14.92	23.75	15.20	16.34	24.99
Unlimited	8.21	20.11	14.99	23.87	15.27	16.42	25.11

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
LARGE GROUP				**$35 Copay**			
20	6.42	15.73	11.72	18.66	11.94	12.84	19.64
30	6.86	16.81	12.53	19.94	12.76	13.72	20.98
40	7.30	17.89	13.33	21.22	13.58	14.60	22.33
60	7.64	18.72	13.95	22.21	14.21	15.28	23.37
Unlimited	7.70	18.87	14.06	22.38	14.32	15.40	23.55
LARGE GROUP				**$40 Copay**			
20	6.25	15.31	11.41	18.17	11.63	12.50	19.12
30	6.66	16.32	12.16	19.36	12.39	13.32	20.37
40	7.10	17.40	12.96	20.64	13.21	14.20	21.72
60	7.49	18.35	13.68	21.77	13.93	14.98	22.91
Unlimited	7.55	18.50	13.79	21.95	14.04	15.10	23.10
LARGE GROUP				**$45 Copay**			
20	6.07	14.87	11.08	17.65	11.29	12.14	18.57
30	6.47	15.85	11.81	18.81	12.03	12.94	19.79
40	6.92	16.95	12.64	20.12	12.87	13.84	21.17
60	7.31	17.91	13.35	21.25	13.60	14.62	22.36
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP				**$50 Copay**			
20	5.89	14.43	10.76	17.12	10.96	11.78	18.02
30	6.32	15.48	11.54	18.37	11.76	12.64	19.33
40	6.76	16.56	12.34	19.65	12.57	13.52	20.68
60	7.12	17.44	13.00	20.70	13.24	14.24	21.78
Unlimited	7.16	17.54	13.07	20.81	13.32	14.32	21.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	6.94	17.00	12.67	20.17	12.91	13.88	21.23
$0/Max $5000	6.51	15.95	11.89	18.92	12.11	13.02	19.91
$0/Max $2500	6.13	15.02	11.19	17.82	11.40	12.26	18.75
$25	6.51	15.95	11.89	18.92	12.11	13.02	19.91
$50	6.13	15.02	11.19	17.82	11.40	12.26	18.75
$100	5.51	13.50	10.06	16.02	10.25	11.02	16.86
$500	2.72	6.66	4.97	7.91	5.06	5.44	8.32
$5,000	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Coinsurance							
80%	5.52	13.52	10.08	16.05	10.27	11.04	16.89
75%	5.21	12.76	9.51	15.15	9.69	10.42	15.94
70%	4.84	11.86	8.84	14.07	9.00	9.68	14.81
			Orthotics Riders				
$0/Max $5000	7.20	17.64	13.15	20.93	13.39	14.40	22.02
$0/Max $2500	6.67	16.34	12.18	19.39	12.41	13.34	20.40
Deductible							
$0	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$0/Max $5000	1.13	2.77	2.06	3.28	2.10	2.26	3.46
$0/Max $2500	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$25	1.13	2.77	2.06	3.28	2.10	2.26	3.46
$50	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$100	0.99	2.43	1.81	2.88	1.84	1.98	3.03
$500	0.48	1.18	0.88	1.40	0.89	0.96	1.47
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.99	2.43	1.81	2.88	1.84	1.98	3.03
75%	0.93	2.28	1.70	2.70	1.73	1.86	2.84
70%	0.83	2.03	1.52	2.41	1.54	1.66	2.54

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.79	1.94	1.44	2.30	1.47	1.58	2.42
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	15.17	37.17	27.70	44.10	28.22	30.34	46.41
3 IVF	18.23	44.66	33.29	52.99	33.91	36.46	55.77
			Nurse Advice Line Rider				
	0.33	0.81	0.60	0.96	0.61	0.66	1.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFITS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Large Group*	540.73	1,324.79	987.37	1,571.90	1,005.76	1,081.46	1,654.09

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.61)	(8.84)	(6.59)	(10.49)	(6.71)	(7.22)	(11.04)
$10	(7.60)	(18.62)	(13.88)	(22.09)	(14.14)	(15.20)	(23.25)
$15	(12.66)	(31.02)	(23.12)	(36.80)	(23.55)	(25.32)	(38.73)
$20	(19.51)	(47.80)	(35.63)	(56.72)	(36.29)	(39.02)	(59.68)
$25	(25.71)	(62.99)	(46.95)	(74.74)	(47.82)	(51.42)	(78.65)
$30	(32.51)	(79.65)	(59.36)	(94.51)	(60.47)	(65.02)	(99.45)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(7.25)	(17.76)	(13.24)	(21.08)	(13.49)	(14.50)	(22.18)
$20	(11.17)	(27.37)	(20.40)	(32.47)	(20.78)	(22.34)	(34.17)
$25	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$30	(18.64)	(45.67)	(34.04)	(54.19)	(34.67)	(37.28)	(57.02)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$10	(5.47)	(13.40)	(9.99)	(15.90)	(10.17)	(10.94)	(16.73)
$15	(8.58)	(21.02)	(15.67)	(24.94)	(15.96)	(17.16)	(26.25)
$20	(12.10)	(29.65)	(22.09)	(35.17)	(22.51)	(24.20)	(37.01)
$25	(15.95)	(39.08)	(29.12)	(46.37)	(29.67)	(31.90)	(48.79)
$30	(20.32)	(49.78)	(37.10)	(59.07)	(37.80)	(40.64)	(62.16)
$35	(24.43)	(59.85)	(44.61)	(71.02)	(45.44)	(48.86)	(74.73)
$40	(28.66)	(70.22)	(52.33)	(83.31)	(53.31)	(57.32)	(87.67)
$45	(33.16)	(81.24)	(60.55)	(96.40)	(61.68)	(66.32)	(101.44)
$50	(37.84)	(92.71)	(69.10)	(110.00)	(70.38)	(75.68)	(115.75)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.24)	(5.49)	(4.09)	(6.51)	(4.17)	(4.48)	(6.85)
$10	(4.61)	(11.29)	(8.42)	(13.40)	(8.57)	(9.22)	(14.10)
$15	(7.25)	(17.76)	(13.24)	(21.08)	(13.49)	(14.50)	(22.18)
$20	(10.22)	(25.04)	(18.66)	(29.71)	(19.01)	(20.44)	(31.26)
$25	(13.47)	(33.00)	(24.60)	(39.16)	(25.05)	(26.94)	(41.20)
$30	(17.17)	(42.07)	(31.35)	(49.91)	(31.94)	(34.34)	(52.52)
$35	(20.67)	(50.64)	(37.74)	(60.09)	(38.45)	(41.34)	(63.23)
$40	(24.24)	(59.39)	(44.26)	(70.47)	(45.09)	(48.48)	(74.15)
$45	(28.02)	(68.65)	(51.16)	(81.45)	(52.12)	(56.04)	(85.71)
$50	(32.00)	(78.40)	(58.43)	(93.02)	(59.52)	(64.00)	(97.89)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$150	(2.19)	(5.37)	(4.00)	(6.37)	(4.07)	(4.38)	(6.70)
$200	(3.10)	(7.60)	(5.66)	(9.01)	(5.77)	(6.20)	(9.48)
$250	(4.46)	(10.93)	(8.14)	(12.97)	(8.30)	(8.92)	(13.64)
$500	(10.68)	(26.17)	(19.50)	(31.05)	(19.86)	(21.36)	(32.67)
$750	(18.30)	(44.84)	(33.42)	(53.20)	(34.04)	(36.60)	(55.98)
$1,000	(27.55)	(67.50)	(50.31)	(80.09)	(51.24)	(55.10)	(84.28)
Copay/Day							
$50 w/3 Day Max	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$50 w/5 Day Max	(2.21)	(5.41)	(4.04)	(6.42)	(4.11)	(4.42)	(6.76)
$100 w/3 Day Max	(4.00)	(9.80)	(7.30)	(11.63)	(7.44)	(8.00)	(12.24)
$100 w/5 Day Max	(5.78)	(14.16)	(10.55)	(16.80)	(10.75)	(11.56)	(17.68)
$250 w/3 Day Max	(13.27)	(32.51)	(24.23)	(38.58)	(24.68)	(26.54)	(40.59)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$75	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$100	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$125	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$150	(2.63)	(6.44)	(4.80)	(7.65)	(4.89)	(5.26)	(8.05)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$25	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$35	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$50	(1.53)	(3.75)	(2.79)	(4.45)	(2.85)	(3.06)	(4.68)
$60	(1.93)	(4.73)	(3.52)	(5.61)	(3.59)	(3.86)	(5.90)
$75	(2.54)	(6.22)	(4.64)	(7.38)	(4.72)	(5.08)	(7.77)
$100	(3.60)	(8.82)	(6.57)	(10.47)	(6.70)	(7.20)	(11.01)
$125	(4.46)	(10.93)	(8.14)	(12.97)	(8.30)	(8.92)	(13.64)
$150	(5.31)	(13.01)	(9.70)	(15.44)	(9.88)	(10.62)	(16.24)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.61	1.49	1.11	1.77	1.13	1.22	1.87
60	1.20	2.94	2.19	3.49	2.23	2.40	3.67
90	1.80	4.41	3.29	5.23	3.35	3.60	5.51
120	2.13	5.22	3.89	6.19	3.96	4.26	6.52
Unlimited	2.75	6.74	5.02	7.99	5.12	5.50	8.41
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$15 copay	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
40/$20 copay	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
40/$25 copay	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
60	0.34	0.83	0.62	0.99	0.63	0.68	1.04
100	0.78	1.91	1.42	2.27	1.45	1.56	2.39
200	2.13	5.22	3.89	6.19	3.96	4.26	6.52

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.83	2.03	1.52	2.41	1.54	1.66	2.54
90	1.73	4.24	3.16	5.03	3.22	3.46	5.29

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.73	1.79	1.33	2.12	1.36	1.46	2.23
90	1.35	3.31	2.47	3.92	2.51	2.70	4.13
120	2.21	5.41	4.04	6.42	4.11	4.42	6.76
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.33	0.81	0.60	0.96	0.61	0.66	1.01
30	0.51	1.25	0.93	1.48	0.95	1.02	1.56
Unlimited	0.73	1.79	1.33	2.12	1.36	1.46	2.23
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.75	9.19	6.85	10.90	6.98	7.50	11.47
60	4.38	10.73	8.00	12.73	8.15	8.76	13.40
90	5.23	12.81	9.55	15.20	9.73	10.46	16.00
Unlimited	5.31	13.01	9.70	15.44	9.88	10.62	16.24
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
60/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$20 copay	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
60/$25 copay	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
120/$0 copay	0.65	1.59	1.19	1.89	1.21	1.30	1.99
120/$5 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.56
120/$10 copay	0.32	0.78	0.58	0.93	0.60	0.64	0.98
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.74	1.81	1.35	2.15	1.38	1.48	2.26
Unlimited/$5 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
Unlimited/$10 copa	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$25	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$30	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$35	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.01)
$40	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$45	(1.74)	(4.26)	(3.18)	(5.06)	(3.24)	(3.48)	(5.32)
$50	(1.94)	(4.75)	(3.54)	(5.64)	(3.61)	(3.88)	(5.93)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$15	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$20	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
$25	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$60	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$100	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$75	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$100	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.22)	(12.79)	(9.53)	(15.17)	(9.71)	(10.44)	(15.97)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	8.70	21.32	15.89	25.29	16.18	17.40	26.61
60	9.17	22.47	16.74	26.66	17.06	18.34	28.05
90	9.52	23.32	17.38	27.67	17.71	19.04	29.12
Unlimited	9.62	23.57	17.57	27.97	17.89	19.24	29.43
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	9.72	23.81	17.75	28.26	18.08	19.44	29.73
30	10.71	26.24	19.56	31.13	19.92	21.42	32.76
40	11.31	27.71	20.65	32.88	21.04	22.62	34.60
60	11.91	29.18	21.75	34.62	22.15	23.82	36.43
Unlimited	12.01	29.42	21.93	34.91	22.34	24.02	36.74
LARGE GROUP				**$5 Copay**			
20	9.15	22.42	16.71	26.60	17.02	18.30	27.99
30	10.07	24.67	18.39	29.27	18.73	20.14	30.80
40	10.70	26.22	19.54	31.10	19.90	21.40	32.73
60	11.21	27.46	20.47	32.59	20.85	22.42	34.29
Unlimited	11.30	27.69	20.63	32.85	21.02	22.60	34.57
LARGE GROUP				**$10 Copay**			
20	8.57	21.00	15.65	24.91	15.94	17.14	26.22
30	9.43	23.10	17.22	27.41	17.54	18.86	28.85
40	9.97	24.43	18.21	28.98	18.54	19.94	30.50
60	10.51	25.75	19.19	30.55	19.55	21.02	32.15
Unlimited	10.59	25.95	19.34	30.79	19.70	21.18	32.39
LARGE GROUP				**$15 Copay**			
20	8.04	19.70	14.68	23.37	14.95	16.08	24.59
30	8.86	21.71	16.18	25.76	16.48	17.72	27.10
40	9.38	22.98	17.13	27.27	17.45	18.76	28.69
60	9.91	24.28	18.10	28.81	18.43	19.82	30.31
Unlimited	10.00	24.50	18.26	29.07	18.60	20.00	30.59
LARGE GROUP				**$20 Copay**			
20	7.57	18.55	13.82	22.01	14.08	15.14	23.16
30	8.29	20.31	15.14	24.10	15.42	16.58	25.36
40	8.75	21.44	15.98	25.44	16.28	17.50	26.77

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	9.30	22.79	16.98	27.04	17.30	18.60	28.45
Unlimited	9.37	22.96	17.11	27.24	17.43	18.74	28.66
LARGE GROUP				$25 Copay			
20	7.03	17.22	12.84	20.44	13.08	14.06	21.50
30	7.71	18.89	14.08	22.41	14.34	15.42	23.58
40	8.24	20.19	15.05	23.95	15.33	16.48	25.21
60	8.66	21.22	15.81	25.17	16.11	17.32	26.49
Unlimited	8.74	21.41	15.96	25.41	16.26	17.48	26.74
LARGE GROUP				$30 Copay			
20	6.72	16.46	12.27	19.54	12.50	13.44	20.56
30	7.28	17.84	13.29	21.16	13.54	14.56	22.27
40	7.74	18.96	14.13	22.50	14.40	15.48	23.68
60	8.13	19.92	14.85	23.63	15.12	16.26	24.87
Unlimited	8.17	20.02	14.92	23.75	15.20	16.34	24.99
LARGE GROUP				$35 Copay			
20	6.37	15.61	11.63	18.52	11.85	12.74	19.49
30	6.81	16.68	12.44	19.80	12.67	13.62	20.83
40	7.25	17.76	13.24	21.08	13.49	14.50	22.18
60	7.60	18.62	13.88	22.09	14.14	15.20	23.25
Unlimited	7.65	18.74	13.97	22.24	14.23	15.30	23.40
LARGE GROUP				$40 Copay			
20	6.22	15.24	11.36	18.08	11.57	12.44	19.03
30	6.62	16.22	12.09	19.24	12.31	13.24	20.25
40	7.05	17.27	12.87	20.49	13.11	14.10	21.57
60	7.44	18.23	13.59	21.63	13.84	14.88	22.76
Unlimited	7.49	18.35	13.68	21.77	13.93	14.98	22.91
LARGE GROUP				$45 Copay			
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.43	15.75	11.74	18.69	11.96	12.86	19.67
40	6.88	16.86	12.56	20.00	12.80	13.76	21.05
60	7.27	17.81	13.28	21.13	13.52	14.54	22.24
Unlimited	7.30	17.89	13.33	21.22	13.58	14.60	22.33
LARGE GROUP				$50 Copay			
20	5.86	14.36	10.70	17.04	10.90	11.72	17.93
30	6.27	15.36	11.45	18.23	11.66	12.54	19.18
40	6.72	16.46	12.27	19.54	12.50	13.44	20.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
60	7.07	17.32	12.91	20.55	13.15	14.14	21.63
Unlimited	7.12	17.44	13.00	20.70	13.24	14.24	21.78

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	4.84	11.86	8.84	14.07	9.00	9.68	14.81
$25	4.59	11.25	8.38	13.34	8.54	9.18	14.04
$50	4.30	10.54	7.85	12.50	8.00	8.60	13.15
$100	3.95	9.68	7.21	11.48	7.35	7.90	12.08
$500	1.87	4.58	3.41	5.44	3.48	3.74	5.72
Coinsurance							
80%	3.89	9.53	7.10	11.31	7.24	7.78	11.90
75%	3.64	8.92	6.65	10.58	6.77	7.28	11.13
70%	3.39	8.31	6.19	9.85	6.31	6.78	10.37
Deductible			**Orthotics Riders**				
$0	0.81	1.98	1.48	2.35	1.51	1.62	2.48
$25	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$50	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$100	0.66	1.62	1.21	1.92	1.23	1.32	2.02
$500	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Coinsurance							
80%	0.66	1.62	1.21	1.92	1.23	1.32	2.02
75%	0.62	1.52	1.13	1.80	1.15	1.24	1.90
70%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.57	1.40	1.04	1.66	1.06	1.14	1.74
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren**	**Employee & Spouse**	**Family**
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	10.23	25.06	18.68	29.74	19.03	20.46	31.29
3 IVF	12.39	30.36	22.62	36.02	23.05	24.78	37.90
			Nurse Advice Line Rider				
	0.33	0.81	0.60	0.96	0.61	0.66	1.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess ll POS LARGE GROUP CONTRACT - BASE BENEFITS *
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
984.00	2,410.80	1,796.78	2,860.49	1,830.24	1,968.00	3,010.06
75% Coinsurance						
935.91	2,292.98	1,708.97	2,720.69	1,740.79	1,871.82	2,862.95
70% Coinsurance						
889.00	2,178.05	1,623.31	2,584.32	1,653.54	1,778.00	2,719.45
50% Coinsurance						
840.92	2,060.25	1,535.52	2,444.55	1,564.11	1,681.84	2,572.37

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max

** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			LARGE GROUP				
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(60.26)	(147.64)	(110.03)	(175.18)	(112.08)	(120.52)	(184.34)
$250	(71.91)	(176.18)	(131.31)	(209.04)	(133.75)	(143.82)	(219.97)
$300	(83.57)	(204.75)	(152.60)	(242.94)	(155.44)	(167.14)	(255.64)
$350	(95.23)	(233.31)	(173.89)	(276.83)	(177.13)	(190.46)	(291.31)
$400	(104.38)	(255.73)	(190.60)	(303.43)	(194.15)	(208.76)	(319.30)
$500	(122.70)	(300.62)	(224.05)	(356.69)	(228.22)	(245.40)	(375.34)
$750	(159.34)	(390.38)	(290.95)	(463.20)	(296.37)	(318.68)	(487.42)
$1,000	(187.57)	(459.55)	(342.50)	(545.27)	(348.88)	(375.14)	(573.78)
$1,500	(230.71)	(565.24)	(421.28)	(670.67)	(429.12)	(461.42)	(705.74)
$2,000	(248.36)	(608.48)	(453.51)	(721.98)	(461.95)	(496.72)	(759.73)
$2,500	(266.08)	(651.90)	(485.86)	(773.49)	(494.91)	(532.16)	(813.94)
$5,000	(312.80)	(766.36)	(571.17)	(909.31)	(581.81)	(625.60)	(956.86)
$10,000	(351.38)	(860.88)	(641.62)	(1,021.46)	(653.57)	(702.76)	(1,074.87)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(49.39)	(121.01)	(90.19)	(143.58)	(91.87)	(98.78)	(151.08)
$250	(58.93)	(144.38)	(107.61)	(171.31)	(109.61)	(117.86)	(180.27)
$300	(68.48)	(167.78)	(125.04)	(199.07)	(127.37)	(136.96)	(209.48)
$350	(77.99)	(191.08)	(142.41)	(226.72)	(145.06)	(155.98)	(238.57)
$400	(85.67)	(209.89)	(156.43)	(249.04)	(159.35)	(171.34)	(262.06)
$500	(101.03)	(247.52)	(184.48)	(293.69)	(187.92)	(202.06)	(309.05)
$750	(131.42)	(321.98)	(239.97)	(382.04)	(244.44)	(262.84)	(402.01)
$1,000	(155.07)	(379.92)	(283.16)	(450.79)	(288.43)	(310.14)	(474.36)
$1,500	(190.92)	(467.75)	(348.62)	(555.00)	(355.11)	(381.84)	(584.02)
$2,000	(207.18)	(507.59)	(378.31)	(602.27)	(385.35)	(414.36)	(633.76)
$2,500	(223.43)	(547.40)	(407.98)	(649.51)	(415.58)	(446.86)	(683.47)
$5,000	(269.95)	(661.38)	(492.93)	(784.74)	(502.11)	(539.90)	(825.78)
$10,000	(308.33)	(755.41)	(563.01)	(896.32)	(573.49)	(616.66)	(943.18)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(38.50)	(94.33)	(70.30)	(111.92)	(71.61)	(77.00)	(117.77)
$250	(45.93)	(112.53)	(83.87)	(133.52)	(85.43)	(91.86)	(140.50)
$300	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$350	(60.78)	(148.91)	(110.98)	(176.69)	(113.05)	(121.56)	(185.93)
$400	(67.01)	(164.17)	(122.36)	(194.80)	(124.64)	(134.02)	(204.98)
$500	(79.31)	(194.31)	(144.82)	(230.55)	(147.52)	(158.62)	(242.61)
$750	(103.48)	(253.53)	(188.95)	(300.82)	(192.47)	(206.96)	(316.55)
$1,000	(122.52)	(300.17)	(223.72)	(356.17)	(227.89)	(245.04)	(374.79)
$1,500	(151.16)	(370.34)	(276.02)	(439.42)	(281.16)	(302.32)	(462.40)
$2,000	(166.01)	(406.72)	(303.13)	(482.59)	(308.78)	(332.02)	(507.82)
$2,500	(180.85)	(443.08)	(330.23)	(525.73)	(336.38)	(361.70)	(553.22)
$5,000	(227.11)	(556.42)	(414.70)	(660.21)	(422.42)	(454.22)	(694.73)
$10,000	(265.32)	(650.03)	(484.47)	(771.29)	(493.50)	(530.64)	(811.61)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(26.47)	(64.85)	(48.33)	(76.95)	(49.23)	(52.94)	(80.97)
$250	(31.71)	(77.69)	(57.90)	(92.18)	(58.98)	(63.42)	(97.00)
$300	(36.99)	(90.63)	(67.54)	(107.53)	(68.80)	(73.98)	(113.15)
$350	(42.24)	(103.49)	(77.13)	(122.79)	(78.57)	(84.48)	(129.21)
$400	(46.81)	(114.68)	(85.48)	(136.08)	(87.07)	(93.62)	(143.19)
$500	(55.91)	(136.98)	(102.09)	(162.53)	(103.99)	(111.82)	(171.03)
$750	(73.37)	(179.76)	(133.97)	(213.29)	(136.47)	(146.74)	(224.44)
$1,000	(87.54)	(214.47)	(159.85)	(254.48)	(162.82)	(175.08)	(267.78)
$1,500	(109.41)	(268.05)	(199.78)	(318.05)	(203.50)	(218.82)	(334.69)
$2,000	(121.06)	(296.60)	(221.06)	(351.92)	(225.17)	(242.12)	(370.32)
$2,500	(132.72)	(325.16)	(242.35)	(385.82)	(246.86)	(265.44)	(405.99)
$5,000	(178.35)	(436.96)	(325.67)	(518.46)	(331.73)	(356.70)	(545.57)
$10,000	(216.01)	(529.22)	(394.43)	(627.94)	(401.78)	(432.02)	(660.77)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(55.79)	(136.69)	(101.87)	(162.18)	(103.77)	(111.58)	(170.66)
$1,500	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$2,000	(63.48)	(155.53)	(115.91)	(184.54)	(118.07)	(126.96)	(194.19)
$3,000	(65.91)	(161.48)	(120.35)	(191.60)	(122.59)	(131.82)	(201.62)
$4,000	(66.91)	(163.93)	(122.18)	(194.51)	(124.45)	(133.82)	(204.68)
$5,000	(67.44)	(165.23)	(123.15)	(196.05)	(125.44)	(134.88)	(206.30)
$7,000	(68.11)	(166.87)	(124.37)	(198.00)	(126.68)	(136.22)	(208.35)
$7,500	(68.66)	(168.22)	(125.37)	(199.59)	(127.71)	(137.32)	(210.03)
$10,000	(70.67)	(173.14)	(129.04)	(205.44)	(131.45)	(141.34)	(216.18)
$20,000	(73.54)	(180.17)	(134.28)	(213.78)	(136.78)	(147.08)	(224.96)
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(53.94)	(132.15)	(98.49)	(156.80)	(100.33)	(107.88)	(165.00)
$1,500	(59.95)	(146.88)	(109.47)	(174.27)	(111.51)	(119.90)	(183.39)
$2,000	(63.27)	(155.01)	(115.53)	(183.93)	(117.68)	(126.54)	(193.54)
$3,000	(66.56)	(163.07)	(121.54)	(193.49)	(123.80)	(133.12)	(203.61)
$4,000	(68.03)	(166.67)	(124.22)	(197.76)	(126.54)	(136.06)	(208.10)
$5,000	(68.86)	(168.71)	(125.74)	(200.18)	(128.08)	(137.72)	(210.64)
$7,000	(69.66)	(170.67)	(127.20)	(202.50)	(129.57)	(139.32)	(213.09)
$7,500	(70.26)	(172.14)	(128.29)	(204.25)	(130.68)	(140.52)	(214.93)
$10,000	(72.74)	(178.21)	(132.82)	(211.46)	(135.30)	(145.48)	(222.51)
$20,000	(76.53)	(187.50)	(139.74)	(222.47)	(142.35)	(153.06)	(234.11)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(52.06)	(127.55)	(95.06)	(151.34)	(96.83)	(104.12)	(159.25)
$1,500	(59.03)	(144.62)	(107.79)	(171.60)	(109.80)	(118.06)	(180.57)
$2,000	(63.06)	(154.50)	(115.15)	(183.32)	(117.29)	(126.12)	(192.90)
$3,000	(67.23)	(164.71)	(122.76)	(195.44)	(125.05)	(134.46)	(205.66)
$4,000	(69.12)	(169.34)	(126.21)	(200.93)	(128.56)	(138.24)	(211.44)
$5,000	(70.24)	(172.09)	(128.26)	(204.19)	(130.65)	(140.48)	(214.86)
$7,000	(71.23)	(174.51)	(130.07)	(207.07)	(132.49)	(142.46)	(217.89)
$7,500	(71.86)	(176.06)	(131.22)	(208.90)	(133.66)	(143.72)	(219.82)
$10,000	(74.57)	(182.70)	(136.16)	(216.77)	(138.70)	(149.14)	(228.11)
$20,000	(79.42)	(194.58)	(145.02)	(230.87)	(147.72)	(158.84)	(242.95)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(58.93)	(144.38)	(107.61)	(171.31)	(109.61)	(117.86)	(180.27)
$1,500	(70.19)	(171.97)	(128.17)	(204.04)	(130.55)	(140.38)	(214.71)
$2,000	(77.48)	(189.83)	(141.48)	(225.23)	(144.11)	(154.96)	(237.01)
$3,000	(86.29)	(211.41)	(157.57)	(250.85)	(160.50)	(172.58)	(263.96)
$4,000	(91.15)	(223.32)	(166.44)	(264.97)	(169.54)	(182.30)	(278.83)
$5,000	(94.11)	(230.57)	(171.84)	(273.58)	(175.04)	(188.22)	(287.88)
$7,000	(97.19)	(238.12)	(177.47)	(282.53)	(180.77)	(194.38)	(297.30)
$7,500	(98.32)	(240.88)	(179.53)	(285.82)	(182.88)	(196.64)	(300.76)
$10,000	(102.89)	(252.08)	(187.88)	(299.10)	(191.38)	(205.78)	(314.74)
$20,000	(112.52)	(275.67)	(205.46)	(327.10)	(209.29)	(225.04)	(344.20)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.45	1.10	0.82	1.31	0.84	0.90	1.38
$1,000,000	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$50,000	(5.78)	(14.16)	(10.55)	(16.80)	(10.75)	(11.56)	(17.68)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
75%	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
70%	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)

Family Deductible Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]

Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement [std: 80th percentile of HIAA]

Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$10	(5.10)	(12.50)	(9.31)	(14.83)	(9.49)	(10.20)	(15.60)
$15	(8.48)	(20.78)	(15.48)	(24.65)	(15.77)	(16.96)	(25.94)
$20	(13.09)	(32.07)	(23.90)	(38.05)	(24.35)	(26.18)	(40.04)
$25	(17.23)	(42.21)	(31.46)	(50.09)	(32.05)	(34.46)	(52.71)
$30	(21.79)	(53.39)	(39.79)	(63.34)	(40.53)	(43.58)	(66.66)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$10	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$15	(4.86)	(11.91)	(8.87)	(14.13)	(9.04)	(9.72)	(14.87)
$20	(7.49)	(18.35)	(13.68)	(21.77)	(13.93)	(14.98)	(22.91)
$25	(9.87)	(24.18)	(18.02)	(28.69)	(18.36)	(19.74)	(30.19)
$30	(12.47)	(30.55)	(22.77)	(36.25)	(23.19)	(24.94)	(38.15)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.76)	(4.31)	(3.21)	(5.12)	(3.27)	(3.52)	(5.38)
$10	(3.66)	(8.97)	(6.68)	(10.64)	(6.81)	(7.32)	(11.20)
$15	(5.75)	(14.09)	(10.50)	(16.72)	(10.70)	(11.50)	(17.59)
$20	(8.09)	(19.82)	(14.77)	(23.52)	(15.05)	(16.18)	(24.75)
$25	(10.69)	(26.19)	(19.52)	(31.08)	(19.88)	(21.38)	(32.70)
$30	(13.61)	(33.34)	(24.85)	(39.56)	(25.31)	(27.22)	(41.63)
$35	(16.35)	(40.06)	(29.86)	(47.53)	(30.41)	(32.70)	(50.01)
$40	(19.20)	(47.04)	(35.06)	(55.81)	(35.71)	(38.40)	(58.73)
$45	(22.21)	(54.41)	(40.56)	(64.56)	(41.31)	(44.42)	(67.94)
$50	(25.34)	(62.08)	(46.27)	(73.66)	(47.13)	(50.68)	(77.52)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$10	(3.10)	(7.60)	(5.66)	(9.01)	(5.77)	(6.20)	(9.48)
$15	(4.86)	(11.91)	(8.87)	(14.13)	(9.04)	(9.72)	(14.87)
$20	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$25	(9.04)	(22.15)	(16.51)	(26.28)	(16.81)	(18.08)	(27.65)
$30	(11.51)	(28.20)	(21.02)	(33.46)	(21.41)	(23.02)	(35.21)
$35	(13.85)	(33.93)	(25.29)	(40.26)	(25.76)	(27.70)	(42.37)
$40	(16.24)	(39.79)	(29.65)	(47.21)	(30.21)	(32.48)	(49.68)
$45	(18.77)	(45.99)	(34.27)	(54.56)	(34.91)	(37.54)	(57.42)
$50	(21.43)	(52.50)	(39.13)	(62.30)	(39.86)	(42.86)	(65.55)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$150	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$200	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$250	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
$500	(7.14)	(17.49)	(13.04)	(20.76)	(13.28)	(14.28)	(21.84)
$750	(12.26)	(30.04)	(22.39)	(35.64)	(22.80)	(24.52)	(37.50)
$1,000	(18.46)	(45.23)	(33.71)	(53.66)	(34.34)	(36.92)	(56.47)
Copay/Day							
$50 w/3 Day Max	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$50 w/5 Day Max	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
$100 w/3 Day Max	(2.70)	(6.62)	(4.93)	(7.85)	(5.02)	(5.40)	(8.26)
$100 w/5 Day Max	(3.88)	(9.51)	(7.08)	(11.28)	(7.22)	(7.76)	(11.87)
$250 w/3 Day Max	(8.89)	(21.78)	(16.23)	(25.84)	(16.54)	(17.78)	(27.19)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$75	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$100	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$125	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$150	(1.75)	(4.29)	(3.20)	(5.09)	(3.26)	(3.50)	(5.35)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$35	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$50	(1.03)	(2.52)	(1.88)	(2.99)	(1.92)	(2.06)	(3.15)
$60	(1.27)	(3.11)	(2.32)	(3.69)	(2.36)	(2.54)	(3.88)
$75	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$100	(2.42)	(5.93)	(4.42)	(7.03)	(4.50)	(4.84)	(7.40)
$125	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
$150	(3.55)	(8.70)	(6.48)	(10.32)	(6.60)	(7.10)	(10.86)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.49	1.20	0.89	1.42	0.91	0.98	1.50
60	0.95	2.33	1.73	2.76	1.77	1.90	2.91
90	1.38	3.38	2.52	4.01	2.57	2.76	4.22
120	1.63	3.99	2.98	4.74	3.03	3.26	4.99
Unlimited	2.11	5.17	3.85	6.13	3.92	4.22	6.45
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
40/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$25 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.54	1.32	0.99	1.57	1.00	1.08	1.65
200	1.44	3.53	2.63	4.19	2.68	2.88	4.40
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.64	1.57	1.17	1.86	1.19	1.28	1.96
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Outpatient Therapies Limit [std: 30 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.56	1.37	1.02	1.63	1.04	1.12	1.71
90	1.05	2.57	1.92	3.05	1.95	2.10	3.21
120	1.69	4.14	3.09	4.91	3.14	3.38	5.17
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.40	0.98	0.73	1.16	0.74	0.80	1.22
Unlimited	0.56	1.37	1.02	1.63	1.04	1.12	1.71
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.50	6.13	4.57	7.27	4.65	5.00	7.65
60	2.93	7.18	5.35	8.52	5.45	5.86	8.96
90	3.50	8.58	6.39	10.17	6.51	7.00	10.71
Unlimited	3.55	8.70	6.48	10.32	6.60	7.10	10.86
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
60/$20 copay	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
60/$25 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
120/$0 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.56
120/$5 copay	0.40	0.98	0.73	1.16	0.74	0.80	1.22
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited/$0 copay	0.58	1.42	1.06	1.69	1.08	1.16	1.77
Unlimited/$5 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$25	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$30	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$35	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$40	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$45	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
$50	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$20	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$25	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$100	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.25)	(5.51)	(4.11)	(6.54)	(4.19)	(4.50)	(6.88)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.50)	(8.58)	(6.39)	(10.17)	(6.51)	(7.00)	(10.71)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess ll POS LARGE GROUP CONTRACT
MENTAL HEALTH
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Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]						
LARGE GROUP							
# Days							
30	9.14	22.39	16.69	26.57	17.00	18.28	27.96
60	9.64	23.62	17.60	28.02	17.93	19.28	29.49
90	9.99	24.48	18.24	29.04	18.58	19.98	30.56
Unlimited	10.10	24.75	18.44	29.36	18.79	20.20	30.90
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]						
# Visits							
LARGE GROUP				**$0 Copay**			
20	10.21	25.01	18.64	29.68	18.99	20.42	31.23
30	11.25	27.56	20.54	32.70	20.93	22.50	34.41
40	11.87	29.08	21.67	34.51	22.08	23.74	36.31
60	12.50	30.63	22.83	36.34	23.25	25.00	38.24
Unlimited	12.62	30.92	23.04	36.69	23.47	25.24	38.60
LARGE GROUP				**$5 Copay**			
20	9.61	23.54	17.55	27.94	17.87	19.22	29.40
30	10.57	25.90	19.30	30.73	19.66	21.14	32.33
40	11.24	27.54	20.52	32.67	20.91	22.48	34.38
60	11.76	28.81	21.47	34.19	21.87	23.52	35.97
Unlimited	11.86	29.06	21.66	34.48	22.06	23.72	36.28
LARGE GROUP				**$10 Copay**			
20	9.00	22.05	16.43	26.16	16.74	18.00	27.53
30	9.90	24.26	18.08	28.78	18.41	19.80	30.28
40	10.47	25.65	19.12	30.44	19.47	20.94	32.03
60	11.04	27.05	20.16	32.09	20.53	22.08	33.77
Unlimited	11.12	27.24	20.31	32.33	20.68	22.24	34.02
LARGE GROUP				**$15 Copay**			
20	8.44	20.68	15.41	24.54	15.70	16.88	25.82
30	9.30	22.79	16.98	27.04	17.30	18.60	28.45
40	9.85	24.13	17.99	28.63	18.32	19.70	30.13
60	10.42	25.53	19.03	30.29	19.38	20.84	31.87
Unlimited	10.51	25.75	19.19	30.55	19.55	21.02	32.15

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP				**$20 Copay**			
20	7.95	19.48	14.52	23.11	14.79	15.90	24.32
30	8.71	21.34	15.90	25.32	16.20	17.42	26.64
40	9.18	22.49	16.76	26.69	17.07	18.36	28.08
60	9.77	23.94	17.84	28.40	18.17	19.54	29.89
Unlimited	9.84	24.11	17.97	28.60	18.30	19.68	30.10
LARGE GROUP				**$25 Copay**			
20	7.39	18.11	13.49	21.48	13.75	14.78	22.61
30	8.12	19.89	14.83	23.60	15.10	16.24	24.84
40	8.65	21.19	15.79	25.15	16.09	17.30	26.46
60	9.10	22.30	16.62	26.45	16.93	18.20	27.84
Unlimited	9.17	22.47	16.74	26.66	17.06	18.34	28.05
LARGE GROUP				**$30 Copay**			
20	7.04	17.25	12.86	20.47	13.09	14.08	21.54
30	7.63	18.69	13.93	22.18	14.19	15.26	23.34
40	8.14	19.94	14.86	23.66	15.14	16.28	24.90
60	8.54	20.92	15.59	24.83	15.88	17.08	26.12
Unlimited	8.58	21.02	15.67	24.94	15.96	17.16	26.25
LARGE GROUP				**$35 Copay**			
20	6.69	16.39	12.22	19.45	12.44	13.38	20.46
30	7.14	17.49	13.04	20.76	13.28	14.28	21.84
40	7.61	18.64	13.90	22.12	14.15	15.22	23.28
60	7.99	19.58	14.59	23.23	14.86	15.98	24.44
Unlimited	8.04	19.70	14.68	23.37	14.95	16.08	24.59

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP				**$40 Copay**			
20	6.51	15.95	11.89	18.92	12.11	13.02	19.91
30	6.94	17.00	12.67	20.17	12.91	13.88	21.23
40	7.41	18.15	13.53	21.54	13.78	14.82	22.67
60	7.81	19.13	14.26	22.70	14.53	15.62	23.89
Unlimited	7.87	19.28	14.37	22.88	14.64	15.74	24.07
LARGE GROUP				**$45 Copay**			
20	6.33	15.51	11.56	18.40	11.77	12.66	19.36
30	6.76	16.56	12.34	19.65	12.57	13.52	20.68
40	7.22	17.69	13.18	20.99	13.43	14.44	22.09
60	7.62	18.67	13.91	22.15	14.17	15.24	23.31
Unlimited	7.65	18.74	13.97	22.24	14.23	15.30	23.40
LARGE GROUP				**$50 Copay**			
20	6.15	15.07	11.23	17.88	11.44	12.30	18.81
30	6.58	16.12	12.02	19.13	12.24	13.16	20.13
40	7.04	17.25	12.86	20.47	13.09	14.08	21.54
60	7.43	18.20	13.57	21.60	13.82	14.86	22.73
Unlimited	7.48	18.33	13.66	21.74	13.91	14.96	22.88

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed
Minimum Mandatory Coverage = Dependent Children to Age 26 EOM

Dependent Children [std: covered to 19 end of month]

Age				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Deductible			**Durable Medical Equipment Riders**				
$0	7.25	17.76	13.24	21.08	13.49	14.50	22.18
$25	6.80	16.66	12.42	19.77	12.65	13.60	20.80
$50	6.40	15.68	11.69	18.60	11.90	12.80	19.58
$100	5.75	14.09	10.50	16.72	10.70	11.50	17.59
$500	2.82	6.91	5.15	8.20	5.25	5.64	8.63
Coinsurance							
80%	5.76	14.11	10.52	16.74	10.71	11.52	17.62
75%	5.42	13.28	9.90	15.76	10.08	10.84	16.58
70%	5.05	12.37	9.22	14.68	9.39	10.10	15.45
Deductible			**Orthotics Riders**				
$0	1.22	2.99	2.23	3.55	2.27	2.44	3.73
$25	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$50	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$100	1.03	2.52	1.88	2.99	1.92	2.06	3.15
$500	0.50	1.23	0.91	1.45	0.93	1.00	1.53
Coinsurance							
80%	1.03	2.52	1.88	2.99	1.92	2.06	3.15
75%	0.96	2.35	1.75	2.79	1.79	1.92	2.94
70%	0.91	2.23	1.66	2.65	1.69	1.82	2.78
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.85	2.08	1.55	2.47	1.58	1.70	2.60
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	15.84	38.81	28.92	46.05	29.46	31.68	48.45
3 IVF	19.00	46.55	34.69	55.23	35.34	38.00	58.12
			Nurse Advice Line Rider				
	0.33	0.81	0.60	0.96	0.61	0.66	1.01

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4th QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	593.76	1,545.11
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.23	5.47
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.39	3.39
Outpatient Mental Health: 20 Visits	6.16	15.13
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.13	2.76
Other Riders		
Durable Medical Equipment	1.64	3.87
Chiropractic: $5 Copay	4.36	11.45
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	145.44	378.16
Infertility Drug Coverage: $7 Brand Copay	3.39	8.89
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	22.73
Inpatient Substance Abuse Rehab: Unlimited days	4.68	11.46
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.65	1.61
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.51	1.23

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
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NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

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Table 1: Drug Rider Base Values pmpm			
Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm				
Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm				
Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

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Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjusti Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	2.5%
3Q2011	1.9%
4Q2011	1.9%
1Q2012-4Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - BASE BENEFITS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	451.34	1,105.79	825.96	1,313.40	839.50	902.69	1,381.11

**** Base rates exclude premium component for mandatory mental health coverage***

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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	490.00	1,200.50	894.74	1,424.43	911.40	980.00	1,498.91

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	38.66	94.71	68.78	111.03	71.90	77.31	117.80

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.02)	(7.40)	(5.53)	(8.78)	(5.62)	(6.04)	(9.24)
$10	(6.34)	(15.54)	(11.61)	(18.46)	(11.80)	(12.69)	(19.41)
$15	(10.56)	(25.87)	(19.32)	(30.72)	(19.64)	(21.11)	(32.30)
$20	(16.29)	(39.91)	(29.81)	(47.40)	(30.29)	(32.58)	(49.85)
$25	(21.46)	(52.58)	(39.27)	(62.45)	(39.91)	(42.92)	(65.67)
$30	(27.14)	(66.49)	(49.67)	(78.99)	(50.48)	(54.28)	(83.06)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.73)	(4.25)	(3.17)	(5.05)	(3.22)	(3.47)	(5.30)
$10	(3.64)	(8.93)	(6.66)	(10.60)	(6.77)	(7.28)	(11.14)
$15	(6.05)	(14.82)	(11.07)	(17.61)	(11.25)	(12.10)	(18.51)
$20	(9.33)	(22.87)	(17.07)	(27.16)	(17.36)	(18.67)	(28.56)
$25	(12.29)	(30.11)	(22.49)	(35.77)	(22.86)	(24.58)	(37.61)
$30	(15.56)	(38.11)	(28.47)	(45.27)	(28.94)	(31.11)	(47.60)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.40)	(4.03)	(6.42)	(4.10)	(4.41)	(6.74)
$10	(4.56)	(11.17)	(8.34)	(13.27)	(8.48)	(9.12)	(13.95)
$15	(7.16)	(17.54)	(13.11)	(20.84)	(13.32)	(14.32)	(21.91)
$20	(10.09)	(24.71)	(18.46)	(29.36)	(18.77)	(20.18)	(30.87)
$25	(13.31)	(32.61)	(24.36)	(38.74)	(24.76)	(26.62)	(40.73)
$30	(16.96)	(41.55)	(31.04)	(49.36)	(31.55)	(33.93)	(51.91)
$35	(20.38)	(49.93)	(37.29)	(59.30)	(37.90)	(40.76)	(62.36)
$40	(23.93)	(58.63)	(43.79)	(69.64)	(44.51)	(47.86)	(73.23)
$45	(27.66)	(67.77)	(50.62)	(80.50)	(51.45)	(55.32)	(84.65)
$50	(31.58)	(77.37)	(57.79)	(91.89)	(58.74)	(63.16)	(96.63)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.87)	(4.57)	(3.42)	(5.44)	(3.47)	(3.73)	(5.71)
$10	(3.86)	(9.45)	(7.06)	(11.22)	(7.17)	(7.71)	(11.80)
$15	(6.05)	(14.82)	(11.07)	(17.61)	(11.25)	(12.10)	(18.51)
$20	(8.54)	(20.92)	(15.63)	(24.85)	(15.88)	(17.07)	(26.12)
$25	(11.25)	(27.56)	(20.58)	(32.74)	(20.93)	(22.50)	(34.43)
$30	(14.34)	(35.14)	(26.24)	(41.73)	(26.67)	(28.68)	(43.88)
$35	(17.25)	(42.26)	(31.57)	(50.19)	(32.08)	(34.50)	(52.77)
$40	(20.24)	(49.58)	(37.04)	(58.88)	(37.64)	(40.47)	(61.92)
$45	(23.39)	(57.30)	(42.80)	(68.06)	(43.50)	(46.78)	(71.57)
$50	(26.70)	(65.42)	(48.87)	(77.70)	(49.66)	(53.41)	(81.71)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.10)	(2.70)	(2.02)	(3.20)	(2.05)	(2.20)	(3.37)
$150	(1.82)	(4.45)	(3.33)	(5.28)	(3.38)	(3.63)	(5.56)
$200	(2.59)	(6.34)	(4.74)	(7.54)	(4.81)	(5.18)	(7.93)
$250	(3.71)	(9.10)	(6.79)	(10.80)	(6.91)	(7.43)	(11.36)
$500	(8.90)	(21.82)	(16.30)	(25.91)	(16.56)	(17.81)	(27.24)
$750	(15.29)	(37.46)	(27.98)	(44.49)	(28.44)	(30.58)	(46.79)
$1,000	(23.00)	(56.36)	(42.10)	(66.93)	(42.78)	(46.00)	(70.38)
Copay/Day							
$50 w/3 Day Max	(1.34)	(3.27)	(2.45)	(3.89)	(2.49)	(2.67)	(4.09)
$50 w/5 Day Max	(1.84)	(4.50)	(3.36)	(5.34)	(3.42)	(3.67)	(5.62)
$100 w/3 Day Max	(3.35)	(8.20)	(6.12)	(9.73)	(6.22)	(6.69)	(10.24)
$100 w/5 Day Max	(4.82)	(11.82)	(8.83)	(14.04)	(8.98)	(9.65)	(14.76)
$250 w/3 Day Max	(11.08)	(27.14)	(20.27)	(32.23)	(20.60)	(22.15)	(33.89)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.58)	(1.43)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$75	(0.94)	(2.30)	(1.71)	(2.73)	(1.74)	(1.88)	(2.88)
$100	(1.34)	(3.27)	(2.45)	(3.89)	(2.49)	(2.67)	(4.09)
$125	(1.75)	(4.29)	(3.21)	(5.11)	(3.26)	(3.51)	(5.37)
$150	(2.19)	(5.38)	(4.01)	(6.39)	(4.08)	(4.39)	(6.71)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.26)	(0.62)	(0.47)	(0.74)	(0.48)	(0.51)	(0.79)
$25	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
$35	(0.74)	(1.83)	(1.37)	(2.16)	(1.39)	(1.49)	(2.27)
$50	(1.26)	(3.10)	(2.32)	(3.68)	(2.36)	(2.53)	(3.87)
$60	(1.61)	(3.95)	(2.95)	(4.69)	(3.00)	(3.22)	(4.93)
$75	(2.12)	(5.20)	(3.89)	(6.17)	(3.95)	(4.24)	(6.49)
$100	(3.01)	(7.37)	(5.51)	(8.75)	(5.60)	(6.02)	(9.21)
$125	(3.71)	(9.10)	(6.79)	(10.80)	(6.91)	(7.43)	(11.36)
$150	(4.43)	(10.84)	(8.10)	(12.88)	(8.23)	(8.85)	(13.55)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.52	1.28	0.95	1.51	0.97	1.04	1.59
60	1.01	2.48	1.85	2.94	1.88	2.02	3.09

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.28)	(8.04)	(5.99)	(9.53)	(6.10)	(6.56)	(10.03)
$10	(6.89)	(16.88)	(12.58)	(20.03)	(12.82)	(13.78)	(21.08)
$15	(11.46)	(28.08)	(20.93)	(33.31)	(21.32)	(22.92)	(35.06)
$20	(17.69)	(43.34)	(32.30)	(51.42)	(32.90)	(35.38)	(54.11)
$25	(23.29)	(57.06)	(42.53)	(67.70)	(43.32)	(46.58)	(71.24)
$30	(29.46)	(72.18)	(53.79)	(85.64)	(54.80)	(58.92)	(90.12)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.87)	(4.58)	(3.41)	(5.44)	(3.48)	(3.74)	(5.72)
$10	(3.95)	(9.68)	(7.21)	(11.48)	(7.35)	(7.90)	(12.08)
$15	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$20	(10.13)	(24.82)	(18.50)	(29.45)	(18.84)	(20.26)	(30.99)
$25	(13.35)	(32.71)	(24.38)	(38.81)	(24.83)	(26.70)	(40.84)
$30	(16.90)	(41.41)	(30.86)	(49.13)	(31.43)	(33.80)	(51.70)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$10	(4.95)	(12.13)	(9.04)	(14.39)	(9.21)	(9.90)	(15.14)
$15	(7.76)	(19.01)	(14.17)	(22.56)	(14.43)	(15.52)	(23.74)
$20	(10.95)	(26.83)	(19.99)	(31.83)	(20.37)	(21.90)	(33.50)
$25	(14.45)	(35.40)	(26.39)	(42.01)	(26.88)	(28.90)	(44.20)
$30	(18.41)	(45.10)	(33.62)	(53.52)	(34.24)	(36.82)	(56.32)
$35	(22.12)	(54.19)	(40.39)	(64.30)	(41.14)	(44.24)	(67.67)
$40	(25.98)	(63.65)	(47.44)	(75.52)	(48.32)	(51.96)	(79.47)
$45	(30.02)	(73.55)	(54.82)	(87.27)	(55.84)	(60.04)	(91.83)
$50	(34.28)	(83.99)	(62.60)	(99.65)	(63.76)	(68.56)	(104.86)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$10	(4.20)	(10.29)	(7.67)	(12.21)	(7.81)	(8.40)	(12.85)
$15	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$20	(9.27)	(22.71)	(16.93)	(26.95)	(17.24)	(18.54)	(28.36)
$25	(12.22)	(29.94)	(22.31)	(35.52)	(22.73)	(24.44)	(37.38)
$30	(15.57)	(38.15)	(28.43)	(45.26)	(28.96)	(31.14)	(47.63)
$35	(18.73)	(45.89)	(34.20)	(54.45)	(34.84)	(37.46)	(57.30)
$40	(21.97)	(53.83)	(40.12)	(63.87)	(40.86)	(43.94)	(67.21)
$45	(25.39)	(62.21)	(46.36)	(73.81)	(47.23)	(50.78)	(77.67)
$50	(28.98)	(71.00)	(52.92)	(84.24)	(53.90)	(57.96)	(88.65)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
$150	(1.98)	(4.85)	(3.62)	(5.76)	(3.68)	(3.96)	(6.06)
$200	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$250	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$500	(9.66)	(23.67)	(17.64)	(28.08)	(17.97)	(19.32)	(29.55)
$750	(16.60)	(40.67)	(30.31)	(48.26)	(30.88)	(33.20)	(50.78)
$1,000	(24.97)	(61.18)	(45.60)	(72.59)	(46.44)	(49.94)	(76.38)
Copay/Day							
$50 w/3 Day Max	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$50 w/5 Day Max	(2.00)	(4.90)	(3.65)	(5.81)	(3.72)	(4.00)	(6.12)
$100 w/3 Day Max	(3.64)	(8.92)	(6.65)	(10.58)	(6.77)	(7.28)	(11.13)
$100 w/5 Day Max	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
$250 w/3 Day Max	(12.02)	(29.45)	(21.95)	(34.94)	(22.36)	(24.04)	(36.77)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
$75	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$100	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$125	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$150	(2.37)	(5.81)	(4.33)	(6.89)	(4.41)	(4.74)	(7.25)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$25	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$35	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$50	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$60	(1.74)	(4.26)	(3.18)	(5.06)	(3.24)	(3.48)	(5.32)
$75	(2.30)	(5.64)	(4.20)	(6.69)	(4.28)	(4.60)	(7.04)
$100	(3.27)	(8.01)	(5.97)	(9.51)	(6.08)	(6.54)	(10.00)
$125	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$150	(4.81)	(11.78)	(8.78)	(13.98)	(8.95)	(9.62)	(14.71)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.56	1.37	1.02	1.63	1.04	1.12	1.71
60	1.10	2.70	2.01	3.20	2.05	2.20	3.36

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.64)	(0.46)	(0.75)	(0.48)	(0.52)	(0.79)
$10	(0.55)	(1.34)	(0.97)	(1.57)	(1.02)	(1.09)	(1.67)
$15	(0.90)	(2.21)	(1.61)	(2.59)	(1.68)	(1.81)	(2.76)
$20	(1.40)	(3.43)	(2.49)	(4.02)	(2.61)	(2.80)	(4.26)
$25	(1.83)	(4.48)	(3.26)	(5.25)	(3.41)	(3.66)	(5.57)
$30	(2.32)	(5.69)	(4.12)	(6.65)	(4.32)	(4.64)	(7.06)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.33)	(0.24)	(0.39)	(0.26)	(0.27)	(0.42)
$10	(0.31)	(0.75)	(0.55)	(0.88)	(0.58)	(0.62)	(0.94)
$15	(0.51)	(1.25)	(0.91)	(1.46)	(0.95)	(1.02)	(1.56)
$20	(0.80)	(1.95)	(1.43)	(2.29)	(1.48)	(1.59)	(2.43)
$25	(1.06)	(2.60)	(1.89)	(3.04)	(1.97)	(2.12)	(3.23)
$30	(1.34)	(3.30)	(2.39)	(3.86)	(2.49)	(2.69)	(4.10)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.18)	(0.43)	(0.32)	(0.50)	(0.33)	(0.35)	(0.54)
$10	(0.39)	(0.96)	(0.70)	(1.12)	(0.73)	(0.78)	(1.19)
$15	(0.60)	(1.47)	(1.06)	(1.72)	(1.11)	(1.20)	(1.83)
$20	(0.86)	(2.12)	(1.53)	(2.47)	(1.60)	(1.72)	(2.63)
$25	(1.14)	(2.79)	(2.03)	(3.27)	(2.12)	(2.28)	(3.47)
$30	(1.45)	(3.55)	(2.58)	(4.16)	(2.69)	(2.89)	(4.41)
$35	(1.74)	(4.26)	(3.10)	(5.00)	(3.24)	(3.48)	(5.31)
$40	(2.05)	(5.02)	(3.65)	(5.88)	(3.81)	(4.10)	(6.24)
$45	(2.36)	(5.78)	(4.20)	(6.77)	(4.39)	(4.72)	(7.18)
$50	(2.70)	(6.62)	(4.81)	(7.76)	(5.02)	(5.40)	(8.23)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.40)	(0.29)	(0.46)	(0.31)	(0.33)	(0.50)
$10	(0.34)	(0.84)	(0.61)	(0.99)	(0.64)	(0.69)	(1.05)
$15	(0.51)	(1.25)	(0.91)	(1.46)	(0.95)	(1.02)	(1.56)
$20	(0.73)	(1.79)	(1.30)	(2.10)	(1.36)	(1.47)	(2.24)
$25	(0.97)	(2.38)	(1.73)	(2.78)	(1.80)	(1.94)	(2.95)
$30	(1.23)	(3.01)	(2.19)	(3.53)	(2.29)	(2.46)	(3.75)
$35	(1.48)	(3.63)	(2.63)	(4.26)	(2.76)	(2.96)	(4.53)
$40	(1.73)	(4.25)	(3.08)	(4.99)	(3.22)	(3.47)	(5.29)
$45	(2.00)	(4.91)	(3.56)	(5.75)	(3.73)	(4.00)	(6.10)
$50	(2.28)	(5.58)	(4.05)	(6.54)	(4.24)	(4.55)	(6.94)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.22)	(0.15)	(0.26)	(0.16)	(0.18)	(0.27)
$150	(0.16)	(0.40)	(0.29)	(0.48)	(0.30)	(0.33)	(0.50)
$200	(0.22)	(0.54)	(0.39)	(0.63)	(0.42)	(0.44)	(0.67)
$250	(0.32)	(0.77)	(0.57)	(0.92)	(0.59)	(0.63)	(0.97)
$500	(0.76)	(1.85)	(1.34)	(2.17)	(1.41)	(1.51)	(2.31)
$750	(1.31)	(3.21)	(2.33)	(3.77)	(2.44)	(2.62)	(3.99)
$1,000	(1.97)	(4.82)	(3.50)	(5.66)	(3.66)	(3.94)	(6.00)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.31)	(0.22)	(0.35)	(0.23)	(0.25)	(0.38)
$50 w/5 Day Max	(0.16)	(0.40)	(0.29)	(0.47)	(0.30)	(0.33)	(0.50)
$100 w/3 Day Max	(0.29)	(0.72)	(0.53)	(0.85)	(0.55)	(0.59)	(0.89)
$100 w/5 Day Max	(0.42)	(1.02)	(0.74)	(1.19)	(0.77)	(0.83)	(1.27)
$250 w/3 Day Max	(0.94)	(2.31)	(1.68)	(2.71)	(1.76)	(1.89)	(2.88)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.11)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
$75	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.24)
$100	(0.12)	(0.31)	(0.22)	(0.35)	(0.23)	(0.25)	(0.38)
$125	(0.16)	(0.39)	(0.28)	(0.44)	(0.29)	(0.31)	(0.47)
$150	(0.18)	(0.43)	(0.32)	(0.50)	(0.33)	(0.35)	(0.54)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$25	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.05)	(0.11)	(0.07)	(0.14)	(0.08)	(0.09)	(0.15)
$50	(0.12)	(0.28)	(0.20)	(0.33)	(0.21)	(0.23)	(0.35)
$60	(0.13)	(0.31)	(0.23)	(0.37)	(0.24)	(0.26)	(0.39)
$75	(0.18)	(0.44)	(0.31)	(0.52)	(0.33)	(0.36)	(0.55)
$100	(0.26)	(0.64)	(0.46)	(0.76)	(0.48)	(0.52)	(0.79)
$125	(0.32)	(0.77)	(0.57)	(0.92)	(0.59)	(0.63)	(0.97)
$150	(0.38)	(0.94)	(0.68)	(1.10)	(0.72)	(0.77)	(1.16)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.09	0.07	0.12	0.07	0.08	0.12
60	0.09	0.22	0.16	0.26	0.17	0.18	0.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.6%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
$10	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$15	8.5%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
$20	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$25	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$30	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.1%	7.8%	7.6%	7.7%	8.1%	7.8%	7.9%
$10	8.5%	8.4%	8.3%	8.3%	8.6%	8.5%	8.4%
$15	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
$20	8.6%	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%
$25	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$30	8.6%	8.7%	8.4%	8.5%	8.6%	8.6%	8.6%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	8.0%	7.9%	7.8%	8.0%	7.9%	8.0%
$10	8.6%	8.6%	8.4%	8.4%	8.6%	8.6%	8.5%
$15	8.4%	8.4%	8.1%	8.3%	8.3%	8.4%	8.4%
$20	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$25	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$30	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$35	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$40	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$45	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$50	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.6%	8.8%	8.5%	8.5%	8.9%	8.8%	8.8%
$10	8.8%	8.9%	8.6%	8.8%	8.9%	8.9%	8.9%
$15	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
$20	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$25	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$35	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$40	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$45	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$50	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	8.2%	8.1%	7.4%	8.1%	7.8%	8.2%	8.0%
$150	8.8%	9.0%	8.7%	9.1%	8.9%	9.1%	9.0%
$200	8.5%	8.5%	8.2%	8.4%	8.7%	8.5%	8.4%
$250	8.6%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Copay/Day							
$50 w/3 Day Max	9.0%	9.5%	9.0%	9.0%	9.2%	9.4%	9.3%
$50 w/5 Day Max	8.7%	8.9%	8.6%	8.8%	8.8%	9.0%	8.9%
$100 w/3 Day Max	8.7%	8.8%	8.7%	8.7%	8.8%	8.8%	8.7%
$100 w/5 Day Max	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$250 w/3 Day Max	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
$75	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$100	9.0%	9.5%	9.0%	9.0%	9.2%	9.4%	9.3%
$125	9.1%	9.1%	8.7%	8.6%	8.9%	8.8%	8.8%
$150	8.2%	8.0%	8.0%	7.8%	8.1%	8.0%	8.0%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
$25	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
$35	6.8%	6.0%	5.1%	6.5%	5.8%	6.0%	6.6%
$50	9.5%	9.0%	8.6%	9.0%	8.9%	9.1%	9.0%
$60	8.1%	7.8%	7.8%	7.9%	8.0%	8.1%	7.9%
$75	8.5%	8.5%	8.0%	8.4%	8.4%	8.5%	8.5%
$100	8.6%	8.7%	8.3%	8.7%	8.6%	8.6%	8.6%
$125	8.6%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$150	8.6%	8.7%	8.4%	8.5%	8.7%	8.7%	8.6%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
60	8.9%	8.9%	8.6%	8.8%	9.0%	8.9%	8.7%

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.52	3.72	2.78	4.43	2.83	3.04	4.65
120	1.77	4.35	3.24	5.16	3.30	3.55	5.43
Unlimited	2.28	5.60	4.18	6.65	4.25	4.57	6.99
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.27)	(0.41)
40/$10 copay	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
40/$15 copay	(0.41)	(1.00)	(0.74)	(1.18)	(0.75)	(0.82)	(1.24)
40/$20 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
40/$25 copay	(0.75)	(1.85)	(1.38)	(2.19)	(1.41)	(1.51)	(2.31)
60	0.27	0.65	0.49	0.78	0.49	0.53	0.82
100	0.67	1.65	1.23	1.96	1.25	1.35	2.06
200	1.77	4.35	3.24	5.16	3.30	3.55	5.43
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.06)	(2.60)	(1.94)	(3.09)	(1.97)	(2.12)	(3.24)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.70	1.72	1.29	2.05	1.31	1.41	2.15
90	1.45	3.55	2.65	4.21	2.69	2.90	4.44
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.62	1.52	1.14	1.82	1.15	1.24	1.91
90	1.14	2.79	2.09	3.33	2.12	2.28	3.50
120	1.84	4.50	3.36	5.34	3.42	3.67	5.62
visits for all other	(Verizon Benefit)						
	1.43	3.50	2.61	4.15	2.65	2.86	4.37
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.88)	(2.15)	(1.60)	(2.55)	(1.63)	(1.75)	(2.68)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.26	0.62	0.47	0.74	0.48	0.51	0.79
30	0.42	1.02	0.77	1.21	0.78	0.84	1.28
Unlimited	0.62	1.52	1.14	1.82	1.15	1.24	1.91
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.12	7.65	5.71	9.08	5.80	6.24	9.55
60	3.66	8.98	6.70	10.66	6.81	7.32	11.21
90	4.37	10.70	7.99	12.70	8.12	8.73	13.36
Unlimited	4.43	10.84	8.10	12.88	8.23	8.85	13.55
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.26)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
60/$10 copay	(0.24)	(0.60)	(0.45)	(0.71)	(0.46)	(0.49)	(0.74)
60/$15 copay	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
60/$20 copay	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
60/$25 copay	(0.64)	(1.57)	(1.17)	(1.87)	(1.19)	(1.29)	(1.97)
120/$0 copay	0.55	1.35	1.01	1.60	1.02	1.10	1.68
120/$5 copay	0.42	1.02	0.77	1.21	0.78	0.84	1.28
120/$10 copay	0.24	0.60	0.45	0.71	0.46	0.49	0.74
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
120/$25 copay	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
Unlimited/$0 copay	0.63	1.55	1.15	1.84	1.17	1.26	1.94
Unlimited/$5 copay	0.48	1.17	0.88	1.40	0.89	0.96	1.47
Unlimited/$10 copay	0.31	0.75	0.56	0.89	0.57	0.61	0.94
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
Unlimited/$25 copay	(0.26)	(0.62)	(0.47)	(0.74)	(0.48)	(0.51)	(0.79)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.16	0.40	0.30	0.48	0.31	0.33	0.50
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.26)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
$20	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$25	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.27)	(0.41)
$10	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
$15	(0.42)	(1.02)	(0.77)	(1.21)	(0.78)	(0.84)	(1.28)
$20	(0.60)	(1.48)	(1.10)	(1.75)	(1.12)	(1.20)	(1.85)
$25	(0.78)	(1.90)	(1.42)	(2.25)	(1.44)	(1.55)	(2.38)
$30	(0.94)	(2.30)	(1.71)	(2.73)	(1.74)	(1.88)	(2.88)
$35	(1.11)	(2.72)	(2.03)	(3.23)	(2.07)	(2.22)	(3.41)
$40	(1.29)	(3.15)	(2.36)	(3.74)	(2.39)	(2.57)	(3.94)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.65	4.04	3.01	4.80	3.07	3.30	5.05
120	1.93	4.73	3.52	5.61	3.59	3.86	5.90
Unlimited	2.48	6.08	4.53	7.21	4.61	4.96	7.59
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
40/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$20 copay	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
40/$25 copay	(0.82)	(2.01)	(1.50)	(2.38)	(1.53)	(1.64)	(2.51)
60	0.30	0.74	0.55	0.87	0.56	0.60	0.92
100	0.72	1.76	1.31	2.09	1.34	1.44	2.20
200	1.93	4.73	3.52	5.61	3.59	3.86	5.90
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.75	1.84	1.37	2.18	1.40	1.50	2.29
90	1.58	3.87	2.89	4.59	2.94	3.16	4.83
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.67	1.64	1.22	1.95	1.25	1.34	2.05
90	1.23	3.01	2.25	3.58	2.29	2.46	3.76
120	2.00	4.90	3.65	5.81	3.72	4.00	6.12
visits for all other	(Verizon Benefit)						
	1.55	3.80	2.83	4.51	2.88	3.10	4.74
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.29	0.71	0.53	0.84	0.54	0.58	0.89
30	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Unlimited	0.67	1.64	1.22	1.95	1.25	1.34	2.05
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.38	8.28	6.17	9.83	6.29	6.76	10.34
60	3.97	9.73	7.25	11.54	7.38	7.94	12.14
90	4.75	11.64	8.67	13.81	8.84	9.50	14.53
Unlimited	4.81	11.78	8.78	13.98	8.95	9.62	14.71
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
60/$20 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60/$25 copay	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
120/$0 copay	0.59	1.45	1.08	1.72	1.10	1.18	1.80
120/$5 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Unlimited/$0 copay	0.68	1.67	1.24	1.98	1.26	1.36	2.08
Unlimited/$5 copay	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited/$10 copay	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$15	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$20	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$25	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$30	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$35	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.40)	(3.67)
$40	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	0.13	0.32	0.23	0.37	0.24	0.26	0.40
120	0.16	0.38	0.28	0.45	0.29	0.31	0.47
Unlimited	0.20	0.48	0.35	0.56	0.36	0.39	0.60
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.01)	(0.02)
40/$10 copay	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
40/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
40/$25 copay	(0.07)	(0.16)	(0.12)	(0.19)	(0.12)	(0.13)	(0.20)
60	0.03	0.09	0.06	0.09	0.07	0.07	0.10
100	0.05	0.11	0.08	0.13	0.09	0.09	0.14
200	0.16	0.38	0.28	0.45	0.29	0.31	0.47
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(0.09)	(0.22)	(0.16)	(0.25)	(0.17)	(0.18)	(0.28)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.08	0.13	0.09	0.09	0.14
90	0.13	0.32	0.24	0.38	0.25	0.26	0.39
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.08	0.13	0.10	0.10	0.14
90	0.09	0.22	0.16	0.25	0.17	0.18	0.26
120	0.16	0.40	0.29	0.47	0.30	0.33	0.50
visits for all other	(Verizon Benefit)						
	0.12	0.30	0.22	0.36	0.23	0.24	0.37
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.17)	(0.26)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.09	0.06	0.10	0.06	0.07	0.10
30	0.04	0.11	0.07	0.13	0.08	0.08	0.13
Unlimited	0.05	0.12	0.08	0.13	0.10	0.10	0.14
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.26	0.63	0.46	0.75	0.49	0.52	0.79
60	0.31	0.75	0.55	0.88	0.57	0.62	0.93
90	0.38	0.94	0.68	1.11	0.72	0.77	1.17
Unlimited	0.38	0.94	0.68	1.10	0.72	0.77	1.16
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.01	0.00	0.01	0.00	0.00	0.01
60/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60/$25 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.09)	(0.14)
120/$0 copay	0.04	0.10	0.07	0.12	0.08	0.08	0.12
120/$5 copay	0.04	0.11	0.07	0.13	0.08	0.08	0.13
120/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
120/$25 copay	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
Unlimited/$0 copay	0.05	0.12	0.09	0.14	0.09	0.10	0.14
Unlimited/$5 copay	0.04	0.10	0.07	0.11	0.08	0.08	0.12
Unlimited/$10 copay	0.03	0.08	0.06	0.10	0.06	0.07	0.10
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.01	0.00	0.00	0.01
Unlimited/$25 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.01	0.02	0.01	0.01	0.01	0.01	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.00	0.01
$20	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.01)	(0.02)
$10	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
$15	(0.04)	(0.11)	(0.07)	(0.13)	(0.08)	(0.08)	(0.13)
$20	(0.05)	(0.11)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
$25	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.25)
$30	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.24)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.26)
$40	(0.12)	(0.30)	(0.21)	(0.36)	(0.23)	(0.25)	(0.37)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.6%
120	9.0%	8.7%	8.6%	8.7%	8.8%	8.7%	8.7%
Unlimited	8.8%	8.6%	8.4%	8.4%	8.5%	8.5%	8.6%
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
40/$10 copay	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
40/$15 copay	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
40/$20 copay	8.8%	8.6%	8.7%	8.4%	8.5%	8.8%	9.2%
40/$25 copay	9.3%	8.6%	8.7%	8.7%	8.5%	8.6%	8.7%
60	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
100	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
200	9.0%	8.7%	8.6%	8.7%	8.8%	8.7%	8.7%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	8.5%	8.5%	8.2%	8.1%	8.6%	8.5%	8.6%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.1%	7.0%	6.2%	6.3%	6.9%	6.4%	6.5%
90	9.0%	9.0%	9.1%	9.0%	9.3%	9.0%	8.8%
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.1%	7.9%	7.0%	7.1%	8.7%	8.1%	7.3%
90	7.9%	7.9%	7.7%	7.5%	8.0%	7.9%	7.4%
120	8.7%	8.9%	8.6%	8.8%	8.8%	9.0%	8.9%
visits for all other	(Verizon Benefit)						
	8.4%	8.6%	8.4%	8.7%	8.7%	8.4%	8.5%
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	9.1%	9.3%	9.4%	9.4%	9.8%	9.7%	9.7%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
30	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
Unlimited	8.1%	7.9%	7.0%	7.1%	8.7%	8.1%	7.3%
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.3%	8.2%	8.1%	8.3%	8.4%	8.3%	8.3%
60	8.5%	8.4%	8.2%	8.3%	8.4%	8.5%	8.3%
90	8.7%	8.8%	8.5%	8.7%	8.9%	8.8%	8.8%
Unlimited	8.6%	8.7%	8.4%	8.5%	8.7%	8.7%	8.6%
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	-3.8%	0.0%	-3.3%	0.0%	0.0%	-3.1%
60/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
60/$15 copay	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
60/$20 copay	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
60/$25 copay	7.8%	7.6%	7.7%	7.5%	7.6%	7.0%	7.1%
120/$0 copay	7.3%	7.4%	6.9%	7.5%	7.8%	7.3%	7.1%
120/$5 copay	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
120/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
120/$25 copay	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
Unlimited/$0 copay	7.9%	7.7%	7.8%	7.6%	7.7%	7.9%	7.2%
Unlimited/$5 copay	8.3%	8.5%	8.0%	7.9%	9.0%	8.3%	8.2%
Unlimited/$10 copay	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
Unlimited/$25 copay	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
Copay	Dialysis Treatment Copay [std: $10]						
$0	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	-3.8%	0.0%	-3.3%	0.0%	0.0%	-3.1%
$20	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$25	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
$10	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
$15	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
$20	8.3%	7.4%	8.2%	8.0%	8.0%	8.3%	7.6%
$25	10.3%	11.1%	10.6%	11.1%	11.1%	11.0%	10.5%
$30	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$35	8.1%	8.1%	7.9%	8.0%	7.7%	8.1%	7.6%
$40	9.3%	9.5%	8.9%	9.6%	9.6%	9.7%	9.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.46)	(3.57)	(2.67)	(4.24)	(2.71)	(2.92)	(4.47)
$50	(1.62)	(3.98)	(2.97)	(4.72)	(3.02)	(3.24)	(4.97)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$10	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$15	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
$20	(0.67)	(1.65)	(1.23)	(1.96)	(1.25)	(1.35)	(2.06)
$25	(0.90)	(2.20)	(1.64)	(2.61)	(1.67)	(1.80)	(2.74)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$25	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$35	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$50	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$60	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
$75	(0.50)	(1.22)	(0.92)	(1.46)	(0.93)	(1.00)	(1.53)
$100	(0.67)	(1.65)	(1.23)	(1.96)	(1.25)	(1.35)	(2.06)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
$35	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$50	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$60	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
$75	(0.34)	(0.83)	(0.61)	(0.98)	(0.62)	(0.67)	(1.03)
$100	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.81)	(6.87)	(5.13)	(8.16)	(5.22)	(5.61)	(8.59)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.36)	(10.67)	(7.97)	(12.68)	(8.10)	(8.71)	(13.33)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.37)	(0.90)	(0.67)	(1.07)	(0.68)	(0.73)	(1.12)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.59)	(3.90)	(2.90)	(4.62)	(2.96)	(3.18)	(4.86)
$50	(1.75)	(4.29)	(3.20)	(5.09)	(3.26)	(3.50)	(5.35)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$25	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$60	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$75	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$100	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$100	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.06)	(7.50)	(5.59)	(8.90)	(5.69)	(6.12)	(9.36)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.74)	(11.61)	(8.66)	(13.78)	(8.82)	(9.48)	(14.50)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(0.13)	(0.33)	(0.23)	(0.38)	(0.25)	(0.26)	(0.39)
$50	(0.13)	(0.31)	(0.23)	(0.37)	(0.24)	(0.26)	(0.38)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$10	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$15	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.11)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
$25	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.26)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$25	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$35	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$60	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$75	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.11)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.09)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.25)	(0.63)	(0.46)	(0.74)	(0.47)	(0.51)	(0.77)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(0.38)	(0.94)	(0.69)	(1.10)	(0.72)	(0.77)	(1.17)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	8.9%	9.2%	8.6%	9.0%	9.2%	8.9%	8.7%
$50	8.0%	7.8%	7.7%	7.8%	7.9%	8.0%	7.6%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$10	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
$15	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
$20	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
$25	8.9%	9.1%	9.1%	9.2%	9.0%	8.9%	9.5%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$25	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$35	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$50	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$60	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
$75	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
$100	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
$35	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$50	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$60	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
$75	11.8%	12.0%	13.1%	12.2%	14.5%	13.4%	12.6%
$100	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.9%	9.2%	9.0%	9.1%	9.0%	9.1%	9.0%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	8.7%	8.8%	8.7%	8.7%	8.9%	8.8%	8.8%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

NYSHIP: Three Month Extension	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

NYSHIP: Three Month Extension	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

NYSHIP: Three Month Extension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

NYSHIP: Three Month Extension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.26	17.79	13.29	21.13	13.50	14.52	22.23
60	7.66	18.77	14.01	22.29	14.25	15.32	23.44
90	7.95	19.47	14.55	23.12	14.78	15.89	24.32
Unlimited	8.03	19.67	14.69	23.36	14.93	16.05	24.56
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.12	19.89	14.86	23.62	15.11	16.24	24.85
30	8.94	21.89	16.35	26.00	16.62	17.87	27.35
40	9.44	23.11	17.27	27.46	17.55	18.87	28.88
60	9.95	24.37	18.20	28.94	18.50	19.89	30.44
Unlimited	10.03	24.56	18.35	29.18	18.65	20.05	30.68
LARGE GROUP			**$5 Copay**				
20	7.64	18.72	13.98	22.24	14.21	15.28	23.38
30	8.40	20.59	15.38	24.46	15.64	16.81	25.71
40	8.93	21.87	16.33	25.97	16.61	17.85	27.32
60	9.35	22.92	17.12	27.21	17.40	18.71	28.62
Unlimited	9.42	23.09	17.25	27.43	17.53	18.85	28.84
LARGE GROUP			**$10 Copay**				
20	7.15	17.51	13.09	20.81	13.30	14.30	21.88
30	7.87	19.29	14.41	22.92	14.65	15.75	24.09
40	8.32	20.39	15.23	24.23	15.48	16.65	25.47
60	8.77	21.49	16.05	25.53	16.32	17.54	26.85
Unlimited	8.84	21.66	16.19	25.73	16.45	17.69	27.06
LARGE GROUP			**$15 Copay**				
20	6.71	16.44	12.28	19.53	12.48	13.42	20.53
30	7.40	18.12	13.54	21.52	13.76	14.79	22.63
40	7.83	19.20	14.33	22.80	14.57	15.67	23.97
60	8.28	20.29	15.16	24.10	15.40	16.56	25.35
Unlimited	8.35	20.47	15.29	24.31	15.53	16.71	25.56
LARGE GROUP			**$20 Copay**				
20	6.31	15.47	11.56	18.37	11.74	12.63	19.32
30	6.93	16.97	12.68	20.16	12.88	13.85	21.20
40	7.30	17.89	13.36	21.26	13.59	14.61	22.35
60	7.76	19.01	14.21	22.59	14.43	15.52	23.76
Unlimited	7.82	19.17	14.32	22.77	14.56	15.65	23.94
LARGE GROUP			**$25 Copay**				
20	5.87	14.37	10.73	17.06	10.91	11.73	17.95
30	6.45	15.79	11.80	18.76	12.00	12.89	19.73
40	6.87	16.84	12.58	20.00	12.79	13.75	21.03
60	7.23	17.72	13.23	21.04	13.45	14.46	22.13
Unlimited	7.29	17.87	13.34	21.23	13.57	14.59	22.32
LARGE GROUP			**$30 Copay**				
20	5.60	13.72	10.25	16.30	10.41	11.20	17.14
30	6.07	14.87	11.11	17.66	11.29	12.14	18.57
40	6.47	15.84	11.83	18.82	12.03	12.93	19.79
60	6.78	16.62	12.41	19.74	12.62	13.57	20.76
Unlimited	6.82	16.72	12.48	19.86	12.69	13.65	20.88
LARGE GROUP			**$35 Copay**				
20	5.32	13.05	9.74	15.49	9.90	10.65	16.29
30	5.68	13.92	10.39	16.53	10.57	11.36	17.38
40	6.05	14.82	11.07	17.61	11.25	12.10	18.51
60	6.34	15.54	11.61	18.46	11.80	12.69	19.41
Unlimited	6.40	15.67	11.70	18.62	11.89	12.79	19.57
LARGE GROUP			**$40 Copay**				
20	5.18	12.70	9.49	15.08	9.64	10.36	15.85
30	5.53	13.55	10.12	16.09	10.28	11.06	16.92
40	5.89	14.42	10.77	17.13	10.94	11.77	18.01
60	6.21	15.22	11.36	18.07	11.56	12.42	19.01
Unlimited	6.25	15.32	11.44	18.20	11.63	12.51	19.14
LARGE GROUP			**$45 Copay**				
20	5.03	12.32	9.20	14.64	9.35	10.06	15.39
30	5.37	13.15	9.82	15.62	9.98	10.73	16.42
40	5.74	14.07	10.51	16.71	10.68	11.49	17.57
60	6.06	14.84	11.09	17.64	11.27	12.12	18.54

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.89	19.33	14.41	22.94	14.68	15.78	24.14
60	8.32	20.38	15.19	24.19	15.48	16.64	25.45
90	8.63	21.14	15.76	25.09	16.05	17.26	26.40
Unlimited	8.71	21.34	15.90	25.32	16.20	17.42	26.64
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.81	21.58	16.09	25.61	16.39	17.62	26.95
30	9.71	23.79	17.73	28.23	18.06	19.42	29.70
40	10.25	25.11	18.72	29.80	19.07	20.50	31.35
60	10.80	26.46	19.72	31.40	20.09	21.60	33.04
Unlimited	10.88	26.66	19.87	31.63	20.24	21.76	33.28
LARGE GROUP			**$5 Copay**				
20	8.29	20.31	15.14	24.10	15.42	16.58	25.36
30	9.12	22.34	16.65	26.51	16.96	18.24	27.90
40	9.70	23.77	17.71	28.20	18.04	19.40	29.67
60	10.15	24.87	18.53	29.51	18.88	20.30	31.05
Unlimited	10.23	25.06	18.68	29.74	19.03	20.46	31.29
LARGE GROUP			**$10 Copay**				
20	7.75	18.99	14.15	22.53	14.42	15.50	23.71
30	8.55	20.95	15.61	24.85	15.90	17.10	26.15
40	9.04	22.15	16.51	26.28	16.81	18.08	27.65
60	9.53	23.35	17.40	27.70	17.73	19.06	29.15
Unlimited	9.60	23.52	17.53	27.91	17.86	19.20	29.37
LARGE GROUP			**$15 Copay**				
20	7.28	17.84	13.29	21.16	13.54	14.56	22.27
30	8.04	19.70	14.68	23.37	14.95	16.08	24.59
40	8.51	20.85	15.54	24.74	15.83	17.02	26.03
60	9.00	22.05	16.43	26.16	16.74	18.00	27.53
Unlimited	9.07	22.22	16.56	26.37	16.87	18.14	27.75
LARGE GROUP			**$20 Copay**				
20	6.86	16.81	12.53	19.94	12.76	13.72	20.98
30	7.52	18.42	13.73	21.86	13.99	15.04	23.00
40	7.93	19.43	14.48	23.05	14.75	15.86	24.26
60	8.43	20.65	15.39	24.51	15.68	16.86	25.79
Unlimited	8.49	20.80	15.50	24.68	15.79	16.98	25.97
LARGE GROUP			**$25 Copay**				
20	6.38	15.63	11.65	18.55	11.87	12.76	19.52
30	7.00	17.15	12.78	20.35	13.02	14.00	21.41
40	7.46	18.28	13.62	21.69	13.88	14.92	22.82
60	7.85	19.23	14.33	22.82	14.60	15.70	24.01
Unlimited	7.92	19.40	14.46	23.02	14.73	15.84	24.23
LARGE GROUP			**$30 Copay**				
20	6.07	14.87	11.08	17.65	11.29	12.14	18.57
30	6.59	16.15	12.03	19.16	12.26	13.18	20.16
40	7.02	17.20	12.82	20.41	13.06	14.04	21.47
60	7.37	18.06	13.46	21.42	13.71	14.74	22.54
Unlimited	7.41	18.15	13.53	21.54	13.78	14.82	22.67
LARGE GROUP			**$35 Copay**				
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.16	15.09	11.25	17.91	11.46	12.32	18.84
40	6.56	16.07	11.98	19.07	12.20	13.12	20.07
60	6.89	16.88	12.58	20.03	12.82	13.78	21.08
Unlimited	6.95	17.03	12.69	20.20	12.93	13.90	21.26
LARGE GROUP			**$40 Copay**				
20	5.61	13.74	10.24	16.31	10.43	11.22	17.16
30	6.00	14.70	10.96	17.44	11.16	12.00	18.35
40	6.40	15.68	11.69	18.60	11.90	12.80	19.58
60	6.74	16.51	12.31	19.59	12.54	13.48	20.62
Unlimited	6.79	16.64	12.40	19.74	12.63	13.58	20.77
LARGE GROUP			**$45 Copay**				
20	5.46	13.38	9.97	15.87	10.16	10.92	16.70
30	5.83	14.28	10.65	16.95	10.84	11.66	17.83
40	6.23	15.26	11.38	18.11	11.59	12.46	19.06
60	6.57	16.10	12.00	19.10	12.22	13.14	20.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.63	1.54	1.12	1.81	1.18	1.26	1.91
60	0.66	1.61	1.18	1.90	1.23	1.32	2.01
90	0.68	1.67	1.21	1.97	1.27	1.37	2.08
Unlimited	0.68	1.67	1.21	1.96	1.27	1.37	2.08
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	0.69	1.69	1.23	1.99	1.28	1.38	2.10
30	0.77	1.90	1.38	2.23	1.44	1.55	2.35
40	0.81	2.00	1.45	2.34	1.52	1.63	2.47
60	0.85	2.09	1.52	2.46	1.59	1.71	2.60
Unlimited	0.85	2.10	1.52	2.45	1.59	1.71	2.60
LARGE GROUP			**$5 Copay**				
20	0.65	1.59	1.16	1.86	1.21	1.30	1.98
30	0.72	1.75	1.27	2.05	1.32	1.43	2.19
40	0.77	1.90	1.38	2.23	1.43	1.55	2.35
60	0.80	1.95	1.41	2.30	1.48	1.59	2.43
Unlimited	0.81	1.97	1.43	2.31	1.50	1.61	2.45
LARGE GROUP			**$10 Copay**				
20	0.60	1.48	1.06	1.72	1.12	1.20	1.83
30	0.68	1.66	1.20	1.93	1.25	1.35	2.06
40	0.72	1.76	1.28	2.05	1.33	1.43	2.18
60	0.76	1.86	1.35	2.17	1.41	1.52	2.30
Unlimited	0.76	1.86	1.34	2.18	1.41	1.51	2.31
LARGE GROUP			**$15 Copay**				
20	0.57	1.40	1.01	1.63	1.06	1.14	1.74
30	0.64	1.58	1.14	1.85	1.19	1.29	1.96
40	0.68	1.65	1.21	1.94	1.26	1.35	2.06
60	0.72	1.76	1.27	2.06	1.34	1.44	2.18
Unlimited	0.72	1.75	1.27	2.06	1.34	1.43	2.19
LARGE GROUP			**$20 Copay**				
20	0.55	1.34	0.97	1.57	1.02	1.09	1.66
30	0.59	1.45	1.05	1.70	1.11	1.19	1.80
40	0.63	1.54	1.12	1.79	1.16	1.25	1.91
60	0.67	1.64	1.18	1.92	1.25	1.34	2.03
Unlimited	0.67	1.63	1.18	1.91	1.23	1.33	2.03
LARGE GROUP			**$25 Copay**				
20	0.51	1.26	0.92	1.49	0.96	1.03	1.57
30	0.55	1.36	0.98	1.59	1.02	1.11	1.68
40	0.59	1.44	1.04	1.69	1.09	1.17	1.79
60	0.62	1.51	1.10	1.78	1.15	1.24	1.88
Unlimited	0.63	1.53	1.12	1.79	1.16	1.25	1.91
LARGE GROUP			**$30 Copay**				
20	0.47	1.15	0.83	1.35	0.88	0.94	1.43
30	0.52	1.28	0.92	1.50	0.97	1.04	1.59
40	0.55	1.36	0.99	1.59	1.03	1.11	1.68
60	0.59	1.44	1.05	1.68	1.09	1.17	1.78
Unlimited	0.59	1.43	1.05	1.68	1.09	1.17	1.79
LARGE GROUP			**$35 Copay**				
20	0.46	1.11	0.81	1.31	0.85	0.91	1.39
30	0.48	1.17	0.86	1.38	0.89	0.96	1.46
40	0.51	1.25	0.91	1.46	0.95	1.02	1.56
60	0.55	1.34	0.97	1.57	1.02	1.09	1.67
Unlimited	0.55	1.36	0.99	1.58	1.04	1.11	1.69
LARGE GROUP			**$40 Copay**				
20	0.43	1.04	0.75	1.23	0.79	0.86	1.31
30	0.47	1.15	0.84	1.35	0.88	0.94	1.43
40	0.51	1.26	0.92	1.47	0.96	1.03	1.57
60	0.53	1.29	0.95	1.52	0.98	1.06	1.61
Unlimited	0.54	1.32	0.96	1.54	1.00	1.07	1.63
LARGE GROUP			**$45 Copay**				
20	0.43	1.06	0.77	1.23	0.81	0.86	1.31
30	0.46	1.13	0.83	1.33	0.86	0.93	1.41
40	0.49	1.19	0.87	1.40	0.91	0.97	1.49
60	0.51	1.26	0.91	1.46	0.95	1.02	1.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.7%	8.7%	8.4%	8.6%	8.7%	8.7%	8.6%
60	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
90	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
30	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.6%
40	8.6%	8.7%	8.4%	8.5%	8.7%	8.6%	8.6%
60	8.5%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
Unlimited	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP			**$5 Copay**				
20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
30	8.6%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
40	8.6%	8.7%	8.5%	8.6%	8.6%	8.7%	8.6%
60	8.6%	8.5%	8.2%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
LARGE GROUP			**$10 Copay**				
20	8.4%	8.5%	8.1%	8.3%	8.4%	8.4%	8.4%
30	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.6%
40	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
60	8.7%	8.7%	8.4%	8.5%	8.6%	8.7%	8.6%
Unlimited	8.6%	8.6%	8.3%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP			**$15 Copay**				
20	8.5%	8.5%	8.2%	8.3%	8.5%	8.5%	8.5%
30	8.6%	8.7%	8.4%	8.6%	8.6%	8.7%	8.7%
40	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
60	8.7%	8.7%	8.4%	8.5%	8.7%	8.7%	8.6%
Unlimited	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP			**$20 Copay**				
20	8.7%	8.7%	8.4%	8.5%	8.7%	8.6%	8.6%
30	8.5%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
40	8.6%	8.6%	8.4%	8.4%	8.5%	8.6%	8.5%
60	8.6%	8.6%	8.3%	8.5%	8.7%	8.6%	8.5%
Unlimited	8.6%	8.5%	8.2%	8.4%	8.4%	8.5%	8.5%
LARGE GROUP			**$25 Copay**				
20	8.7%	8.8%	8.6%	8.7%	8.8%	8.8%	8.7%
30	8.5%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
40	8.6%	8.6%	8.3%	8.5%	8.5%	8.5%	8.5%
60	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.4%	8.5%	8.6%	8.6%
LARGE GROUP			**$30 Copay**				
20	8.4%	8.4%	8.1%	8.3%	8.5%	8.4%	8.3%
30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
40	8.5%	8.6%	8.4%	8.4%	8.6%	8.6%	8.5%
60	8.7%	8.7%	8.5%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP			**$35 Copay**				
20	8.6%	8.5%	8.3%	8.5%	8.6%	8.5%	8.5%
30	8.5%	8.4%	8.3%	8.3%	8.4%	8.5%	8.4%
40	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
60	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.6%	8.7%	8.5%	8.5%	8.7%	8.7%	8.6%
LARGE GROUP			**$40 Copay**				
20	8.3%	8.2%	7.9%	8.2%	8.2%	8.3%	8.3%
30	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
40	8.7%	8.7%	8.5%	8.6%	8.8%	8.8%	8.7%
60	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP			**$45 Copay**				
20	8.5%	8.6%	8.4%	8.4%	8.7%	8.5%	8.5%
30	8.6%	8.6%	8.5%	8.5%	8.6%	8.7%	8.6%
40	8.5%	8.5%	8.3%	8.4%	8.5%	8.4%	8.5%
60	8.4%	8.5%	8.2%	8.3%	8.4%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.09	14.92	11.15	17.72	11.32	12.18	18.64
LARGE GROUP			**$50 Copay**				
20	4.89	11.97	8.95	14.22	9.09	9.77	14.95
30	5.23	12.82	9.58	15.23	9.73	10.47	16.01
40	5.60	13.72	10.25	16.30	10.41	11.20	17.14
60	5.91	14.47	10.81	17.19	10.99	11.81	18.07
Unlimited	5.95	14.57	10.88	17.31	11.06	11.89	18.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.61	16.19	12.07	19.22	12.29	13.22	20.22
LARGE GROUP			**$50 Copay**				
20	5.31	13.01	9.70	15.44	9.88	10.62	16.24
30	5.68	13.92	10.37	16.51	10.56	11.36	17.38
40	6.07	14.87	11.08	17.65	11.29	12.14	18.57
60	6.42	15.73	11.72	18.66	11.94	12.84	19.64
Unlimited	6.46	15.83	11.80	18.78	12.02	12.92	19.76

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.52	1.27	0.92	1.50	0.97	1.04	1.58
LARGE GROUP			**$50 Copay**				
20	0.42	1.04	0.75	1.22	0.79	0.85	1.29
30	0.45	1.10	0.79	1.28	0.83	0.89	1.37
40	0.47	1.15	0.83	1.35	0.88	0.94	1.43
60	0.51	1.26	0.91	1.47	0.95	1.03	1.57
Unlimited	0.51	1.26	0.92	1.47	0.96	1.03	1.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	8.5%	8.5%	8.3%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP			**$50 Copay**				
20	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.6%
30	8.6%	8.6%	8.2%	8.4%	8.5%	8.5%	8.6%
40	8.4%	8.4%	8.1%	8.3%	8.5%	8.4%	8.3%
60	8.6%	8.7%	8.4%	8.6%	8.6%	8.7%	8.7%
Unlimited	8.6%	8.6%	8.5%	8.5%	8.7%	8.7%	8.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.04	9.89	7.40	11.75	7.52	8.08	12.36
$0/Max $5000	3.84	9.39	7.02	11.16	7.13	7.67	11.74
$0/Max $2500	3.59	8.79	6.57	10.44	6.68	7.18	10.99
$25	3.84	9.39	7.02	11.16	7.13	7.67	11.74
$50	3.59	8.79	6.57	10.44	6.68	7.18	10.99
$100	3.29	8.07	6.03	9.59	6.13	6.59	10.08
$500	1.58	3.88	2.90	4.60	2.94	3.16	4.83
$5,000	0.26	0.62	0.47	0.74	0.48	0.51	0.79
Coinsurance							
80%	3.24	7.95	5.94	9.44	6.03	6.49	9.92
75%	3.04	7.45	5.56	8.84	5.65	6.08	9.30
70%	2.84	6.95	5.19	8.25	5.27	5.67	8.68
Deductible			**Orthotics Riders**				
$0	0.69	1.70	1.26	2.02	1.29	1.39	2.12
$0/Max $5000	0.66	1.62	1.21	1.93	1.23	1.33	2.03
$0/Max $2500	0.62	1.52	1.14	1.82	1.15	1.24	1.91
$25	0.66	1.62	1.21	1.93	1.23	1.33	2.03
$50	0.62	1.52	1.14	1.82	1.15	1.24	1.91
$100	0.56	1.38	1.03	1.63	1.04	1.12	1.71
$500	0.28	0.67	0.50	0.81	0.51	0.55	0.85
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.56	1.38	1.03	1.63	1.04	1.12	1.71
75%	0.53	1.30	0.97	1.54	0.99	1.06	1.62
70%	0.50	1.22	0.92	1.46	0.93	1.00	1.53
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.32	3.22	2.41	3.83	2.45	2.63	4.03
12 Months	2.11	5.17	3.87	6.14	3.93	4.22	6.46
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.06	5.05	3.77	6.00	3.84	4.12	6.30
12 Months	3.28	8.05	6.01	9.56	6.11	6.57	10.05
			Private Duty Nursing Riders				
In Full	0.48	1.17	0.88	1.40	0.89	0.96	1.47
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.14	0.35	0.27	0.42	0.27	0.29	0.44
			Dental Network Access				
	0.41	1.00	0.74	1.18	0.75	0.82	1.24
			Infertility Rider				
Limit							
2 IVF	8.55	20.94	15.65	24.88	15.90	17.10	26.15
3 IVF	10.33	25.32	18.91	30.07	19.22	20.67	31.62
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.54	6.22	4.65	7.40	4.72	5.08	7.77

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.38	10.73	8.00	12.73	8.15	8.76	13.40
$0/Max $5000	4.17	10.22	7.61	12.12	7.76	8.34	12.76
$0/Max $2500	3.89	9.53	7.10	11.31	7.24	7.78	11.90
$25	4.17	10.22	7.61	12.12	7.76	8.34	12.76
$50	3.89	9.53	7.10	11.31	7.24	7.78	11.90
$100	3.58	8.77	6.54	10.41	6.66	7.16	10.95
$500	1.71	4.19	3.12	4.97	3.18	3.42	5.23
$5,000	0.29	0.71	0.53	0.84	0.54	0.58	0.89
Coinsurance							
80%	3.52	8.62	6.43	10.23	6.55	7.04	10.77
75%	3.30	8.09	6.03	9.59	6.14	6.60	10.09
70%	3.09	7.57	5.64	8.98	5.75	6.18	9.45
Deductible			**Orthotics Riders**				
$0	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$0/Max $5000	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$0/Max $2500	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$25	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$50	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$100	0.61	1.49	1.11	1.77	1.13	1.22	1.87
$500	0.31	0.76	0.57	0.90	0.58	0.62	0.95
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.61	1.49	1.11	1.77	1.13	1.22	1.87
75%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
70%	0.54	1.32	0.99	1.57	1.00	1.08	1.65
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.52	1.27	0.95	1.51	0.97	1.04	1.59
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
			Infertility Rider				
Limit							
2 IVF	9.28	22.74	16.95	26.98	17.26	18.56	28.39
3 IVF	11.22	27.49	20.49	32.62	20.87	22.44	34.32
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.76	6.76	5.04	8.02	5.13	5.52	8.44

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.34	0.84	0.60	0.98	0.63	0.68	1.04
$0/Max $5000	0.33	0.83	0.59	0.96	0.63	0.67	1.02
$0/Max $2500	0.30	0.74	0.53	0.87	0.56	0.60	0.91
$25	0.33	0.83	0.59	0.96	0.63	0.67	1.02
$50	0.30	0.74	0.53	0.87	0.56	0.60	0.91
$100	0.29	0.70	0.51	0.82	0.53	0.57	0.87
$500	0.13	0.31	0.22	0.37	0.24	0.26	0.40
$5,000	0.03	0.09	0.06	0.10	0.06	0.07	0.10
Coinsurance							
80%	0.28	0.67	0.49	0.79	0.52	0.55	0.85
75%	0.26	0.64	0.47	0.75	0.49	0.52	0.79
70%	0.25	0.62	0.45	0.73	0.48	0.51	0.77
Deductible			**Orthotics Riders**				
$0	0.05	0.11	0.09	0.13	0.09	0.09	0.14
$0/Max $5000	0.05	0.12	0.09	0.13	0.09	0.09	0.14
$0/Max $2500	0.05	0.12	0.08	0.13	0.10	0.10	0.14
$25	0.05	0.12	0.09	0.13	0.09	0.09	0.14
$50	0.05	0.12	0.08	0.13	0.10	0.10	0.14
$100	0.05	0.11	0.08	0.14	0.09	0.10	0.16
$500	0.03	0.09	0.07	0.09	0.07	0.07	0.10
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.05	0.11	0.08	0.14	0.09	0.10	0.16
75%	0.04	0.10	0.07	0.12	0.07	0.08	0.12
70%	0.04	0.10	0.07	0.11	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.36	0.23	0.25	0.37
12 Months	0.18	0.44	0.31	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.41	0.30	0.48	0.31	0.34	0.52
12 Months	0.29	0.70	0.51	0.82	0.53	0.57	0.87
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.11	0.08	0.08	0.12
80% hrs 73-504	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-504	0.01	0.02	0.00	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.09	0.08	0.14
			Infertility Rider				
Limit							
2 IVF	0.73	1.80	1.30	2.10	1.36	1.46	2.24
3 IVF	0.89	2.17	1.58	2.55	1.65	1.77	2.70
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	0.22	0.54	0.39	0.62	0.41	0.44	0.67

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.4%	8.5%	8.1%	8.3%	8.4%	8.4%	8.4%
$0/Max $5000	8.6%	8.8%	8.4%	8.6%	8.8%	8.7%	8.7%
$0/Max $2500	8.4%	8.4%	8.1%	8.3%	8.4%	8.4%	8.3%
$25	8.6%	8.8%	8.4%	8.6%	8.8%	8.7%	8.7%
$50	8.4%	8.4%	8.1%	8.3%	8.4%	8.4%	8.3%
$100	8.8%	8.7%	8.5%	8.6%	8.6%	8.6%	8.6%
$500	8.2%	8.0%	7.6%	8.0%	8.2%	8.2%	8.3%
$5,000	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
Coinsurance							
80%	8.6%	8.4%	8.2%	8.4%	8.6%	8.5%	8.6%
75%	8.6%	8.6%	8.5%	8.5%	8.7%	8.6%	8.5%
70%	8.8%	8.9%	8.7%	8.8%	9.1%	9.0%	8.9%
Deductible			**Orthotics Riders**				
$0	7.2%	6.5%	7.1%	6.4%	7.0%	6.5%	6.6%
$0/Max $5000	7.6%	7.4%	7.4%	6.7%	7.3%	6.8%	6.9%
$0/Max $2500	8.1%	7.9%	7.0%	7.1%	8.7%	8.1%	7.3%
$25	7.6%	7.4%	7.4%	6.7%	7.3%	6.8%	6.9%
$50	8.1%	7.9%	7.0%	7.1%	8.7%	8.1%	7.3%
$100	8.9%	8.0%	7.8%	8.6%	8.7%	8.9%	9.4%
$500	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	8.9%	8.0%	7.8%	8.6%	8.7%	8.9%	9.4%
75%	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
70%	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	9.1%	9.6%	9.1%	9.4%	9.4%	9.5%	9.2%
12 Months	8.5%	8.5%	8.0%	8.5%	8.4%	8.5%	8.5%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.3%	8.1%	8.0%	8.0%	8.1%	8.3%	8.3%
12 Months	8.8%	8.7%	8.5%	8.6%	8.7%	8.7%	8.7%
			Private Duty Nursing Riders				
In Full	8.3%	8.5%	8.0%	7.9%	9.0%	8.3%	8.2%
80% hrs 73-504	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-504	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
			Dental Network Access				
	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
			Infertility Rider				
Limit							
2 IVF	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.6%
3 IVF	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	8.7%	8.7%	8.4%	8.4%	8.7%	8.7%	8.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
833.44	2,041.94	1,525.20	2,425.31	1,550.20	1,666.88	2,550.34
80% Coinsurance						
820.94	2,011.29	1,502.31	2,388.93	1,526.94	1,641.87	2,512.06
75% Coinsurance						
781.34	1,914.28	1,429.85	2,273.71	1,453.29	1,562.68	2,390.91
70% Coinsurance						
741.76	1,817.31	1,357.42	2,158.52	1,379.67	1,483.51	2,269.77
50% Coinsurance						
702.18	1,720.34	1,284.99	2,043.35	1,306.06	1,404.37	2,148.67

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
904.81	2,216.78	1,652.18	2,630.28	1,682.95	1,809.62	2,767.81
80% Coinsurance						
891.23	2,183.51	1,627.39	2,590.81	1,657.69	1,782.46	2,726.27
75% Coinsurance						
848.26	2,078.24	1,548.92	2,465.89	1,577.76	1,696.52	2,594.83
70% Coinsurance						
805.27	1,972.91	1,470.42	2,340.92	1,497.80	1,610.54	2,463.32
50% Coinsurance						
762.30	1,867.64	1,391.96	2,216.01	1,417.88	1,524.60	2,331.88

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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
71.37	174.84	126.98	204.97	132.75	142.74	217.47
80% Coinsurance						
70.29	172.22	125.08	201.88	130.75	140.59	214.21
75% Coinsurance						
66.92	163.96	119.07	192.18	124.47	133.84	203.92
70% Coinsurance						
63.51	155.60	113.00	182.40	118.13	127.03	193.55
50% Coinsurance						
60.12	147.30	106.97	172.66	111.82	120.23	183.21

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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
80% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
75% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
70% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
50% Coinsurance						
8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(37.65)	(92.24)	(68.90)	(109.56)	(70.02)	(75.30)	(115.20)
$350	(49.83)	(122.07)	(91.19)	(144.99)	(92.68)	(99.65)	(152.47)
$500	(64.12)	(157.09)	(117.33)	(186.58)	(119.26)	(128.23)	(196.20)
$750	(83.30)	(204.09)	(152.45)	(242.41)	(154.95)	(166.61)	(254.91)
$1,000	(98.00)	(240.11)	(179.35)	(285.18)	(182.28)	(196.00)	(299.88)
$1,500	(120.52)	(295.28)	(220.55)	(350.73)	(224.18)	(241.05)	(368.80)
$2,500	(134.74)	(330.12)	(246.57)	(392.10)	(250.62)	(269.48)	(412.31)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(50.31)	(123.25)	(92.07)	(146.39)	(93.57)	(100.61)	(153.94)
$250	(60.02)	(147.04)	(109.83)	(174.64)	(111.63)	(120.03)	(183.65)
$300	(69.75)	(170.88)	(127.64)	(202.97)	(129.73)	(139.50)	(213.42)
$350	(79.48)	(194.72)	(145.44)	(231.29)	(147.83)	(158.96)	(243.21)
$400	(87.13)	(213.47)	(159.45)	(253.54)	(162.06)	(174.26)	(266.62)
$500	(102.41)	(250.90)	(187.40)	(298.00)	(190.47)	(204.82)	(313.36)
$750	(133.00)	(325.85)	(243.38)	(387.02)	(247.38)	(266.00)	(406.97)
$1,000	(156.55)	(383.55)	(286.49)	(455.56)	(291.18)	(313.10)	(479.04)
$1,500	(192.57)	(471.79)	(352.40)	(560.37)	(358.17)	(385.13)	(589.25)
$2,000	(207.30)	(507.90)	(379.37)	(603.26)	(385.59)	(414.61)	(634.35)
$2,500	(222.09)	(544.13)	(406.43)	(646.29)	(413.10)	(444.19)	(679.61)
$5,000	(261.09)	(639.67)	(477.80)	(759.77)	(485.62)	(522.18)	(798.94)
$10,000	(293.29)	(718.56)	(536.72)	(853.47)	(545.52)	(586.58)	(897.47)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(41.23)	(101.01)	(75.45)	(119.97)	(76.68)	(82.46)	(126.16)
$250	(49.17)	(120.47)	(89.98)	(143.10)	(91.46)	(98.35)	(150.47)
$300	(57.16)	(140.05)	(104.60)	(166.34)	(106.31)	(114.32)	(174.91)
$350	(65.11)	(159.51)	(119.15)	(189.47)	(121.09)	(130.21)	(199.23)
$400	(71.51)	(175.21)	(130.87)	(208.10)	(133.01)	(143.02)	(218.83)
$500	(84.33)	(206.62)	(154.33)	(245.41)	(156.86)	(168.67)	(258.06)
$750	(109.70)	(268.77)	(200.76)	(319.23)	(204.04)	(219.40)	(335.68)
$1,000	(129.44)	(317.13)	(236.87)	(376.67)	(240.75)	(258.88)	(396.08)
$1,500	(159.36)	(390.45)	(291.64)	(463.75)	(296.42)	(318.73)	(487.65)
$2,000	(172.93)	(423.68)	(316.47)	(503.23)	(321.65)	(345.86)	(529.17)
$2,500	(186.50)	(456.92)	(341.29)	(542.70)	(346.88)	(372.99)	(570.68)
$5,000	(225.32)	(552.03)	(412.34)	(655.68)	(419.09)	(450.64)	(689.47)
$10,000	(257.36)	(630.52)	(470.96)	(748.90)	(478.69)	(514.71)	(787.51)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(32.14)	(78.74)	(58.81)	(93.52)	(59.78)	(64.28)	(98.35)
$250	(38.34)	(93.94)	(70.17)	(111.58)	(71.32)	(76.68)	(117.33)
$300	(44.54)	(109.13)	(81.52)	(129.62)	(82.85)	(89.09)	(136.30)
$350	(50.73)	(124.30)	(92.84)	(147.63)	(94.37)	(101.47)	(155.24)
$400	(55.93)	(137.02)	(102.35)	(162.75)	(104.02)	(111.85)	(171.14)
$500	(66.21)	(162.21)	(121.17)	(192.67)	(123.14)	(132.42)	(202.59)
$750	(86.37)	(211.62)	(158.06)	(251.35)	(160.65)	(172.75)	(264.30)
$1,000	(102.28)	(250.57)	(187.16)	(297.63)	(190.23)	(204.55)	(312.97)
$1,500	(126.17)	(309.13)	(230.90)	(367.17)	(234.68)	(252.35)	(386.09)
$2,000	(138.56)	(339.47)	(253.56)	(403.20)	(257.71)	(277.11)	(423.98)
$2,500	(150.95)	(369.83)	(276.24)	(439.26)	(280.77)	(301.90)	(461.91)
$5,000	(189.57)	(464.44)	(346.91)	(551.64)	(352.59)	(379.13)	(580.07)
$10,000	(221.45)	(542.56)	(405.26)	(644.43)	(411.90)	(442.90)	(677.65)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(22.09)	(54.13)	(40.43)	(64.29)	(41.10)	(44.19)	(67.61)
$250	(26.47)	(64.85)	(48.44)	(77.02)	(49.24)	(52.94)	(81.00)
$300	(30.89)	(75.67)	(56.52)	(89.87)	(57.45)	(61.77)	(94.51)
$350	(35.25)	(86.36)	(64.50)	(102.58)	(65.57)	(70.50)	(107.87)
$400	(39.07)	(95.72)	(71.49)	(113.68)	(72.66)	(78.13)	(119.54)
$500	(46.68)	(114.35)	(85.41)	(135.82)	(86.81)	(93.35)	(142.83)
$750	(61.24)	(150.04)	(112.07)	(178.21)	(113.90)	(122.48)	(187.39)
$1,000	(73.08)	(179.05)	(133.74)	(212.67)	(135.94)	(146.17)	(223.64)
$1,500	(91.32)	(223.74)	(167.12)	(265.74)	(169.86)	(182.64)	(279.44)
$2,000	(101.04)	(247.55)	(184.91)	(294.03)	(187.94)	(202.08)	(309.18)
$2,500	(110.78)	(271.41)	(202.74)	(322.38)	(206.05)	(221.56)	(339.00)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(40.87)	(100.13)	(74.63)	(118.81)	(76.02)	(81.74)	(125.02)
$350	(54.10)	(132.55)	(98.79)	(157.27)	(100.63)	(108.20)	(165.49)
$500	(69.61)	(170.54)	(127.11)	(202.36)	(129.47)	(139.22)	(212.94)
$750	(90.44)	(221.58)	(165.14)	(262.91)	(168.22)	(180.88)	(276.66)
$1,000	(106.39)	(260.66)	(194.27)	(309.28)	(197.89)	(212.78)	(325.45)
$1,500	(130.84)	(320.56)	(238.91)	(380.35)	(243.36)	(261.68)	(400.24)
$2,500	(146.27)	(358.36)	(267.09)	(425.21)	(272.06)	(292.54)	(447.44)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(54.62)	(133.82)	(99.74)	(158.78)	(101.59)	(109.24)	(167.08)
$250	(65.15)	(159.62)	(118.96)	(189.39)	(121.18)	(130.30)	(199.29)
$300	(75.72)	(185.51)	(138.26)	(220.12)	(140.84)	(151.44)	(231.63)
$350	(86.29)	(211.41)	(157.57)	(250.85)	(160.50)	(172.58)	(263.96)
$400	(94.58)	(231.72)	(172.70)	(274.94)	(175.92)	(189.16)	(289.32)
$500	(111.18)	(272.39)	(203.01)	(323.20)	(206.79)	(222.36)	(340.10)
$750	(144.38)	(353.73)	(263.64)	(419.71)	(268.55)	(288.76)	(441.66)
$1,000	(169.95)	(416.38)	(310.33)	(494.04)	(316.11)	(339.90)	(519.88)
$1,500	(209.06)	(512.20)	(381.74)	(607.74)	(388.85)	(418.12)	(639.51)
$2,000	(225.05)	(551.37)	(410.94)	(654.22)	(418.59)	(450.10)	(688.43)
$2,500	(241.10)	(590.70)	(440.25)	(700.88)	(448.45)	(482.20)	(737.52)
$5,000	(283.43)	(694.40)	(517.54)	(823.93)	(527.18)	(566.86)	(867.01)
$10,000	(318.41)	(780.10)	(581.42)	(925.62)	(592.24)	(636.82)	(974.02)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(44.75)	(109.64)	(81.71)	(130.09)	(83.24)	(89.50)	(136.89)
$250	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$300	(62.05)	(152.02)	(113.30)	(180.38)	(115.41)	(124.10)	(189.81)
$350	(70.68)	(173.17)	(129.06)	(205.47)	(131.46)	(141.36)	(216.21)
$400	(77.63)	(190.19)	(141.75)	(225.67)	(144.39)	(155.26)	(237.47)
$500	(91.56)	(224.32)	(167.19)	(266.16)	(170.30)	(183.12)	(280.08)
$750	(119.09)	(291.77)	(217.46)	(346.19)	(221.51)	(238.18)	(364.30)
$1,000	(140.52)	(344.27)	(256.59)	(408.49)	(261.37)	(281.04)	(429.85)
$1,500	(173.01)	(423.87)	(315.92)	(502.94)	(321.80)	(346.02)	(529.24)
$2,000	(187.73)	(459.94)	(342.79)	(545.73)	(349.18)	(375.46)	(574.27)
$2,500	(202.47)	(496.05)	(369.71)	(588.58)	(376.59)	(404.94)	(619.36)
$5,000	(244.61)	(599.29)	(446.66)	(711.08)	(454.97)	(489.22)	(748.26)
$10,000	(279.40)	(684.53)	(510.18)	(812.22)	(519.68)	(558.80)	(854.68)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(34.89)	(85.48)	(63.71)	(101.43)	(64.90)	(69.78)	(106.73)
$250	(41.63)	(101.99)	(76.02)	(121.02)	(77.43)	(83.26)	(127.35)
$300	(48.35)	(118.46)	(88.29)	(140.55)	(89.93)	(96.70)	(147.90)
$350	(55.07)	(134.92)	(100.56)	(160.09)	(102.43)	(110.14)	(168.46)
$400	(60.72)	(148.76)	(110.87)	(176.51)	(112.94)	(121.44)	(185.74)
$500	(71.87)	(176.08)	(131.23)	(208.93)	(133.68)	(143.74)	(219.85)
$750	(93.77)	(229.74)	(171.22)	(272.59)	(174.41)	(187.54)	(286.84)
$1,000	(111.04)	(272.05)	(202.76)	(322.79)	(206.53)	(222.08)	(339.67)
$1,500	(136.96)	(335.55)	(250.09)	(398.14)	(254.75)	(273.92)	(418.96)
$2,000	(150.42)	(368.53)	(274.67)	(437.27)	(279.78)	(300.84)	(460.13)
$2,500	(163.88)	(401.51)	(299.24)	(476.40)	(304.82)	(327.76)	(501.31)
$5,000	(205.80)	(504.21)	(375.79)	(598.26)	(382.79)	(411.60)	(629.54)
$10,000	(240.41)	(589.00)	(438.99)	(698.87)	(447.16)	(480.82)	(735.41)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(23.98)	(58.75)	(43.79)	(69.71)	(44.60)	(47.96)	(73.35)
$250	(28.74)	(70.41)	(52.48)	(83.55)	(53.46)	(57.48)	(87.92)
$300	(33.54)	(82.17)	(61.24)	(97.50)	(62.38)	(67.08)	(102.60)
$350	(38.27)	(93.76)	(69.88)	(111.25)	(71.18)	(76.54)	(117.07)
$400	(42.41)	(103.90)	(77.44)	(123.29)	(78.88)	(84.82)	(129.73)
$500	(50.67)	(124.14)	(92.52)	(147.30)	(94.25)	(101.34)	(155.00)
$750	(66.48)	(162.88)	(121.39)	(193.26)	(123.65)	(132.96)	(203.36)
$1,000	(79.34)	(194.38)	(144.87)	(230.64)	(147.57)	(158.68)	(242.70)
$1,500	(99.14)	(242.89)	(181.03)	(288.20)	(184.40)	(198.28)	(303.27)
$2,000	(109.69)	(268.74)	(200.29)	(318.87)	(204.02)	(219.38)	(335.54)
$2,500	(120.27)	(294.66)	(219.61)	(349.62)	(223.70)	(240.54)	(367.91)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(3.22)	(7.89)	(5.73)	(9.25)	(6.00)	(6.44)	(9.82)
$350	(4.27)	(10.48)	(7.60)	(12.28)	(7.95)	(8.55)	(13.02)
$500	(5.49)	(13.45)	(9.78)	(15.78)	(10.21)	(10.99)	(16.74)
$750	(7.14)	(17.49)	(12.69)	(20.50)	(13.27)	(14.27)	(21.75)
$1,000	(8.39)	(20.55)	(14.92)	(24.10)	(15.61)	(16.78)	(25.57)
$1,500	(10.32)	(25.28)	(18.36)	(29.62)	(19.18)	(20.63)	(31.44)
$2,500	(11.53)	(28.24)	(20.52)	(33.11)	(21.44)	(23.06)	(35.13)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(4.31)	(10.57)	(7.67)	(12.39)	(8.02)	(8.63)	(13.14)
$250	(5.13)	(12.58)	(9.13)	(14.75)	(9.55)	(10.27)	(15.64)
$300	(5.97)	(14.63)	(10.62)	(17.15)	(11.11)	(11.94)	(18.21)
$350	(6.81)	(16.69)	(12.13)	(19.56)	(12.67)	(13.62)	(20.75)
$400	(7.45)	(18.25)	(13.25)	(21.40)	(13.86)	(14.90)	(22.70)
$500	(8.77)	(21.49)	(15.61)	(25.20)	(16.32)	(17.54)	(26.74)
$750	(11.38)	(27.88)	(20.26)	(32.69)	(21.17)	(22.76)	(34.69)
$1,000	(13.40)	(32.83)	(23.84)	(38.48)	(24.93)	(26.80)	(40.84)
$1,500	(16.49)	(40.41)	(29.34)	(47.37)	(30.68)	(32.99)	(50.26)
$2,000	(17.75)	(43.47)	(31.57)	(50.96)	(33.00)	(35.49)	(54.08)
$2,500	(19.01)	(46.57)	(33.82)	(54.59)	(35.35)	(38.01)	(57.91)
$5,000	(22.34)	(54.73)	(39.74)	(64.16)	(41.56)	(44.68)	(68.07)
$10,000	(25.12)	(61.54)	(44.70)	(72.15)	(46.72)	(50.24)	(76.55)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(3.52)	(8.63)	(6.26)	(10.12)	(6.56)	(7.04)	(10.73)
$250	(4.21)	(10.31)	(7.49)	(12.08)	(7.83)	(8.41)	(12.82)
$300	(4.89)	(11.97)	(8.70)	(14.04)	(9.10)	(9.78)	(14.90)
$350	(5.57)	(13.66)	(9.91)	(16.00)	(10.37)	(11.15)	(16.98)
$400	(6.12)	(14.98)	(10.88)	(17.57)	(11.38)	(12.24)	(18.64)
$500	(7.23)	(17.70)	(12.86)	(20.75)	(13.44)	(14.45)	(22.02)
$750	(9.39)	(23.00)	(16.70)	(26.96)	(17.47)	(18.78)	(28.62)
$1,000	(11.08)	(27.14)	(19.72)	(31.82)	(20.62)	(22.16)	(33.77)
$1,500	(13.65)	(33.42)	(24.28)	(39.19)	(25.38)	(27.29)	(41.59)
$2,000	(14.80)	(36.26)	(26.32)	(42.50)	(27.53)	(29.60)	(45.10)
$2,500	(15.97)	(39.13)	(28.42)	(45.88)	(29.71)	(31.95)	(48.68)
$5,000	(19.29)	(47.26)	(34.32)	(55.40)	(35.88)	(38.58)	(58.79)
$10,000	(22.04)	(54.01)	(39.22)	(63.32)	(40.99)	(44.09)	(67.17)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(2.75)	(6.74)	(4.90)	(7.91)	(5.12)	(5.50)	(8.38)
$250	(3.29)	(8.05)	(5.85)	(9.44)	(6.11)	(6.58)	(10.02)
$300	(3.81)	(9.33)	(6.77)	(10.93)	(7.08)	(7.61)	(11.60)
$350	(4.34)	(10.62)	(7.72)	(12.46)	(8.06)	(8.67)	(13.22)
$400	(4.79)	(11.74)	(8.52)	(13.76)	(8.92)	(9.59)	(14.60)
$500	(5.66)	(13.87)	(10.06)	(16.26)	(10.54)	(11.32)	(17.26)
$750	(7.40)	(18.12)	(13.16)	(21.24)	(13.76)	(14.79)	(22.54)
$1,000	(8.76)	(21.48)	(15.60)	(25.16)	(16.30)	(17.53)	(26.70)
$1,500	(10.79)	(26.42)	(19.19)	(30.97)	(20.07)	(21.57)	(32.87)
$2,000	(11.86)	(29.06)	(21.11)	(34.07)	(22.07)	(23.73)	(36.15)
$2,500	(12.93)	(31.68)	(23.00)	(37.14)	(24.05)	(25.86)	(39.40)
$5,000	(16.23)	(39.77)	(28.88)	(46.62)	(30.20)	(32.47)	(49.47)
$10,000	(18.96)	(46.44)	(33.73)	(54.44)	(35.26)	(37.92)	(57.76)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(1.89)	(4.62)	(3.36)	(5.42)	(3.50)	(3.77)	(5.74)
$250	(2.27)	(5.56)	(4.04)	(6.53)	(4.22)	(4.54)	(6.92)
$300	(2.65)	(6.50)	(4.72)	(7.63)	(4.93)	(5.31)	(8.09)
$350	(3.02)	(7.40)	(5.38)	(8.67)	(5.61)	(6.04)	(9.20)
$400	(3.34)	(8.18)	(5.95)	(9.61)	(6.22)	(6.69)	(10.19)
$500	(3.99)	(9.79)	(7.11)	(11.48)	(7.44)	(7.99)	(12.17)
$750	(5.24)	(12.84)	(9.32)	(15.05)	(9.75)	(10.48)	(15.97)
$1,000	(6.26)	(15.33)	(11.13)	(17.97)	(11.63)	(12.51)	(19.06)
$1,500	(7.82)	(19.15)	(13.91)	(22.46)	(14.54)	(15.64)	(23.83)
$2,000	(8.65)	(21.19)	(15.38)	(24.84)	(16.08)	(17.30)	(26.36)
$2,500	(9.49)	(23.25)	(16.87)	(27.24)	(17.65)	(18.98)	(28.91)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$250	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$300	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$400	8.6%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$250	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$300	8.6%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$400	8.6%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$250	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$300	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$350	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$400	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$500	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,500	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$250	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$300	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$350	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$400	8.5%	8.5%	8.3%	8.5%	8.6%	8.6%	8.5%
$500	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(148.87)	(364.73)	(272.43)	(433.20)	(276.90)	(297.74)	(455.54)
$10,000	(180.30)	(441.72)	(329.94)	(524.66)	(335.35)	(360.59)	(551.71)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(29.26)	(71.70)	(53.55)	(85.16)	(54.43)	(58.53)	(89.55)
$1,500	(31.91)	(78.17)	(58.38)	(92.84)	(59.34)	(63.81)	(97.63)
$2,000	(33.31)	(81.62)	(60.97)	(96.94)	(61.97)	(66.63)	(101.94)
$3,000	(34.52)	(84.57)	(63.17)	(100.44)	(64.20)	(69.03)	(105.62)
$4,000	(35.07)	(85.91)	(64.18)	(102.05)	(65.23)	(70.14)	(107.30)
$5,000	(35.35)	(86.62)	(64.70)	(102.88)	(65.76)	(70.71)	(108.18)
$7,000	(35.68)	(87.41)	(65.29)	(103.83)	(66.36)	(71.36)	(109.18)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(46.58)	(114.13)	(85.25)	(135.56)	(86.65)	(93.17)	(142.55)
$1,500	(50.81)	(124.47)	(92.97)	(147.85)	(94.50)	(101.61)	(155.47)
$2,000	(52.99)	(129.83)	(96.97)	(154.19)	(98.56)	(105.98)	(162.15)
$3,000	(55.01)	(134.77)	(100.66)	(160.08)	(102.32)	(110.02)	(168.33)
$4,000	(55.86)	(136.84)	(102.21)	(162.54)	(103.89)	(111.71)	(170.92)
$5,000	(56.30)	(137.94)	(103.04)	(163.84)	(104.72)	(112.61)	(172.29)
$7,000	(56.84)	(139.27)	(104.03)	(165.41)	(105.73)	(113.69)	(173.94)
$7,500	(57.30)	(140.39)	(104.87)	(166.75)	(106.58)	(114.61)	(175.35)
$10,000	(58.98)	(144.49)	(107.93)	(171.63)	(109.70)	(117.95)	(180.47)
$20,000	(61.37)	(150.37)	(112.31)	(178.59)	(114.16)	(122.75)	(187.80)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(45.01)	(110.28)	(82.38)	(130.99)	(83.72)	(90.03)	(137.74)
$1,500	(50.03)	(122.57)	(91.56)	(145.59)	(93.05)	(100.06)	(153.09)
$2,000	(52.81)	(129.38)	(96.63)	(153.66)	(98.22)	(105.61)	(161.59)
$3,000	(55.55)	(136.10)	(101.65)	(161.65)	(103.33)	(111.10)	(169.98)
$4,000	(56.79)	(139.15)	(103.93)	(165.27)	(105.63)	(113.59)	(173.79)
$5,000	(57.48)	(140.82)	(105.18)	(167.26)	(106.91)	(114.95)	(175.88)
$7,000	(58.15)	(142.46)	(106.42)	(169.22)	(108.16)	(116.30)	(177.94)
$7,500	(58.65)	(143.70)	(107.33)	(170.68)	(109.09)	(117.30)	(179.47)
$10,000	(60.71)	(148.74)	(111.10)	(176.66)	(112.92)	(121.42)	(185.77)
$20,000	(63.88)	(156.51)	(116.90)	(185.90)	(118.82)	(127.77)	(195.48)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(43.45)	(106.46)	(79.52)	(126.45)	(80.82)	(86.90)	(132.97)
$1,500	(49.27)	(120.71)	(90.16)	(143.36)	(91.64)	(98.53)	(150.76)
$2,000	(52.63)	(128.95)	(96.32)	(153.16)	(97.90)	(105.26)	(161.06)
$3,000	(56.11)	(137.47)	(102.68)	(163.28)	(104.37)	(112.22)	(171.70)
$4,000	(57.70)	(141.37)	(105.59)	(167.91)	(107.32)	(115.40)	(176.56)
$5,000	(58.63)	(143.65)	(107.29)	(170.62)	(109.05)	(117.26)	(179.41)
$7,000	(59.45)	(145.65)	(108.78)	(172.98)	(110.57)	(118.89)	(181.91)
$7,500	(59.98)	(146.94)	(109.75)	(174.53)	(111.56)	(119.95)	(183.53)
$10,000	(62.25)	(152.51)	(113.91)	(181.15)	(115.79)	(124.50)	(190.49)
$20,000	(66.29)	(162.41)	(121.31)	(192.90)	(123.30)	(132.58)	(202.85)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(49.17)	(120.47)	(89.98)	(143.10)	(91.46)	(98.35)	(150.47)
$1,500	(58.59)	(143.54)	(107.22)	(170.49)	(108.98)	(117.18)	(179.29)
$2,000	(64.67)	(158.44)	(118.34)	(188.18)	(120.28)	(129.34)	(197.88)
$3,000	(72.02)	(176.45)	(131.80)	(209.59)	(133.96)	(144.04)	(220.39)
$4,000	(76.06)	(186.35)	(139.19)	(221.34)	(141.47)	(152.12)	(232.74)
$5,000	(78.55)	(192.44)	(143.75)	(228.58)	(146.10)	(157.10)	(240.36)
$7,000	(81.12)	(198.75)	(148.45)	(236.06)	(150.89)	(162.24)	(248.23)
$7,500	(82.07)	(201.07)	(150.18)	(238.82)	(152.65)	(164.14)	(251.13)
$10,000	(85.88)	(210.42)	(157.17)	(249.92)	(159.74)	(171.77)	(262.80)
$20,000	(93.92)	(230.11)	(171.88)	(273.31)	(174.70)	(187.84)	(287.40)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.36	0.88	0.65	1.04	0.66	0.71	1.09
$1,000,000	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$50,000	(4.82)	(11.82)	(8.83)	(14.04)	(8.98)	(9.65)	(14.76)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(161.61)	(395.94)	(295.10)	(469.80)	(300.59)	(323.22)	(494.36)
$10,000	(195.74)	(479.56)	(357.42)	(569.02)	(364.08)	(391.48)	(598.77)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(31.77)	(77.84)	(58.01)	(92.36)	(59.09)	(63.54)	(97.18)
$1,500	(34.65)	(84.89)	(63.27)	(100.73)	(64.45)	(69.30)	(105.99)
$2,000	(36.16)	(88.59)	(66.03)	(105.12)	(67.26)	(72.32)	(110.61)
$3,000	(37.48)	(91.83)	(68.44)	(108.95)	(69.71)	(74.96)	(114.65)
$4,000	(38.07)	(93.27)	(69.52)	(110.67)	(70.81)	(76.14)	(116.46)
$5,000	(38.38)	(94.03)	(70.08)	(111.57)	(71.39)	(76.76)	(117.40)
$7,000	(38.73)	(94.89)	(70.72)	(112.59)	(72.04)	(77.46)	(118.48)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(50.56)	(123.87)	(92.32)	(146.98)	(94.04)	(101.12)	(154.66)
$1,500	(55.17)	(135.17)	(100.74)	(160.38)	(102.62)	(110.34)	(168.77)
$2,000	(57.52)	(140.92)	(105.03)	(167.21)	(106.99)	(115.04)	(175.95)
$3,000	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$4,000	(60.64)	(148.57)	(110.73)	(176.28)	(112.79)	(121.28)	(185.50)
$5,000	(61.12)	(149.74)	(111.61)	(177.68)	(113.68)	(122.24)	(186.97)
$7,000	(61.71)	(151.19)	(112.68)	(179.39)	(114.78)	(123.42)	(188.77)
$7,500	(62.21)	(152.41)	(113.60)	(180.84)	(115.71)	(124.42)	(190.30)
$10,000	(64.03)	(156.87)	(116.92)	(186.14)	(119.10)	(128.06)	(195.87)
$20,000	(66.62)	(163.22)	(121.65)	(193.66)	(123.91)	(133.24)	(203.79)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(48.86)	(119.71)	(89.22)	(142.04)	(90.88)	(97.72)	(149.46)
$1,500	(54.31)	(133.06)	(99.17)	(157.88)	(101.02)	(108.62)	(166.13)
$2,000	(57.34)	(140.48)	(104.70)	(166.69)	(106.65)	(114.68)	(175.40)
$3,000	(60.30)	(147.74)	(110.11)	(175.29)	(112.16)	(120.60)	(184.46)
$4,000	(61.66)	(151.07)	(112.59)	(179.25)	(114.69)	(123.32)	(188.62)
$5,000	(62.40)	(152.88)	(113.94)	(181.40)	(116.06)	(124.80)	(190.88)
$7,000	(63.13)	(154.67)	(115.28)	(183.52)	(117.42)	(126.26)	(193.11)
$7,500	(63.67)	(155.99)	(116.26)	(185.09)	(118.43)	(127.34)	(194.77)
$10,000	(65.90)	(161.46)	(120.33)	(191.57)	(122.57)	(131.80)	(201.59)
$20,000	(69.35)	(169.91)	(126.63)	(201.60)	(128.99)	(138.70)	(212.14)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(47.17)	(115.57)	(86.13)	(137.12)	(87.74)	(94.34)	(144.29)
$1,500	(53.50)	(131.08)	(97.69)	(155.52)	(99.51)	(107.00)	(163.66)
$2,000	(57.14)	(139.99)	(104.34)	(166.11)	(106.28)	(114.28)	(174.79)
$3,000	(60.92)	(149.25)	(111.24)	(177.09)	(113.31)	(121.84)	(186.35)
$4,000	(62.64)	(153.47)	(114.38)	(182.09)	(116.51)	(125.28)	(191.62)
$5,000	(63.65)	(155.94)	(116.22)	(185.03)	(118.39)	(127.30)	(194.71)
$7,000	(64.54)	(158.12)	(117.85)	(187.62)	(120.04)	(129.08)	(197.43)
$7,500	(65.11)	(159.52)	(118.89)	(189.27)	(121.10)	(130.22)	(199.17)
$10,000	(67.58)	(165.57)	(123.40)	(196.46)	(125.70)	(135.16)	(206.73)
$20,000	(71.97)	(176.33)	(131.42)	(209.22)	(133.86)	(143.94)	(220.16)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$1,500	(63.61)	(155.84)	(116.15)	(184.91)	(118.31)	(127.22)	(194.58)
$2,000	(70.20)	(171.99)	(128.19)	(204.07)	(130.57)	(140.40)	(214.74)
$3,000	(78.19)	(191.57)	(142.77)	(227.30)	(145.43)	(156.38)	(239.18)
$4,000	(82.57)	(202.30)	(150.77)	(240.03)	(153.58)	(165.14)	(252.58)
$5,000	(85.27)	(208.91)	(155.70)	(247.88)	(158.60)	(170.54)	(260.84)
$7,000	(88.06)	(215.75)	(160.80)	(255.99)	(163.79)	(176.12)	(269.38)
$7,500	(89.09)	(218.27)	(162.68)	(258.98)	(165.71)	(178.18)	(272.53)
$10,000	(93.24)	(228.44)	(170.26)	(271.05)	(173.43)	(186.48)	(285.22)
$20,000	(101.96)	(249.80)	(186.18)	(296.40)	(189.65)	(203.92)	(311.90)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.40	0.98	0.73	1.16	0.74	0.80	1.22
$1,000,000	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$50,000	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(12.74)	(31.21)	(22.67)	(36.60)	(23.69)	(25.48)	(38.82)
$10,000	(15.44)	(37.84)	(27.48)	(44.36)	(28.73)	(30.89)	(47.06)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(2.51)	(6.14)	(4.46)	(7.20)	(4.66)	(5.01)	(7.63)
$1,500	(2.74)	(6.72)	(4.89)	(7.89)	(5.11)	(5.49)	(8.36)
$2,000	(2.85)	(6.97)	(5.06)	(8.18)	(5.29)	(5.69)	(8.67)
$3,000	(2.96)	(7.26)	(5.27)	(8.51)	(5.51)	(5.93)	(9.03)
$4,000	(3.00)	(7.36)	(5.34)	(8.62)	(5.58)	(6.00)	(9.16)
$5,000	(3.03)	(7.41)	(5.38)	(8.69)	(5.63)	(6.05)	(9.22)
$7,000	(3.05)	(7.48)	(5.43)	(8.76)	(5.68)	(6.10)	(9.30)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(3.98)	(9.74)	(7.07)	(11.42)	(7.39)	(7.95)	(12.11)
$1,500	(4.36)	(10.70)	(7.77)	(12.53)	(8.12)	(8.73)	(13.30)
$2,000	(4.53)	(11.09)	(8.06)	(13.02)	(8.43)	(9.06)	(13.80)
$3,000	(4.71)	(11.54)	(8.39)	(13.53)	(8.76)	(9.42)	(14.35)
$4,000	(4.78)	(11.73)	(8.52)	(13.74)	(8.90)	(9.57)	(14.58)
$5,000	(4.82)	(11.80)	(8.57)	(13.84)	(8.96)	(9.63)	(14.68)
$7,000	(4.87)	(11.92)	(8.65)	(13.98)	(9.05)	(9.73)	(14.83)
$7,500	(4.91)	(12.02)	(8.73)	(14.09)	(9.13)	(9.81)	(14.95)
$10,000	(5.05)	(12.38)	(8.99)	(14.51)	(9.40)	(10.11)	(15.40)
$20,000	(5.25)	(12.85)	(9.34)	(15.07)	(9.75)	(10.49)	(15.99)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(3.85)	(9.43)	(6.84)	(11.05)	(7.16)	(7.69)	(11.72)
$1,500	(4.28)	(10.49)	(7.61)	(12.29)	(7.97)	(8.56)	(13.04)
$2,000	(4.53)	(11.10)	(8.07)	(13.03)	(8.43)	(9.07)	(13.81)
$3,000	(4.75)	(11.64)	(8.46)	(13.64)	(8.83)	(9.50)	(14.48)
$4,000	(4.87)	(11.92)	(8.66)	(13.98)	(9.06)	(9.73)	(14.83)
$5,000	(4.92)	(12.06)	(8.76)	(14.14)	(9.15)	(9.85)	(15.00)
$7,000	(4.98)	(12.21)	(8.86)	(14.30)	(9.26)	(9.96)	(15.17)
$7,500	(5.02)	(12.29)	(8.93)	(14.41)	(9.34)	(10.04)	(15.30)
$10,000	(5.19)	(12.72)	(9.23)	(14.91)	(9.65)	(10.38)	(15.82)
$20,000	(5.47)	(13.40)	(9.73)	(15.70)	(10.17)	(10.93)	(16.66)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(3.72)	(9.11)	(6.61)	(10.67)	(6.92)	(7.44)	(11.32)
$1,500	(4.23)	(10.37)	(7.53)	(12.16)	(7.87)	(8.47)	(12.90)
$2,000	(4.51)	(11.04)	(8.02)	(12.95)	(8.38)	(9.02)	(13.73)
$3,000	(4.81)	(11.78)	(8.56)	(13.81)	(8.94)	(9.62)	(14.65)
$4,000	(4.94)	(12.10)	(8.79)	(14.18)	(9.19)	(9.88)	(15.06)
$5,000	(5.02)	(12.29)	(8.93)	(14.41)	(9.34)	(10.04)	(15.30)
$7,000	(5.09)	(12.47)	(9.07)	(14.64)	(9.47)	(10.19)	(15.52)
$7,500	(5.13)	(12.58)	(9.14)	(14.74)	(9.54)	(10.27)	(15.64)
$10,000	(5.33)	(13.06)	(9.49)	(15.31)	(9.91)	(10.66)	(16.24)
$20,000	(5.68)	(13.92)	(10.11)	(16.32)	(10.56)	(11.36)	(17.31)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(4.21)	(10.31)	(7.49)	(12.08)	(7.83)	(8.41)	(12.82)
$1,500	(5.02)	(12.30)	(8.93)	(14.42)	(9.33)	(10.04)	(15.29)
$2,000	(5.53)	(13.55)	(9.85)	(15.89)	(10.29)	(11.06)	(16.86)
$3,000	(6.17)	(15.12)	(10.97)	(17.71)	(11.47)	(12.34)	(18.79)
$4,000	(6.51)	(15.95)	(11.58)	(18.69)	(12.11)	(13.02)	(19.84)
$5,000	(6.72)	(16.47)	(11.95)	(19.30)	(12.50)	(13.44)	(20.48)
$7,000	(6.94)	(17.00)	(12.35)	(19.93)	(12.90)	(13.88)	(21.15)
$7,500	(7.02)	(17.20)	(12.50)	(20.16)	(13.06)	(14.04)	(21.40)
$10,000	(7.36)	(18.02)	(13.09)	(21.13)	(13.69)	(14.71)	(22.42)
$20,000	(8.04)	(19.69)	(14.30)	(23.09)	(14.95)	(16.08)	(24.50)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.04	0.10	0.08	0.12	0.08	0.09	0.13
$1,000,000	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$50,000	(0.42)	(1.02)	(0.74)	(1.19)	(0.77)	(0.83)	(1.27)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$2,000	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$3,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,000	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$1,500	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$2,000	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$3,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$20,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	11.1%	11.4%	12.3%	11.5%	12.1%	12.7%	11.9%
$1,000,000	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$50,000	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.36)	(0.88)	(0.65)	(1.04)	(0.66)	(0.71)	(1.09)
75%	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
70%	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
75%	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
70%	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
75%	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
70%	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	11.1%	11.4%	12.3%	11.5%	12.1%	12.7%	11.9%
75%	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
70%	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.03)	(4.98)	(3.71)	(5.91)	(3.77)	(4.06)	(6.21)
$10	(4.25)	(10.42)	(7.78)	(12.37)	(7.92)	(8.51)	(13.02)
$15	(7.08)	(17.34)	(12.95)	(20.60)	(13.17)	(14.16)	(21.66)
$20	(10.92)	(26.76)	(19.99)	(31.79)	(20.32)	(21.85)	(33.43)
$25	(14.38)	(35.24)	(26.32)	(41.85)	(26.75)	(28.76)	(44.01)
$30	(18.19)	(44.55)	(33.28)	(52.93)	(33.82)	(36.37)	(55.65)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.15)	(2.83)	(2.11)	(3.36)	(2.14)	(2.31)	(3.53)
$10	(2.44)	(5.98)	(4.46)	(7.09)	(4.54)	(4.88)	(7.46)
$15	(4.06)	(9.95)	(7.43)	(11.81)	(7.55)	(8.12)	(12.42)
$20	(6.25)	(15.32)	(11.44)	(18.20)	(11.63)	(12.51)	(19.14)
$25	(8.24)	(20.20)	(15.09)	(23.98)	(15.33)	(16.48)	(25.21)
$30	(10.41)	(25.51)	(19.05)	(30.30)	(19.37)	(20.83)	(31.86)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.48)	(3.62)	(2.70)	(4.30)	(2.75)	(2.96)	(4.53)
$10	(3.06)	(7.50)	(5.60)	(8.90)	(5.69)	(6.12)	(9.36)
$15	(4.79)	(11.75)	(8.77)	(13.95)	(8.91)	(9.59)	(14.67)
$20	(6.75)	(16.54)	(12.35)	(19.65)	(12.56)	(13.50)	(20.67)
$25	(8.91)	(21.84)	(16.31)	(25.94)	(16.59)	(17.83)	(27.27)
$30	(11.36)	(27.84)	(20.80)	(33.07)	(21.13)	(22.73)	(34.77)
$35	(13.65)	(33.44)	(24.98)	(39.72)	(25.39)	(27.30)	(41.76)
$40	(16.02)	(39.26)	(29.33)	(46.63)	(29.80)	(32.05)	(49.03)
$45	(18.53)	(45.41)	(33.92)	(53.93)	(34.48)	(37.07)	(56.71)
$50	(21.15)	(51.83)	(38.71)	(61.56)	(39.35)	(42.31)	(64.73)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.25)	(3.07)	(2.30)	(3.65)	(2.34)	(2.51)	(3.84)
$10	(2.59)	(6.34)	(4.74)	(7.54)	(4.81)	(5.18)	(7.93)
$15	(4.06)	(9.95)	(7.43)	(11.81)	(7.55)	(8.12)	(12.42)
$20	(5.71)	(13.99)	(10.46)	(16.63)	(10.63)	(11.42)	(17.48)
$25	(7.54)	(18.47)	(13.79)	(21.93)	(14.03)	(15.08)	(23.06)
$30	(9.61)	(23.54)	(17.58)	(27.96)	(17.87)	(19.22)	(29.41)
$35	(11.56)	(28.32)	(21.14)	(33.63)	(21.49)	(23.11)	(35.36)
$40	(13.56)	(33.21)	(24.81)	(39.44)	(25.21)	(27.11)	(41.48)
$45	(15.67)	(38.38)	(28.67)	(45.59)	(29.14)	(31.33)	(47.94)
$50	(17.89)	(43.83)	(32.74)	(52.06)	(33.27)	(35.78)	(54.74)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.74)	(1.83)	(1.37)	(2.16)	(1.39)	(1.49)	(2.27)
$150	(1.21)	(2.98)	(2.22)	(3.53)	(2.25)	(2.43)	(3.71)
$200	(1.73)	(4.25)	(3.17)	(5.05)	(3.22)	(3.47)	(5.30)
$250	(2.48)	(6.07)	(4.54)	(7.21)	(4.61)	(4.96)	(7.59)
$500	(5.97)	(14.62)	(10.92)	(17.36)	(11.10)	(11.93)	(18.26)
$750	(10.24)	(25.09)	(18.74)	(29.80)	(19.04)	(20.48)	(31.33)
$1,000	(15.40)	(37.74)	(28.18)	(44.82)	(28.65)	(30.80)	(47.13)
Copay/Day							
$50 w/3 Day Max	(0.90)	(2.20)	(1.64)	(2.61)	(1.67)	(1.80)	(2.74)
$50 w/5 Day Max	(1.23)	(3.02)	(2.25)	(3.59)	(2.30)	(2.47)	(3.77)
$100 w/3 Day Max	(2.24)	(5.50)	(4.11)	(6.53)	(4.17)	(4.49)	(6.86)
$100 w/5 Day Max	(3.23)	(7.93)	(5.92)	(9.40)	(6.02)	(6.47)	(9.89)
$250 w/3 Day Max	(7.43)	(18.20)	(13.59)	(21.60)	(13.81)	(14.85)	(22.73)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.80)	(1.21)
$75	(0.63)	(1.55)	(1.15)	(1.84)	(1.17)	(1.26)	(1.94)
$100	(0.90)	(2.20)	(1.64)	(2.61)	(1.67)	(1.80)	(2.74)
$125	(1.17)	(2.88)	(2.14)	(3.42)	(2.18)	(2.35)	(3.59)
$150	(1.47)	(3.60)	(2.69)	(4.27)	(2.73)	(2.94)	(4.50)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
$25	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$35	(0.50)	(1.22)	(0.92)	(1.46)	(0.93)	(1.00)	(1.53)
$50	(0.85)	(2.07)	(1.55)	(2.47)	(1.57)	(1.69)	(2.59)
$60	(1.07)	(2.62)	(1.96)	(3.12)	(1.99)	(2.14)	(3.27)
$75	(1.42)	(3.48)	(2.59)	(4.12)	(2.64)	(2.84)	(4.34)
$100	(2.02)	(4.95)	(3.69)	(5.88)	(3.75)	(4.04)	(6.18)
$125	(2.48)	(6.07)	(4.54)	(7.21)	(4.61)	(4.96)	(7.59)
$150	(2.97)	(7.27)	(5.44)	(8.64)	(5.52)	(5.94)	(9.08)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.40	0.98	0.72	1.15	0.74	0.80	1.21
60	0.78	1.90	1.42	2.25	1.44	1.55	2.38
90	1.16	2.85	2.13	3.39	2.16	2.33	3.56
120	1.36	3.33	2.48	3.95	2.52	2.71	4.15
Unlimited	1.75	4.29	3.21	5.11	3.26	3.51	5.37
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.39)	(4.02)	(6.40)	(4.09)	(4.40)	(6.73)
$10	(4.62)	(11.32)	(8.44)	(13.43)	(8.59)	(9.24)	(14.13)
$15	(7.68)	(18.82)	(14.02)	(22.33)	(14.28)	(15.36)	(23.49)
$20	(11.86)	(29.06)	(21.66)	(34.48)	(22.06)	(23.72)	(36.28)
$25	(15.61)	(38.24)	(28.50)	(45.38)	(29.03)	(31.22)	(47.75)
$30	(19.75)	(48.39)	(36.06)	(57.41)	(36.74)	(39.50)	(60.42)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$10	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$15	(4.40)	(10.78)	(8.03)	(12.79)	(8.18)	(8.80)	(13.46)
$20	(6.79)	(16.64)	(12.40)	(19.74)	(12.63)	(13.58)	(20.77)
$25	(8.94)	(21.90)	(16.32)	(25.99)	(16.63)	(17.88)	(27.35)
$30	(11.30)	(27.69)	(20.63)	(32.85)	(21.02)	(22.60)	(34.57)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$10	(3.32)	(8.13)	(6.06)	(9.65)	(6.18)	(6.64)	(10.16)
$15	(5.21)	(12.76)	(9.51)	(15.15)	(9.69)	(10.42)	(15.94)
$20	(7.34)	(17.98)	(13.40)	(21.34)	(13.65)	(14.68)	(22.45)
$25	(9.67)	(23.69)	(17.66)	(28.11)	(17.99)	(19.34)	(29.58)
$30	(12.34)	(30.23)	(22.53)	(35.87)	(22.95)	(24.68)	(37.75)
$35	(14.82)	(36.31)	(27.06)	(43.08)	(27.57)	(29.64)	(45.33)
$40	(17.39)	(42.61)	(31.75)	(50.55)	(32.35)	(34.78)	(53.20)
$45	(20.12)	(49.29)	(36.74)	(58.49)	(37.42)	(40.24)	(61.55)
$50	(22.96)	(56.25)	(41.92)	(66.74)	(42.71)	(45.92)	(70.23)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$10	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$15	(4.40)	(10.78)	(8.03)	(12.79)	(8.18)	(8.80)	(13.46)
$20	(6.20)	(15.19)	(11.32)	(18.02)	(11.53)	(12.40)	(18.97)
$25	(8.18)	(20.04)	(14.94)	(23.78)	(15.21)	(16.36)	(25.02)
$30	(10.43)	(25.55)	(19.05)	(30.32)	(19.40)	(20.86)	(31.91)
$35	(12.54)	(30.72)	(22.90)	(36.45)	(23.32)	(25.08)	(38.36)
$40	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$45	(17.01)	(41.67)	(31.06)	(49.45)	(31.64)	(34.02)	(52.03)
$50	(19.42)	(47.58)	(35.46)	(56.45)	(36.12)	(38.84)	(59.41)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$150	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$200	(1.87)	(4.58)	(3.41)	(5.44)	(3.48)	(3.74)	(5.72)
$250	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$500	(6.48)	(15.88)	(11.83)	(18.84)	(12.05)	(12.96)	(19.82)
$750	(11.11)	(27.22)	(20.29)	(32.30)	(20.66)	(22.22)	(33.99)
$1,000	(16.72)	(40.96)	(30.53)	(48.61)	(31.10)	(33.44)	(51.15)
Copay/Day							
$50 w/3 Day Max	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$50 w/5 Day Max	(1.33)	(3.26)	(2.43)	(3.87)	(2.47)	(2.66)	(4.07)
$100 w/3 Day Max	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$100 w/5 Day Max	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$250 w/3 Day Max	(8.07)	(19.77)	(14.74)	(23.46)	(15.01)	(16.14)	(24.69)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$100	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$125	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$150	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$35	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$50	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
$60	(1.16)	(2.84)	(2.12)	(3.37)	(2.16)	(2.32)	(3.55)
$75	(1.54)	(3.77)	(2.81)	(4.48)	(2.86)	(3.08)	(4.71)
$100	(2.19)	(5.37)	(4.00)	(6.37)	(4.07)	(4.38)	(6.70)
$125	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$150	(3.22)	(7.89)	(5.88)	(9.36)	(5.99)	(6.44)	(9.85)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.44	1.08	0.80	1.28	0.82	0.88	1.35
60	0.86	2.11	1.57	2.50	1.60	1.72	2.63
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
120	1.48	3.63	2.70	4.30	2.75	2.96	4.53
Unlimited	1.91	4.68	3.49	5.55	3.55	3.82	5.84
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.41)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$10	(0.37)	(0.90)	(0.66)	(1.06)	(0.67)	(0.73)	(1.11)
$15	(0.60)	(1.48)	(1.07)	(1.73)	(1.11)	(1.20)	(1.83)
$20	(0.94)	(2.30)	(1.67)	(2.69)	(1.74)	(1.87)	(2.85)
$25	(1.23)	(3.00)	(2.18)	(3.53)	(2.28)	(2.46)	(3.74)
$30	(1.56)	(3.84)	(2.78)	(4.48)	(2.92)	(3.13)	(4.77)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.21)	(0.15)	(0.24)	(0.17)	(0.17)	(0.26)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.65)
$15	(0.34)	(0.83)	(0.60)	(0.98)	(0.63)	(0.68)	(1.04)
$20	(0.54)	(1.32)	(0.96)	(1.54)	(1.00)	(1.07)	(1.63)
$25	(0.70)	(1.70)	(1.23)	(2.01)	(1.30)	(1.40)	(2.14)
$30	(0.89)	(2.18)	(1.58)	(2.55)	(1.65)	(1.77)	(2.71)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.39)
$10	(0.26)	(0.63)	(0.46)	(0.75)	(0.49)	(0.52)	(0.80)
$15	(0.42)	(1.01)	(0.74)	(1.20)	(0.78)	(0.83)	(1.27)
$20	(0.59)	(1.44)	(1.05)	(1.69)	(1.09)	(1.18)	(1.78)
$25	(0.76)	(1.85)	(1.35)	(2.17)	(1.40)	(1.51)	(2.31)
$30	(0.98)	(2.39)	(1.73)	(2.80)	(1.82)	(1.95)	(2.98)
$35	(1.17)	(2.87)	(2.08)	(3.36)	(2.18)	(2.34)	(3.57)
$40	(1.37)	(3.35)	(2.42)	(3.92)	(2.55)	(2.73)	(4.17)
$45	(1.59)	(3.88)	(2.82)	(4.56)	(2.94)	(3.17)	(4.84)
$50	(1.81)	(4.42)	(3.21)	(5.18)	(3.36)	(3.61)	(5.50)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.29)	(0.20)	(0.33)	(0.21)	(0.23)	(0.35)
$10	(0.22)	(0.54)	(0.39)	(0.63)	(0.42)	(0.44)	(0.67)
$15	(0.34)	(0.83)	(0.60)	(0.98)	(0.63)	(0.68)	(1.04)
$20	(0.49)	(1.20)	(0.86)	(1.39)	(0.90)	(0.98)	(1.49)
$25	(0.64)	(1.57)	(1.15)	(1.85)	(1.18)	(1.28)	(1.96)
$30	(0.82)	(2.01)	(1.47)	(2.36)	(1.53)	(1.64)	(2.50)
$35	(0.98)	(2.40)	(1.76)	(2.82)	(1.83)	(1.97)	(3.00)
$40	(1.16)	(2.85)	(2.07)	(3.35)	(2.17)	(2.33)	(3.55)
$45	(1.34)	(3.29)	(2.39)	(3.86)	(2.50)	(2.69)	(4.09)
$50	(1.53)	(3.75)	(2.72)	(4.39)	(2.85)	(3.06)	(4.67)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.05)	(0.11)	(0.07)	(0.14)	(0.08)	(0.09)	(0.15)
$150	(0.09)	(0.21)	(0.15)	(0.25)	(0.17)	(0.17)	(0.27)
$200	(0.14)	(0.33)	(0.24)	(0.39)	(0.26)	(0.27)	(0.42)
$250	(0.21)	(0.52)	(0.37)	(0.61)	(0.39)	(0.42)	(0.64)
$500	(0.51)	(1.26)	(0.91)	(1.48)	(0.95)	(1.03)	(1.56)
$750	(0.87)	(2.13)	(1.55)	(2.50)	(1.62)	(1.74)	(2.66)
$1,000	(1.32)	(3.22)	(2.35)	(3.79)	(2.45)	(2.64)	(4.02)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.26)
$50 w/5 Day Max	(0.10)	(0.24)	(0.18)	(0.28)	(0.17)	(0.19)	(0.30)
$100 w/3 Day Max	(0.19)	(0.45)	(0.33)	(0.53)	(0.35)	(0.37)	(0.57)
$100 w/5 Day Max	(0.28)	(0.67)	(0.49)	(0.80)	(0.51)	(0.55)	(0.85)
$250 w/3 Day Max	(0.64)	(1.57)	(1.15)	(1.86)	(1.20)	(1.29)	(1.96)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
$75	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
$100	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.26)
$125	(0.09)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.26)
$150	(0.13)	(0.32)	(0.23)	(0.38)	(0.25)	(0.26)	(0.39)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$35	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.21)	(0.15)	(0.23)	(0.16)	(0.17)	(0.25)
$60	(0.09)	(0.22)	(0.16)	(0.25)	(0.17)	(0.18)	(0.28)
$75	(0.12)	(0.29)	(0.22)	(0.36)	(0.22)	(0.24)	(0.37)
$100	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$125	(0.21)	(0.52)	(0.37)	(0.61)	(0.39)	(0.42)	(0.64)
$150	(0.25)	(0.62)	(0.44)	(0.72)	(0.47)	(0.50)	(0.77)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.08	0.13	0.08	0.08	0.14
60	0.08	0.21	0.15	0.25	0.16	0.17	0.25
90	0.09	0.21	0.15	0.24	0.17	0.17	0.26
120	0.12	0.30	0.22	0.35	0.23	0.25	0.38
Unlimited	0.16	0.39	0.28	0.44	0.29	0.31	0.47
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.2%	8.4%	8.3%	8.5%	8.4%	8.4%
$10	8.7%	8.6%	8.5%	8.6%	8.5%	8.6%	8.5%
$15	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
$20	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$25	8.6%	8.5%	8.3%	8.4%	8.5%	8.6%	8.5%
$30	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.8%	7.4%	7.1%	7.1%	7.9%	7.4%	7.4%
$10	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%	8.7%
$15	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
$20	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$25	8.5%	8.4%	8.2%	8.4%	8.5%	8.5%	8.5%
$30	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.8%	8.8%	8.9%	8.8%	8.7%	8.8%	8.6%
$10	8.5%	8.4%	8.2%	8.4%	8.6%	8.5%	8.5%
$15	8.8%	8.6%	8.4%	8.6%	8.8%	8.7%	8.7%
$20	8.7%	8.7%	8.5%	8.6%	8.7%	8.7%	8.6%
$25	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
$30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$35	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$40	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$45	8.6%	8.5%	8.3%	8.5%	8.5%	8.6%	8.5%
$50	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	9.6%	9.4%	8.7%	9.0%	9.0%	9.2%	9.1%
$10	8.5%	8.5%	8.2%	8.4%	8.7%	8.5%	8.4%
$15	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
$20	8.6%	8.6%	8.2%	8.4%	8.5%	8.6%	8.5%
$25	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
$30	8.5%	8.5%	8.4%	8.4%	8.6%	8.5%	8.5%
$35	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$45	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$50	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	6.8%	6.0%	5.1%	6.5%	5.8%	6.0%	6.6%
$150	7.4%	7.0%	6.8%	7.1%	7.6%	7.0%	7.3%
$200	8.1%	7.8%	7.6%	7.7%	8.1%	7.8%	7.9%
$250	8.5%	8.6%	8.1%	8.5%	8.5%	8.5%	8.4%
$500	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$1,000	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.5%
Copay/Day							
$50 w/3 Day Max	8.9%	9.1%	9.1%	9.2%	9.0%	8.9%	9.5%
$50 w/5 Day Max	8.1%	7.9%	8.0%	7.8%	7.4%	7.7%	8.0%
$100 w/3 Day Max	8.5%	8.2%	8.0%	8.1%	8.4%	8.2%	8.3%
$100 w/5 Day Max	8.7%	8.4%	8.3%	8.5%	8.5%	8.5%	8.6%
$250 w/3 Day Max	8.6%	8.6%	8.5%	8.6%	8.7%	8.7%	8.6%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	10.0%	10.2%	11.1%	11.3%	10.8%	10.0%	11.6%
$75	7.9%	7.7%	7.8%	7.6%	7.7%	7.9%	7.2%
$100	8.9%	9.1%	9.1%	9.2%	9.0%	8.

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
40/$15 copay	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
40/$20 copay	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
40/$25 copay	(0.50)	(1.22)	(0.92)	(1.46)	(0.93)	(1.00)	(1.53)
60	0.18	0.45	0.34	0.53	0.34	0.37	0.56
100	0.45	1.10	0.83	1.31	0.84	0.90	1.38
200	1.19	2.93	2.18	3.47	2.22	2.39	3.65

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.82)	(2.00)	(1.49)	(2.38)	(1.52)	(1.63)	(2.50)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.54	1.33	0.99	1.57	1.01	1.08	1.65
90	1.10	2.70	2.02	3.20	2.05	2.20	3.37

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.47	1.15	0.86	1.37	0.88	0.94	1.44
90	0.87	2.12	1.59	2.52	1.61	1.73	2.65
120	1.41	3.45	2.58	4.10	2.62	2.82	4.30

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.67)	(1.65)	(1.23)	(1.96)	(1.25)	(1.35)	(2.06)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.19	0.48	0.36	0.56	0.36	0.39	0.59
30	0.32	0.78	0.58	0.92	0.59	0.63	0.97
Unlimited	0.47	1.15	0.86	1.37	0.88	0.94	1.44

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.09	5.12	3.83	6.09	3.89	4.18	6.40
60	2.46	6.02	4.50	7.15	4.57	4.92	7.52
90	2.93	7.17	5.36	8.52	5.45	5.85	8.96
Unlimited	2.97	7.27	5.44	8.64	5.52	5.94	9.08

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
60/$15 copay	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
60/$20 copay	(0.41)	(1.00)	(0.74)	(1.18)	(0.75)	(0.82)	(1.24)
60/$25 copay	(0.50)	(1.22)	(0.92)	(1.46)	(0.93)	(1.00)	(1.53)
120/$0 copay	0.42	1.02	0.77	1.21	0.78	0.84	1.28
120/$5 copay	0.32	0.78	0.58	0.92	0.59	0.63	0.97
120/$10 copay	0.18	0.45	0.34	0.53	0.34	0.37	0.56
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.12)	(0.30)	(0.22)	(0.36)	(0.22)	(0.24)	(0.38)
120/$25 copay	(0.23)	(0.57)	(0.43)	(0.68)	(0.44)	(0.47)	(0.71)
)nlimited/$0 copa	0.49	1.20	0.90	1.43	0.91	0.98	1.50
)nlimited/$5 copa	0.37	0.90	0.67	1.07	0.68	0.73	1.12
nlimited/$10 copa	0.23	0.57	0.43	0.68	0.44	0.47	0.71
nlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
nlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
nlimited/$25 copa	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.12	0.30	0.22	0.36	0.22	0.24	0.38
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$25	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
$15	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
$20	(0.41)	(1.00)	(0.74)	(1.18)	(0.75)	(0.82)	(1.24)
$25	(0.52)	(1.28)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$30	(0.63)	(1.55)	(1.15)	(1.84)	(1.17)	(1.26)	(1.94)
$35	(0.74)	(1.83)	(1.37)	(2.16)	(1.39)	(1.49)	(2.27)
$40	(0.86)	(2.10)	(1.57)	(2.49)	(1.59)	(1.71)	(2.62)
$45	(0.98)	(2.40)	(1.80)	(2.85)	(1.83)	(1.96)	(3.00)
$50	(1.08)	(2.65)	(1.98)	(3.14)	(2.01)	(2.16)	(3.30)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$10	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$15	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$20	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
$25	(0.60)	(1.48)	(1.10)	(1.75)	(1.12)	(1.20)	(1.85)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$20 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
40/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.49	1.20	0.89	1.42	0.91	0.98	1.50
200	1.28	3.14	2.34	3.72	2.38	2.56	3.92

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.58	1.42	1.06	1.69	1.08	1.16	1.77
90	1.19	2.92	2.17	3.46	2.21	2.38	3.64

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.51	1.25	0.93	1.48	0.95	1.02	1.56
90	0.95	2.33	1.73	2.76	1.77	1.90	2.91
120	1.53	3.75	2.79	4.45	2.85	3.06	4.68

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited	0.51	1.25	0.93	1.48	0.95	1.02	1.56

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.26	5.54	4.13	6.57	4.20	4.52	6.91
60	2.67	6.54	4.88	7.76	4.97	5.34	8.17
90	3.18	7.79	5.81	9.24	5.91	6.36	9.73
Unlimited	3.22	7.89	5.88	9.36	5.99	6.44	9.85

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
60/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
120/$0 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
120/$5 copay	0.35	0.86	0.64	1.02	0.65	0.70	1.07
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copa	0.53	1.30	0.97	1.54	0.99	1.06	1.62
Unlimited/$5 copa	0.41	1.00	0.75	1.19	0.76	0.82	1.25
Unlimited/$10 copa	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copa	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$20	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$25	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$30	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$35	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$40	(0.94)	(2.30)	(1.72)	(2.73)	(1.75)	(1.88)	(2.88)
$45	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$50	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$25	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
40/$15 copay	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
40/$20 copay	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
40/$25 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
60	0.01	0.02	0.01	0.02	0.01	0.01	0.02
100	0.04	0.10	0.06	0.11	0.07	0.08	0.12
200	0.09	0.21	0.16	0.25	0.16	0.17	0.27

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.17)	(0.25)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.09	0.07	0.12	0.07	0.08	0.12
90	0.09	0.22	0.15	0.26	0.16	0.18	0.27

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.07	0.11	0.07	0.08	0.12
90	0.08	0.21	0.14	0.24	0.16	0.17	0.26
120	0.12	0.30	0.21	0.35	0.23	0.24	0.38

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.05)	(0.11)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.01	0.01	0.02	0.01	0.01	0.02
30	0.03	0.08	0.06	0.10	0.06	0.07	0.10
Unlimited	0.04	0.10	0.07	0.11	0.07	0.08	0.12

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.17	0.42	0.30	0.48	0.31	0.34	0.51
60	0.21	0.52	0.38	0.61	0.40	0.42	0.65
90	0.25	0.62	0.45	0.72	0.46	0.51	0.77
Unlimited	0.25	0.62	0.44	0.72	0.47	0.50	0.77

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
60/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.11	0.07	0.13	0.08	0.08	0.13
120/$5 copay	0.03	0.08	0.06	0.10	0.06	0.07	0.10
120/$10 copay	0.01	0.02	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
120/$25 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Unlimited/$0 copa	0.04	0.10	0.07	0.11	0.08	0.08	0.12
Unlimited/$5 copa	0.04	0.10	0.08	0.12	0.08	0.09	0.13
Unlimited/$10 copa	0.01	0.02	0.01	0.02	0.01	0.01	0.02
Unlimited/$15 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copa	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.01	0.02	0.02	0.02	0.02	0.02	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
$25	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
$35	(0.05)	(0.11)	(0.07)	(0.14)	(0.08)	(0.09)	(0.15)
$40	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.17)	(0.26)
$45	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.16)	(0.24)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$10	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.05)	(0.11)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
40/$15 copay	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
40/$20 copay	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
40/$25 copay	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
60	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
100	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
200	7.6%	7.2%	7.3%	7.2%	7.2%	7.1%	7.4%

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	9.8%	10.5%	10.1%	10.1%	9.9%	10.4%	10.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.4%	6.8%	7.1%	7.6%	6.9%	7.4%	7.3%
90	8.2%	8.1%	7.4%	8.1%	7.8%	8.2%	8.0%

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
90	9.2%	9.9%	8.8%	9.5%	9.9%	9.8%	9.8%
120	8.5%	8.7%	8.1%	8.5%	8.8%	8.5%	8.8%

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
30	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
Unlimited	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.1%	8.2%	7.8%	7.9%	8.0%	8.1%	8.0%
60	8.5%	8.6%	8.4%	8.5%	8.8%	8.5%	8.6%
90	8.5%	8.6%	8.4%	8.5%	8.4%	8.7%	8.6%
Unlimited	8.4%	8.5%	8.1%	8.3%	8.5%	8.4%	8.5%

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
60/$15 copay	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
60/$20 copay	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
60/$25 copay	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
120/$0 copay	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
120/$5 copay	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
120/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	8.3%	6.7%	9.1%	5.6%	9.1%	8.3%	5.3%
120/$25 copay	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
Unlimited/$0 copa	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
Unlimited/$5 copa	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
Unlimited/$10 copa	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
Unlimited/$15 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copa	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$35	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.27)	(0.41)
$50	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$60	(0.26)	(0.62)	(0.47)	(0.74)	(0.48)	(0.51)	(0.79)
$75	(0.34)	(0.83)	(0.61)	(0.98)	(0.62)	(0.67)	(1.03)
$100	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$50	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$60	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
$75	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
$100	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(1.88)	(4.60)	(3.44)	(5.46)	(3.49)	(3.75)	(5.74)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(2.93)	(7.17)	(5.36)	(8.52)	(5.45)	(5.85)	(8.96)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.26)	(0.62)	(0.47)	(0.74)	(0.48)	(0.51)	(0.79)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$75	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$100	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.01)	(0.02)
$50	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.09)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$50	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$75	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$100	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.17)	(0.42)	(0.30)	(0.50)	(0.32)	(0.35)	(0.53)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(0.25)	(0.62)	(0.45)	(0.72)	(0.46)	(0.51)	(0.77)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$35	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
$50	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$60	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
$75	11.8%	12.0%	13.1%	12.2%	14.5%	13.4%	12.6%
$100	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$50	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$60	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
$75	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
$100	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	9.0%	9.1%	8.7%	9.2%	9.2%	9.3%	9.2%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	8.5%	8.6%	8.4%	8.5%	8.4%	8.7%	8.6%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.63	18.70	13.96	22.21	14.19	15.26	23.35
60	8.05	19.72	14.73	23.42	14.97	16.10	24.62
90	8.34	20.44	15.27	24.28	15.51	16.69	25.53
Unlimited	8.43	20.64	15.42	24.52	15.67	16.85	25.79
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.53	20.89	15.61	24.82	15.86	17.05	26.09
30	9.38	22.99	17.18	27.31	17.45	18.77	28.71
40	9.90	24.27	18.13	28.83	18.42	19.81	30.30
60	10.44	25.59	19.11	30.40	19.43	20.89	31.96
Unlimited	10.53	25.79	19.27	30.63	19.58	21.05	32.21
LARGE GROUP			**$5 Copay**				
20	8.02	19.65	14.67	23.33	14.91	16.03	24.53
30	8.82	21.61	16.15	25.67	16.41	17.65	27.00
40	9.37	22.97	17.16	27.27	17.43	18.75	28.68
60	9.82	24.06	17.97	28.58	18.27	19.65	30.06
Unlimited	9.89	24.25	18.11	28.79	18.40	19.79	30.27
LARGE GROUP			**$10 Copay**				
20	7.51	18.39	13.74	21.85	13.96	15.01	22.97
30	8.27	20.27	15.14	24.07	15.38	16.54	25.32
40	8.74	21.42	15.99	25.44	16.26	17.48	26.74
60	9.21	22.56	16.85	26.81	17.14	18.42	28.18
Unlimited	9.28	22.75	16.98	27.01	17.27	18.56	28.41
LARGE GROUP			**$15 Copay**				
20	7.05	17.27	12.90	20.51	13.11	14.10	21.56
30	7.76	19.01	14.21	22.59	14.43	15.52	23.76
40	8.22	20.15	15.05	23.92	15.29	16.44	25.15
60	8.70	21.32	15.92	25.32	16.19	17.40	26.62
Unlimited	8.77	21.49	16.05	25.53	16.32	17.54	26.85
LARGE GROUP			**$20 Copay**				
20	6.63	16.25	12.14	19.30	12.33	13.26	20.29
30	7.27	17.82	13.31	21.17	13.53	14.55	22.26
40	7.67	18.79	14.04	22.32	14.27	15.34	23.47
60	8.15	19.97	14.91	23.72	15.16	16.30	24.94
Unlimited	8.21	20.11	15.02	23.90	15.27	16.42	25.12
LARGE GROUP			**$25 Copay**				
20	6.16	15.10	11.27	17.93	11.45	12.32	18.85
30	6.77	16.60	12.39	19.71	12.60	13.55	20.73
40	7.22	17.70	13.22	21.01	13.43	14.44	22.09
60	7.59	18.59	13.89	22.08	14.12	15.18	23.23
Unlimited	7.66	18.77	14.01	22.29	14.25	15.32	23.44
LARGE GROUP			**$30 Copay**				
20	5.88	14.39	10.75	17.10	10.92	11.75	17.98
30	6.38	15.62	11.67	18.55	11.86	12.75	19.51
40	6.79	16.65	12.43	19.77	12.64	13.59	20.79
60	7.12	17.44	13.03	20.72	13.24	14.24	21.79
Unlimited	7.16	17.54	13.11	20.84	13.32	14.32	21.91
LARGE GROUP			**$35 Copay**				
20	5.59	13.70	10.23	16.27	10.39	11.18	17.11
30	5.97	14.62	10.92	17.36	11.10	11.93	18.26
40	6.35	15.57	11.63	18.49	11.82	12.71	19.44
60	6.66	16.32	12.19	19.38	12.39	13.32	20.38
Unlimited	6.71	16.44	12.28	19.53	12.48	13.42	20.53
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.28	20.29	15.12	24.07	15.40	16.56	25.33
60	8.74	21.41	15.96	25.41	16.26	17.48	26.74
90	9.06	22.20	16.54	26.34	16.85	18.12	27.71
Unlimited	9.15	22.42	16.71	26.60	17.02	18.30	27.99
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.26	22.69	16.91	26.92	17.22	18.52	28.33
30	10.19	24.97	18.61	29.62	18.95	20.38	31.17
40	10.75	26.34	19.63	31.25	20.00	21.50	32.88
60	11.33	27.76	20.69	32.94	21.07	22.66	34.66
Unlimited	11.43	28.00	20.87	33.23	21.26	22.86	34.96
LARGE GROUP			**$5 Copay**				
20	8.70	21.32	15.89	25.29	16.18	17.40	26.61
30	9.58	23.47	17.49	27.85	17.82	19.16	29.31
40	10.18	24.94	18.59	29.59	18.93	20.36	31.14
60	10.67	26.14	19.48	31.02	19.85	21.34	32.64
Unlimited	10.74	26.31	19.61	31.22	19.98	21.48	32.85
LARGE GROUP			**$10 Copay**				
20	8.15	19.97	14.88	23.69	15.16	16.30	24.93
30	8.99	22.03	16.42	26.13	16.72	17.98	27.50
40	9.49	23.25	17.33	27.59	17.65	18.98	29.03
60	10.00	24.50	18.26	29.07	18.60	20.00	30.59
Unlimited	10.08	24.70	18.41	29.30	18.75	20.16	30.83
LARGE GROUP			**$15 Copay**				
20	7.65	18.74	13.97	22.24	14.23	15.30	23.40
30	8.43	20.65	15.39	24.51	15.68	16.86	25.79
40	8.92	21.85	16.29	25.93	16.59	17.84	27.29
60	9.44	23.13	17.24	27.44	17.56	18.88	28.88
Unlimited	9.53	23.35	17.40	27.70	17.73	19.06	29.15
LARGE GROUP			**$20 Copay**				
20	7.19	17.62	13.13	20.90	13.37	14.38	21.99
30	7.90	19.36	14.43	22.97	14.69	15.80	24.17
40	8.33	20.41	15.21	24.22	15.49	16.66	25.48
60	8.84	21.66	16.14	25.70	16.44	17.68	27.04
Unlimited	8.91	21.83	16.27	25.90	16.57	17.82	27.26
LARGE GROUP			**$25 Copay**				
20	6.68	16.37	12.20	19.42	12.42	13.36	20.43
30	7.36	18.03	13.44	21.40	13.69	14.72	22.51
40	7.84	19.21	14.32	22.79	14.58	15.68	23.98
60	8.23	20.16	15.03	23.92	15.31	16.46	25.18
Unlimited	8.32	20.38	15.19	24.19	15.48	16.64	25.45
LARGE GROUP			**$30 Copay**				
20	6.39	15.66	11.67	18.58	11.89	12.78	19.55
30	6.93	16.98	12.65	20.15	12.89	13.86	21.20
40	7.38	18.08	13.48	21.45	13.73	14.76	22.58
60	7.72	18.91	14.10	22.44	14.36	15.44	23.62
Unlimited	7.76	19.01	14.17	22.56	14.43	15.52	23.74
LARGE GROUP			**$35 Copay**				
20	6.06	14.85	11.07	17.62	11.27	12.12	18.54
30	6.48	15.88	11.83	18.84	12.05	12.96	19.82
40	6.90	16.91	12.60	20.06	12.83	13.80	21.11
60	7.22	17.69	13.18	20.99	13.43	14.44	22.09
Unlimited	7.28	17.84	13.29	21.16	13.54	14.56	22.27
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.65	1.59	1.16	1.86	1.21	1.30	1.98
60	0.69	1.69	1.23	1.99	1.29	1.38	2.12
90	0.72	1.76	1.27	2.06	1.34	1.43	2.18
Unlimited	0.72	1.78	1.29	2.08	1.35	1.45	2.20
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	0.73	1.80	1.30	2.10	1.36	1.47	2.24
30	0.81	1.98	1.43	2.31	1.50	1.61	2.46
40	0.85	2.07	1.50	2.42	1.58	1.69	2.58
60	0.89	2.17	1.58	2.54	1.64	1.77	2.70
Unlimited	0.90	2.21	1.60	2.60	1.68	1.81	2.75
LARGE GROUP			**$5 Copay**				
20	0.68	1.67	1.22	1.96	1.27	1.37	2.08
30	0.76	1.86	1.34	2.18	1.41	1.51	2.31
40	0.81	1.97	1.43	2.32	1.50	1.61	2.46
60	0.85	2.08	1.51	2.44	1.58	1.69	2.58
Unlimited	0.85	2.06	1.50	2.43	1.58	1.69	2.58
LARGE GROUP			**$10 Copay**				
20	0.64	1.58	1.14	1.84	1.20	1.29	1.96
30	0.72	1.76	1.28	2.06	1.34	1.44	2.18
40	0.75	1.83	1.34	2.15	1.39	1.50	2.29
60	0.79	1.94	1.41	2.26	1.46	1.58	2.41
Unlimited	0.80	1.95	1.43	2.29	1.48	1.60	2.42
LARGE GROUP			**$15 Copay**				
20	0.60	1.47	1.07	1.73	1.12	1.20	1.84
30	0.67	1.64	1.18	1.92	1.25	1.34	2.03
40	0.70	1.70	1.24	2.01	1.30	1.40	2.14
60	0.74	1.81	1.32	2.12	1.37	1.48	2.26
Unlimited	0.76	1.86	1.35	2.17	1.41	1.52	2.30
LARGE GROUP			**$20 Copay**				
20	0.56	1.37	0.99	1.60	1.04	1.12	1.70
30	0.63	1.54	1.12	1.80	1.16	1.25	1.91
40	0.66	1.62	1.17	1.90	1.22	1.32	2.01
60	0.69	1.69	1.23	1.98	1.28	1.38	2.10
Unlimited	0.70	1.72	1.25	2.00	1.30	1.40	2.14
LARGE GROUP			**$25 Copay**				
20	0.52	1.27	0.93	1.49	0.97	1.04	1.58
30	0.59	1.43	1.05	1.69	1.09	1.17	1.78
40	0.62	1.51	1.10	1.78	1.15	1.24	1.89
60	0.64	1.57	1.14	1.84	1.19	1.28	1.95
Unlimited	0.66	1.61	1.18	1.90	1.23	1.32	2.01
LARGE GROUP			**$30 Copay**				
20	0.51	1.27	0.92	1.48	0.97	1.03	1.57
30	0.55	1.36	0.98	1.60	1.03	1.11	1.69
40	0.59	1.43	1.05	1.68	1.09	1.17	1.79
60	0.60	1.47	1.07	1.72	1.12	1.20	1.83
Unlimited	0.60	1.47	1.06	1.72	1.11	1.20	1.83
LARGE GROUP			**$35 Copay**				
20	0.47	1.15	0.84	1.35	0.88	0.94	1.43
30	0.51	1.26	0.91	1.48	0.95	1.03	1.56
40	0.55	1.34	0.97	1.57	1.01	1.09	1.67
60	0.56	1.37	0.99	1.61	1.04	1.12	1.71
Unlimited	0.57	1.40	1.01	1.63	1.06	1.14	1.74
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
60	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
90	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Unlimited	8.5%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
40	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
60	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP			**$5 Copay**				
20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
60	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
LARGE GROUP			**$10 Copay**				
20	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
30	8.7%	8.7%	8.5%	8.6%	8.7%	8.7%	8.6%
40	8.6%	8.5%	8.4%	8.5%	8.5%	8.6%	8.6%
60	8.6%	8.6%	8.4%	8.4%	8.5%	8.6%	8.6%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP			**$15 Copay**				
20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
30	8.6%	8.6%	8.3%	8.5%	8.7%	8.6%	8.5%
40	8.5%	8.4%	8.2%	8.4%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.7%	8.7%	8.4%	8.5%	8.6%	8.7%	8.6%
LARGE GROUP			**$20 Copay**				
20	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
30	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
40	8.6%	8.6%	8.3%	8.5%	8.5%	8.6%	8.6%
60	8.5%	8.5%	8.2%	8.3%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP			**$25 Copay**				
20	8.4%	8.4%	8.3%	8.3%	8.5%	8.4%	8.4%
30	8.7%	8.6%	8.5%	8.6%	8.7%	8.6%	8.6%
40	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP			**$30 Copay**				
20	8.7%	8.8%	8.6%	8.7%	8.9%	8.8%	8.7%
30	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.7%
40	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.2%	8.3%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.1%	8.3%	8.3%	8.4%	8.4%
LARGE GROUP			**$35 Copay**				
20	8.4%	8.4%	8.2%	8.3%	8.5%	8.4%	8.4%
30	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
40	8.7%	8.6%	8.3%	8.5%	8.5%	8.6%	8.6%
60	8.4%	8.4%	8.1%	8.3%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.2%	8.3%	8.5%	8.5%	8.5%
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee + Child(ren)	Employee & Spouse	Family
20	5.44	13.32	9.95	15.82	10.11	10.87	16.64
30	5.80	14.22	10.62	16.89	10.79	11.61	17.76
40	6.18	15.15	11.31	17.98	11.50	12.36	18.91
60	6.52	15.97	11.92	18.96	12.13	13.04	19.94
Unlimited	6.57	16.10	12.03	19.11	12.22	13.14	20.10
LARGE GROUP				**$45 Copay**			
20	5.28	12.94	9.67	15.37	9.82	10.57	16.17
30	5.63	13.79	10.30	16.38	10.48	11.26	17.23
40	6.03	14.77	11.04	17.54	11.21	12.06	18.44
60	6.36	15.60	11.65	18.52	11.84	12.73	19.47
Unlimited	6.40	15.67	11.70	18.62	11.89	12.79	19.57
LARGE GROUP				**$50 Copay**			
20	5.13	12.57	9.38	14.93	9.55	10.26	15.70
30	5.50	13.47	10.06	15.99	10.23	11.00	16.82
40	5.88	14.39	10.75	17.10	10.92	11.75	17.98
60	6.20	15.20	11.35	18.04	11.54	12.40	18.97
Unlimited	6.24	15.29	11.42	18.17	11.61	12.48	19.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee + Child(ren)	Employee & Spouse	Family
20	5.91	14.48	10.79	17.18	10.99	11.82	18.08
30	6.30	15.44	11.50	18.31	11.72	12.60	19.27
40	6.71	16.44	12.25	19.51	12.48	13.42	20.53
60	7.08	17.35	12.93	20.58	13.17	14.16	21.66
Unlimited	7.13	17.47	13.02	20.73	13.26	14.26	21.81
LARGE GROUP				**$45 Copay**			
20	5.74	14.06	10.48	16.69	10.68	11.48	17.56
30	6.11	14.97	11.16	17.76	11.36	12.22	18.69
40	6.54	16.02	11.94	19.01	12.16	13.08	20.01
60	6.91	16.93	12.62	20.09	12.85	13.82	21.14
Unlimited	6.95	17.03	12.69	20.20	12.93	13.90	21.26
LARGE GROUP				**$50 Copay**			
20	5.56	13.62	10.15	16.16	10.34	11.12	17.01
30	5.97	14.63	10.90	17.35	11.10	11.94	18.26
40	6.39	15.66	11.67	18.58	11.89	12.78	19.55
60	6.73	16.49	12.29	19.56	12.52	13.46	20.59
Unlimited	6.77	16.59	12.36	19.68	12.59	13.54	20.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee + Child(ren)	Employee & Spouse	Family
20	0.47	1.16	0.84	1.36	0.88	0.95	1.44
30	0.50	1.22	0.88	1.42	0.93	0.99	1.51
40	0.53	1.29	0.94	1.53	0.98	1.06	1.62
60	0.56	1.38	1.01	1.62	1.04	1.12	1.72
Unlimited	0.56	1.37	0.99	1.62	1.04	1.12	1.71
LARGE GROUP				**$45 Copay**			
20	0.46	1.12	0.81	1.32	0.86	0.91	1.39
30	0.48	1.18	0.86	1.38	0.88	0.96	1.46
40	0.51	1.25	0.90	1.47	0.95	1.02	1.57
60	0.55	1.33	0.97	1.57	1.01	1.09	1.67
Unlimited	0.55	1.36	0.99	1.58	1.04	1.11	1.69
LARGE GROUP				**$50 Copay**			
20	0.43	1.05	0.77	1.23	0.79	0.86	1.31
30	0.47	1.16	0.84	1.36	0.87	0.94	1.44
40	0.51	1.27	0.92	1.48	0.97	1.03	1.57
60	0.53	1.29	0.94	1.52	0.98	1.06	1.62
Unlimited	0.53	1.30	0.94	1.51	0.98	1.06	1.61

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee + Child(ren)	Employee & Spouse	Family
20	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.7%
30	8.6%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
40	8.6%	8.5%	8.3%	8.5%	8.5%	8.6%	8.6%
60	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.5%	8.5%	8.2%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$45 Copay**			
20	8.7%	8.7%	8.4%	8.6%	8.8%	8.6%	8.6%
30	8.5%	8.6%	8.3%	8.4%	8.4%	8.5%	8.5%
40	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
60	8.6%	8.5%	8.3%	8.5%	8.5%	8.6%	8.6%
Unlimited	8.6%	8.7%	8.5%	8.5%	8.7%	8.7%	8.6%
LARGE GROUP				**$50 Copay**			
20	8.4%	8.4%	8.2%	8.2%	8.3%	8.4%	8.3%
30	8.5%	8.6%	8.3%	8.5%	8.5%	8.5%	8.6%
40	8.7%	8.8%	8.6%	8.7%	8.9%	8.8%	8.7%
60	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.2%	8.3%	8.4%	8.5%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.05	14.82	11.07	17.61	11.25	12.10	18.51
$0/Max $5000	5.67	13.89	10.37	16.50	10.55	11.34	17.35
$0/Max $2500	5.34	13.10	9.78	15.56	9.95	10.69	16.35
$25	5.67	13.89	10.37	16.50	10.55	11.34	17.35
$50	5.34	13.10	9.78	15.56	9.95	10.69	16.35
$100	4.79	11.75	8.77	13.95	8.91	9.59	14.67
$500	2.36	5.77	4.31	6.85	4.39	4.71	7.21
$5,000	0.32	0.78	0.58	0.92	0.59	0.63	0.97
Coinsurance							
80%	4.80	11.77	8.79	13.98	8.94	9.61	14.70
75%	4.53	11.10	8.29	13.18	8.43	9.06	13.86
70%	4.21	10.32	7.71	12.26	7.83	8.43	12.89
			Orthotics Riders				
$0/Max $5000	6.27	15.37	11.48	18.26	11.67	12.55	19.20
$0/Max $2500	5.81	14.25	10.64	16.92	10.81	11.63	17.79
Deductible							
$0	1.03	2.52	1.89	3.00	1.92	2.06	3.15
$0/Max $5000	0.99	2.43	1.82	2.88	1.84	1.98	3.03
$0/Max $2500	0.94	2.30	1.71	2.73	1.74	1.88	2.88
$25	0.99	2.43	1.82	2.88	1.84	1.98	3.03
$50	0.94	2.30	1.71	2.73	1.74	1.88	2.88
$100	0.85	2.07	1.55	2.47	1.57	1.69	2.59
$500	0.41	1.00	0.74	1.18	0.75	0.82	1.24
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.85	2.07	1.55	2.47	1.57	1.69	2.59
75%	0.79	1.93	1.44	2.28	1.46	1.57	2.41
70%	0.73	1.80	1.35	2.14	1.37	1.47	2.24
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.32	3.22	2.41	3.83	2.45	2.63	4.03
12 Months	2.11	5.17	3.87	6.14	3.93	4.22	6.46
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.06	5.05	3.77	6.00	3.84	4.12	6.30
12 Months	3.28	8.05	6.01	9.56	6.11	6.57	10.05
			Private Duty Nursing Riders				
In Full	0.71	1.75	1.31	2.08	1.33	1.43	2.18
80% hrs 73-504	0.12	0.30	0.22	0.36	0.22	0.24	0.38
100% hrs 73-504	0.21	0.52	0.39	0.62	0.40	0.43	0.65
			Dental Network Access				
	0.41	1.00	0.74	1.18	0.75	0.82	1.24
Limit			**Infertility Rider**				
2 IVF	13.21	32.36	24.17	38.43	24.57	26.42	40.42
3 IVF	15.87	38.88	29.04	46.19	29.52	31.74	48.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.56	16.07	11.98	19.07	12.20	13.12	20.07
$0/Max $5000	6.15	15.07	11.23	17.88	11.44	12.30	18.81
$0/Max $2500	5.80	14.21	10.59	16.86	10.79	11.60	17.74
$25	6.15	15.07	11.23	17.88	11.44	12.30	18.81
$50	5.80	14.21	10.59	16.86	10.79	11.60	17.74
$100	5.21	12.76	9.51	15.15	9.69	10.42	15.94
$500	2.57	6.30	4.69	7.47	4.78	5.14	7.86
$5,000	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Coinsurance							
80%	5.22	12.79	9.53	15.17	9.71	10.44	15.97
75%	4.92	12.05	8.98	14.30	9.15	9.84	15.05
70%	4.57	11.20	8.34	13.28	8.50	9.14	13.98
			Orthotics Riders				
$0/Max $5000	6.81	16.68	12.44	19.80	12.67	13.62	20.83
$0/Max $2500	6.31	15.46	11.52	18.34	11.74	12.62	19.30
Deductible							
$0	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$0/Max $5000	1.07	2.62	1.95	3.11	1.99	2.14	3.27
$0/Max $2500	1.02	2.50	1.86	2.97	1.90	2.04	3.12
$25	1.07	2.62	1.95	3.11	1.99	2.14	3.27
$50	1.02	2.50	1.86	2.97	1.90	2.04	3.12
$100	0.93	2.28	1.70	2.70	1.73	1.86	2.84
$500	0.45	1.10	0.82	1.31	0.84	0.90	1.38
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.93	2.28	1.70	2.70	1.73	1.86	2.84
75%	0.87	2.13	1.59	2.53	1.62	1.74	2.66
70%	0.78	1.91	1.42	2.27	1.45	1.56	2.39
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.76	1.86	1.39	2.21	1.41	1.52	2.32
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	14.34	35.13	26.18	41.69	26.67	28.68	43.87
3 IVF	17.23	42.21	31.46	50.09	32.05	34.46	52.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.51	1.25	0.91	1.46	0.95	1.02	1.56
$0/Max $5000	0.48	1.18	0.86	1.38	0.89	0.96	1.46
$0/Max $2500	0.46	1.11	0.81	1.30	0.84	0.91	1.39
$25	0.48	1.18	0.86	1.38	0.89	0.96	1.46
$50	0.46	1.11	0.81	1.30	0.84	0.91	1.39
$100	0.42	1.01	0.74	1.20	0.78	0.83	1.27
$500	0.21	0.53	0.38	0.62	0.39	0.43	0.65
$5,000	0.03	0.08	0.06	0.10	0.06	0.07	0.10
Coinsurance							
80%	0.42	1.02	0.74	1.19	0.77	0.83	1.27
75%	0.39	0.95	0.69	1.12	0.72	0.78	1.19
70%	0.36	0.88	0.63	1.02	0.67	0.71	1.09
			Orthotics Riders				
$0/Max $5000	0.54	1.31	0.96	1.54	1.00	1.07	1.63
$0/Max $2500	0.50	1.21	0.88	1.42	0.93	0.99	1.51
Deductible							
$0	0.09	0.22	0.16	0.26	0.16	0.18	0.28
$0/Max $5000	0.08	0.19	0.13	0.23	0.15	0.16	0.24
$0/Max $2500	0.08	0.20	0.15	0.24	0.16	0.16	0.24
$25	0.08	0.19	0.13	0.23	0.15	0.16	0.24
$50	0.08	0.20	0.15	0.24	0.16	0.16	0.24
$100	0.08	0.21	0.15	0.23	0.16	0.17	0.25
$500	0.04	0.10	0.08	0.13	0.09	0.08	0.14
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.08	0.21	0.15	0.23	0.16	0.17	0.25
75%	0.08	0.20	0.15	0.25	0.16	0.17	0.25
70%	0.05	0.11	0.07	0.13	0.08	0.09	0.15
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.36	0.23	0.25	0.37
12 Months	0.18	0.44	0.31	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.41	0.30	0.48	0.31	0.34	0.52
12 Months	0.29	0.70	0.51	0.82	0.53	0.57	0.87
			Private Duty Nursing Riders				
In Full	0.05	0.11	0.08	0.13	0.08	0.09	0.14
80% hrs 73-504	0.01	0.02	0.02	0.02	0.02	0.02	0.02
100% hrs 73-504	0.01	0.02	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.09	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	1.13	2.77	2.01	3.26	2.10	2.26	3.45
3 IVF	1.36	3.33	2.42	3.90	2.53	2.72	4.15

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
$0/Max $5000	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
$0/Max $2500	8.6%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
$25	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
$50	8.6%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
$100	8.8%	8.6%	8.4%	8.6%	8.8%	8.7%	8.7%
$500	8.9%	9.2%	8.8%	9.1%	8.9%	9.1%	9.0%
$5,000	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
Coinsurance							
80%	8.8%	8.7%	8.4%	8.5%	8.6%	8.6%	8.6%
75%	8.6%	8.6%	8.3%	8.5%	8.5%	8.6%	8.6%
70%	8.6%	8.5%	8.2%	8.3%	8.6%	8.4%	8.5%
			Orthotics Riders				
$0/Max $5000	8.6%	8.5%	8.4%	8.4%	8.6%	8.5%	8.5%
$0/Max $2500	8.6%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
Deductible							
$0	8.7%	8.7%	8.5%	8.7%	8.3%	8.7%	8.9%
$0/Max $5000	8.1%	7.8%	7.1%	8.0%	8.2%	8.1%	7.9%
$0/Max $2500	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$25	8.1%	7.8%	7.1%	8.0%	8.2%	8.1%	7.9%
$50	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$100	9.4%	10.1%	9.7%	9.3%	10.2%	10.1%	9.7%
$500	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	9.4%	10.1%	9.7%	9.3%	10.2%	10.1%	9.7%
75%	10.1%	10.4%	10.4%	11.0%	11.0%	10.8%	10.4%
70%	6.8%	6.1%	5.2%	6.1%	5.8%	6.1%	6.7%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	9.1%	9.6%	9.1%	9.4%	9.4%	9.5%	9.2%
12 Months	8.5%	8.5%	8.0%	8.5%	8.4%	8.5%	8.5%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.3%	8.1%	8.0%	8.0%	8.1%	8.3%	8.3%
12 Months	8.8%	8.7%	8.5%	8.6%	8.7%	8.7%	8.7%
			Private Duty Nursing Riders				
In Full	7.0%	6.3%	6.1%	6.2%	6.0%	6.3%	6.4%
80% hrs 73-504	8.3%	6.7%	9.1%	5.6%	9.1%	8.3%	5.3%
100% hrs 73-504	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
			Dental Network Access				
	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
Limit			**Infertility Rider**				
2 IVF	8.6%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
3 IVF	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	470.73	1,153.29	861.44	1,369.83	875.56	941.46	1,440.44

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	511.05	1,252.07	933.18	1,485.62	950.55	1,022.10	1,563.30

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	40.32	98.78	71.74	115.79	74.99	80.64	122.86

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%

**** Base rates exclude premium component for mandatory mental health cove***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.15)	(7.72)	(5.76)	(9.17)	(5.87)	(6.30)	(9.65)
$10	(6.62)	(16.22)	(12.12)	(19.27)	(12.31)	(13.24)	(20.26)
$15	(11.02)	(26.99)	(20.16)	(32.06)	(20.49)	(22.03)	(33.71)
$20	(16.99)	(41.64)	(31.10)	(49.45)	(31.61)	(33.99)	(52.00)
$25	(22.38)	(54.83)	(40.95)	(65.13)	(41.63)	(44.76)	(68.48)
$30	(28.31)	(69.35)	(51.80)	(82.37)	(52.65)	(56.61)	(86.62)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.81)	(4.43)	(3.30)	(5.25)	(3.36)	(3.61)	(5.53)
$10	(3.79)	(9.29)	(6.95)	(11.05)	(7.06)	(7.59)	(11.61)
$15	(6.30)	(15.44)	(11.54)	(18.34)	(11.72)	(12.61)	(19.29)
$20	(9.73)	(23.84)	(17.81)	(28.32)	(18.09)	(19.46)	(29.77)
$25	(12.82)	(31.42)	(23.46)	(37.31)	(23.85)	(25.64)	(39.23)
$30	(16.23)	(39.76)	(29.70)	(47.23)	(30.18)	(32.46)	(49.65)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.30)	(5.62)	(4.20)	(6.68)	(4.27)	(4.59)	(7.03)
$10	(4.75)	(11.65)	(8.70)	(13.83)	(8.84)	(9.51)	(14.55)
$15	(7.47)	(18.29)	(13.67)	(21.73)	(13.89)	(14.93)	(22.85)
$20	(10.53)	(25.79)	(19.27)	(30.63)	(19.58)	(21.05)	(32.21)
$25	(13.88)	(34.01)	(25.41)	(40.40)	(25.82)	(27.76)	(42.48)
$30	(17.70)	(43.36)	(32.39)	(51.50)	(32.92)	(35.39)	(54.15)
$35	(21.26)	(52.08)	(38.90)	(61.85)	(39.54)	(42.51)	(65.05)
$40	(24.96)	(61.15)	(45.68)	(72.63)	(46.42)	(49.92)	(76.38)
$45	(28.86)	(70.70)	(52.81)	(83.97)	(53.67)	(57.71)	(88.30)
$50	(32.94)	(80.69)	(60.27)	(95.84)	(61.26)	(65.87)	(100.79)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.95)	(4.77)	(3.57)	(5.67)	(3.62)	(3.90)	(5.96)
$10	(4.02)	(9.84)	(7.35)	(11.70)	(7.48)	(8.04)	(12.30)
$15	(6.30)	(15.44)	(11.54)	(18.34)	(11.72)	(12.61)	(19.29)
$20	(8.90)	(21.82)	(16.30)	(25.91)	(16.56)	(17.81)	(27.24)
$25	(11.73)	(28.74)	(21.47)	(34.14)	(21.82)	(23.46)	(35.89)
$30	(14.95)	(36.64)	(27.37)	(43.51)	(27.82)	(29.91)	(45.76)
$35	(17.99)	(44.08)	(32.93)	(52.36)	(33.47)	(35.99)	(55.06)
$40	(21.10)	(51.70)	(38.62)	(61.41)	(39.25)	(42.21)	(64.58)
$45	(24.40)	(59.77)	(44.65)	(71.00)	(45.38)	(48.80)	(74.66)
$50	(27.86)	(68.25)	(50.98)	(81.06)	(51.82)	(55.71)	(85.24)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.15)	(2.83)	(2.11)	(3.36)	(2.14)	(2.31)	(3.53)
$150	(1.90)	(4.65)	(3.47)	(5.52)	(3.53)	(3.79)	(5.80)
$200	(2.70)	(6.62)	(4.95)	(7.86)	(5.03)	(5.41)	(8.27)
$250	(3.88)	(9.50)	(7.09)	(11.28)	(7.21)	(7.75)	(11.86)
$500	(9.29)	(22.77)	(17.00)	(27.04)	(17.28)	(18.58)	(28.44)
$750	(15.94)	(39.06)	(29.17)	(46.39)	(29.65)	(31.89)	(48.79)
$1,000	(23.99)	(58.77)	(43.90)	(69.81)	(44.63)	(47.98)	(73.41)
Copay/Day							
$50 w/3 Day Max	(1.40)	(3.43)	(2.56)	(4.07)	(2.60)	(2.79)	(4.27)
$50 w/5 Day Max	(1.92)	(4.70)	(3.51)	(5.58)	(3.57)	(3.84)	(5.87)
$100 w/3 Day Max	(3.49)	(8.55)	(6.39)	(10.15)	(6.49)	(6.98)	(10.68)
$100 w/5 Day Max	(5.03)	(12.32)	(9.20)	(14.64)	(9.35)	(10.06)	(15.39)
$250 w/3 Day Max	(11.56)	(28.32)	(21.14)	(33.63)	(21.49)	(23.11)	(35.36)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.60)	(1.48)	(1.10)	(1.75)	(1.12)	(1.20)	(1.85)
$75	(0.98)	(2.40)	(1.80)	(2.85)	(1.83)	(1.96)	(3.00)
$100	(1.40)	(3.43)	(2.56)	(4.07)	(2.60)	(2.79)	(4.27)
$125	(1.83)	(4.48)	(3.35)	(5.31)	(3.40)	(3.65)	(5.59)
$150	(2.28)	(5.60)	(4.18)	(6.65)	(4.25)	(4.57)	(6.99)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
$25	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$35	(0.78)	(1.90)	(1.42)	(2.25)	(1.44)	(1.55)	(2.38)
$50	(1.32)	(3.22)	(2.41)	(3.83)	(2.45)	(2.63)	(4.03)
$60	(1.68)	(4.12)	(3.08)	(4.90)	(3.13)	(3.37)	(5.15)
$75	(2.21)	(5.43)	(4.05)	(6.44)	(4.12)	(4.43)	(6.77)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.41)	(8.35)	(6.23)	(9.91)	(6.34)	(6.82)	(10.43)
$10	(7.18)	(17.59)	(13.11)	(20.87)	(13.35)	(14.36)	(21.96)
$15	(11.96)	(29.30)	(21.84)	(34.77)	(22.25)	(23.92)	(36.59)
$20	(18.44)	(45.18)	(33.67)	(53.61)	(34.30)	(36.88)	(56.41)
$25	(24.30)	(59.54)	(44.37)	(70.64)	(45.20)	(48.60)	(74.33)
$30	(30.73)	(75.29)	(56.11)	(89.33)	(57.16)	(61.46)	(94.00)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.97)	(4.83)	(3.60)	(5.73)	(3.66)	(3.94)	(6.03)
$10	(4.12)	(10.09)	(7.52)	(11.98)	(7.66)	(8.24)	(12.60)
$15	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$20	(10.56)	(25.87)	(19.28)	(30.70)	(19.64)	(21.12)	(32.30)
$25	(13.92)	(34.10)	(25.42)	(40.47)	(25.89)	(27.84)	(42.58)
$30	(17.62)	(43.17)	(32.17)	(51.22)	(32.77)	(35.24)	(53.90)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.50)	(6.13)	(4.57)	(7.27)	(4.65)	(5.00)	(7.65)
$10	(5.17)	(12.67)	(9.44)	(15.03)	(9.62)	(10.34)	(15.82)
$15	(8.11)	(19.87)	(14.81)	(23.58)	(15.08)	(16.22)	(24.81)
$20	(11.43)	(28.00)	(20.87)	(33.23)	(21.26)	(22.86)	(34.96)
$25	(15.07)	(36.92)	(27.52)	(43.81)	(28.03)	(30.14)	(46.10)
$30	(19.21)	(47.06)	(35.08)	(55.84)	(35.73)	(38.42)	(58.76)
$35	(23.08)	(56.55)	(42.14)	(67.09)	(42.93)	(46.16)	(70.60)
$40	(27.10)	(66.40)	(49.48)	(78.78)	(50.41)	(54.20)	(82.90)
$45	(31.33)	(76.76)	(57.21)	(91.08)	(58.27)	(62.66)	(95.84)
$50	(35.76)	(87.61)	(65.30)	(103.95)	(66.51)	(71.52)	(109.39)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.12)	(5.19)	(3.87)	(6.16)	(3.94)	(4.24)	(6.49)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$20	(9.66)	(23.67)	(17.64)	(28.08)	(17.97)	(19.32)	(29.55)
$25	(12.73)	(31.19)	(23.24)	(37.01)	(23.68)	(25.46)	(38.94)
$30	(16.23)	(39.76)	(29.64)	(47.18)	(30.19)	(32.46)	(49.65)
$35	(19.53)	(47.85)	(35.66)	(56.77)	(36.33)	(39.06)	(59.74)
$40	(22.91)	(56.13)	(41.83)	(66.60)	(42.61)	(45.82)	(70.08)
$45	(26.49)	(64.90)	(48.37)	(77.01)	(49.27)	(52.98)	(81.03)
$50	(30.24)	(74.09)	(55.22)	(87.91)	(56.25)	(60.48)	(92.50)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$150	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$200	(2.92)	(7.15)	(5.33)	(8.49)	(5.43)	(5.84)	(8.93)
$250	(4.22)	(10.34)	(7.71)	(12.27)	(7.85)	(8.44)	(12.91)
$500	(10.09)	(24.72)	(18.42)	(29.33)	(18.77)	(20.18)	(30.87)
$750	(17.30)	(42.39)	(31.59)	(50.29)	(32.18)	(34.60)	(52.92)
$1,000	(26.05)	(63.82)	(47.57)	(75.73)	(48.45)	(52.10)	(79.69)
Copay/Day							
$50 w/3 Day Max	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$50 w/5 Day Max	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$100 w/3 Day Max	(3.79)	(9.29)	(6.92)	(11.02)	(7.05)	(7.58)	(11.59)
$100 w/5 Day Max	(5.46)	(13.38)	(9.97)	(15.87)	(10.16)	(10.92)	(16.70)
$250 w/3 Day Max	(12.54)	(30.72)	(22.90)	(36.45)	(23.32)	(25.08)	(38.36)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$75	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$100	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$125	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$150	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$25	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$35	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$50	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$60	(1.82)	(4.46)	(3.32)	(5.29)	(3.39)	(3.64)	(5.57)
$75	(2.39)	(5.86)	(4.36)	(6.95)	(4.45)	(4.78)	(7.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.63)	(0.47)	(0.74)	(0.47)	(0.52)	(0.78)
$10	(0.56)	(1.37)	(0.99)	(1.60)	(1.04)	(1.12)	(1.70)
$15	(0.94)	(2.31)	(1.68)	(2.71)	(1.76)	(1.89)	(2.88)
$20	(1.45)	(3.54)	(2.57)	(4.16)	(2.69)	(2.89)	(4.41)
$25	(1.92)	(4.71)	(3.42)	(5.51)	(3.57)	(3.84)	(5.85)
$30	(2.42)	(5.94)	(4.31)	(6.96)	(4.51)	(4.85)	(7.38)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$10	(0.33)	(0.80)	(0.57)	(0.93)	(0.60)	(0.65)	(0.99)
$15	(0.55)	(1.34)	(0.97)	(1.57)	(1.02)	(1.09)	(1.66)
$20	(0.83)	(2.03)	(1.47)	(2.38)	(1.55)	(1.66)	(2.53)
$25	(1.10)	(2.68)	(1.96)	(3.16)	(2.04)	(2.20)	(3.35)
$30	(1.39)	(3.41)	(2.47)	(3.99)	(2.59)	(2.78)	(4.25)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.20)	(0.51)	(0.37)	(0.59)	(0.38)	(0.41)	(0.62)
$10	(0.42)	(1.02)	(0.74)	(1.20)	(0.78)	(0.83)	(1.27)
$15	(0.64)	(1.58)	(1.14)	(1.85)	(1.19)	(1.29)	(1.96)
$20	(0.90)	(2.21)	(1.60)	(2.60)	(1.68)	(1.81)	(2.75)
$25	(1.19)	(2.91)	(2.11)	(3.41)	(2.21)	(2.38)	(3.62)
$30	(1.51)	(3.70)	(2.69)	(4.34)	(2.81)	(3.03)	(4.61)
$35	(1.82)	(4.47)	(3.24)	(5.24)	(3.39)	(3.65)	(5.55)
$40	(2.14)	(5.25)	(3.80)	(6.15)	(3.99)	(4.28)	(6.52)
$45	(2.47)	(6.06)	(4.40)	(7.11)	(4.60)	(4.95)	(7.54)
$50	(2.82)	(6.92)	(5.03)	(8.11)	(5.25)	(5.65)	(8.60)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.42)	(0.30)	(0.49)	(0.32)	(0.34)	(0.53)
$10	(0.34)	(0.84)	(0.61)	(0.97)	(0.63)	(0.68)	(1.04)
$15	(0.55)	(1.34)	(0.97)	(1.57)	(1.02)	(1.09)	(1.66)
$20	(0.76)	(1.85)	(1.34)	(2.17)	(1.41)	(1.51)	(2.31)
$25	(1.00)	(2.45)	(1.77)	(2.87)	(1.86)	(2.00)	(3.05)
$30	(1.28)	(3.12)	(2.27)	(3.67)	(2.37)	(2.55)	(3.89)
$35	(1.54)	(3.77)	(2.73)	(4.41)	(2.86)	(3.07)	(4.68)
$40	(1.81)	(4.43)	(3.21)	(5.19)	(3.36)	(3.61)	(5.50)
$45	(2.09)	(5.13)	(3.72)	(6.01)	(3.89)	(4.18)	(6.37)
$50	(2.38)	(5.84)	(4.24)	(6.85)	(4.43)	(4.77)	(7.26)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.21)	(0.15)	(0.24)	(0.17)	(0.17)	(0.26)
$150	(0.17)	(0.42)	(0.31)	(0.50)	(0.32)	(0.35)	(0.53)
$200	(0.22)	(0.53)	(0.38)	(0.63)	(0.40)	(0.43)	(0.66)
$250	(0.34)	(0.84)	(0.62)	(0.99)	(0.64)	(0.69)	(1.05)
$500	(0.80)	(1.95)	(1.42)	(2.29)	(1.49)	(1.60)	(2.43)
$750	(1.36)	(3.33)	(2.42)	(3.90)	(2.53)	(2.71)	(4.13)
$1,000	(2.06)	(5.05)	(3.67)	(5.92)	(3.82)	(4.12)	(6.28)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.29)	(0.22)	(0.35)	(0.23)	(0.25)	(0.38)
$50 w/5 Day Max	(0.17)	(0.42)	(0.31)	(0.50)	(0.32)	(0.34)	(0.52)
$100 w/3 Day Max	(0.30)	(0.74)	(0.53)	(0.87)	(0.56)	(0.60)	(0.91)
$100 w/5 Day Max	(0.43)	(1.06)	(0.77)	(1.23)	(0.81)	(0.86)	(1.31)
$250 w/3 Day Max	(0.98)	(2.40)	(1.76)	(2.82)	(1.83)	(1.97)	(3.00)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.11)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
$75	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.16)	(0.24)
$100	(0.12)	(0.29)	(0.22)	(0.35)	(0.23)	(0.25)	(0.38)
$125	(0.16)	(0.40)	(0.28)	(0.47)	(0.30)	(0.33)	(0.50)
$150	(0.20)	(0.48)	(0.35)	(0.56)	(0.36)	(0.39)	(0.60)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.25)
$50	(0.12)	(0.31)	(0.22)	(0.36)	(0.23)	(0.25)	(0.37)
$60	(0.14)	(0.34)	(0.24)	(0.39)	(0.26)	(0.27)	(0.42)
$75	(0.18)	(0.43)	(0.31)	(0.51)	(0.33)	(0.35)	(0.54)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.2%	8.2%	8.1%	8.0%	8.3%	8.1%
$10	8.5%	8.4%	8.2%	8.3%	8.4%	8.5%	8.4%
$15	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$25	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$30	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.8%	9.0%	9.1%	9.1%	8.9%	9.1%	9.0%
$10	8.7%	8.6%	8.2%	8.4%	8.5%	8.6%	8.5%
$15	8.7%	8.7%	8.4%	8.6%	8.7%	8.6%	8.6%
$20	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$25	8.6%	8.5%	8.4%	8.5%	8.6%	8.6%	8.5%
$30	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.6%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.7%	9.1%	8.8%	8.8%	8.9%	8.9%	8.8%
$10	8.8%	8.8%	8.5%	8.7%	8.8%	8.7%	8.7%
$15	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$20	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$25	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$30	8.5%	8.5%	8.3%	8.4%	8.5%	8.6%	8.5%
$35	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$45	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$50	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.7%	8.8%	8.4%	8.6%	8.8%	8.7%	8.9%
$10	8.5%	8.5%	8.3%	8.3%	8.4%	8.5%	8.5%
$15	8.7%	8.7%	8.4%	8.6%	8.7%	8.6%	8.6%
$20	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
$25	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
$30	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$35	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$45	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$50	8.5%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	7.8%	7.4%	7.1%	7.1%	7.9%	7.4%	7.4%
$150	8.9%	9.0%	8.9%	9.1%	9.1%	9.2%	9.1%
$200	8.1%	8.0%	7.7%	8.0%	8.0%	7.9%	8.0%
$250	8.8%	8.8%	8.7%	8.8%	8.9%	8.9%	8.9%
$500	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
$750	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$1,000	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Copay/Day							
$50 w/3 Day Max	8.6%	8.5%	8.6%	8.6%	8.8%	9.0%	8.9%
$50 w/5 Day Max	8.9%	8.9%	8.8%	9.0%	9.0%	8.9%	8.9%
$100 w/3 Day Max	8.6%	8.7%	8.3%	8.6%	8.6%	8.6%	8.5%
$100 w/5 Day Max	8.5%	8.6%	8.4%	8.4%	8.7%	8.5%	8.5%
$250 w/3 Day Max	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.3%	7.4%	8.2%	8.0%	8.0%	8.3%	7.6%
$75	8.2%	8.3%	7.8%	8.1%	7.7%	8.2%	8.0%
$100	8.6%	8.5%	8.6%	8.6%	8.8%	9.0%	8.9%
$125	8.7%	8.9%	8.4%	8.9%	8.8%	9.0%	8.9%
$150	8.8%	8.6%	8.4%	8.4%	8.5%	8.5%	8.6%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
$25	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$35	10.3%	11.1%	10.6%	11.1%	11.1%	11.0%	10.5%
$50	9.1%	9.6%	9.1%	9.4%	9.4%	9.5%	9.2%
$60	8.3%	8.3%	7.8%	8.0%	8.3%	8.0%	8.2%
$75	8.1%	7.9%	7.7%	7.9%	8.0%	7.9%	8.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.14)	(7.70)	(5.75)	(9.14)	(5.84)	(6.28)	(9.61)
$125	(3.88)	(9.50)	(7.09)	(11.28)	(7.21)	(7.75)	(11.86)
$150	(4.62)	(11.32)	(8.46)	(13.44)	(8.60)	(9.24)	(14.14)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.54	1.33	0.99	1.57	1.01	1.08	1.65
60	1.05	2.57	1.92	3.06	1.96	2.10	3.21
90	1.58	3.88	2.90	4.60	2.94	3.16	4.83
120	1.85	4.52	3.38	5.38	3.44	3.69	5.65
Unlimited	2.39	5.84	4.37	6.95	4.44	4.77	7.30
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
40/$10 copay	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
40/$15 copay	(0.43)	(1.05)	(0.79)	(1.24)	(0.80)	(0.86)	(1.32)
40/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.81)
40/$25 copay	(0.79)	(1.93)	(1.44)	(2.28)	(1.46)	(1.57)	(2.41)
60	0.28	0.67	0.50	0.81	0.51	0.55	0.85
100	0.70	1.72	1.29	2.05	1.31	1.41	2.15
200	1.85	4.52	3.38	5.38	3.44	3.69	5.65
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.10)	(2.70)	(2.02)	(3.20)	(2.05)	(2.20)	(3.37)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.73	1.80	1.35	2.14	1.37	1.47	2.24
90	1.51	3.70	2.76	4.40	2.81	3.02	4.62
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.65	1.60	1.19	1.90	1.21	1.31	2.00
90	1.19	2.93	2.18	3.47	2.22	2.39	3.65
120	1.92	4.70	3.51	5.58	3.57	3.84	5.87
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.92)	(2.25)	(1.68)	(2.67)	(1.70)	(1.84)	(2.81)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.27	0.65	0.49	0.78	0.49	0.53	0.82
30	0.44	1.07	0.81	1.28	0.82	0.88	1.35
Unlimited	0.65	1.60	1.19	1.90	1.21	1.31	2.00
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.25	7.98	5.96	9.47	6.05	6.51	9.96
60	3.81	9.34	6.98	11.10	7.10	7.63	11.67
90	4.55	11.15	8.32	13.24	8.47	9.10	13.92
Unlimited	4.62	11.32	8.46	13.44	8.60	9.24	14.14
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.26)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
60/$10 copay	(0.26)	(0.62)	(0.47)	(0.74)	(0.48)	(0.51)	(0.79)
60/$15 copay	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.80)	(1.21)
60/$20 copay	(0.55)	(1.35)	(1.01)	(1.60)	(1.02)	(1.10)	(1.68)
60/$25 copay	(0.67)	(1.65)	(1.23)	(1.96)	(1.25)	(1.35)	(2.06)
120/$0 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
120/$5 copay	0.44	1.07	0.81	1.28	0.82	0.88	1.35
120/$10 copay	0.26	0.62	0.47	0.74	0.48	0.51	0.79
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
120/$25 copay	(0.32)	(0.78)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
Unlimited/$0 copay	0.66	1.62	1.21	1.93	1.23	1.33	2.03
Unlimited/$5 copay	0.50	1.22	0.92	1.46	0.93	1.00	1.53
Unlimited/$10 copa	0.32	0.78	0.58	0.92	0.59	0.63	0.97
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
Unlimited/$25 copa	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.43	0.32	0.50	0.33	0.35	0.53
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.26)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
$125	(4.22)	(10.34)	(7.71)	(12.27)	(7.85)	(8.44)	(12.91)
$150	(5.01)	(12.27)	(9.15)	(14.56)	(9.32)	(10.02)	(15.33)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.58	1.42	1.06	1.69	1.08	1.16	1.77
60	1.14	2.79	2.08	3.31	2.12	2.28	3.49
90	1.71	4.19	3.12	4.97	3.18	3.42	5.23
120	2.01	4.92	3.67	5.84	3.74	4.02	6.15
Unlimited	2.60	6.37	4.75	7.56	4.84	5.20	7.95
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$20 copay	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
40/$25 copay	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
60	0.31	0.76	0.57	0.90	0.58	0.62	0.95
100	0.75	1.84	1.37	2.18	1.40	1.50	2.29
200	2.01	4.92	3.67	5.84	3.74	4.02	6.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.78	1.91	1.42	2.27	1.45	1.56	2.39
90	1.64	4.02	2.99	4.77	3.05	3.28	5.02
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.70	1.72	1.28	2.03	1.30	1.40	2.14
90	1.28	3.14	2.34	3.72	2.38	2.56	3.92
120	2.09	5.12	3.82	6.08	3.89	4.18	6.39
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.30	0.74	0.55	0.87	0.56	0.60	0.92
30	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Unlimited	0.70	1.72	1.28	2.03	1.30	1.40	2.14
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.54	8.67	6.46	10.29	6.58	7.08	10.83
60	4.14	10.14	7.56	12.03	7.70	8.28	12.66
90	4.94	12.10	9.02	14.36	9.19	9.88	15.11
Unlimited	5.01	12.27	9.15	14.56	9.32	10.02	15.33
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
60/$15 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
60/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60/$25 copay	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
120/$0 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
120/$5 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$10 copay	0.29	0.71	0.53	0.84	0.54	0.58	0.89
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
Unlimited/$0 copay	0.71	1.74	1.30	2.06	1.32	1.42	2.17
Unlimited/$5 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$10 copa	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(0.26)	(0.63)	(0.46)	(0.74)	(0.48)	(0.52)	(0.79)
$125	(0.34)	(0.84)	(0.62)	(0.99)	(0.64)	(0.69)	(1.05)
$150	(0.39)	(0.95)	(0.69)	(1.12)	(0.72)	(0.78)	(1.19)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.09	0.07	0.12	0.07	0.08	0.12
60	0.09	0.22	0.16	0.25	0.16	0.18	0.28
90	0.13	0.31	0.22	0.37	0.24	0.26	0.40
120	0.16	0.40	0.29	0.46	0.30	0.33	0.50
Unlimited	0.21	0.53	0.38	0.61	0.40	0.43	0.65
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
40/$10 copay	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
40/$15 copay	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.12)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.15)
40/$25 copay	(0.08)	(0.20)	(0.15)	(0.25)	(0.16)	(0.17)	(0.25)
60	0.03	0.09	0.07	0.09	0.07	0.07	0.10
100	0.05	0.12	0.08	0.13	0.09	0.09	0.14
200	0.16	0.40	0.29	0.46	0.30	0.33	0.50
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.09)	(0.22)	(0.15)	(0.26)	(0.16)	(0.18)	(0.27)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.11	0.07	0.13	0.08	0.09	0.15
90	0.13	0.32	0.23	0.37	0.24	0.26	0.40
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.13	0.09	0.09	0.14
90	0.09	0.21	0.16	0.25	0.16	0.17	0.27
120	0.17	0.42	0.31	0.50	0.32	0.34	0.52
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.25)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.09	0.06	0.09	0.07	0.07	0.10
30	0.04	0.11	0.07	0.12	0.07	0.08	0.12
Unlimited	0.05	0.12	0.09	0.13	0.09	0.09	0.14
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.29	0.69	0.50	0.82	0.53	0.57	0.87
60	0.33	0.80	0.58	0.93	0.60	0.65	0.99
90	0.39	0.95	0.70	1.12	0.72	0.78	1.19
Unlimited	0.39	0.95	0.69	1.12	0.72	0.78	1.19
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.01	0.00	0.01	0.00	0.00	0.01
60/$10 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
60/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.12)
60/$25 copay	(0.05)	(0.11)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
120/$0 copay	0.05	0.12	0.09	0.14	0.09	0.10	0.16
120/$5 copay	0.04	0.11	0.07	0.12	0.07	0.08	0.12
120/$10 copay	0.03	0.09	0.06	0.10	0.06	0.07	0.10
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
120/$25 copay	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
Unlimited/$0 copay	0.05	0.12	0.09	0.13	0.09	0.09	0.14
Unlimited/$5 copay	0.04	0.10	0.07	0.11	0.07	0.08	0.12
Unlimited/$10 copa	0.03	0.08	0.06	0.10	0.06	0.07	0.10
Unlimited/$15 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copa	0.00	0.00	0.00	0.01	0.00	0.00	0.01
Unlimited/$25 copa	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.01	0.01	0.01	0.02	0.00	0.01	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.00	0.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	8.3%	8.2%	8.0%	8.1%	8.2%	8.3%	8.2%
$125	8.8%	8.8%	8.7%	8.8%	8.9%	8.9%	8.9%
$150	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.4%	6.8%	7.1%	7.6%	6.9%	7.4%	7.3%
60	8.6%	8.6%	8.3%	8.2%	8.2%	8.6%	8.7%
90	8.2%	8.0%	7.6%	8.0%	8.2%	8.2%	8.3%
120	8.6%	8.8%	8.6%	8.6%	8.7%	8.9%	8.8%
Unlimited	8.8%	9.1%	8.7%	8.8%	9.0%	9.0%	8.9%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
40/$10 copay	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
40/$15 copay	9.3%	9.5%	8.9%	10.5%	8.7%	9.3%	9.1%
40/$20 copay	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.3%
40/$25 copay	10.1%	10.4%	10.4%	11.0%	11.0%	10.8%	10.4%
60	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
100	7.1%	7.0%	6.2%	6.3%	6.9%	6.4%	6.5%
200	8.6%	8.8%	8.6%	8.6%	8.7%	8.9%	8.8%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	8.2%	8.1%	7.4%	8.1%	7.8%	8.2%	8.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	6.8%	6.1%	5.2%	6.1%	5.8%	6.1%	6.7%
90	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.7%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.7%	7.5%	7.6%	6.8%	7.4%	6.9%	7.0%
90	7.6%	7.2%	7.3%	7.2%	7.2%	7.1%	7.4%
120	8.9%	8.9%	8.8%	9.0%	9.0%	8.9%	8.9%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.7%	8.9%	8.9%	9.0%	9.4%	8.7%	8.9%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
30	9.1%	10.3%	8.6%	9.4%	8.5%	9.1%	8.9%
Unlimited	7.7%	7.5%	7.6%	6.8%	7.4%	6.9%	7.0%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.9%	8.6%	8.4%	8.7%	8.8%	8.8%	8.7%
60	8.7%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
90	8.6%	8.5%	8.4%	8.5%	8.5%	8.6%	8.5%
Unlimited	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	-3.8%	0.0%	-3.3%	0.0%	0.0%	-3.1%
60/$10 copay	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
60/$15 copay	10.0%	10.2%	11.1%	11.3%	10.8%	10.0%	11.6%
60/$20 copay	7.3%	7.4%	6.9%	7.5%	7.8%	7.3%	7.1%
60/$25 copay	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
120/$0 copay	8.8%	8.6%	8.7%	8.4%	8.5%	8.8%	9.2%
120/$5 copay	9.1%	10.3%	8.6%	9.4%	8.5%	9.1%	8.9%
120/$10 copay	11.5%	14.5%	12.8%	13.5%	12.5%	13.7%	12.7%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
120/$25 copay	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
Unlimited/$0 copay	7.6%	7.4%	7.4%	6.7%	7.3%	6.8%	6.9%
Unlimited/$5 copay	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
Unlimited/$10 copa	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
Unlimited/$15 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copa	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
Unlimited/$25 copa	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	5.9%	2.3%	3.1%	4.0%	0.0%	2.9%	3.8%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-3.8%	0.0%	-3.3%	0.0%	0.0%	-3.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$25	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$10	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
$15	(0.44)	(1.07)	(0.81)	(1.28)	(0.82)	(0.88)	(1.35)
$20	(0.63)	(1.55)	(1.15)	(1.84)	(1.17)	(1.26)	(1.94)
$25	(0.81)	(1.98)	(1.48)	(2.35)	(1.50)	(1.61)	(2.47)
$30	(0.98)	(2.40)	(1.80)	(2.85)	(1.83)	(1.96)	(3.00)
$35	(1.16)	(2.85)	(2.13)	(3.39)	(2.16)	(2.33)	(3.56)
$40	(1.34)	(3.27)	(2.45)	(3.89)	(2.49)	(2.67)	(4.09)
$45	(1.52)	(3.72)	(2.78)	(4.43)	(2.83)	(3.04)	(4.65)
$50	(1.69)	(4.15)	(3.10)	(4.93)	(3.15)	(3.39)	(5.18)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$10	(0.32)	(0.78)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
$15	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$20	(0.70)	(1.72)	(1.29)	(2.05)	(1.31)	(1.41)	(2.15)
$25	(0.94)	(2.30)	(1.71)	(2.73)	(1.74)	(1.88)	(2.88)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$25	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$35	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$50	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$60	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.80)	(1.21)
$75	(0.52)	(1.28)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$100	(0.70)	(1.72)	(1.29)	(2.05)	(1.31)	(1.41)	(2.15)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
$35	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$50	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
$60	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)
$75	(0.35)	(0.85)	(0.63)	(1.01)	(0.64)	(0.69)	(1.06)
$100	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.93)	(7.17)	(5.36)	(8.52)	(5.45)	(5.85)	(8.96)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.54)	(11.12)	(8.30)	(13.21)	(8.45)	(9.08)	(13.89)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.39)	(0.95)	(0.71)	(1.13)	(0.72)	(0.78)	(1.18)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$20	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$25	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
$30	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$35	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
$40	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$45	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
$50	(1.83)	(4.48)	(3.34)	(5.32)	(3.40)	(3.66)	(5.60)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
$25	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$60	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$100	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.93)	(12.08)	(9.00)	(14.33)	(9.17)	(9.86)	(15.08)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$10	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
$15	(0.04)	(0.11)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
$25	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.17)	(0.25)
$30	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.16)	(0.24)
$35	(0.09)	(0.21)	(0.15)	(0.24)	(0.17)	(0.17)	(0.26)
$40	(0.12)	(0.31)	(0.22)	(0.35)	(0.23)	(0.25)	(0.38)
$45	(0.13)	(0.32)	(0.23)	(0.37)	(0.24)	(0.26)	(0.40)
$50	(0.14)	(0.33)	(0.24)	(0.39)	(0.25)	(0.27)	(0.42)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$10	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
$25	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.24)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$25	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$35	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$60	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
$75	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.12)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.11)	(0.08)	(0.12)	(0.09)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.25)	(0.62)	(0.45)	(0.72)	(0.46)	(0.51)	(0.77)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(0.39)	(0.96)	(0.70)	(1.12)	(0.72)	(0.78)	(1.19)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.14)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$25	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$10	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
$15	9.1%	10.3%	8.6%	9.4%	8.5%	9.1%	8.9%
$20	7.9%	7.7%	7.8%	7.6%	7.7%	7.9%	7.2%
$25	9.9%	10.1%	10.1%	10.2%	10.7%	10.6%	10.1%
$30	8.2%	8.3%	7.8%	8.1%	7.7%	8.2%	8.0%
$35	7.8%	7.4%	7.0%	7.1%	7.9%	7.3%	7.3%
$40	9.0%	9.5%	9.0%	9.0%	9.2%	9.4%	9.3%
$45	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.6%
$50	8.3%	8.0%	7.7%	7.9%	7.9%	8.0%	8.1%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$10	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
$15	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$20	7.1%	7.0%	6.2%	6.3%	6.9%	6.4%	6.5%
$25	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$25	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$35	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$50	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
$60	10.0%	10.2%	11.1%	11.3%	10.8%	10.0%	11.6%
$75	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
$100	7.1%	7.0%	6.2%	6.3%	6.9%	6.4%	6.5%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
$35	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$50	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
$60	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%
$75	11.4%	12.9%	12.7%	11.9%	14.1%	13.0%	12.3%
$100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	8.5%	8.6%	8.4%	8.5%	8.4%	8.7%	8.6%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	8.6%	8.6%	8.4%	8.5%	8.5%	8.6%	8.6%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	10.3%	10.5%	11.3%	10.6%	11.1%	10.3%	11.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
19	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
19	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.58	18.56	13.87	22.05	14.10	15.16	23.19
60	7.99	19.56	14.62	23.25	14.85	15.97	24.44
90	8.28	20.29	15.16	24.10	15.40	16.56	25.35
Unlimited	8.37	20.51	15.32	24.37	15.58	16.75	25.62
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.47	20.75	15.49	24.63	15.75	16.93	25.91
30	9.32	22.84	17.06	27.13	17.34	18.65	28.53
40	9.84	24.11	18.01	28.64	18.31	19.69	30.12
60	10.37	25.42	18.98	30.18	19.30	20.75	31.74
Unlimited	10.46	25.61	19.14	30.43	19.45	20.91	32.00
LARGE GROUP				**$5 Copay**			
20	7.97	19.51	14.58	23.18	14.82	15.93	24.38
30	8.76	21.47	16.03	25.50	16.30	17.52	26.82
40	9.31	22.82	17.04	27.10	17.32	18.63	28.50
60	9.75	23.89	17.84	28.38	18.14	19.50	29.84
Unlimited	9.83	24.09	17.99	28.61	18.29	19.67	30.09
LARGE GROUP				**$10 Copay**			
20	7.46	18.27	13.65	21.70	13.87	14.91	22.82
30	8.21	20.11	15.02	23.90	15.27	16.42	25.12
40	8.68	21.27	15.88	25.26	16.15	17.36	26.56
60	9.15	22.42	16.75	26.62	17.01	18.30	28.00
Unlimited	9.22	22.59	16.87	26.84	17.15	18.44	28.21
LARGE GROUP				**$15 Copay**			
20	7.00	17.15	12.80	20.36	13.02	13.99	21.41
30	7.71	18.89	14.11	22.44	14.34	15.42	23.59
40	8.17	20.01	14.95	23.78	15.20	16.34	25.00
60	8.64	21.17	15.81	25.14	16.07	17.28	26.44
Unlimited	8.71	21.34	15.94	25.35	16.20	17.42	26.65
LARGE GROUP				**$20 Copay**			
20	6.59	16.15	12.06	19.18	12.26	13.18	20.17
30	7.22	17.70	13.22	21.01	13.43	14.44	22.09
40	7.62	18.67	13.94	22.17	14.17	15.24	23.32
60	8.10	19.84	14.82	23.57	15.07	16.20	24.79
Unlimited	8.16	19.99	14.93	23.75	15.18	16.32	24.97
LARGE GROUP				**$25 Copay**			
20	6.12	14.99	11.20	17.81	11.38	12.24	18.73
30	6.72	16.47	12.30	19.56	12.51	13.44	20.57
40	7.17	17.56	13.12	20.87	13.34	14.34	21.94
60	7.54	18.47	13.79	21.93	14.03	15.08	23.06
Unlimited	7.61	18.65	13.92	22.14	14.16	15.22	23.29
LARGE GROUP				**$30 Copay**			
20	5.84	14.32	10.70	17.00	10.87	11.69	17.88
30	6.33	15.51	11.59	18.43	11.78	12.67	19.38
40	6.74	16.51	12.34	19.62	12.54	13.48	20.63
60	7.08	17.34	12.95	20.60	13.17	14.16	21.66
Unlimited	7.12	17.44	13.03	20.72	13.24	14.24	21.79
LARGE GROUP				**$35 Copay**			
20	5.55	13.60	10.16	16.15	10.32	11.10	16.98
30	5.93	14.51	10.84	17.25	11.03	11.85	18.14
40	6.30	15.44	11.54	18.34	11.72	12.61	19.29
60	6.62	16.22	12.12	19.27	12.31	13.24	20.26
Unlimited	6.67	16.34	12.21	19.41	12.40	13.34	20.41
LARGE GROUP				**$40 Copay**			
20	5.41	13.25	9.89	15.73	10.06	10.81	16.54
30	5.76	14.12	10.55	16.77	10.72	11.53	17.64
40	6.14	15.05	11.24	17.87	11.42	12.28	18.79
60	6.48	15.87	11.85	18.85	12.05	12.95	19.82
Unlimited	6.52	15.97	11.92	18.96	12.13	13.04	19.94
LARGE GROUP				**$45 Copay**			
20	5.24	12.84	9.60	15.26	9.75	10.49	16.04
30	5.60	13.72	10.25	16.30	10.41	11.20	17.14
40	5.99	14.67	10.95	17.42	11.14	11.97	18.32
60	6.32	15.49	11.58	18.40	11.76	12.65	19.35

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.22	20.14	15.01	23.90	15.29	16.44	25.14
60	8.67	21.24	15.83	25.20	16.13	17.34	26.52
90	9.00	22.05	16.43	26.16	16.74	18.00	27.53
Unlimited	9.09	22.27	16.60	26.42	16.91	18.18	27.81
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.19	22.52	16.78	26.72	17.09	18.38	28.11
30	10.12	24.79	18.48	29.42	18.82	20.24	30.96
40	10.69	26.19	19.52	31.08	19.88	21.38	32.70
60	11.26	27.59	20.56	32.73	20.94	22.52	34.44
Unlimited	11.35	27.81	20.73	32.99	21.11	22.70	34.72
LARGE GROUP				**$5 Copay**			
20	8.65	21.19	15.79	25.15	16.09	17.30	26.46
30	9.52	23.32	17.38	27.67	17.71	19.04	29.12
40	10.11	24.77	18.46	29.39	18.80	20.22	30.93
60	10.59	25.95	19.34	30.79	19.70	21.18	32.39
Unlimited	10.68	26.17	19.50	31.05	19.86	21.36	32.67
LARGE GROUP				**$10 Copay**			
20	8.10	19.85	14.79	23.55	15.07	16.20	24.78
30	8.91	21.83	16.27	25.90	16.57	17.82	27.26
40	9.42	23.08	17.20	27.38	17.52	18.84	28.82
60	9.93	24.33	18.13	28.87	18.47	19.86	30.38
Unlimited	10.01	24.52	18.28	29.10	18.62	20.02	30.62
LARGE GROUP				**$15 Copay**			
20	7.60	18.62	13.88	22.09	14.14	15.20	23.25
30	8.37	20.51	15.28	24.33	15.57	16.74	25.60
40	8.87	21.73	16.20	25.79	16.50	17.74	27.13
60	9.37	22.96	17.11	27.24	17.43	18.74	28.66
Unlimited	9.45	23.15	17.26	27.47	17.58	18.90	28.91
LARGE GROUP				**$20 Copay**			
20	7.15	17.52	13.06	20.79	13.30	14.30	21.87
30	7.84	19.21	14.32	22.79	14.58	15.68	23.98
40	8.27	20.26	15.10	24.04	15.38	16.54	25.30
60	8.79	21.54	16.05	25.55	16.35	17.58	26.89
Unlimited	8.86	21.71	16.18	25.76	16.48	17.72	27.10
LARGE GROUP				**$25 Copay**			
20	6.64	16.27	12.12	19.30	12.35	13.28	20.31
30	7.29	17.86	13.31	21.19	13.56	14.58	22.30
40	7.79	19.09	14.22	22.65	14.49	15.58	23.83
60	8.18	20.04	14.94	23.78	15.21	16.36	25.02
Unlimited	8.26	20.24	15.08	24.01	15.36	16.52	25.27
LARGE GROUP				**$30 Copay**			
20	6.35	15.56	11.60	18.46	11.81	12.70	19.42
30	6.88	16.86	12.56	20.00	12.80	13.76	21.05
40	7.32	17.93	13.37	21.28	13.62	14.64	22.39
60	7.68	18.82	14.02	22.33	14.28	15.36	23.49
Unlimited	7.72	18.91	14.10	22.44	14.36	15.44	23.62
LARGE GROUP				**$35 Copay**			
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.44	15.78	11.76	18.72	11.98	12.88	19.70
40	6.85	16.78	12.51	19.91	12.74	13.70	20.95
60	7.18	17.59	13.11	20.87	13.35	14.36	21.96
Unlimited	7.23	17.71	13.20	21.02	13.45	14.46	22.12
LARGE GROUP				**$40 Copay**			
20	5.88	14.41	10.74	17.09	10.94	11.76	17.99
30	6.26	15.34	11.43	18.20	11.64	12.52	19.15
40	6.66	16.32	12.16	19.36	12.39	13.32	20.37
60	7.03	17.22	12.84	20.44	13.08	14.06	21.50
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP				**$45 Copay**			
20	5.69	13.94	10.39	16.54	10.58	11.38	17.41
30	6.07	14.87	11.08	17.65	11.29	12.14	18.57
40	6.50	15.93	11.87	18.90	12.09	13.00	19.88
60	6.87	16.83	12.54	19.97	12.78	13.74	21.02

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.64	1.58	1.14	1.85	1.19	1.28	1.95
60	0.68	1.68	1.21	1.95	1.28	1.37	2.08
90	0.72	1.76	1.27	2.06	1.34	1.44	2.18
Unlimited	0.72	1.76	1.28	2.05	1.33	1.43	2.19
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.72	1.77	1.29	2.09	1.34	1.45	2.20
30	0.80	1.95	1.42	2.29	1.48	1.59	2.43
40	0.85	2.08	1.51	2.44	1.57	1.69	2.58
60	0.89	2.17	1.58	2.55	1.64	1.77	2.70
Unlimited	0.89	2.20	1.59	2.56	1.66	1.79	2.72
LARGE GROUP				**$5 Copay**			
20	0.68	1.68	1.21	1.97	1.27	1.37	2.08
30	0.76	1.85	1.35	2.17	1.41	1.52	2.30
40	0.80	1.95	1.42	2.29	1.48	1.59	2.43
60	0.84	2.06	1.50	2.41	1.56	1.68	2.55
Unlimited	0.85	2.08	1.51	2.44	1.57	1.69	2.58
LARGE GROUP				**$10 Copay**			
20	0.64	1.58	1.14	1.85	1.20	1.29	1.96
30	0.70	1.72	1.25	2.00	1.30	1.40	2.14
40	0.74	1.81	1.32	2.12	1.37	1.48	2.26
60	0.78	1.91	1.38	2.25	1.46	1.56	2.38
Unlimited	0.79	1.93	1.41	2.26	1.47	1.58	2.41
LARGE GROUP				**$15 Copay**			
20	0.60	1.47	1.08	1.73	1.12	1.21	1.84
30	0.66	1.62	1.17	1.89	1.23	1.32	2.01
40	0.70	1.72	1.25	2.01	1.30	1.40	2.13
60	0.73	1.79	1.30	2.10	1.36	1.46	2.22
Unlimited	0.74	1.81	1.32	2.12	1.38	1.48	2.26
LARGE GROUP				**$20 Copay**			
20	0.56	1.37	1.00	1.61	1.04	1.12	1.70
30	0.62	1.51	1.10	1.78	1.15	1.24	1.89
40	0.65	1.59	1.16	1.87	1.21	1.30	1.98
60	0.69	1.70	1.23	1.98	1.28	1.38	2.10
Unlimited	0.70	1.72	1.25	2.01	1.30	1.40	2.13
LARGE GROUP				**$25 Copay**			
20	0.52	1.28	0.92	1.49	0.97	1.04	1.58
30	0.57	1.39	1.01	1.63	1.05	1.14	1.73
40	0.62	1.53	1.10	1.78	1.15	1.24	1.89
60	0.64	1.57	1.15	1.85	1.18	1.28	1.96
Unlimited	0.65	1.59	1.16	1.87	1.20	1.30	1.98
LARGE GROUP				**$30 Copay**			
20	0.51	1.24	0.90	1.46	0.94	1.01	1.54
30	0.55	1.35	0.97	1.57	1.02	1.09	1.67
40	0.58	1.42	1.03	1.66	1.08	1.16	1.76
60	0.60	1.48	1.07	1.73	1.11	1.20	1.83
Unlimited	0.60	1.47	1.07	1.72	1.12	1.20	1.83
LARGE GROUP				**$35 Copay**			
20	0.47	1.15	0.83	1.35	0.88	0.94	1.44
30	0.51	1.27	0.92	1.47	0.95	1.03	1.56
40	0.55	1.34	0.97	1.57	1.02	1.09	1.66
60	0.56	1.37	0.99	1.60	1.04	1.12	1.70
Unlimited	0.56	1.37	0.99	1.61	1.05	1.12	1.71
LARGE GROUP				**$40 Copay**			
20	0.47	1.16	0.85	1.36	0.88	0.95	1.45
30	0.50	1.22	0.88	1.43	0.92	0.99	1.51
40	0.52	1.27	0.92	1.49	0.97	1.04	1.58
60	0.55	1.35	0.99	1.59	1.03	1.11	1.68
Unlimited	0.56	1.38	1.01	1.62	1.04	1.12	1.72
LARGE GROUP				**$45 Copay**			
20	0.45	1.10	0.79	1.28	0.83	0.89	1.37
30	0.47	1.15	0.83	1.35	0.88	0.94	1.43
40	0.51	1.26	0.92	1.48	0.95	1.03	1.56
60	0.55	1.34	0.96	1.57	1.02	1.09	1.67

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.4%	8.5%	8.2%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
90	8.7%	8.7%	8.4%	8.5%	8.7%	8.7%	8.6%
Unlimited	8.6%	8.6%	8.4%	8.4%	8.5%	8.5%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.5%	8.5%	8.3%	8.5%	8.5%	8.6%	8.5%
30	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
60	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
LARGE GROUP				**$5 Copay**			
20	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
30	8.7%	8.6%	8.4%	8.5%	8.7%	8.7%	8.6%
40	8.6%	8.5%	8.3%	8.5%	8.5%	8.5%	8.5%
60	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP				**$10 Copay**			
20	8.6%	8.6%	8.4%	8.5%	8.7%	8.7%	8.6%
30	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.2%	8.5%	8.6%	8.5%	8.5%
Unlimited	8.6%	8.5%	8.4%	8.4%	8.6%	8.6%	8.5%
LARGE GROUP				**$15 Copay**			
20	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
30	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
40	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
60	8.4%	8.5%	8.2%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP				**$20 Copay**			
20	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.4%
30	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.6%
40	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
60	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP				**$25 Copay**			
20	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.4%
30	8.5%	8.4%	8.2%	8.3%	8.4%	8.5%	8.4%
40	8.6%	8.7%	8.4%	8.5%	8.6%	8.6%	8.6%
60	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP				**$30 Copay**			
20	8.7%	8.7%	8.4%	8.6%	8.6%	8.6%	8.6%
30	8.7%	8.7%	8.4%	8.5%	8.7%	8.6%	8.6%
40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
60	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
Unlimited	8.4%	8.4%	8.2%	8.3%	8.5%	8.4%	8.4%
LARGE GROUP				**$35 Copay**			
20	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
30	8.6%	8.8%	8.5%	8.5%	8.6%	8.7%	8.6%
40	8.7%	8.7%	8.4%	8.6%	8.7%	8.6%	8.6%
60	8.5%	8.4%	8.2%	8.3%	8.4%	8.5%	8.4%
Unlimited	8.4%	8.4%	8.1%	8.3%	8.5%	8.4%	8.4%
LARGE GROUP				**$40 Copay**			
20	8.7%	8.8%	8.6%	8.6%	8.7%	8.8%	8.8%
30	8.7%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
40	8.5%	8.4%	8.2%	8.3%	8.5%	8.5%	8.4%
60	8.5%	8.5%	8.4%	8.4%	8.5%	8.6%	8.5%
Unlimited	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP				**$45 Copay**			
20	8.6%	8.6%	8.2%	8.4%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.1%	8.3%	8.5%	8.4%	8.3%
40	8.5%	8.6%	8.4%	8.5%	8.5%	8.6%	8.5%
60	8.7%	8.7%	8.3%	8.5%	8.7%	8.6%	8.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.35	15.57	11.63	18.49	11.82	12.71	19.44
LARGE GROUP			**$50 Copay**				
20	5.10	12.50	9.33	14.84	9.49	10.20	15.61
30	5.46	13.37	9.99	15.88	10.15	10.91	16.70
40	5.84	14.32	10.70	17.00	10.87	11.69	17.88
60	6.16	15.10	11.27	17.93	11.45	12.32	18.85
Unlimited	6.20	15.20	11.35	18.04	11.54	12.40	18.97

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.90	16.91	12.60	20.06	12.83	13.80	21.11
LARGE GROUP			**$50 Copay**				
20	5.53	13.55	10.10	16.08	10.29	11.06	16.92
30	5.93	14.53	10.83	17.24	11.03	11.86	18.14
40	6.35	15.56	11.60	18.46	11.81	12.70	19.42
60	6.68	16.37	12.20	19.42	12.42	13.36	20.43
Unlimited	6.73	16.49	12.29	19.56	12.52	13.46	20.59

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.55	1.34	0.97	1.57	1.01	1.09	1.67
LARGE GROUP			**$50 Copay**				
20	0.43	1.05	0.77	1.24	0.80	0.86	1.31
30	0.47	1.16	0.84	1.36	0.88	0.95	1.44
40	0.51	1.24	0.90	1.46	0.94	1.01	1.54
60	0.52	1.27	0.93	1.49	0.97	1.04	1.58
Unlimited	0.53	1.29	0.94	1.52	0.98	1.06	1.62

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	8.7%	8.6%	8.3%	8.5%	8.5%	8.6%	8.6%
LARGE GROUP			**$50 Copay**				
20	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
30	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.6%
40	8.7%	8.7%	8.4%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.3%	8.3%	8.5%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.21	10.32	7.71	12.26	7.83	8.43	12.89
$25	4.00	9.79	7.31	11.64	7.44	8.00	12.24
$50	3.74	9.17	6.85	10.89	6.97	7.49	11.45
$100	3.44	8.43	6.29	10.01	6.40	6.87	10.52
$500	1.65	4.05	3.02	4.80	3.07	3.30	5.06
Coinsurance							
80%	3.39	8.29	6.20	9.85	6.30	6.77	10.36
75%	3.17	7.77	5.80	9.23	5.90	6.34	9.71
70%	2.96	7.25	5.42	8.61	5.50	5.92	9.05
Deductible			**Orthotics Riders**				
$0	0.72	1.77	1.33	2.11	1.35	1.45	2.21
$25	0.69	1.70	1.26	2.02	1.29	1.39	2.12
$50	0.65	1.60	1.19	1.90	1.21	1.31	2.00
$100	0.58	1.43	1.06	1.69	1.08	1.16	1.77
$500	0.29	0.70	0.52	0.83	0.53	0.57	0.88
Coinsurance							
80%	0.58	1.43	1.06	1.69	1.08	1.16	1.77
75%	0.55	1.35	1.01	1.60	1.02	1.10	1.68
70%	0.52	1.28	0.95	1.51	0.97	1.04	1.59
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.32	3.22	2.41	3.83	2.45	2.63	4.03
12 Months	2.11	5.17	3.87	6.14	3.93	4.22	6.46
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.06	5.05	3.77	6.00	3.84	4.12	6.30
12 Months	3.28	8.05	6.01	9.56	6.11	6.57	10.05
			Private Duty Nursing Riders				
In Full	0.50	1.22	0.92	1.46	0.93	1.00	1.53
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.15	0.38	0.28	0.45	0.29	0.31	0.47
			Dental Network Access				
	0.41	1.00	0.74	1.18	0.75	0.82	1.24
Limit			**Infertility Rider**				
2 IVF	8.91	21.84	16.31	25.94	16.59	17.83	27.27
3 IVF	10.78	26.42	19.73	31.38	20.05	21.56	32.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.57	11.20	8.34	13.28	8.50	9.14	13.98
$25	4.34	10.63	7.92	12.62	8.07	8.68	13.28
$50	4.06	9.95	7.41	11.80	7.55	8.12	12.42
$100	3.74	9.16	6.83	10.87	6.96	7.48	11.44
$500	1.78	4.36	3.25	5.17	3.31	3.56	5.45
Coinsurance							
80%	3.68	9.02	6.72	10.70	6.84	7.36	11.26
75%	3.43	8.40	6.26	9.97	6.38	6.86	10.49
70%	3.21	7.86	5.86	9.33	5.97	6.42	9.82
Deductible			**Orthotics Riders**				
$0	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$25	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$50	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$100	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$500	0.32	0.78	0.58	0.93	0.60	0.64	0.98
Coinsurance							
80%	0.63	1.54	1.15	1.83	1.17	1.26	1.93
75%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
70%	0.56	1.37	1.02	1.63	1.04	1.12	1.71
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.54	1.32	0.99	1.57	1.00	1.08	1.65
80% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	9.67	23.69	17.66	28.11	17.99	19.34	29.58
3 IVF	11.71	28.69	21.38	34.04	21.78	23.42	35.82

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.36	0.88	0.63	1.02	0.67	0.71	1.09
$25	0.34	0.84	0.61	0.98	0.63	0.68	1.04
$50	0.32	0.78	0.56	0.91	0.58	0.63	0.97
$100	0.30	0.73	0.54	0.86	0.56	0.61	0.92
$500	0.13	0.31	0.23	0.37	0.24	0.26	0.39
Coinsurance							
80%	0.29	0.73	0.52	0.85	0.54	0.59	0.90
75%	0.26	0.63	0.46	0.74	0.48	0.52	0.78
70%	0.25	0.61	0.44	0.72	0.47	0.50	0.77
Deductible			**Orthotics Riders**				
$0	0.05	0.12	0.08	0.13	0.08	0.09	0.15
$25	0.05	0.11	0.09	0.13	0.09	0.09	0.14
$50	0.05	0.12	0.09	0.13	0.09	0.09	0.14
$100	0.05	0.11	0.09	0.14	0.09	0.10	0.16
$500	0.03	0.08	0.06	0.10	0.07	0.07	0.10
Coinsurance							
80%	0.05	0.11	0.09	0.14	0.09	0.10	0.16
75%	0.04	0.10	0.07	0.12	0.08	0.08	0.12
70%	0.04	0.09	0.07	0.12	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.36	0.23	0.25	0.37
12 Months	0.18	0.44	0.31	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.41	0.30	0.48	0.31	0.34	0.52
12 Months	0.29	0.70	0.51	0.82	0.53	0.57	0.87
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.11	0.07	0.08	0.12
80% hrs 73-50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-50	0.01	0.01	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.09	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	0.76	1.85	1.35	2.17	1.40	1.51	2.31
3 IVF	0.93	2.27	1.65	2.66	1.73	1.86	2.83

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.6%	8.5%	8.2%	8.3%	8.6%	8.4%	8.5%
$25	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$50	8.6%	8.5%	8.2%	8.4%	8.3%	8.4%	8.5%
$100	8.7%	8.7%	8.6%	8.6%	8.7%	8.9%	8.7%
$500	7.9%	7.7%	7.6%	7.7%	7.8%	7.9%	7.7%
Coinsurance							
80%	8.6%	8.8%	8.4%	8.6%	8.6%	8.7%	8.7%
75%	8.2%	8.1%	7.9%	8.0%	8.1%	8.2%	8.0%
70%	8.4%	8.4%	8.1%	8.4%	8.5%	8.4%	8.5%
Deductible			**Orthotics Riders**				
$0	6.9%	6.8%	6.0%	6.2%	5.9%	6.2%	6.8%
$25	7.2%	6.5%	7.1%	6.4%	7.0%	6.5%	6.6%
$50	7.7%	7.5%	7.6%	6.8%	7.4%	6.9%	7.0%
$100	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
$500	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
Coinsurance							
80%	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
75%	7.3%	7.4%	6.9%	7.5%	7.8%	7.3%	7.1%
70%	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	9.1%	9.6%	9.1%	9.4%	9.4%	9.5%	9.2%
12 Months	8.5%	8.5%	8.0%	8.5%	8.4%	8.5%	8.5%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.3%	8.1%	8.0%	8.0%	8.1%	8.3%	8.3%
12 Months	8.8%	8.7%	8.5%	8.6%	8.7%	8.7%	8.7%
			Private Duty Nursing Riders				
In Full	8.0%	8.2%	7.6%	7.5%	7.5%	8.0%	7.8%
80% hrs 73-50	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-50	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
			Dental Network Access				
	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
Limit			**Infertility Rider**				
2 IVF	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.5%
3 IVF	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
856.62	2,098.72	1,567.61	2,492.76	1,593.31	1,713.24	2,621.25
75% Coinsurance						
814.76	1,996.16	1,491.01	2,370.95	1,515.45	1,629.52	2,493.16
70% Coinsurance						
773.92	1,896.10	1,416.27	2,252.10	1,439.49	1,547.84	2,368.19
50% Coinsurance						
732.06	1,793.54	1,339.66	2,130.29	1,361.63	1,464.11	2,240.09

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
929.97	2,278.43	1,698.13	2,703.42	1,729.74	1,859.94	2,844.78
75% Coinsurance						
884.52	2,167.07	1,615.13	2,571.30	1,645.21	1,769.04	2,705.75
70% Coinsurance						
840.19	2,058.47	1,534.19	2,442.43	1,562.75	1,680.38	2,570.14
50% Coinsurance						
794.75	1,947.14	1,451.21	2,310.34	1,478.24	1,589.50	2,431.14

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
73.35	179.71	130.52	210.66	136.43	146.70	223.53
75% Coinsurance						
69.76	170.91	124.12	200.35	129.76	139.52	212.59
70% Coinsurance						
66.27	162.37	117.92	190.33	123.26	132.54	201.95
50% Coinsurance						
62.69	153.60	111.55	180.05	116.61	125.39	191.05

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
75% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
70% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
50% Coinsurance						
8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(52.47)	(128.55)	(96.02)	(152.68)	(97.59)	(104.94)	(160.56)
$250	(62.60)	(153.37)	(114.56)	(182.16)	(116.43)	(125.19)	(191.55)
$300	(72.75)	(178.22)	(133.13)	(211.69)	(135.31)	(145.49)	(222.60)
$350	(82.90)	(203.09)	(151.69)	(241.23)	(154.18)	(165.79)	(253.66)
$400	(90.87)	(222.64)	(166.29)	(264.44)	(169.02)	(181.74)	(278.07)
$500	(106.81)	(261.69)	(195.47)	(310.83)	(198.68)	(213.63)	(326.85)
$750	(138.72)	(339.86)	(253.86)	(403.68)	(258.02)	(277.44)	(424.48)
$1,000	(163.28)	(400.04)	(298.81)	(475.15)	(303.71)	(326.56)	(499.64)
$1,500	(200.85)	(492.08)	(367.56)	(584.47)	(373.58)	(401.70)	(614.59)
$2,000	(216.22)	(529.74)	(395.68)	(629.20)	(402.17)	(432.44)	(661.63)
$2,500	(231.64)	(567.53)	(423.90)	(674.08)	(430.86)	(463.28)	(708.83)
$5,000	(272.32)	(667.18)	(498.34)	(792.45)	(506.51)	(544.64)	(833.30)
$10,000	(305.90)	(749.46)	(559.80)	(890.16)	(568.97)	(611.80)	(936.04)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(43.00)	(105.36)	(78.69)	(125.14)	(79.99)	(86.01)	(131.59)
$250	(51.29)	(125.65)	(93.85)	(149.24)	(95.39)	(102.57)	(156.94)
$300	(59.62)	(146.06)	(109.10)	(173.49)	(110.89)	(119.24)	(182.44)
$350	(67.90)	(166.36)	(124.26)	(197.59)	(126.30)	(135.80)	(207.77)
$400	(74.58)	(182.72)	(136.49)	(217.04)	(138.72)	(149.16)	(228.23)
$500	(87.96)	(215.52)	(160.98)	(255.98)	(163.62)	(175.93)	(269.17)
$750	(114.41)	(280.32)	(209.38)	(332.94)	(212.81)	(228.83)	(350.10)
$1,000	(135.01)	(330.77)	(247.06)	(392.87)	(251.11)	(270.01)	(413.12)
$1,500	(166.22)	(407.24)	(304.18)	(483.69)	(309.17)	(332.44)	(508.63)
$2,000	(180.37)	(441.89)	(330.07)	(524.87)	(335.48)	(360.73)	(551.92)
$2,500	(194.51)	(476.56)	(355.96)	(566.04)	(361.79)	(389.03)	(595.21)
$5,000	(235.01)	(575.77)	(430.06)	(683.87)	(437.11)	(470.02)	(719.12)
$10,000	(268.42)	(657.63)	(491.21)	(781.12)	(499.27)	(536.85)	(821.38)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(33.52)	(82.12)	(61.33)	(97.53)	(62.34)	(67.03)	(102.56)
$250	(39.99)	(97.98)	(73.19)	(116.38)	(74.39)	(79.99)	(122.38)
$300	(46.46)	(113.83)	(85.03)	(135.20)	(86.41)	(92.92)	(142.17)
$350	(52.92)	(129.65)	(96.84)	(153.99)	(98.43)	(105.84)	(161.93)
$400	(58.33)	(142.92)	(106.75)	(169.75)	(108.50)	(116.67)	(178.50)
$500	(69.05)	(169.19)	(126.37)	(200.95)	(128.44)	(138.11)	(211.30)
$750	(90.09)	(220.71)	(164.86)	(262.15)	(167.57)	(180.17)	(275.67)
$1,000	(106.67)	(261.34)	(195.21)	(310.42)	(198.41)	(213.34)	(326.41)
$1,500	(131.60)	(322.42)	(240.83)	(382.96)	(244.78)	(263.20)	(402.70)
$2,000	(144.51)	(354.06)	(264.46)	(420.54)	(268.79)	(289.03)	(442.21)
$2,500	(157.44)	(385.72)	(288.11)	(458.14)	(292.83)	(314.87)	(481.76)
$5,000	(197.72)	(484.41)	(361.82)	(575.35)	(367.75)	(395.43)	(605.01)
$10,000	(230.98)	(565.90)	(422.69)	(672.15)	(429.62)	(461.96)	(706.80)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(23.04)	(56.46)	(42.17)	(67.05)	(42.86)	(46.08)	(70.51)
$250	(27.61)	(67.65)	(50.53)	(80.35)	(51.36)	(55.22)	(84.49)
$300	(32.21)	(78.92)	(58.95)	(93.74)	(59.91)	(64.42)	(98.56)
$350	(36.77)	(90.09)	(67.29)	(107.01)	(68.39)	(73.54)	(112.52)
$400	(40.75)	(99.84)	(74.57)	(118.58)	(75.80)	(81.50)	(124.70)
$500	(48.68)	(119.28)	(89.10)	(141.67)	(90.56)	(97.37)	(148.97)
$750	(63.87)	(156.49)	(116.88)	(185.86)	(118.80)	(127.74)	(195.45)
$1,000	(76.22)	(186.75)	(139.50)	(221.81)	(141.78)	(152.45)	(233.24)
$1,500	(95.25)	(233.36)	(174.31)	(277.17)	(177.16)	(190.50)	(291.45)
$2,000	(105.39)	(258.19)	(192.86)	(306.67)	(196.02)	(210.77)	(322.48)
$2,500	(115.55)	(283.09)	(211.45)	(336.23)	(214.91)	(231.09)	(353.57)
$5,000	(155.27)	(380.42)	(284.15)	(451.85)	(288.81)	(310.55)	(475.14)
$10,000	(188.05)	(460.71)	(344.13)	(547.22)	(349.77)	(376.09)	(575.42)
LARGE GROUP							
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(48.58)	(119.02)	(88.90)	(141.37)	(90.36)	(97.17)	(148.67)
$1,500	(52.99)	(129.83)	(96.97)	(154.19)	(98.56)	(105.98)	(162.15)
$2,000	(55.26)	(135.39)	(101.13)	(160.81)	(102.79)	(110.53)	(169.11)
$3,000	(57.38)	(140.57)	(105.00)	(166.96)	(106.72)	(114.75)	(175.57)
$4,000	(58.25)	(142.72)	(106.60)	(169.51)	(108.34)	(116.50)	(178.26)
$5,000	(58.72)	(143.87)	(107.46)	(170.88)	(109.22)	(117.44)	(179.68)
$7,000	(59.29)	(145.27)	(108.51)	(172.54)	(110.28)	(118.59)	(181.44)
$7,500	(59.77)	(146.44)	(109.38)	(173.94)	(111.18)	(119.54)	(182.91)
$10,000	(61.52)	(150.72)	(112.58)	(179.01)	(114.42)	(123.03)	(188.24)
$20,000	(64.02)	(156.84)	(117.15)	(186.28)	(119.06)	(128.03)	(195.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(56.96)	(139.55)	(104.01)	(165.58)	(105.95)	(113.92)	(174.24)
$250	(67.96)	(166.50)	(124.09)	(197.56)	(126.41)	(135.92)	(207.89)
$300	(78.98)	(193.50)	(144.22)	(229.59)	(146.90)	(157.96)	(241.60)
$350	(90.00)	(220.50)	(164.34)	(261.63)	(167.40)	(180.00)	(275.31)
$400	(98.65)	(241.69)	(180.13)	(286.78)	(183.49)	(197.30)	(301.77)
$500	(115.96)	(284.10)	(211.74)	(337.10)	(215.69)	(231.92)	(354.72)
$750	(150.59)	(368.95)	(274.98)	(437.77)	(280.10)	(301.18)	(460.65)
$1,000	(177.27)	(434.31)	(323.70)	(515.32)	(329.72)	(354.54)	(542.27)
$1,500	(218.05)	(534.22)	(398.16)	(633.87)	(405.57)	(436.10)	(667.01)
$2,000	(234.73)	(575.09)	(428.62)	(682.36)	(436.60)	(469.46)	(718.04)
$2,500	(251.47)	(616.10)	(459.18)	(731.02)	(467.73)	(502.94)	(769.25)
$5,000	(295.63)	(724.29)	(539.82)	(859.40)	(549.87)	(591.26)	(904.33)
$10,000	(332.09)	(813.62)	(606.40)	(965.39)	(617.69)	(664.18)	(1,015.86)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(46.68)	(114.37)	(85.24)	(135.70)	(86.82)	(93.36)	(142.79)
$250	(55.69)	(136.44)	(101.69)	(161.89)	(103.58)	(111.38)	(170.36)
$300	(64.72)	(158.56)	(118.18)	(188.14)	(120.38)	(129.44)	(197.98)
$350	(73.71)	(180.59)	(134.59)	(214.27)	(137.10)	(147.42)	(225.48)
$400	(80.96)	(198.35)	(147.83)	(235.35)	(150.59)	(161.92)	(247.66)
$500	(95.49)	(233.95)	(174.36)	(277.59)	(177.61)	(190.98)	(292.10)
$750	(124.21)	(304.31)	(226.81)	(361.08)	(231.03)	(248.42)	(379.96)
$1,000	(146.56)	(359.07)	(267.62)	(426.05)	(272.60)	(293.12)	(448.33)
$1,500	(180.44)	(442.08)	(329.48)	(524.54)	(335.62)	(360.88)	(551.97)
$2,000	(195.81)	(479.73)	(357.55)	(569.22)	(364.21)	(391.62)	(598.98)
$2,500	(211.16)	(517.34)	(385.58)	(613.84)	(392.76)	(422.32)	(645.94)
$5,000	(255.13)	(625.07)	(465.87)	(741.66)	(474.54)	(510.26)	(780.44)
$10,000	(291.40)	(713.93)	(532.10)	(847.10)	(542.00)	(582.80)	(891.39)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(36.39)	(89.16)	(66.45)	(105.79)	(67.69)	(72.78)	(111.32)
$250	(43.41)	(106.35)	(79.27)	(126.19)	(80.74)	(86.82)	(132.79)
$300	(50.44)	(123.58)	(92.10)	(146.63)	(93.82)	(100.88)	(154.30)
$350	(57.45)	(140.75)	(104.90)	(167.01)	(106.86)	(114.90)	(175.74)
$400	(63.33)	(155.16)	(115.64)	(184.10)	(117.79)	(126.66)	(193.73)
$500	(74.96)	(183.65)	(136.88)	(217.91)	(139.43)	(149.92)	(229.30)
$750	(97.80)	(239.61)	(178.58)	(284.30)	(181.91)	(195.60)	(299.17)
$1,000	(115.80)	(283.71)	(211.45)	(336.63)	(215.39)	(231.60)	(354.23)
$1,500	(142.86)	(350.01)	(260.86)	(415.29)	(265.72)	(285.72)	(437.01)
$2,000	(156.89)	(384.38)	(286.48)	(456.08)	(291.82)	(313.78)	(479.93)
$2,500	(170.92)	(418.75)	(312.10)	(496.86)	(317.91)	(341.84)	(522.84)
$5,000	(214.64)	(525.87)	(391.93)	(623.96)	(399.23)	(429.28)	(656.58)
$10,000	(250.76)	(614.36)	(457.89)	(728.96)	(466.41)	(501.52)	(767.07)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(25.02)	(61.30)	(45.69)	(72.73)	(46.54)	(50.04)	(76.54)
$250	(29.97)	(73.43)	(54.73)	(87.12)	(55.74)	(59.94)	(91.68)
$300	(34.96)	(85.65)	(63.84)	(101.63)	(65.03)	(69.92)	(106.94)
$350	(39.92)	(97.80)	(72.89)	(116.05)	(74.25)	(79.84)	(122.12)
$400	(44.24)	(108.39)	(80.78)	(128.61)	(82.29)	(88.48)	(135.33)
$500	(52.85)	(129.48)	(96.50)	(153.63)	(98.30)	(105.70)	(161.67)
$750	(69.34)	(169.88)	(126.61)	(201.57)	(128.97)	(138.68)	(212.11)
$1,000	(82.74)	(202.71)	(151.08)	(240.53)	(153.90)	(165.48)	(253.10)
$1,500	(103.41)	(253.35)	(188.83)	(300.61)	(192.34)	(206.82)	(316.33)
$2,000	(114.41)	(280.30)	(208.91)	(332.59)	(212.80)	(228.82)	(349.98)
$2,500	(125.44)	(307.33)	(229.05)	(364.65)	(233.32)	(250.88)	(383.72)
$5,000	(168.56)	(412.97)	(307.79)	(490.00)	(313.52)	(337.12)	(515.63)
$10,000	(204.15)	(500.17)	(372.78)	(593.46)	(379.72)	(408.30)	(624.49)
LARGE GROUP							
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(52.73)	(129.19)	(96.28)	(153.29)	(98.08)	(105.46)	(161.30)
$1,500	(57.52)	(140.92)	(105.03)	(167.21)	(106.99)	(115.04)	(175.95)
$2,000	(60.00)	(147.00)	(109.56)	(174.42)	(111.60)	(120.00)	(183.54)
$3,000	(62.29)	(152.61)	(113.74)	(181.08)	(115.86)	(124.58)	(190.55)
$4,000	(63.24)	(154.94)	(115.48)	(183.84)	(117.63)	(126.48)	(193.45)
$5,000	(63.74)	(156.16)	(116.39)	(185.29)	(118.56)	(127.48)	(194.98)
$7,000	(64.37)	(157.71)	(117.54)	(187.12)	(119.73)	(128.74)	(196.91)
$7,500	(64.89)	(158.98)	(118.49)	(188.64)	(120.70)	(129.78)	(198.50)
$10,000	(66.79)	(163.64)	(121.96)	(194.16)	(124.23)	(133.58)	(204.31)
$20,000	(69.50)	(170.28)	(126.91)	(202.04)	(129.27)	(139.00)	(212.60)

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HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(4.49)	(11.00)	(7.99)	(12.90)	(8.36)	(8.98)	(13.68)
$250	(5.36)	(13.13)	(9.53)	(15.40)	(9.98)	(10.73)	(16.34)
$300	(6.23)	(15.28)	(11.09)	(17.90)	(11.59)	(12.47)	(19.00)
$350	(7.10)	(17.41)	(12.65)	(20.40)	(13.22)	(14.21)	(21.65)
$400	(7.78)	(19.05)	(13.84)	(22.34)	(14.47)	(15.56)	(23.70)
$500	(9.15)	(22.41)	(16.27)	(26.27)	(17.01)	(18.29)	(27.87)
$750	(11.87)	(29.09)	(21.12)	(34.09)	(22.08)	(23.74)	(36.17)
$1,000	(13.99)	(34.27)	(24.89)	(40.17)	(26.01)	(27.98)	(42.63)
$1,500	(17.20)	(42.14)	(30.60)	(49.40)	(31.99)	(34.40)	(52.42)
$2,000	(18.51)	(45.35)	(32.94)	(53.16)	(34.43)	(37.02)	(56.41)
$2,500	(19.83)	(48.57)	(35.28)	(56.94)	(36.87)	(39.66)	(60.42)
$5,000	(23.31)	(57.11)	(41.48)	(66.95)	(43.36)	(46.62)	(71.03)
$10,000	(26.19)	(64.16)	(46.60)	(75.23)	(48.72)	(52.38)	(79.82)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(3.68)	(9.01)	(6.55)	(10.56)	(6.83)	(7.35)	(11.20)
$250	(4.40)	(10.79)	(7.84)	(12.65)	(8.19)	(8.81)	(13.42)
$300	(5.10)	(12.50)	(9.08)	(14.65)	(9.49)	(10.20)	(15.54)
$350	(5.81)	(14.23)	(10.33)	(16.68)	(10.80)	(11.62)	(17.71)
$400	(6.38)	(15.63)	(11.34)	(18.31)	(11.87)	(12.76)	(19.43)
$500	(7.53)	(18.43)	(13.38)	(21.61)	(13.99)	(15.05)	(22.93)
$750	(9.80)	(23.99)	(17.43)	(28.14)	(18.22)	(19.59)	(29.86)
$1,000	(11.55)	(28.30)	(20.56)	(33.18)	(21.49)	(23.11)	(35.21)
$1,500	(14.22)	(34.84)	(25.30)	(40.85)	(26.45)	(28.44)	(43.34)
$2,000	(15.44)	(37.84)	(27.48)	(44.35)	(28.73)	(30.89)	(47.06)
$2,500	(16.65)	(40.78)	(29.62)	(47.80)	(30.97)	(33.29)	(50.73)
$5,000	(20.12)	(49.30)	(35.81)	(57.79)	(37.43)	(40.24)	(61.32)
$10,000	(22.98)	(56.30)	(40.89)	(65.98)	(42.73)	(45.95)	(70.01)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(2.87)	(7.04)	(5.12)	(8.26)	(5.35)	(5.75)	(8.76)
$250	(3.42)	(8.37)	(6.08)	(9.81)	(6.35)	(6.83)	(10.41)
$300	(3.98)	(9.75)	(7.07)	(11.43)	(7.41)	(7.96)	(12.13)
$350	(4.53)	(11.10)	(8.06)	(13.02)	(8.43)	(9.06)	(13.81)
$400	(5.00)	(12.24)	(8.89)	(14.35)	(9.29)	(9.99)	(15.23)
$500	(5.91)	(14.46)	(10.51)	(16.96)	(10.99)	(11.81)	(18.00)
$750	(7.71)	(18.90)	(13.72)	(22.15)	(14.34)	(15.43)	(23.50)
$1,000	(9.13)	(22.37)	(16.24)	(26.21)	(16.98)	(18.26)	(27.82)
$1,500	(11.26)	(27.59)	(20.03)	(32.33)	(20.94)	(22.52)	(34.31)
$2,000	(12.38)	(30.32)	(22.02)	(35.54)	(23.03)	(24.75)	(37.72)
$2,500	(13.48)	(33.03)	(23.99)	(38.72)	(25.08)	(26.97)	(41.08)
$5,000	(16.92)	(41.46)	(30.11)	(48.61)	(31.48)	(33.85)	(51.57)
$10,000	(19.78)	(48.46)	(35.20)	(56.81)	(36.79)	(39.56)	(60.27)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(1.98)	(4.84)	(3.52)	(5.68)	(3.68)	(3.96)	(6.03)
$250	(2.36)	(5.78)	(4.20)	(6.77)	(4.38)	(4.72)	(7.19)
$300	(2.75)	(6.73)	(4.89)	(7.89)	(5.12)	(5.50)	(8.38)
$350	(3.15)	(7.71)	(5.60)	(9.04)	(5.86)	(6.30)	(9.60)
$400	(3.49)	(8.55)	(6.21)	(10.03)	(6.49)	(6.98)	(10.63)
$500	(4.17)	(10.20)	(7.40)	(11.96)	(7.74)	(8.33)	(12.70)
$750	(5.47)	(13.39)	(9.73)	(15.71)	(10.17)	(10.94)	(16.66)
$1,000	(6.52)	(15.96)	(11.58)	(18.72)	(12.12)	(13.03)	(19.86)
$1,500	(8.16)	(19.99)	(14.52)	(23.44)	(15.18)	(16.32)	(24.88)
$2,000	(9.02)	(22.11)	(16.05)	(25.92)	(16.78)	(18.05)	(27.50)
$2,500	(9.89)	(24.24)	(17.60)	(28.42)	(18.41)	(19.79)	(30.15)
$5,000	(13.29)	(32.55)	(23.64)	(38.15)	(24.71)	(26.57)	(40.49)
$10,000	(16.10)	(39.46)	(28.65)	(46.24)	(29.95)	(32.21)	(49.07)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(4.15)	(10.17)	(7.38)	(11.92)	(7.72)	(8.29)	(12.63)
$1,500	(4.53)	(11.09)	(8.06)	(13.02)	(8.43)	(9.06)	(13.80)
$2,000	(4.74)	(11.61)	(8.43)	(13.61)	(8.81)	(9.47)	(14.43)
$3,000	(4.91)	(12.04)	(8.74)	(14.12)	(9.14)	(9.83)	(14.98)
$4,000	(4.99)	(12.22)	(8.88)	(14.33)	(9.29)	(9.98)	(15.19)
$5,000	(5.02)	(12.29)	(8.93)	(14.41)	(9.34)	(10.04)	(15.30)
$7,000	(5.08)	(12.44)	(9.03)	(14.58)	(9.45)	(10.15)	(15.47)
$7,500	(5.12)	(12.54)	(9.11)	(14.70)	(9.52)	(10.24)	(15.59)
$10,000	(5.27)	(12.92)	(9.38)	(15.15)	(9.81)	(10.55)	(16.07)
$20,000	(5.48)	(13.44)	(9.76)	(15.76)	(10.21)	(10.97)	(16.71)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$250	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$300	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$400	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$250	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$300	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$400	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$250	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$300	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$350	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$400	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$500	8.6%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$250	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$350	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$400	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$500	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
$750	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,000	8.6%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
LARGE GROUP							
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$7,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(46.95)	(115.03)	(85.91)	(136.63)	(87.33)	(93.90)	(143.67)
$1,500	(52.18)	(127.85)	(95.49)	(151.86)	(97.06)	(104.37)	(159.68)
$2,000	(55.08)	(134.95)	(100.80)	(160.28)	(102.45)	(110.16)	(168.54)
$3,000	(57.94)	(141.94)	(106.02)	(168.60)	(107.76)	(115.87)	(177.29)
$4,000	(59.23)	(145.12)	(108.40)	(172.36)	(110.17)	(118.46)	(181.24)
$5,000	(59.95)	(146.87)	(109.70)	(174.44)	(111.50)	(119.89)	(183.44)
$7,000	(60.65)	(148.59)	(110.99)	(176.49)	(112.81)	(121.30)	(185.59)
$7,500	(61.17)	(149.87)	(111.95)	(178.00)	(113.77)	(122.34)	(187.18)
$10,000	(63.32)	(155.14)	(115.88)	(184.26)	(117.78)	(126.64)	(193.76)
$20,000	(66.63)	(163.23)	(121.93)	(193.88)	(123.93)	(133.25)	(203.88)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(45.32)	(111.03)	(82.94)	(131.88)	(84.29)	(90.64)	(138.68)
$1,500	(51.39)	(125.90)	(94.04)	(149.54)	(95.58)	(102.78)	(157.24)
$2,000	(54.90)	(134.50)	(100.46)	(159.75)	(102.11)	(109.79)	(167.98)
$3,000	(58.53)	(143.39)	(107.11)	(170.32)	(108.86)	(117.06)	(179.09)
$4,000	(60.18)	(147.44)	(110.13)	(175.12)	(111.93)	(120.36)	(184.15)
$5,000	(61.15)	(149.82)	(111.90)	(177.94)	(113.74)	(122.30)	(187.12)
$7,000	(62.01)	(151.92)	(113.48)	(180.44)	(115.33)	(124.01)	(189.74)
$7,500	(62.56)	(153.27)	(114.47)	(182.04)	(116.35)	(125.11)	(191.42)
$10,000	(64.92)	(159.06)	(118.81)	(188.92)	(120.76)	(129.85)	(198.67)
$20,000	(69.14)	(169.38)	(126.52)	(201.18)	(128.59)	(138.27)	(211.56)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(51.29)	(125.65)	(93.85)	(149.24)	(95.39)	(102.57)	(156.94)
$1,500	(61.11)	(149.72)	(111.83)	(177.83)	(113.66)	(122.22)	(186.99)
$2,000	(67.45)	(165.26)	(123.44)	(196.29)	(125.46)	(134.91)	(206.41)
$3,000	(75.12)	(184.05)	(137.48)	(218.61)	(139.73)	(150.25)	(229.88)
$4,000	(79.34)	(194.37)	(145.19)	(230.87)	(147.56)	(158.67)	(242.77)
$5,000	(81.93)	(200.72)	(149.93)	(238.40)	(152.39)	(163.85)	(250.70)
$7,000	(84.61)	(207.29)	(154.84)	(246.21)	(157.38)	(169.22)	(258.91)
$7,500	(85.60)	(209.71)	(156.64)	(249.09)	(159.21)	(171.20)	(261.94)
$10,000	(89.58)	(219.46)	(163.92)	(260.67)	(166.62)	(179.15)	(274.10)
$20,000	(97.96)	(240.01)	(179.27)	(285.07)	(182.20)	(195.92)	(299.76)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.38	0.93	0.69	1.10	0.70	0.75	1.15
$1,000,000	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$50,000	(5.03)	(12.32)	(9.20)	(14.64)	(9.35)	(10.06)	(15.39)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
75%	(0.32)	(0.78)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
70%	(0.28)	(0.67)	(0.50)	(0.81)	(0.51)	(0.55)	(0.85)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(50.97)	(124.88)	(93.07)	(148.17)	(94.80)	(101.94)	(155.92)
$1,500	(56.65)	(138.79)	(103.44)	(164.68)	(105.37)	(113.30)	(173.29)
$2,000	(59.79)	(146.49)	(109.18)	(173.81)	(111.21)	(119.58)	(182.90)
$3,000	(62.90)	(154.11)	(114.86)	(182.85)	(116.99)	(125.80)	(192.41)
$4,000	(64.30)	(157.54)	(117.41)	(186.92)	(119.60)	(128.60)	(196.69)
$5,000	(65.08)	(159.45)	(118.84)	(189.19)	(121.05)	(130.16)	(199.08)
$7,000	(65.84)	(161.31)	(120.22)	(191.40)	(122.46)	(131.68)	(201.40)
$7,500	(66.40)	(162.68)	(121.25)	(193.02)	(123.50)	(132.80)	(203.12)
$10,000	(68.74)	(168.41)	(125.52)	(199.83)	(127.86)	(137.48)	(210.28)
$20,000	(72.33)	(177.21)	(132.07)	(210.26)	(134.53)	(144.66)	(221.26)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(49.21)	(120.56)	(89.86)	(143.05)	(91.53)	(98.42)	(150.53)
$1,500	(55.79)	(136.69)	(101.87)	(162.18)	(103.77)	(111.58)	(170.66)
$2,000	(59.60)	(146.02)	(108.83)	(173.26)	(110.86)	(119.20)	(182.32)
$3,000	(63.54)	(155.67)	(116.02)	(184.71)	(118.18)	(127.08)	(194.37)
$4,000	(65.33)	(160.06)	(119.29)	(189.91)	(121.51)	(130.66)	(199.84)
$5,000	(66.38)	(162.63)	(121.21)	(192.97)	(123.47)	(132.76)	(203.06)
$7,000	(67.32)	(164.93)	(122.93)	(195.70)	(125.22)	(134.64)	(205.93)
$7,500	(67.92)	(166.40)	(124.02)	(197.44)	(126.33)	(135.84)	(207.77)
$10,000	(70.48)	(172.68)	(128.70)	(204.89)	(131.09)	(140.96)	(215.60)
$20,000	(75.06)	(183.90)	(137.06)	(218.20)	(139.61)	(150.12)	(229.61)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(55.69)	(136.44)	(101.69)	(161.89)	(103.58)	(111.38)	(170.36)
$1,500	(66.34)	(162.53)	(121.14)	(192.85)	(123.39)	(132.68)	(202.93)
$2,000	(73.23)	(179.41)	(133.72)	(212.88)	(136.21)	(146.46)	(224.01)
$3,000	(81.55)	(199.80)	(148.91)	(237.07)	(151.68)	(163.10)	(249.46)
$4,000	(86.14)	(211.04)	(157.29)	(250.41)	(160.22)	(172.28)	(263.50)
$5,000	(88.95)	(217.93)	(162.42)	(258.58)	(165.45)	(177.90)	(272.10)
$7,000	(91.85)	(225.03)	(167.72)	(267.01)	(170.84)	(183.70)	(280.97)
$7,500	(92.92)	(227.65)	(169.67)	(270.12)	(172.83)	(185.84)	(284.24)
$10,000	(97.24)	(238.24)	(177.56)	(282.68)	(180.87)	(194.48)	(297.46)
$20,000	(106.34)	(260.53)	(194.18)	(309.13)	(197.79)	(212.68)	(325.29)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$1,000,000	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$50,000	(5.46)	(13.38)	(9.97)	(15.87)	(10.16)	(10.92)	(16.70)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
75%	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
70%	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

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DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(4.02)	(9.85)	(7.16)	(11.54)	(7.47)	(8.04)	(12.25)
$1,500	(4.47)	(10.94)	(7.95)	(12.82)	(8.31)	(8.93)	(13.61)
$2,000	(4.71)	(11.54)	(8.38)	(13.53)	(8.76)	(9.42)	(14.36)
$3,000	(4.96)	(12.17)	(8.84)	(14.25)	(9.23)	(9.93)	(15.12)
$4,000	(5.07)	(12.42)	(9.01)	(14.56)	(9.43)	(10.14)	(15.45)
$5,000	(5.13)	(12.58)	(9.14)	(14.75)	(9.55)	(10.27)	(15.64)
$7,000	(5.19)	(12.72)	(9.23)	(14.91)	(9.65)	(10.38)	(15.81)
$7,500	(5.23)	(12.81)	(9.30)	(15.02)	(9.73)	(10.46)	(15.94)
$10,000	(5.42)	(13.27)	(9.64)	(15.57)	(10.08)	(10.84)	(16.52)
$20,000	(5.70)	(13.98)	(10.14)	(16.38)	(10.60)	(11.41)	(17.38)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(3.89)	(9.53)	(6.92)	(11.17)	(7.24)	(7.78)	(11.85)
$1,500	(4.40)	(10.79)	(7.83)	(12.64)	(8.19)	(8.80)	(13.42)
$2,000	(4.70)	(11.52)	(8.37)	(13.51)	(8.75)	(9.41)	(14.34)
$3,000	(5.01)	(12.28)	(8.91)	(14.39)	(9.32)	(10.02)	(15.28)
$4,000	(5.15)	(12.62)	(9.16)	(14.79)	(9.58)	(10.30)	(15.69)
$5,000	(5.23)	(12.81)	(9.31)	(15.03)	(9.73)	(10.46)	(15.94)
$7,000	(5.31)	(13.01)	(9.45)	(15.26)	(9.89)	(10.63)	(16.19)
$7,500	(5.36)	(13.13)	(9.55)	(15.40)	(9.98)	(10.73)	(16.35)
$10,000	(5.56)	(13.62)	(9.89)	(15.97)	(10.33)	(11.11)	(16.93)
$20,000	(5.92)	(14.52)	(10.54)	(17.02)	(11.02)	(11.85)	(18.05)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(4.40)	(10.79)	(7.84)	(12.65)	(8.19)	(8.81)	(13.42)
$1,500	(5.23)	(12.81)	(9.31)	(15.02)	(9.73)	(10.46)	(15.94)
$2,000	(5.78)	(14.15)	(10.28)	(16.59)	(10.75)	(11.55)	(17.60)
$3,000	(6.43)	(15.75)	(11.43)	(18.46)	(11.95)	(12.85)	(19.58)
$4,000	(6.80)	(16.67)	(12.10)	(19.54)	(12.66)	(13.61)	(20.73)
$5,000	(7.02)	(17.21)	(12.49)	(20.18)	(13.06)	(14.05)	(21.40)
$7,000	(7.24)	(17.74)	(12.88)	(20.80)	(13.46)	(14.48)	(22.06)
$7,500	(7.32)	(17.94)	(13.03)	(21.03)	(13.62)	(14.64)	(22.30)
$10,000	(7.66)	(18.78)	(13.64)	(22.01)	(14.25)	(15.33)	(23.36)
$20,000	(8.38)	(20.52)	(14.91)	(24.06)	(15.59)	(16.76)	(25.53)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.04	0.10	0.08	0.12	0.08	0.09	0.13
$1,000,000	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$50,000	(0.43)	(1.06)	(0.77)	(1.23)	(0.81)	(0.86)	(1.31)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
75%	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
70%	(0.03)	(0.09)	(0.07)	(0.09)	(0.07)	(0.07)	(0.10)

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PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,500	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$1,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$1,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$2,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$3,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$4,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$5,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$7,000	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$7,500	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$10,000	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$20,000	8.6%	8.5%	8.3%	8.4%	8.6%	8.6%	8.5%
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
$1,000,000	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
$50,000	8.5%	8.6%	8.4%	8.4%	8.7%	8.5%	8.5%
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
75%	9.4%	10.3%	10.3%	10.9%	10.2%	11.1%	10.3%
70%	10.7%	13.4%	14.0%	11.1%	13.7%	12.7%	11.8%

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed]

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.12)	(5.20)	(3.89)	(6.17)	(3.95)	(4.24)	(6.49)
$10	(4.44)	(10.87)	(8.12)	(12.91)	(8.25)	(8.87)	(13.58)
$15	(7.38)	(18.09)	(13.52)	(21.49)	(13.74)	(14.77)	(22.59)
$20	(11.39)	(27.92)	(20.85)	(33.15)	(21.20)	(22.79)	(34.86)
$25	(15.00)	(36.76)	(27.46)	(43.67)	(27.91)	(30.01)	(45.91)
$30	(18.97)	(46.48)	(34.72)	(55.21)	(35.29)	(37.94)	(58.06)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.20)	(2.95)	(2.20)	(3.50)	(2.23)	(2.41)	(3.68)
$10	(2.54)	(6.22)	(4.65)	(7.40)	(4.72)	(5.08)	(7.77)
$15	(4.23)	(10.37)	(7.74)	(12.32)	(7.87)	(8.47)	(12.95)
$20	(6.52)	(15.97)	(11.92)	(18.96)	(12.13)	(13.04)	(19.94)
$25	(8.60)	(21.06)	(15.74)	(25.02)	(15.99)	(17.20)	(26.32)
$30	(10.86)	(26.61)	(19.88)	(31.61)	(20.21)	(21.73)	(33.24)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.54)	(3.77)	(2.82)	(4.48)	(2.87)	(3.08)	(4.71)
$10	(3.19)	(7.82)	(5.84)	(9.29)	(5.94)	(6.39)	(9.77)
$15	(5.00)	(12.25)	(9.15)	(14.55)	(9.29)	(10.00)	(15.29)
$20	(7.04)	(17.25)	(12.88)	(20.48)	(13.09)	(14.08)	(21.53)
$25	(9.30)	(22.79)	(17.02)	(27.07)	(17.30)	(18.60)	(28.47)
$30	(11.85)	(29.04)	(21.69)	(34.49)	(22.04)	(23.70)	(36.27)
$35	(14.24)	(34.88)	(26.06)	(41.43)	(26.49)	(28.48)	(43.57)
$40	(16.72)	(40.96)	(30.59)	(48.64)	(31.10)	(33.44)	(51.15)
$45	(19.33)	(47.36)	(35.37)	(56.24)	(35.96)	(38.66)	(59.15)
$50	(22.06)	(54.05)	(40.37)	(64.20)	(41.03)	(44.13)	(67.51)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.31)	(3.20)	(2.39)	(3.79)	(2.43)	(2.61)	(4.00)
$10	(2.70)	(6.62)	(4.95)	(7.86)	(5.03)	(5.41)	(8.27)
$15	(4.23)	(10.37)	(7.74)	(12.32)	(7.87)	(8.47)	(12.95)
$20	(5.96)	(14.60)	(10.90)	(17.33)	(11.08)	(11.91)	(18.23)
$25	(7.86)	(19.27)	(14.39)	(22.89)	(14.63)	(15.73)	(24.06)
$30	(10.03)	(24.56)	(18.35)	(29.18)	(18.65)	(20.05)	(30.68)
$35	(12.06)	(29.54)	(22.06)	(35.09)	(22.43)	(24.11)	(36.89)
$40	(14.14)	(34.64)	(25.87)	(41.14)	(26.30)	(28.27)	(43.26)
$45	(16.34)	(40.04)	(29.91)	(47.55)	(30.40)	(32.68)	(50.00)
$50	(18.66)	(45.71)	(34.14)	(54.28)	(34.70)	(37.31)	(57.09)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.78)	(1.90)	(1.42)	(2.25)	(1.44)	(1.55)	(2.38)
$150	(1.26)	(3.10)	(2.32)	(3.68)	(2.36)	(2.53)	(3.87)
$200	(1.81)	(4.43)	(3.30)	(5.25)	(3.36)	(3.61)	(5.53)
$250	(2.58)	(6.32)	(4.72)	(7.51)	(4.80)	(5.16)	(7.89)
$500	(6.22)	(15.25)	(11.38)	(18.11)	(11.58)	(12.44)	(19.04)
$750	(10.68)	(26.16)	(19.54)	(31.08)	(19.86)	(21.36)	(32.68)
$1,000	(16.07)	(39.36)	(29.40)	(46.75)	(29.89)	(32.13)	(49.16)
Copay/Day							
$50 w/3 Day Max	(0.94)	(2.30)	(1.71)	(2.73)	(1.74)	(1.88)	(2.88)
$50 w/5 Day Max	(1.29)	(3.15)	(2.36)	(3.74)	(2.39)	(2.57)	(3.94)
$100 w/3 Day Max	(2.34)	(5.72)	(4.27)	(6.79)	(4.35)	(4.67)	(7.15)
$100 w/5 Day Max	(3.38)	(8.27)	(6.18)	(9.82)	(6.28)	(6.75)	(10.33)
$250 w/3 Day Max	(7.74)	(18.97)	(14.17)	(22.53)	(14.40)	(15.48)	(23.69)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.42)	(1.02)	(0.77)	(1.21)	(0.78)	(0.84)	(1.28)
$75	(0.66)	(1.62)	(1.21)	(1.93)	(1.23)	(1.33)	(2.03)
$100	(0.94)	(2.30)	(1.71)	(2.73)	(1.74)	(1.88)	(2.88)
$125	(1.22)	(3.00)	(2.24)	(3.56)	(2.27)	(2.45)	(3.74)
$150	(1.53)	(3.75)	(2.81)	(4.46)	(2.85)	(3.06)	(4.68)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.43)	(0.32)	(0.50)	(0.33)	(0.35)	(0.53)
$25	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$35	(0.52)	(1.28)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$50	(0.89)	(2.17)	(1.62)	(2.58)	(1.65)	(1.77)	(2.71)
$60	(1.12)	(2.75)	(2.05)	(3.26)	(2.09)	(2.24)	(3.44)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.30)	(5.64)	(4.20)	(6.69)	(4.28)	(4.60)	(7.04)
$10	(4.82)	(11.81)	(8.80)	(14.01)	(8.97)	(9.64)	(14.74)
$15	(8.01)	(19.62)	(14.63)	(23.29)	(14.90)	(16.02)	(24.50)
$20	(12.37)	(30.31)	(22.59)	(35.96)	(23.01)	(24.74)	(37.84)
$25	(16.28)	(39.89)	(29.73)	(47.33)	(30.28)	(32.56)	(49.80)
$30	(20.59)	(50.45)	(37.60)	(59.86)	(38.30)	(41.18)	(62.98)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$10	(2.76)	(6.76)	(5.04)	(8.02)	(5.13)	(5.52)	(8.44)
$15	(4.59)	(11.25)	(8.38)	(13.34)	(8.54)	(9.18)	(14.04)
$20	(7.08)	(17.35)	(12.93)	(20.58)	(13.17)	(14.16)	(21.66)
$25	(9.33)	(22.86)	(17.04)	(27.12)	(17.35)	(18.66)	(28.54)
$30	(11.79)	(28.89)	(21.53)	(34.27)	(21.93)	(23.58)	(36.07)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$10	(3.45)	(8.45)	(6.30)	(10.03)	(6.42)	(6.90)	(10.55)
$15	(5.43)	(13.30)	(9.92)	(15.79)	(10.10)	(10.86)	(16.61)
$20	(7.64)	(18.72)	(13.95)	(22.21)	(14.21)	(15.28)	(23.37)
$25	(10.10)	(24.75)	(18.44)	(29.36)	(18.79)	(20.20)	(30.90)
$30	(12.87)	(31.53)	(23.50)	(37.41)	(23.94)	(25.74)	(39.37)
$35	(15.46)	(37.88)	(28.23)	(44.94)	(28.76)	(30.92)	(47.29)
$40	(18.15)	(44.47)	(33.14)	(52.76)	(33.76)	(36.30)	(55.52)
$45	(20.99)	(51.43)	(38.33)	(61.02)	(39.04)	(41.98)	(64.21)
$50	(23.95)	(58.68)	(43.73)	(69.62)	(44.55)	(47.90)	(73.26)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$10	(2.92)	(7.15)	(5.33)	(8.49)	(5.43)	(5.84)	(8.93)
$15	(4.59)	(11.25)	(8.38)	(13.34)	(8.54)	(9.18)	(14.04)
$20	(6.47)	(15.85)	(11.81)	(18.81)	(12.03)	(12.94)	(19.79)
$25	(8.54)	(20.92)	(15.59)	(24.83)	(15.88)	(17.08)	(26.12)
$30	(10.88)	(26.66)	(19.87)	(31.63)	(20.24)	(21.76)	(33.28)
$35	(13.09)	(32.07)	(23.90)	(38.05)	(24.35)	(26.18)	(40.04)
$40	(15.35)	(37.61)	(28.03)	(44.62)	(28.55)	(30.70)	(46.96)
$45	(17.74)	(43.46)	(32.39)	(51.57)	(33.00)	(35.48)	(54.27)
$50	(20.26)	(49.64)	(36.99)	(58.90)	(37.68)	(40.52)	(61.98)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$150	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$200	(1.97)	(4.83)	(3.60)	(5.73)	(3.66)	(3.94)	(6.03)
$250	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$500	(6.75)	(16.54)	(12.33)	(19.62)	(12.56)	(13.50)	(20.65)
$750	(11.59)	(28.40)	(21.16)	(33.69)	(21.56)	(23.18)	(35.45)
$1,000	(17.45)	(42.75)	(31.86)	(50.73)	(32.46)	(34.90)	(53.38)
Copay/Day							
$50 w/3 Day Max	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$50 w/5 Day Max	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$100 w/3 Day Max	(2.55)	(6.25)	(4.66)	(7.41)	(4.74)	(5.10)	(7.80)
$100 w/5 Day Max	(3.67)	(8.99)	(6.70)	(10.67)	(6.83)	(7.34)	(11.23)
$250 w/3 Day Max	(8.40)	(20.58)	(15.34)	(24.42)	(15.62)	(16.80)	(25.70)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$100	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$125	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$150	(1.66)	(4.07)	(3.03)	(4.83)	(3.09)	(3.32)	(5.08)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$35	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$50	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
$60	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)

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DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.18)	(0.44)	(0.31)	(0.52)	(0.33)	(0.36)	(0.55)
$10	(0.38)	(0.94)	(0.68)	(1.10)	(0.72)	(0.77)	(1.16)
$15	(0.63)	(1.53)	(1.11)	(1.80)	(1.16)	(1.25)	(1.91)
$20	(0.98)	(2.39)	(1.74)	(2.81)	(1.81)	(1.95)	(2.98)
$25	(1.28)	(3.13)	(2.27)	(3.66)	(2.37)	(2.55)	(3.89)
$30	(1.62)	(3.97)	(2.88)	(4.65)	(3.01)	(3.24)	(4.92)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.21)	(0.16)	(0.25)	(0.17)	(0.17)	(0.27)
$10	(0.22)	(0.54)	(0.39)	(0.62)	(0.41)	(0.44)	(0.67)
$15	(0.36)	(0.88)	(0.64)	(1.02)	(0.67)	(0.71)	(1.09)
$20	(0.56)	(1.38)	(1.01)	(1.62)	(1.04)	(1.12)	(1.72)
$25	(0.73)	(1.80)	(1.30)	(2.10)	(1.36)	(1.46)	(2.22)
$30	(0.93)	(2.28)	(1.65)	(2.66)	(1.72)	(1.85)	(2.83)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.23)	(0.37)	(0.24)	(0.26)	(0.40)
$10	(0.26)	(0.63)	(0.46)	(0.74)	(0.48)	(0.51)	(0.78)
$15	(0.43)	(1.05)	(0.77)	(1.24)	(0.81)	(0.86)	(1.32)
$20	(0.60)	(1.47)	(1.07)	(1.73)	(1.12)	(1.20)	(1.84)
$25	(0.80)	(1.96)	(1.42)	(2.29)	(1.49)	(1.60)	(2.43)
$30	(1.02)	(2.49)	(1.81)	(2.92)	(1.90)	(2.04)	(3.10)
$35	(1.22)	(3.00)	(2.17)	(3.51)	(2.27)	(2.44)	(3.72)
$40	(1.43)	(3.51)	(2.55)	(4.12)	(2.66)	(2.86)	(4.37)
$45	(1.66)	(4.07)	(2.96)	(4.78)	(3.08)	(3.32)	(5.06)
$50	(1.89)	(4.63)	(3.36)	(5.42)	(3.52)	(3.77)	(5.75)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.30)	(0.22)	(0.37)	(0.23)	(0.25)	(0.37)
$10	(0.22)	(0.53)	(0.38)	(0.63)	(0.40)	(0.43)	(0.66)
$15	(0.36)	(0.88)	(0.64)	(1.02)	(0.67)	(0.71)	(1.09)
$20	(0.51)	(1.25)	(0.91)	(1.48)	(0.95)	(1.03)	(1.56)
$25	(0.68)	(1.65)	(1.20)	(1.94)	(1.25)	(1.35)	(2.06)
$30	(0.85)	(2.10)	(1.52)	(2.45)	(1.59)	(1.71)	(2.60)
$35	(1.03)	(2.53)	(1.84)	(2.96)	(1.92)	(2.07)	(3.15)
$40	(1.21)	(2.97)	(2.16)	(3.48)	(2.25)	(2.43)	(3.70)
$45	(1.40)	(3.42)	(2.48)	(4.02)	(2.60)	(2.80)	(4.27)
$50	(1.60)	(3.93)	(2.85)	(4.62)	(2.98)	(3.21)	(4.89)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.25)
$150	(0.12)	(0.28)	(0.20)	(0.33)	(0.21)	(0.23)	(0.35)
$200	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$250	(0.22)	(0.54)	(0.39)	(0.63)	(0.41)	(0.44)	(0.68)
$500	(0.53)	(1.29)	(0.95)	(1.51)	(0.98)	(1.06)	(1.61)
$750	(0.91)	(2.24)	(1.62)	(2.61)	(1.70)	(1.82)	(2.77)
$1,000	(1.38)	(3.39)	(2.46)	(3.98)	(2.57)	(2.77)	(4.22)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.24)
$50 w/5 Day Max	(0.12)	(0.30)	(0.21)	(0.36)	(0.23)	(0.25)	(0.37)
$100 w/3 Day Max	(0.21)	(0.53)	(0.39)	(0.62)	(0.39)	(0.43)	(0.65)
$100 w/5 Day Max	(0.29)	(0.72)	(0.52)	(0.85)	(0.55)	(0.59)	(0.90)
$250 w/3 Day Max	(0.66)	(1.61)	(1.17)	(1.89)	(1.22)	(1.32)	(2.01)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.07)	(0.13)	(0.08)	(0.08)	(0.13)
$75	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.09)	(0.14)
$100	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.16)	(0.24)
$125	(0.10)	(0.23)	(0.17)	(0.28)	(0.19)	(0.19)	(0.30)
$150	(0.13)	(0.32)	(0.22)	(0.37)	(0.24)	(0.26)	(0.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.01)	(0.01)	(0.02)	0.00	(0.01)	(0.02)
$25	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$35	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.17)	(0.26)
$60	(0.09)	(0.21)	(0.16)	(0.26)	(0.16)	(0.18)	(0.26)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.5%	8.0%	8.4%	8.4%	8.5%	8.5%
$10	8.6%	8.6%	8.4%	8.5%	8.7%	8.7%	8.5%
$15	8.5%	8.5%	8.2%	8.4%	8.4%	8.5%	8.5%
$20	8.6%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
$25	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
$30	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.5%	7.1%	7.3%	7.1%	7.6%	7.1%	7.3%
$10	8.7%	8.7%	8.4%	8.4%	8.7%	8.7%	8.6%
$15	8.5%	8.5%	8.3%	8.3%	8.5%	8.4%	8.4%
$20	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%
$25	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.4%
$30	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.5%	8.2%	8.3%	8.4%	8.4%	8.5%
$10	8.2%	8.1%	7.9%	8.0%	8.1%	8.0%	8.0%
$15	8.6%	8.6%	8.4%	8.5%	8.7%	8.6%	8.6%
$20	8.5%	8.5%	8.3%	8.4%	8.6%	8.5%	8.5%
$25	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$30	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$35	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
$45	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
$50	8.6%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	9.2%	9.4%	9.2%	9.8%	9.5%	9.6%	9.3%
$10	8.1%	8.0%	7.7%	8.0%	8.0%	7.9%	8.0%
$15	8.5%	8.5%	8.3%	8.3%	8.5%	8.4%	8.4%
$20	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$25	8.7%	8.6%	8.3%	8.5%	8.5%	8.6%	8.6%
$30	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
$35	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
$40	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
$45	8.6%	8.5%	8.3%	8.5%	8.6%	8.6%	8.5%
$50	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	10.3%	11.1%	10.6%	11.1%	11.1%	11.0%	10.5%
$150	9.5%	9.0%	8.6%	9.0%	8.9%	9.1%	9.0%
$200	8.8%	9.0%	9.1%	9.1%	8.9%	9.1%	9.0%
$250	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.6%
$500	8.5%	8.5%	8.3%	8.3%	8.5%	8.5%	8.5%
$750	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
$1,000	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Copay/Day							
$50 w/3 Day Max	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$50 w/5 Day Max	9.3%	9.5%	8.9%	9.6%	9.6%	9.7%	9.4%
$100 w/3 Day Max	9.0%	9.3%	9.1%	9.1%	9.0%	9.2%	9.1%
$100 w/5 Day Max	8.6%	8.7%	8.4%	8.7%	8.8%	8.7%	8.7%
$250 w/3 Day Max	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
$75	7.6%	7.4%	7.4%	6.7%	7.3%	6.8%	6.9%
$100	8.5%	8.7%	8.8%	8.8%	9.2%	8.5%	8.3%
$125	8.2%	7.7%	7.6%	7.9%	8.4%	7.8%	8.0%
$150	8.5%	8.5%	7.8%	8.3%	8.4%	8.5%	8.5%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	5.9%	2.3%	3.1%	4.0%	0.0%	2.9%	3.8%
$25	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
$35	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
$50	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
$60	8.0%	7.6%	7.8%	8.0%	7.7%	8.0%	7.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.48)	(3.62)	(2.70)	(4.30)	(2.75)	(2.96)	(4.53)
$100	(2.11)	(5.17)	(3.87)	(6.14)	(3.93)	(4.22)	(6.46)
$125	(2.58)	(6.32)	(4.72)	(7.51)	(4.80)	(5.16)	(7.89)
$150	(3.10)	(7.60)	(5.67)	(9.03)	(5.76)	(6.20)	(9.49)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.42	1.02	0.77	1.21	0.78	0.84	1.28
60	0.81	1.98	1.48	2.35	1.50	1.61	2.47
90	1.21	2.98	2.22	3.53	2.25	2.43	3.71
120	1.42	3.48	2.59	4.12	2.64	2.84	4.34
Unlimited	1.83	4.48	3.35	5.31	3.40	3.65	5.59
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
40/$15 copay	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
40/$20 copay	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.80)	(1.21)
40/$25 copay	(0.52)	(1.28)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
60	0.19	0.48	0.36	0.56	0.36	0.39	0.59
100	0.47	1.15	0.86	1.37	0.88	0.94	1.44
200	1.24	3.05	2.27	3.62	2.32	2.49	3.80
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.85)	(2.07)	(1.55)	(2.47)	(1.57)	(1.69)	(2.59)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.56	1.38	1.03	1.63	1.04	1.12	1.71
90	1.15	2.83	2.11	3.36	2.14	2.31	3.53
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.49	1.20	0.90	1.43	0.91	0.98	1.50
90	0.91	2.22	1.66	2.64	1.69	1.82	2.77
120	1.47	3.60	2.69	4.27	2.73	2.94	4.50
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.70)	(1.72)	(1.29)	(2.05)	(1.31)	(1.41)	(2.15)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.50	0.38	0.59	0.38	0.41	0.62
30	0.33	0.80	0.60	0.95	0.61	0.65	1.00
Unlimited	0.49	1.20	0.90	1.43	0.91	0.98	1.50
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.18	5.34	4.00	6.35	4.06	4.37	6.68
60	2.56	6.27	4.68	7.45	4.76	5.12	7.83
90	3.05	7.48	5.58	8.87	5.67	6.10	9.33
Unlimited	3.10	7.60	5.67	9.03	5.76	6.20	9.49
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
60/$15 copay	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
60/$20 copay	(0.43)	(1.05)	(0.79)	(1.24)	(0.80)	(0.86)	(1.32)
60/$25 copay	(0.52)	(1.28)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
120/$0 copay	0.44	1.07	0.81	1.28	0.82	0.88	1.35
120/$5 copay	0.33	0.80	0.60	0.95	0.61	0.65	1.00
120/$10 copay	0.19	0.48	0.36	0.56	0.36	0.39	0.59
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.27)	(0.41)
120/$25 copay	(0.24)	(0.60)	(0.45)	(0.71)	(0.46)	(0.49)	(0.74)
Unlimited/$0 copay	0.51	1.25	0.94	1.49	0.95	1.02	1.56
Unlimited/$5 copay	0.39	0.95	0.71	1.13	0.72	0.78	1.18
Unlimited/$10 copay	0.24	0.60	0.45	0.71	0.46	0.49	0.74
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.33	0.24	0.39	0.24	0.27	0.41
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$100	(2.29)	(5.61)	(4.18)	(6.66)	(4.26)	(4.58)	(7.01)
$125	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$150	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.46	1.13	0.84	1.34	0.86	0.92	1.41
60	0.89	2.18	1.63	2.59	1.66	1.78	2.72
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98
120	1.54	3.77	2.81	4.48	2.86	3.08	4.71
Unlimited	1.99	4.88	3.63	5.78	3.70	3.98	6.09
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.51	1.25	0.93	1.48	0.95	1.02	1.56
200	1.35	3.31	2.47	3.92	2.51	2.70	4.13
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.61	1.49	1.11	1.77	1.13	1.22	1.87
90	1.24	3.04	2.26	3.60	2.31	2.48	3.79
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.53	1.30	0.97	1.54	0.99	1.06	1.62
90	0.99	2.43	1.81	2.88	1.84	1.98	3.03
120	1.60	3.92	2.92	4.65	2.98	3.20	4.89
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.62
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.36	5.78	4.31	6.86	4.39	4.72	7.22
60	2.78	6.81	5.08	8.08	5.17	5.56	8.50
90	3.31	8.11	6.04	9.62	6.16	6.62	10.13
Unlimited	3.36	8.23	6.14	9.77	6.25	6.72	10.28
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
60/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
120/$0 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$5 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
Unlimited/$0 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$5 copay	0.43	1.05	0.79	1.25	0.80	0.86	1.32
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.39)
$100	(0.18)	(0.44)	(0.31)	(0.52)	(0.33)	(0.36)	(0.55)
$125	(0.22)	(0.54)	(0.39)	(0.63)	(0.41)	(0.44)	(0.68)
$150	(0.26)	(0.63)	(0.47)	(0.74)	(0.49)	(0.52)	(0.79)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.11	0.07	0.13	0.08	0.08	0.13
60	0.08	0.20	0.15	0.24	0.16	0.17	0.25
90	0.09	0.21	0.15	0.25	0.17	0.17	0.27
120	0.12	0.29	0.22	0.36	0.22	0.24	0.37
Unlimited	0.16	0.40	0.28	0.47	0.30	0.33	0.50
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
40/$15 copay	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
40/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
40/$25 copay	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60	0.01	0.01	0.01	0.02	0.01	0.01	0.02
100	0.04	0.10	0.07	0.11	0.07	0.08	0.12
200	0.11	0.26	0.20	0.30	0.19	0.21	0.33
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.08)	(0.21)	(0.15)	(0.23)	(0.16)	(0.17)	(0.25)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.11	0.08	0.14	0.09	0.10	0.16
90	0.09	0.21	0.15	0.24	0.17	0.17	0.26
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.07	0.11	0.08	0.08	0.12
90	0.08	0.21	0.15	0.24	0.15	0.16	0.26
120	0.13	0.32	0.23	0.38	0.25	0.26	0.39
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.05)	(0.12)	(0.08)	(0.13)	(0.09)	(0.09)	(0.14)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.01	0.00	0.02	0.01	0.01	0.02
30	0.04	0.11	0.08	0.13	0.08	0.09	0.13
Unlimited	0.04	0.10	0.07	0.11	0.08	0.08	0.12
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.18	0.44	0.31	0.51	0.33	0.35	0.54
60	0.22	0.54	0.40	0.63	0.41	0.44	0.67
90	0.26	0.63	0.46	0.75	0.49	0.52	0.80
Unlimited	0.26	0.63	0.47	0.74	0.49	0.52	0.79
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.12)
60/$25 copay	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.11	0.07	0.12	0.07	0.08	0.12
120/$5 copay	0.04	0.11	0.08	0.13	0.08	0.09	0.13
120/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.01)	(0.02)
120/$25 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Unlimited/$0 copay	0.04	0.10	0.06	0.11	0.07	0.08	0.12
Unlimited/$5 copay	0.04	0.10	0.08	0.12	0.08	0.08	0.14
Unlimited/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copay	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.01	0.01	0.02	0.02	0.02	0.01	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	8.8%	8.8%	8.9%	8.8%	8.7%	8.8%	8.6%
$100	8.5%	8.5%	8.0%	8.5%	8.4%	8.5%	8.5%
$125	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.6%
$150	8.4%	8.3%	8.3%	8.2%	8.5%	8.4%	8.3%
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	9.5%	10.8%	9.1%	10.7%	10.3%	9.5%	10.2%
60	9.9%	10.1%	10.1%	10.2%	10.7%	10.6%	10.1%
90	7.4%	7.0%	6.8%	7.1%	7.6%	7.0%	7.3%
120	8.5%	8.3%	8.5%	8.7%	8.3%	8.5%	8.5%
Unlimited	8.7%	8.9%	8.4%	8.9%	8.8%	9.0%	8.9%
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
40/$15 copay	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
40/$20 copay	10.0%	10.2%	11.1%	11.3%	10.8%	10.0%	11.6%
40/$25 copay	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
60	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
200	8.9%	8.5%	8.8%	8.3%	8.2%	8.4%	8.7%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	9.4%	10.1%	9.7%	9.3%	10.2%	10.1%	9.7%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.9%	8.0%	7.8%	8.6%	8.7%	8.9%	9.4%
90	7.8%	7.4%	7.1%	7.1%	7.9%	7.4%	7.4%
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
90	8.8%	9.5%	9.0%	9.1%	8.9%	8.8%	9.4%
120	8.8%	8.9%	8.6%	8.9%	9.2%	8.8%	8.7%
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	7.1%	7.0%	6.2%	6.3%	6.9%	6.4%	6.5%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
30	12.1%	13.8%	13.3%	13.7%	13.1%	13.8%	13.0%
Unlimited	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.3%	8.2%	7.7%	8.0%	8.1%	8.0%	8.1%
60	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%
90	8.5%	8.4%	8.2%	8.5%	8.6%	8.5%	8.6%
Unlimited	8.4%	8.3%	8.3%	8.2%	8.5%	8.4%	8.3%
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
60/$15 copay	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
60/$20 copay	9.3%	9.5%	8.9%	10.5%	8.7%	9.3%	9.1%
60/$25 copay	7.7%	7.0%	7.4%	7.9%	7.2%	7.7%	7.5%
120/$0 copay	9.1%	10.3%	8.6%	9.4%	8.5%	9.1%	8.9%
120/$5 copay	12.1%	13.8%	13.3%	13.7%	13.1%	13.8%	13.0%
120/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
120/$25 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
Unlimited/$0 copay	7.8%	8.0%	6.4%	7.4%	7.4%	7.8%	7.7%
Unlimited/$5 copay	10.3%	10.5%	11.3%	10.6%	11.1%	10.3%	11.9%
Unlimited/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copay	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
$25	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$15	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
$20	(0.43)	(1.05)	(0.79)	(1.24)	(0.80)	(0.86)	(1.32)
$25	(0.54)	(1.33)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
$30	(0.66)	(1.62)	(1.21)	(1.93)	(1.23)	(1.33)	(2.03)
$35	(0.78)	(1.90)	(1.42)	(2.25)	(1.44)	(1.55)	(2.38)
$40	(0.90)	(2.20)	(1.64)	(2.61)	(1.67)	(1.80)	(2.74)
$45	(1.02)	(2.50)	(1.87)	(2.97)	(1.90)	(2.04)	(3.12)
$50	(1.13)	(2.77)	(2.07)	(3.29)	(2.10)	(2.26)	(3.47)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$10	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$15	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$25	(0.63)	(1.55)	(1.15)	(1.84)	(1.17)	(1.26)	(1.94)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$35	(0.14)	(0.35)	(0.27)	(0.42)	(0.27)	(0.29)	(0.44)
$50	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$60	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)
$75	(0.35)	(0.85)	(0.63)	(1.01)	(0.64)	(0.69)	(1.06)
$100	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.27)	(0.17)	(0.18)	(0.29)
$50	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$60	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$75	(0.23)	(0.57)	(0.43)	(0.68)	(0.44)	(0.47)	(0.71)
$100	(0.31)	(0.75)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(1.96)	(4.79)	(3.58)	(5.70)	(3.64)	(3.92)	(6.00)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(3.05)	(7.48)	(5.58)	(8.87)	(5.67)	(6.10)	(9.33)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.27)	(0.65)	(0.49)	(0.78)	(0.49)	(0.53)	(0.82)

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HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$25	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$30	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$35	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$40	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$45	(1.11)	(2.72)	(2.03)	(3.23)	(2.06)	(2.22)	(3.40)
$50	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$25	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(3.31)	(8.11)	(6.04)	(9.62)	(6.16)	(6.62)	(10.13)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
$25	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.12)
$25	(0.04)	(0.09)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.09)	(0.14)
$35	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.25)
$40	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.26)
$45	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.26)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$10	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.14)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.02)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.11)	(0.08)	(0.12)	(0.09)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$50	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$75	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$100	(0.03)	(0.08)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.17)	(0.43)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(0.26)	(0.63)	(0.46)	(0.75)	(0.49)	(0.52)	(0.80)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.03)	(0.09)	(0.06)	(0.09)	(0.07)	(0.07)	(0.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
$25	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$15	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
$20	9.3%	9.5%	8.9%	10.5%	8.7%	9.3%	9.1%
$25	7.4%	6.8%	7.1%	7.6%	6.9%	7.4%	7.3%
$30	7.6%	7.4%	7.4%	6.7%	7.3%	6.8%	6.9%
$35	10.3%	11.1%	10.6%	11.1%	11.1%	11.0%	10.5%
$40	8.9%	9.1%	9.1%	9.2%	9.0%	8.9%	9.5%
$45	8.8%	8.8%	8.6%	8.8%	8.4%	8.8%	9.0%
$50	8.0%	7.9%	7.7%	7.9%	8.1%	8.0%	7.5%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$10	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$15	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
$20	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$25	7.9%	7.7%	7.8%	7.6%	7.7%	7.9%	7.2%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$35	7.1%	5.7%	0.0%	4.8%	3.7%	3.4%	4.5%
$50	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$60	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%
$75	11.4%	12.9%	12.7%	11.9%	14.1%	13.0%	12.3%
$100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	-3.7%	0.0%	0.0%	-3.4%
$50	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$60	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$75	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
$100	9.7%	10.7%	10.7%	11.2%	10.5%	11.5%	10.6%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	8.7%	9.0%	8.7%	8.6%	8.8%	8.7%	8.7%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	8.5%	8.4%	8.2%	8.5%	8.6%	8.5%	8.6%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	11.1%	13.8%	12.2%	11.5%	14.3%	13.2%	12.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	7.96	19.49	14.56	23.15	14.80	15.91	24.35
60	8.39	20.56	15.36	24.43	15.62	16.79	25.68
90	8.70	21.32	15.92	25.32	16.19	17.40	26.62
Unlimited	8.79	21.54	16.09	25.58	16.35	17.58	26.91
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	8.89	21.79	16.28	25.89	16.54	17.79	27.21
30	9.79	23.99	17.92	28.50	18.22	19.58	29.97
40	10.33	25.32	18.91	30.07	19.22	20.67	31.62
60	10.89	26.69	19.93	31.70	20.26	21.79	33.33
Unlimited	10.98	26.89	20.08	31.94	20.41	21.95	33.59
LARGE GROUP	**$5 Copay**						
20	8.36	20.49	15.31	24.34	15.56	16.73	25.59
30	9.20	22.54	16.84	26.78	17.12	18.40	28.15
40	9.78	23.97	17.90	28.47	18.20	19.56	29.94
60	10.24	25.09	18.74	29.80	19.04	20.48	31.33
Unlimited	10.32	25.29	18.89	30.04	19.20	20.64	31.59
LARGE GROUP	**$10 Copay**						
20	7.83	19.20	14.33	22.80	14.57	15.67	23.97
30	8.63	21.14	15.79	25.11	16.05	17.26	26.41
40	9.12	22.34	16.69	26.54	16.96	18.24	27.91
60	9.61	23.54	17.58	27.96	17.87	19.22	29.41
Unlimited	9.68	23.72	17.72	28.17	18.00	19.36	29.62
LARGE GROUP	**$15 Copay**						
20	7.35	18.01	13.45	21.40	13.68	14.71	22.50
30	8.10	19.84	14.82	23.57	15.07	16.20	24.79
40	8.58	21.01	15.70	24.96	15.95	17.16	26.24
60	9.08	22.25	16.62	26.42	16.88	18.16	27.77
Unlimited	9.15	22.42	16.75	26.62	17.01	18.30	28.00
LARGE GROUP	**$20 Copay**						
20	6.92	16.94	12.66	20.12	12.86	13.83	21.17
30	7.59	18.59	13.89	22.08	14.12	15.18	23.23
40	8.00	19.59	14.64	23.27	14.87	15.99	24.47
60	8.50	20.82	15.54	24.72	15.80	16.99	26.00
Unlimited	8.57	20.99	15.68	24.93	15.93	17.14	26.21
LARGE GROUP	**$25 Copay**						
20	6.43	15.75	11.76	18.70	11.95	12.85	19.67
30	7.07	17.32	12.93	20.57	13.15	14.14	21.63
40	7.53	18.44	13.78	21.91	14.00	15.06	23.03
60	7.92	19.39	14.48	23.03	14.72	15.83	24.23
Unlimited	7.99	19.56	14.62	23.25	14.85	15.97	24.44
LARGE GROUP	**$30 Copay**						
20	6.13	15.01	11.22	17.84	11.40	12.26	18.76
30	6.65	16.29	12.17	19.35	12.37	13.30	20.35
40	7.09	17.37	12.97	20.62	13.19	14.18	21.70
60	7.43	18.20	13.59	21.60	13.81	14.85	22.73
Unlimited	7.47	18.29	13.67	21.73	13.89	14.93	22.85
LARGE GROUP	**$35 Copay**						
20	5.83	14.29	10.68	16.98	10.85	11.67	17.85
30	6.22	15.25	11.38	18.11	11.58	12.44	19.04
40	6.63	16.25	12.14	19.30	12.33	13.26	20.29
60	6.95	17.01	12.71	20.22	12.92	13.89	21.26
Unlimited	7.00	17.15	12.80	20.36	13.02	13.99	21.41
LARGE GROUP	**$40 Copay**						
20	5.67	13.89	10.37	16.50	10.55	11.34	17.35
30	6.05	14.82	11.07	17.61	11.25	12.10	18.51
40	6.45	15.79	11.80	18.76	12.00	12.89	19.73
60	6.79	16.65	12.43	19.77	12.64	13.59	20.79
Unlimited	6.85	16.79	12.55	19.95	12.75	13.71	20.97
LARGE GROUP	**$45 Copay**						
20	5.51	13.49	10.08	16.02	10.24	11.02	16.85

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	8.64	21.17	15.78	25.12	16.07	17.28	26.43
60	9.11	22.32	16.63	26.48	16.94	18.22	27.87
90	9.44	23.13	17.24	27.44	17.56	18.88	28.88
Unlimited	9.55	23.40	17.44	27.76	17.76	19.10	29.21
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	9.65	23.64	17.62	28.05	17.95	19.30	29.52
30	10.63	26.04	19.41	30.90	19.77	21.26	32.52
40	11.22	27.49	20.49	32.62	20.87	22.44	34.32
60	11.82	28.96	21.58	34.36	21.99	23.64	36.16
Unlimited	11.92	29.20	21.77	34.65	22.17	23.84	36.46
LARGE GROUP	**$5 Copay**						
20	9.08	22.25	16.58	26.40	16.89	18.16	27.78
30	9.99	24.48	18.24	29.04	18.58	19.98	30.56
40	10.62	26.02	19.39	30.87	19.75	21.24	32.49
60	11.11	27.22	20.29	32.30	20.66	22.22	33.99
Unlimited	11.21	27.46	20.47	32.59	20.85	22.42	34.29
LARGE GROUP	**$10 Copay**						
20	8.51	20.85	15.54	24.74	15.83	17.02	26.03
30	9.36	22.93	17.09	27.21	17.41	18.72	28.63
40	9.89	24.23	18.06	28.75	18.40	19.78	30.25
60	10.43	25.55	19.05	30.32	19.40	20.86	31.91
Unlimited	10.51	25.75	19.19	30.55	19.55	21.02	32.15
LARGE GROUP	**$15 Copay**						
20	7.98	19.55	14.57	23.20	14.84	15.96	24.41
30	8.79	21.54	16.05	25.55	16.35	17.58	26.89
40	9.31	22.81	17.00	27.06	17.32	18.62	28.48
60	9.85	24.13	17.99	28.63	18.32	19.70	30.13
Unlimited	9.93	24.33	18.13	28.87	18.47	19.86	30.38
LARGE GROUP	**$20 Copay**						
20	7.51	18.40	13.71	21.83	13.97	15.02	22.97
30	8.23	20.16	15.03	23.92	15.31	16.46	25.18
40	8.68	21.27	15.85	25.23	16.14	17.36	26.55
60	9.23	22.61	16.85	26.83	17.17	18.46	28.23
Unlimited	9.30	22.79	16.98	27.04	17.30	18.60	28.45
LARGE GROUP	**$25 Copay**						
20	6.98	17.10	12.75	20.29	12.98	13.96	21.35
30	7.67	18.79	14.01	22.30	14.27	15.34	23.46
40	8.17	20.02	14.92	23.75	15.20	16.34	24.99
60	8.60	21.07	15.70	25.00	16.00	17.20	26.31
Unlimited	8.67	21.24	15.83	25.20	16.13	17.34	26.52
LARGE GROUP	**$30 Copay**						
20	6.65	16.29	12.14	19.33	12.37	13.30	20.34
30	7.21	17.66	13.17	20.96	13.41	14.42	22.06
40	7.69	18.84	14.04	22.35	14.30	15.38	23.52
60	8.07	19.77	14.74	23.46	15.01	16.14	24.69
Unlimited	8.11	19.87	14.81	23.58	15.08	16.22	24.81
LARGE GROUP	**$35 Copay**						
20	6.33	15.51	11.56	18.40	11.77	12.66	19.36
30	6.75	16.54	12.33	19.62	12.56	13.50	20.65
40	7.19	17.62	13.13	20.90	13.37	14.38	21.99
60	7.55	18.50	13.79	21.95	14.04	15.10	23.10
Unlimited	7.60	18.62	13.88	22.09	14.14	15.20	23.25
LARGE GROUP	**$40 Copay**						
20	6.15	15.07	11.23	17.88	11.44	12.30	18.81
30	6.56	16.07	11.98	19.07	12.20	13.12	20.07
40	7.00	17.15	12.78	20.35	13.02	14.00	21.41
60	7.38	18.08	13.48	21.45	13.73	14.76	22.58
Unlimited	7.44	18.23	13.59	21.63	13.84	14.88	22.76
LARGE GROUP	**$45 Copay**						
20	5.98	14.65	10.92	17.38	11.12	11.96	18.29

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MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	0.68	1.68	1.22	1.97	1.27	1.37	2.08
60	0.72	1.76	1.27	2.05	1.32	1.43	2.19
90	0.74	1.81	1.32	2.12	1.37	1.48	2.26
Unlimited	0.76	1.86	1.35	2.18	1.41	1.52	2.30
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	0.76	1.85	1.34	2.16	1.41	1.51	2.31
30	0.84	2.05	1.49	2.40	1.55	1.68	2.55
40	0.89	2.17	1.58	2.55	1.65	1.77	2.70
60	0.93	2.27	1.65	2.66	1.73	1.85	2.83
Unlimited	0.94	2.31	1.69	2.71	1.76	1.89	2.87
LARGE GROUP	**$5 Copay**						
20	0.72	1.76	1.27	2.06	1.33	1.43	2.19
30	0.79	1.94	1.40	2.26	1.46	1.58	2.41
40	0.84	2.05	1.49	2.40	1.55	1.68	2.55
60	0.87	2.13	1.55	2.50	1.62	1.74	2.66
Unlimited	0.89	2.17	1.58	2.55	1.65	1.78	2.70
LARGE GROUP	**$10 Copay**						
20	0.68	1.65	1.21	1.94	1.26	1.35	2.06
30	0.73	1.79	1.30	2.10	1.36	1.46	2.22
40	0.77	1.89	1.37	2.21	1.44	1.54	2.34
60	0.82	2.01	1.47	2.36	1.53	1.64	2.50
Unlimited	0.83	2.03	1.47	2.38	1.55	1.66	2.53
LARGE GROUP	**$15 Copay**						
20	0.63	1.54	1.12	1.80	1.16	1.25	1.91
30	0.69	1.70	1.23	1.98	1.28	1.38	2.10
40	0.73	1.80	1.30	2.10	1.37	1.46	2.24
60	0.77	1.88	1.37	2.21	1.44	1.54	2.36
Unlimited	0.78	1.91	1.38	2.25	1.46	1.56	2.38
LARGE GROUP	**$20 Copay**						
20	0.59	1.46	1.05	1.71	1.11	1.19	1.80
30	0.64	1.57	1.14	1.84	1.19	1.28	1.95
40	0.68	1.68	1.21	1.96	1.27	1.37	2.08
60	0.73	1.79	1.31	2.11	1.37	1.47	2.23
Unlimited	0.73	1.80	1.30	2.11	1.37	1.46	2.24
LARGE GROUP	**$25 Copay**						
20	0.55	1.35	0.99	1.59	1.03	1.11	1.68
30	0.60	1.47	1.08	1.73	1.12	1.20	1.83
40	0.64	1.58	1.14	1.84	1.20	1.28	1.96
60	0.68	1.68	1.22	1.97	1.28	1.37	2.08
Unlimited	0.68	1.68	1.21	1.95	1.28	1.37	2.08
LARGE GROUP	**$30 Copay**						
20	0.52	1.28	0.92	1.49	0.97	1.04	1.58
30	0.56	1.37	1.00	1.61	1.04	1.12	1.71
40	0.60	1.47	1.07	1.73	1.11	1.20	1.82
60	0.64	1.57	1.15	1.86	1.20	1.29	1.96
Unlimited	0.64	1.58	1.14	1.85	1.19	1.29	1.96
LARGE GROUP	**$35 Copay**						
20	0.50	1.22	0.88	1.42	0.92	0.99	1.51
30	0.53	1.29	0.95	1.51	0.98	1.06	1.61
40	0.56	1.37	0.99	1.60	1.04	1.12	1.70
60	0.60	1.49	1.08	1.73	1.12	1.21	1.84
Unlimited	0.60	1.47	1.08	1.73	1.12	1.21	1.84
LARGE GROUP	**$40 Copay**						
20	0.48	1.18	0.86	1.38	0.89	0.96	1.46
30	0.51	1.25	0.91	1.46	0.95	1.02	1.56
40	0.55	1.36	0.98	1.59	1.02	1.11	1.68
60	0.59	1.43	1.05	1.68	1.09	1.17	1.79
Unlimited	0.59	1.44	1.04	1.68	1.09	1.17	1.79
LARGE GROUP	**$45 Copay**						
20	0.47	1.16	0.84	1.36	0.88	0.94	1.44

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MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	8.5%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
60	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
90	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	8.5%	8.5%	8.2%	8.3%	8.5%	8.5%	8.5%
30	8.6%	8.5%	8.3%	8.4%	8.5%	8.6%	8.5%
40	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
60	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP	**$5 Copay**						
20	8.6%	8.6%	8.3%	8.5%	8.5%	8.5%	8.6%
30	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.6%
40	8.6%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
60	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
LARGE GROUP	**$10 Copay**						
20	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
30	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.4%
40	8.4%	8.5%	8.2%	8.3%	8.5%	8.4%	8.4%
60	8.5%	8.5%	8.4%	8.4%	8.6%	8.5%	8.5%
Unlimited	8.6%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
LARGE GROUP	**$15 Copay**						
20	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
30	8.5%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
40	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
60	8.5%	8.4%	8.2%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.2%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP	**$20 Copay**						
20	8.5%	8.6%	8.3%	8.5%	8.6%	8.6%	8.5%
30	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
40	8.5%	8.6%	8.3%	8.4%	8.5%	8.6%	8.5%
60	8.6%	8.6%	8.4%	8.5%	8.7%	8.7%	8.6%
Unlimited	8.5%	8.6%	8.3%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP	**$25 Copay**						
20	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.5%
30	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%
40	8.5%	8.6%	8.3%	8.4%	8.6%	8.5%	8.5%
60	8.6%	8.7%	8.4%	8.6%	8.7%	8.7%	8.6%
Unlimited	8.5%	8.6%	8.3%	8.4%	8.6%	8.6%	8.5%
LARGE GROUP	**$30 Copay**						
20	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.4%
30	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.2%	8.4%	8.4%	8.5%	8.4%
60	8.6%	8.6%	8.5%	8.6%	8.7%	8.7%	8.6%
Unlimited	8.6%	8.6%	8.3%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP	**$35 Copay**						
20	8.6%	8.5%	8.2%	8.4%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.3%	8.3%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
60	8.6%	8.8%	8.5%	8.6%	8.7%	8.7%	8.7%
Unlimited	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
LARGE GROUP	**$40 Copay**						
20	8.5%	8.5%	8.3%	8.4%	8.4%	8.5%	8.4%
30	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
40	8.5%	8.6%	8.3%	8.5%	8.5%	8.6%	8.5%
60	8.7%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
Unlimited	8.6%	8.6%	8.3%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP	**$45 Copay**						
20	8.5%	8.6%	8.3%	8.5%	8.6%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	5.88	14.39	10.75	17.10	10.92	11.75	17.98
40	6.28	15.39	11.50	18.29	11.69	12.57	19.23
60	6.64	16.27	12.15	19.32	12.35	13.28	20.32
Unlimited	6.67	16.34	12.21	19.41	12.40	13.34	20.41
LARGE GROUP				**$50 Copay**			
20	5.36	13.12	9.80	15.59	9.97	10.71	16.39
30	5.73	14.05	10.49	16.68	10.66	11.46	17.54
40	6.13	15.01	11.22	17.84	11.40	12.26	18.76
60	6.47	15.84	11.83	18.82	12.03	12.93	19.79
Unlimited	6.51	15.94	11.91	18.94	12.11	13.02	19.91

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.39	15.66	11.67	18.58	11.89	12.78	19.55
40	6.83	16.73	12.47	19.85	12.70	13.66	20.89
60	7.20	17.64	13.15	20.93	13.39	14.40	22.02
Unlimited	7.23	17.71	13.20	21.02	13.45	14.46	22.12
LARGE GROUP				**$50 Copay**			
20	5.82	14.26	10.63	16.92	10.83	11.64	17.80
30	6.22	15.24	11.36	18.08	11.57	12.44	19.03
40	6.65	16.29	12.14	19.33	12.37	13.30	20.34
60	7.02	17.20	12.82	20.41	13.06	14.04	21.47
Unlimited	7.07	17.32	12.91	20.55	13.15	14.14	21.63

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	0.51	1.27	0.92	1.48	0.97	1.03	1.57
40	0.55	1.34	0.97	1.56	1.01	1.09	1.66
60	0.56	1.37	1.00	1.61	1.04	1.12	1.70
Unlimited	0.56	1.37	0.99	1.61	1.05	1.12	1.71
LARGE GROUP				**$50 Copay**			
20	0.46	1.14	0.83	1.33	0.86	0.93	1.41
30	0.49	1.19	0.87	1.40	0.91	0.98	1.49
40	0.52	1.28	0.92	1.49	0.97	1.04	1.58
60	0.55	1.36	0.99	1.59	1.03	1.11	1.68
Unlimited	0.56	1.38	1.00	1.61	1.04	1.12	1.72

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	8.7%	8.8%	8.6%	8.7%	8.9%	8.8%	8.7%
40	8.8%	8.7%	8.4%	8.5%	8.6%	8.7%	8.6%
60	8.4%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.1%	8.3%	8.5%	8.4%	8.4%
LARGE GROUP				**$50 Copay**			
20	8.6%	8.7%	8.5%	8.5%	8.6%	8.7%	8.6%
30	8.6%	8.5%	8.3%	8.4%	8.5%	8.6%	8.5%
40	8.5%	8.5%	8.2%	8.4%	8.5%	8.5%	8.4%
60	8.5%	8.6%	8.4%	8.4%	8.6%	8.6%	8.5%
Unlimited	8.6%	8.7%	8.4%	8.5%	8.6%	8.6%	8.6%

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DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
% add-on	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

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DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
				Grandchildren			
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
				Grandchildren			
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
				Class II Dependents			
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.30	15.44	11.54	18.34	11.72	12.61	19.29
$25	5.92	14.49	10.82	17.22	11.01	11.83	18.11
$50	5.58	13.67	10.21	16.24	10.37	11.16	17.07
$100	5.00	12.25	9.15	14.55	9.29	10.00	15.29
$500	2.46	6.02	4.50	7.15	4.57	4.92	7.52
Coinsurance							
80%	5.01	12.27	9.17	14.58	9.31	10.02	15.32
75%	4.72	11.57	8.64	13.74	8.78	9.45	14.45
70%	4.40	10.77	8.05	12.79	8.18	8.79	13.45
Deductible			**Orthotics Riders**				
$0	1.07	2.62	1.96	3.12	1.99	2.14	3.27
$25	1.03	2.52	1.89	3.00	1.92	2.06	3.15
$50	0.98	2.40	1.80	2.85	1.83	1.96	3.00
$100	0.89	2.17	1.62	2.58	1.65	1.77	2.71
$500	0.43	1.05	0.79	1.24	0.80	0.86	1.32
Coinsurance							
80%	0.89	2.17	1.62	2.58	1.65	1.77	2.71
75%	0.82	2.00	1.49	2.38	1.52	1.63	2.50
70%	0.77	1.88	1.40	2.22	1.43	1.53	2.35
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.32	3.22	2.41	3.83	2.45	2.63	4.03
12 Months	2.11	5.17	3.87	6.14	3.93	4.22	6.46
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.06	5.05	3.77	6.00	3.84	4.12	6.30
12 Months	3.28	8.05	6.01	9.56	6.11	6.57	10.05
			Private Duty Nursing Riders				
In Full	0.74	1.83	1.37	2.16	1.39	1.49	2.27
80% hrs 73-504	0.13	0.33	0.24	0.39	0.24	0.27	0.41
100% hrs 73-504	0.22	0.55	0.41	0.65	0.42	0.45	0.68
			Dental Network Access				
	0.41	1.00	0.74	1.18	0.75	0.82	1.24
Limit			**Infertility Rider**				
2 IVF	13.78	33.76	25.21	40.10	25.63	27.56	42.17
3 IVF	16.55	40.56	30.29	48.17	30.79	33.11	50.65

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HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.85	16.78	12.51	19.91	12.74	13.70	20.95
$25	6.43	15.75	11.74	18.69	11.96	12.86	19.67
$50	6.05	14.82	11.05	17.59	11.25	12.10	18.51
$100	5.43	13.30	9.92	15.79	10.10	10.86	16.61
$500	2.67	6.54	4.88	7.76	4.97	5.34	8.17
Coinsurance							
80%	5.44	13.33	9.93	15.81	10.12	10.88	16.64
75%	5.12	12.54	9.35	14.88	9.52	10.24	15.66
70%	4.78	11.71	8.73	13.90	8.89	9.56	14.62
Deductible			**Orthotics Riders**				
$0	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$25	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$50	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$100	0.97	2.38	1.77	2.82	1.80	1.94	2.97
$500	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Coinsurance							
80%	0.97	2.38	1.77	2.82	1.80	1.94	2.97
75%	0.90	2.21	1.64	2.62	1.67	1.80	2.75
70%	0.85	2.08	1.55	2.47	1.58	1.70	2.60
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.44	3.53	2.63	4.19	2.68	2.88	4.40
12 Months	2.29	5.61	4.18	6.66	4.26	4.58	7.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.23	5.46	4.07	6.48	4.15	4.46	6.82
12 Months	3.57	8.75	6.52	10.38	6.64	7.14	10.92
			Private Duty Nursing Riders				
In Full	0.79	1.94	1.44	2.30	1.47	1.58	2.42
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Limit			**Infertility Rider**				
2 IVF	14.97	36.68	27.34	43.52	27.84	29.94	45.79
3 IVF	17.96	44.00	32.79	52.21	33.41	35.92	54.94

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DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.55	1.34	0.97	1.57	1.02	1.09	1.66
$25	0.51	1.26	0.92	1.47	0.95	1.03	1.56
$50	0.47	1.15	0.84	1.35	0.88	0.94	1.44
$100	0.43	1.05	0.77	1.24	0.81	0.86	1.32
$500	0.21	0.52	0.38	0.61	0.40	0.42	0.65
Coinsurance							
80%	0.43	1.06	0.76	1.23	0.81	0.86	1.32
75%	0.40	0.97	0.71	1.14	0.74	0.79	1.21
70%	0.38	0.94	0.68	1.11	0.71	0.77	1.17
Deductible			**Orthotics Riders**				
$0	0.09	0.22	0.16	0.25	0.17	0.18	0.28
$25	0.09	0.22	0.16	0.26	0.16	0.18	0.28
$50	0.08	0.20	0.14	0.23	0.14	0.16	0.24
$100	0.08	0.21	0.15	0.24	0.15	0.17	0.26
$500	0.04	0.10	0.07	0.13	0.07	0.08	0.12
Coinsurance							
80%	0.08	0.21	0.15	0.24	0.15	0.17	0.26
75%	0.08	0.21	0.15	0.24	0.15	0.17	0.25
70%	0.08	0.20	0.15	0.25	0.15	0.17	0.25
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.36	0.23	0.25	0.37
12 Months	0.18	0.44	0.31	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.41	0.30	0.48	0.31	0.34	0.52
12 Months	0.29	0.70	0.51	0.82	0.53	0.57	0.87
			Private Duty Nursing Riders				
In Full	0.05	0.11	0.07	0.14	0.08	0.09	0.15
80% hrs 73-504	0.01	0.01	0.02	0.02	0.02	0.01	0.02
100% hrs 73-504	0.01	0.01	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.09	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	1.19	2.92	2.13	3.42	2.21	2.38	3.62
3 IVF	1.41	3.44	2.50	4.04	2.62	2.81	4.29

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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.7%	8.7%	8.4%	8.6%	8.7%	8.6%	8.6%
$25	8.6%	8.7%	8.5%	8.5%	8.6%	8.7%	8.6%
$50	8.4%	8.4%	8.2%	8.3%	8.5%	8.4%	8.4%
$100	8.6%	8.6%	8.4%	8.5%	8.7%	8.6%	8.6%
$500	8.5%	8.6%	8.4%	8.5%	8.8%	8.5%	8.6%
Coinsurance							
80%	8.6%	8.6%	8.3%	8.4%	8.7%	8.6%	8.6%
75%	8.5%	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%
70%	8.6%	8.7%	8.4%	8.7%	8.7%	8.8%	8.7%
Deductible			**Orthotics Riders**				
$0	8.4%	8.4%	8.2%	8.0%	8.5%	8.4%	8.6%
$25	8.7%	8.7%	8.5%	8.7%	8.3%	8.7%	8.9%
$50	8.2%	8.3%	7.8%	8.1%	7.7%	8.2%	8.0%
$100	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
$500	9.3%	9.5%	8.9%	10.5%	8.7%	9.3%	9.1%
Coinsurance							
80%	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
75%	9.8%	10.5%	10.1%	10.1%	9.9%	10.4%	10.0%
70%	10.4%	10.6%	10.7%	11.3%	10.5%	11.1%	10.6%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	9.1%	9.6%	9.1%	9.4%	9.4%	9.5%	9.2%
12 Months	8.5%	8.5%	8.0%	8.5%	8.4%	8.5%	8.5%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.3%	8.1%	8.0%	8.0%	8.1%	8.3%	8.3%
12 Months	8.8%	8.7%	8.5%	8.6%	8.7%	8.7%	8.7%
			Private Duty Nursing Riders				
In Full	6.8%	6.0%	5.1%	6.5%	5.8%	6.0%	6.6%
80% hrs 73-504	7.7%	3.0%	8.3%	5.1%	8.3%	3.7%	4.9%
100% hrs 73-504	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
			Dental Network Access				
	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
Limit			**Infertility Rider**				
2 IVF	8.6%	8.6%	8.4%	8.5%	8.6%	8.6%	8.6%
3 IVF	8.5%	8.5%	8.3%	8.4%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
LARGE GROUP HMO
VHLI - LGRP - 01
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	550.71	1,433.05
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.07	5.07
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.29	3.15
Outpatient Mental Health: 20 Visits	5.72	14.03
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.05	2.56
Other Riders		
Durable Medical Equipment	1.52	3.59
Chiropractic: $5 Copay	4.04	10.62
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	134.90	350.74
Infertility Drug Coverage: $7 Brand Copay	3.15	8.24
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.08
Inpatient Substance Abuse Rehab: Unlimited days	4.34	10.63
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.61	1.49
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.47	1.15
Dependent Children [std: covered to 19 end of month]		
Age	**End of Month**	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	561.17	1,460.28
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.11	5.17
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.31	3.21
Outpatient Mental Health: 20 Visits	5.72	14.03
	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.07	2.61
Other Riders		
Durable Medical Equipment	1.55	3.66
Chiropractic: $5 Copay	4.12	10.82
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	137.46	357.40
Infertility Drug Coverage: $7 Brand Copay	3.21	8.40
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.48
Inpatient Substance Abuse Rehab: Unlimited days	4.42	10.83
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.62	1.52
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.48	1.17
Dependent Children [std: covered to 19 end of month]		
Age	**End of Month**	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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LARGE GROUP HMO
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JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	10.46	27.23
Mental Health Coverage		
Inpatient Mental Health: 30 Days	0.04	0.10
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.02	0.06
Outpatient Mental Health: 20 Visits	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.02	0.05
Other Riders		
Durable Medical Equipment	0.03	0.07
Chiropractic: $5 Copay	0.08	0.20
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	2.56	6.66
Infertility Drug Coverage: $7 Brand Copay	0.06	0.16
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	0.40
Inpatient Substance Abuse Rehab: Unlimited days	0.08	0.20
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.01	0.03
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.01	0.02
Dependent Children [std: covered to 19 end of month]		
Age	**End of Month**	
30	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	1.9%	1.9%
Mental Health Coverage		
Inpatient Mental Health: 30 Days	1.9%	2.0%
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.6%	1.9%
Outpatient Mental Health: 20 Visits	0.0%	0.0%
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.9%	2.0%
Other Riders		
Durable Medical Equipment	2.0%	1.9%
Chiropractic: $5 Copay	2.0%	1.9%
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	1.9%	1.9%
Infertility Drug Coverage: $7 Brand Copay	1.9%	1.9%
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	N/A
Inpatient Substance Abuse Rehab: Unlimited days	1.8%	1.9%
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	1.6%	2.0%
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	2.1%	1.7%
Dependent Children [std: covered to 19 end of month]		
Age	**End of Month**	
30	#DIV/0!	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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1st QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2010 1st QUARTER

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.00	0.00	0.00
$750 *	0.00	0.00	0.00
$1,000	0.00	0.00	0.00
$2,000	0.00	0.00	0.00
$2,500	0.00	0.00	0.00
$3,000	0.00	0.00	0.00
$4,000	0.00	0.00	0.00
$5,000	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	#DIV/0!	0.0%
$1,000	0.0%	0.0%	#DIV/0!	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.0%	#DIV/0!	0.0%	#DIV/0!
$750 *	0.0%	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	2.5%

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	**2.5%**
3Q2011	**1.9%**
4Q2011	**1.9%**
1Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.00
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.00
$2,000 (Brand & Generic)	0.00
$2,500 (Brand & Generic)	0.00
$3,000 (Brand & Generic)	0.00
$4,000 (Brand & Generic)	0.00
$5,000 (Brand & Generic)	0.00
[c] Non Formulary Coverage, Generic Only Plans	0.00
[d] PICA Adjustm Applies only to New York City account	0.00
[e] IC Adjustme Applies only to New York City account	0.00
[f] Product Fact HMO, Access I, and EPO	0.00
POS, Access II, and PPO	0.00
[g] Trend per Quarter	(0.03)
2Q2010-2Q2011	0.03
3Q2011	0.02
4Q2011	0.02
1Q2012	0.02

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	0.00
Family	0.00
Three Tier	
Individual EE	0.00
Two Persons	0.00
Family	0.00
Four Tier	
Individual EE	0.00
EE + Child(ren)	0.00
EE + Spouse	0.00
Family	0.00

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.0%
$2,000 (Brand & Generic)	0.0%
$2,500 (Brand & Generic)	0.0%
$3,000 (Brand & Generic)	0.0%
$4,000 (Brand & Generic)	0.0%
$5,000 (Brand & Generic)	0.0%
[c] Non Formulary Coverage, Generic Only Plans	0.0%
[d] PICA Adjustm Applies only to New York City account	0.0%
[e] IC Adjustme Applies only to New York City account	0.0%
[f] Product Fact HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
2Q2010-2Q2011	#DIV/0!
3Q2011	#DIV/0!
4Q2011	#DIV/0!
1Q2012	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	0.0%
Family	0.0%
Three Tier	
Individual EE	0.0%
Two Persons	0.0%
Family	0.0%
Four Tier	
Individual EE	0.0%
EE + Child(ren)	0.0%
EE + Spouse	0.0%
Family	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO GROUP CONTRACT - BASE BENEFITS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	460.38	1,127.91	840.62	1,338.31	856.28	920.72	1,408.28

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	499.31	1,223.31	911.74	1,451.49	928.72	998.62	1,527.39

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	38.93	95.40	71.12	113.18	72.44	77.90	119.11

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group*	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.08)	(7.55)	(5.62)	(8.95)	(5.73)	(6.16)	(9.42)
$10	(6.47)	(15.85)	(11.81)	(18.81)	(12.03)	(12.94)	(19.79)
$15	(10.77)	(26.39)	(19.67)	(31.31)	(20.03)	(21.54)	(32.94)
$20	(16.62)	(40.72)	(30.35)	(48.31)	(30.91)	(33.24)	(50.84)
$25	(21.89)	(53.63)	(39.97)	(63.63)	(40.71)	(43.78)	(66.96)
$30	(27.68)	(67.81)	(50.54)	(80.46)	(51.48)	(55.36)	(84.67)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.76)	(4.31)	(3.21)	(5.12)	(3.27)	(3.52)	(5.38)
$10	(3.71)	(9.09)	(6.77)	(10.78)	(6.90)	(7.42)	(11.35)
$15	(6.17)	(15.12)	(11.27)	(17.94)	(11.48)	(12.34)	(18.87)
$20	(9.52)	(23.32)	(17.38)	(27.67)	(17.71)	(19.04)	(29.12)
$25	(12.54)	(30.72)	(22.90)	(36.45)	(23.32)	(25.08)	(38.36)
$30	(15.87)	(38.88)	(28.98)	(46.13)	(29.52)	(31.74)	(48.55)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.24)	(5.49)	(4.09)	(6.51)	(4.17)	(4.48)	(6.85)
$10	(4.65)	(11.39)	(8.49)	(13.52)	(8.65)	(9.30)	(14.22)
$15	(7.30)	(17.88)	(13.33)	(21.22)	(13.58)	(14.60)	(22.33)
$20	(10.29)	(25.21)	(18.79)	(29.91)	(19.14)	(20.58)	(31.48)
$25	(13.58)	(33.27)	(24.80)	(39.48)	(25.26)	(27.16)	(41.54)
$30	(17.30)	(42.38)	(31.59)	(50.29)	(32.18)	(34.60)	(52.92)
$35	(20.79)	(50.93)	(37.96)	(60.44)	(38.67)	(41.58)	(63.60)
$40	(24.41)	(59.80)	(44.57)	(70.96)	(45.40)	(48.82)	(74.67)
$45	(28.21)	(69.11)	(51.51)	(82.01)	(52.47)	(56.42)	(86.29)
$50	(32.21)	(78.91)	(58.81)	(93.63)	(59.91)	(64.42)	(98.53)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$10	(3.94)	(9.65)	(7.19)	(11.45)	(7.33)	(7.88)	(12.05)
$15	(6.17)	(15.12)	(11.27)	(17.94)	(11.48)	(12.34)	(18.87)
$20	(8.71)	(21.34)	(15.90)	(25.32)	(16.20)	(17.42)	(26.64)
$25	(11.48)	(28.13)	(20.96)	(33.37)	(21.35)	(22.96)	(35.12)
$30	(14.63)	(35.84)	(26.71)	(42.53)	(27.21)	(29.26)	(44.75)
$35	(17.60)	(43.12)	(32.14)	(51.16)	(32.73)	(35.20)	(53.84)
$40	(20.64)	(50.57)	(37.69)	(60.00)	(38.39)	(41.28)	(63.14)
$45	(23.86)	(58.46)	(43.57)	(69.36)	(44.38)	(47.72)	(72.99)
$50	(27.23)	(66.71)	(49.72)	(79.16)	(50.65)	(54.46)	(83.30)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$150	(1.86)	(4.56)	(3.40)	(5.41)	(3.46)	(3.72)	(5.69)
$200	(2.64)	(6.47)	(4.82)	(7.67)	(4.91)	(5.28)	(8.08)
$250	(3.78)	(9.26)	(6.90)	(10.99)	(7.03)	(7.56)	(11.56)
$500	(9.08)	(22.25)	(16.58)	(26.40)	(16.89)	(18.16)	(27.78)
$750	(15.60)	(38.22)	(28.48)	(45.35)	(29.01)	(31.20)	(47.72)
$1,000	(23.46)	(57.48)	(42.84)	(68.20)	(43.63)	(46.92)	(71.76)
Copay/Day							
$50 w/3 Day Max	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$50 w/5 Day Max	(1.88)	(4.61)	(3.43)	(5.47)	(3.50)	(3.76)	(5.75)
$100 w/3 Day Max	(3.42)	(8.38)	(6.24)	(9.94)	(6.36)	(6.84)	(10.46)
$100 w/5 Day Max	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
$250 w/3 Day Max	(11.30)	(27.68)	(20.63)	(32.85)	(21.02)	(22.60)	(34.57)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$75	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$100	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$125	(1.79)	(4.39)	(3.27)	(5.20)	(3.33)	(3.58)	(5.48)
$150	(2.23)	(5.46)	(4.07)	(6.48)	(4.15)	(4.46)	(6.82)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
$25	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$35	(0.75)	(1.84)	(1.37)	(2.18)	(1.39)	(1.50)	(2.29)
$50	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$60	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$75	(2.16)	(5.29)	(3.94)	(6.28)	(4.02)	(4.32)	(6.61)
$100	(3.07)	(7.52)	(5.61)	(8.92)	(5.71)	(6.14)	(9.39)
$125	(3.78)	(9.26)	(6.90)	(10.99)	(7.03)	(7.56)	(11.56)
$150	(4.52)	(11.07)	(8.25)	(13.14)	(8.41)	(9.04)	(13.83)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.53	1.30	0.97	1.54	0.99	1.06	1.62
60	1.03	2.52	1.88	2.99	1.92	2.06	3.15

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.34)	(8.18)	(6.10)	(9.71)	(6.21)	(6.68)	(10.22)
$10	(7.02)	(17.20)	(12.82)	(20.41)	(13.06)	(14.04)	(21.47)
$15	(11.68)	(28.62)	(21.33)	(33.95)	(21.72)	(23.36)	(35.73)
$20	(18.03)	(44.17)	(32.92)	(52.41)	(33.54)	(36.06)	(55.15)
$25	(23.73)	(58.14)	(43.33)	(68.98)	(44.14)	(47.46)	(72.59)
$30	(30.02)	(73.55)	(54.82)	(87.27)	(55.84)	(60.04)	(91.83)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$10	(4.03)	(9.87)	(7.36)	(11.72)	(7.50)	(8.06)	(12.33)
$15	(6.68)	(16.37)	(12.20)	(19.42)	(12.42)	(13.36)	(20.43)
$20	(10.32)	(25.28)	(18.84)	(30.00)	(19.20)	(20.64)	(31.57)
$25	(13.60)	(33.32)	(24.83)	(39.54)	(25.30)	(27.20)	(41.60)
$30	(17.22)	(42.19)	(31.44)	(50.06)	(32.03)	(34.44)	(52.68)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$10	(5.04)	(12.35)	(9.20)	(14.65)	(9.37)	(10.08)	(15.42)
$15	(7.91)	(19.38)	(14.44)	(22.99)	(14.71)	(15.82)	(24.20)
$20	(11.16)	(27.34)	(20.38)	(32.44)	(20.76)	(22.32)	(34.14)
$25	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$30	(18.76)	(45.96)	(34.26)	(54.54)	(34.89)	(37.52)	(57.39)
$35	(22.54)	(55.22)	(41.16)	(65.52)	(41.92)	(45.08)	(68.95)
$40	(26.47)	(64.85)	(48.33)	(76.95)	(49.23)	(52.94)	(80.97)
$45	(30.59)	(74.95)	(55.86)	(88.93)	(56.90)	(61.18)	(93.57)
$50	(34.93)	(85.58)	(63.78)	(101.54)	(64.97)	(69.86)	(106.85)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$10	(4.28)	(10.49)	(7.82)	(12.44)	(7.96)	(8.56)	(13.09)
$15	(6.68)	(16.37)	(12.20)	(19.42)	(12.42)	(13.36)	(20.43)
$20	(9.45)	(23.15)	(17.26)	(27.47)	(17.58)	(18.90)	(28.91)
$25	(12.45)	(30.50)	(22.73)	(36.19)	(23.16)	(24.90)	(38.08)
$30	(15.87)	(38.88)	(28.98)	(46.13)	(29.52)	(31.74)	(48.55)
$35	(19.09)	(46.77)	(34.86)	(55.49)	(35.51)	(38.18)	(58.40)
$40	(22.39)	(54.86)	(40.88)	(65.09)	(41.65)	(44.78)	(68.49)
$45	(25.87)	(63.38)	(47.24)	(75.20)	(48.12)	(51.74)	(79.14)
$50	(29.53)	(72.35)	(53.92)	(85.84)	(54.93)	(59.06)	(90.33)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
$150	(2.02)	(4.95)	(3.69)	(5.87)	(3.76)	(4.04)	(6.18)
$200	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$250	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$500	(9.84)	(24.11)	(17.97)	(28.60)	(18.30)	(19.68)	(30.10)
$750	(16.92)	(41.45)	(30.90)	(49.19)	(31.47)	(33.84)	(51.76)
$1,000	(25.44)	(62.33)	(46.45)	(73.95)	(47.32)	(50.88)	(77.82)
Copay/Day							
$50 w/3 Day Max	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$50 w/5 Day Max	(2.04)	(5.00)	(3.73)	(5.93)	(3.79)	(4.08)	(6.24)
$100 w/3 Day Max	(3.71)	(9.09)	(6.77)	(10.78)	(6.90)	(7.42)	(11.35)
$100 w/5 Day Max	(5.34)	(13.08)	(9.75)	(15.52)	(9.93)	(10.68)	(16.34)
$250 w/3 Day Max	(12.25)	(30.01)	(22.37)	(35.61)	(22.79)	(24.50)	(37.47)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$75	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$100	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$125	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$150	(2.42)	(5.93)	(4.42)	(7.03)	(4.50)	(4.84)	(7.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$25	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$35	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$50	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$60	(1.77)	(4.34)	(3.23)	(5.15)	(3.29)	(3.54)	(5.41)
$75	(2.34)	(5.73)	(4.27)	(6.80)	(4.35)	(4.68)	(7.16)
$100	(3.33)	(8.16)	(6.08)	(9.68)	(6.19)	(6.66)	(10.19)
$125	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$150	(4.90)	(12.01)	(8.95)	(14.24)	(9.11)	(9.80)	(14.99)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.57	1.40	1.04	1.66	1.06	1.14	1.74
60	1.12	2.74	2.05	3.26	2.08	2.24	3.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.63)	(0.48)	(0.76)	(0.48)	(0.52)	(0.80)
$10	(0.55)	(1.35)	(1.01)	(1.60)	(1.03)	(1.10)	(1.68)
$15	(0.91)	(2.23)	(1.66)	(2.64)	(1.69)	(1.82)	(2.79)
$20	(1.41)	(3.45)	(2.57)	(4.10)	(2.63)	(2.82)	(4.31)
$25	(1.84)	(4.51)	(3.36)	(5.35)	(3.43)	(3.68)	(5.63)
$30	(2.34)	(5.74)	(4.28)	(6.81)	(4.36)	(4.68)	(7.16)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.28)	(0.43)	(0.28)	(0.30)	(0.46)
$10	(0.32)	(0.78)	(0.59)	(0.94)	(0.60)	(0.64)	(0.98)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.94)	(1.02)	(1.56)
$20	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$25	(1.06)	(2.60)	(1.93)	(3.09)	(1.98)	(2.12)	(3.24)
$30	(1.35)	(3.31)	(2.46)	(3.93)	(2.51)	(2.70)	(4.13)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.19)	(0.46)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$10	(0.39)	(0.96)	(0.71)	(1.13)	(0.72)	(0.78)	(1.20)
$15	(0.61)	(1.50)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$20	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
$25	(1.14)	(2.79)	(2.08)	(3.31)	(2.12)	(2.28)	(3.49)
$30	(1.46)	(3.58)	(2.67)	(4.25)	(2.71)	(2.92)	(4.47)
$35	(1.75)	(4.29)	(3.20)	(5.08)	(3.25)	(3.50)	(5.35)
$40	(2.06)	(5.05)	(3.76)	(5.99)	(3.83)	(4.12)	(6.30)
$45	(2.38)	(5.84)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$50	(2.72)	(6.67)	(4.97)	(7.91)	(5.06)	(5.44)	(8.32)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.34)	(0.84)	(0.63)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.94)	(1.02)	(1.56)
$20	(0.74)	(1.81)	(1.36)	(2.15)	(1.38)	(1.48)	(2.27)
$25	(0.97)	(2.37)	(1.77)	(2.82)	(1.81)	(1.94)	(2.96)
$30	(1.24)	(3.04)	(2.27)	(3.60)	(2.31)	(2.48)	(3.80)
$35	(1.49)	(3.65)	(2.72)	(4.33)	(2.78)	(2.98)	(4.56)
$40	(1.75)	(4.29)	(3.19)	(5.09)	(3.26)	(3.50)	(5.35)
$45	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$50	(2.30)	(5.64)	(4.20)	(6.68)	(4.28)	(4.60)	(7.03)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.27)
$150	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.49)
$200	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$250	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$500	(0.76)	(1.86)	(1.39)	(2.20)	(1.41)	(1.52)	(2.32)
$750	(1.32)	(3.23)	(2.42)	(3.84)	(2.46)	(2.64)	(4.04)
$1,000	(1.98)	(4.85)	(3.61)	(5.75)	(3.69)	(3.96)	(6.06)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$50 w/5 Day Max	(0.16)	(0.39)	(0.30)	(0.46)	(0.29)	(0.32)	(0.49)
$100 w/3 Day Max	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$100 w/5 Day Max	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.29)
$250 w/3 Day Max	(0.95)	(2.33)	(1.74)	(2.76)	(1.77)	(1.90)	(2.90)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
$75	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
$100	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$125	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$150	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.08)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.06)	(0.14)	(0.11)	(0.17)	(0.12)	(0.12)	(0.19)
$50	(0.12)	(0.29)	(0.21)	(0.35)	(0.22)	(0.24)	(0.36)
$60	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.39)
$75	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$100	(0.26)	(0.64)	(0.47)	(0.76)	(0.48)	(0.52)	(0.80)
$125	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$150	(0.38)	(0.94)	(0.70)	(1.10)	(0.70)	(0.76)	(1.16)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.07	0.12	0.07	0.08	0.12
60	0.09	0.22	0.17	0.27	0.16	0.18	0.28

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.3%	8.5%	8.5%	8.4%	8.4%	8.5%
$10	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
$15	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.5%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.6%	8.7%	8.4%	8.6%	8.5%	8.6%
$10	8.6%	8.6%	8.7%	8.7%	8.7%	8.6%	8.6%
$15	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	8.3%
$20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$25	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.4%	8.6%	8.4%	8.4%	8.5%	8.5%
$10	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%
$15	8.4%	8.4%	8.3%	8.3%	8.3%	8.4%	8.4%
$20	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
$35	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$45	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.3%	8.3%	8.5%	8.5%	8.4%	8.4%
$10	8.6%	8.7%	8.8%	8.6%	8.6%	8.6%	8.6%
$15	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	8.3%
$20	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$35	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	8.0%	8.0%	7.8%	8.0%	8.2%	8.0%	7.9%
$150	8.6%	8.6%	8.5%	8.5%	8.7%	8.6%	8.6%
$200	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.3%
$250	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%
$500	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%	8.4%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
Copay/Day							
$50 w/3 Day Max	8.8%	8.6%	8.8%	8.8%	8.6%	8.8%	8.8%
$50 w/5 Day Max	8.5%	8.5%	8.7%	8.4%	8.3%	8.5%	8.5%
$100 w/3 Day Max	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$100 w/5 Day Max	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.6%
$250 w/3 Day Max	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.9%
$75	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$100	8.8%	8.6%	8.8%	8.8%	8.6%	8.8%	8.8%
$125	8.9%	8.9%	8.9%	9.0%	9.0%	8.9%	8.9%
$150	8.5%	8.6%	8.6%	8.5%	8.4%	8.5%	8.5%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
$25	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
$35	8.0%	7.6%	8.0%	7.8%	8.6%	8.0%	8.3%
$50	9.3%	9.2%	8.9%	9.3%	9.2%	9.3%	9.1%
$60	7.9%	8.0%	8.0%	8.0%	7.9%	7.9%	7.8%
$75	8.3%	8.3%	8.4%	8.3%	8.2%	8.3%	8.3%
$100	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%
$125	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%
$150	8.4%	8.5%	8.5%	8.4%	8.3%	8.4%	8.4%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
60	8.7%	8.7%	9.0%	9.0%	8.3%	8.7%	8.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.55	3.80	2.83	4.51	2.88	3.10	4.74
120	1.81	4.43	3.30	5.26	3.37	3.62	5.54
Unlimited	2.33	5.71	4.25	6.77	4.33	4.66	7.13
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
40/$10 copay	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
40/$15 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
40/$20 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
40/$25 copay	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
60	0.28	0.69	0.51	0.81	0.52	0.56	0.86
100	0.68	1.67	1.24	1.98	1.26	1.36	2.08
200	1.81	4.43	3.30	5.26	3.37	3.62	5.54
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.71	1.74	1.30	2.06	1.32	1.42	2.17
90	1.48	3.63	2.70	4.30	2.75	2.96	4.53
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.63	1.54	1.15	1.83	1.17	1.26	1.93
90	1.16	2.84	2.12	3.37	2.16	2.32	3.55
120	1.88	4.61	3.43	5.47	3.50	3.76	5.75
visits for all other	(Verizon Benefit)						
	1.46	3.58	2.67	4.24	2.72	2.92	4.47
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.90)	(2.20)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.27	0.66	0.49	0.78	0.50	0.54	0.83
30	0.43	1.05	0.79	1.25	0.80	0.86	1.32
Unlimited	0.63	1.54	1.15	1.83	1.17	1.26	1.93
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.18	7.79	5.81	9.24	5.91	6.36	9.73
60	3.73	9.14	6.81	10.84	6.94	7.46	11.41
90	4.46	10.93	8.14	12.97	8.30	8.92	13.64
Unlimited	4.52	11.07	8.25	13.14	8.41	9.04	13.83
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.24)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
60/$15 copay	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
60/$20 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
60/$25 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
120/$0 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
120/$5 copay	0.43	1.05	0.79	1.25	0.80	0.86	1.32
120/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
120/$25 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Unlimited/$0 copay	0.64	1.57	1.17	1.86	1.19	1.28	1.96
Unlimited/$5 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Unlimited/$10 copay	0.32	0.78	0.58	0.93	0.60	0.64	0.98
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.16	0.39	0.29	0.47	0.30	0.32	0.49
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.24)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$25	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$10	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$15	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$20	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$25	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$30	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$35	(1.13)	(2.77)	(2.06)	(3.28)	(2.10)	(2.26)	(3.46)
$40	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.68	4.12	3.07	4.88	3.12	3.36	5.14
120	1.97	4.83	3.60	5.73	3.66	3.94	6.03
Unlimited	2.53	6.20	4.62	7.35	4.71	5.06	7.74
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
40/$15 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$20 copay	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
40/$25 copay	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
60	0.31	0.76	0.57	0.90	0.58	0.62	0.95
100	0.73	1.79	1.33	2.12	1.36	1.46	2.23
200	1.97	4.83	3.60	5.73	3.66	3.94	6.03
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.76	1.86	1.39	2.21	1.41	1.52	2.32
90	1.61	3.94	2.94	4.68	2.99	3.22	4.92
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.68	1.67	1.24	1.98	1.26	1.36	2.08
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
120	2.04	5.00	3.73	5.93	3.79	4.08	6.24
visits for all other	(Verizon Benefit)						
	1.58	3.87	2.89	4.59	2.94	3.16	4.83
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.30	0.74	0.55	0.87	0.56	0.60	0.92
30	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Unlimited	0.68	1.67	1.24	1.98	1.26	1.36	2.08
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.44	8.43	6.28	10.00	6.40	6.88	10.52
60	4.05	9.92	7.40	11.77	7.53	8.10	12.39
90	4.84	11.86	8.84	14.07	9.00	9.68	14.81
Unlimited	4.90	12.01	8.95	14.24	9.11	9.80	14.99
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
60/$20 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
60/$25 copay	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
120/$0 copay	0.60	1.47	1.10	1.74	1.12	1.20	1.84
120/$5 copay	0.47	1.15	0.86	1.37	0.87	0.94	1.44
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
Unlimited/$0 copay	0.69	1.69	1.26	2.01	1.28	1.38	2.11
Unlimited/$5 copay	0.53	1.30	0.97	1.54	0.99	1.06	1.62
Unlimited/$10 copay	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$15	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$20	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$25	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$30	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$35	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$40	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	0.13	0.32	0.24	0.37	0.24	0.26	0.40
120	0.16	0.40	0.30	0.47	0.29	0.32	0.49
Unlimited	0.20	0.49	0.37	0.58	0.38	0.40	0.61
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
40/$10 copay	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
40/$15 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
40/$25 copay	(0.07)	(0.17)	(0.12)	(0.20)	(0.13)	(0.14)	(0.21)
60	0.03	0.07	0.06	0.09	0.06	0.06	0.09
100	0.05	0.12	0.09	0.14	0.10	0.10	0.15
200	0.16	0.40	0.30	0.47	0.29	0.32	0.49
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(0.09)	(0.22)	(0.17)	(0.26)	(0.17)	(0.18)	(0.28)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.15	0.09	0.10	0.15
90	0.13	0.31	0.24	0.38	0.24	0.26	0.39
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.13	0.09	0.15	0.09	0.10	0.15
90	0.09	0.22	0.16	0.26	0.17	0.18	0.27
120	0.16	0.39	0.30	0.46	0.29	0.32	0.49
visits for all other	(Verizon Benefit)						
	0.12	0.29	0.22	0.35	0.22	0.24	0.36
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.25)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.08	0.06	0.09	0.06	0.06	0.09
30	0.04	0.10	0.07	0.12	0.07	0.08	0.12
Unlimited	0.05	0.13	0.09	0.15	0.09	0.10	0.15
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.26	0.64	0.47	0.76	0.49	0.52	0.79
60	0.32	0.78	0.59	0.93	0.59	0.64	0.98
90	0.38	0.93	0.70	1.10	0.70	0.76	1.17
Unlimited	0.38	0.94	0.70	1.10	0.70	0.76	1.16
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
60/$15 copay	(0.04)	(0.09)	(0.08)	(0.12)	(0.07)	(0.08)	(0.13)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.12)
60/$25 copay	(0.05)	(0.13)	(0.09)	(0.14)	(0.09)	(0.10)	(0.15)
120/$0 copay	0.04	0.10	0.08	0.11	0.08	0.08	0.13
120/$5 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.12
120/$10 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
120/$25 copay	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
Unlimited/$0 copay	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Unlimited/$5 copay	0.04	0.10	0.08	0.12	0.08	0.08	0.12
Unlimited/$10 copay	0.03	0.08	0.06	0.09	0.05	0.06	0.09
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copay	(0.03)	(0.08)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.01	0.03	0.02	0.02	0.02	0.02	0.03
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.02)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$25	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.13)	(0.10)	(0.15)	(0.10)	(0.10)	(0.15)
$25	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$30	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
$35	(0.09)	(0.22)	(0.17)	(0.27)	(0.17)	(0.18)	(0.27)
$40	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	8.4%	8.4%	8.5%	8.2%	8.3%	8.4%	8.4%
120	8.8%	9.0%	9.1%	8.9%	8.6%	8.8%	8.8%
Unlimited	8.6%	8.6%	8.7%	8.6%	8.8%	8.6%	8.6%
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
40/$10 copay	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
40/$15 copay	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
40/$20 copay	8.6%	8.5%	8.5%	8.3%	8.3%	8.6%	9.0%
40/$25 copay	9.1%	9.0%	8.5%	8.9%	9.1%	9.1%	8.9%
60	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
100	7.4%	7.2%	7.3%	7.1%	7.9%	7.4%	7.2%
200	8.8%	9.0%	9.1%	8.9%	8.6%	8.8%	8.8%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	8.3%	8.3%	8.6%	8.3%	8.5%	8.3%	8.5%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.0%	6.9%	6.9%	7.3%	6.8%	7.0%	6.9%
90	8.8%	8.5%	8.9%	8.8%	8.7%	8.8%	8.6%
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.9%	8.4%	7.8%	8.2%	7.7%	7.9%	7.8%
90	7.8%	7.7%	7.5%	7.7%	7.9%	7.8%	7.6%
120	8.5%	8.5%	8.7%	8.4%	8.3%	8.5%	8.5%
visits for all other	(Verizon Benefit)						
	8.2%	8.1%	8.2%	8.3%	8.1%	8.2%	8.1%
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	8.9%	9.1%	9.1%	8.8%	9.0%	8.9%	9.1%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
30	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
Unlimited	7.9%	8.4%	7.8%	8.2%	7.7%	7.9%	7.8%
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.2%	8.2%	8.1%	8.2%	8.3%	8.2%	8.1%
60	8.6%	8.5%	8.7%	8.6%	8.5%	8.6%	8.6%
90	8.5%	8.5%	8.6%	8.5%	8.4%	8.5%	8.6%
Unlimited	8.4%	8.5%	8.5%	8.4%	8.3%	8.4%	8.4%
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	4.2%	3.4%	4.5%	4.3%	4.4%	4.2%	4.1%
60/$15 copay	10.3%	9.4%	11.3%	10.6%	9.6%	10.3%	10.9%
60/$20 copay	7.4%	7.6%	7.1%	7.6%	8.0%	7.4%	7.3%
60/$25 copay	7.7%	8.2%	7.6%	7.4%	7.4%	7.7%	7.5%
120/$0 copay	7.1%	7.3%	7.8%	6.7%	7.7%	7.1%	7.6%
120/$5 copay	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
120/$10 copay	4.2%	3.4%	4.5%	4.3%	4.4%	4.2%	4.1%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
120/$25 copay	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
Unlimited/$0 copay	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.7%
Unlimited/$5 copay	8.2%	8.3%	9.0%	8.5%	8.8%	8.2%	8.0%
Unlimited/$10 copay	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copay	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
Copay	Dialysis Treatment Copay [std: $10]						
$0	6.3%	7.7%	6.9%	4.3%	6.7%	6.3%	6.1%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	5.0%	4.1%	2.7%	5.2%	5.4%	5.0%	4.9%
$25	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
$10	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
$15	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
$20	8.2%	8.7%	9.0%	8.5%	8.8%	8.2%	8.0%
$25	10.0%	10.2%	10.3%	9.9%	10.1%	10.0%	9.8%
$30	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$35	8.0%	7.9%	8.3%	8.2%	8.1%	8.0%	7.8%
$40	9.1%	9.3%	9.1%	9.1%	8.9%	9.1%	8.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$50	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$15	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$20	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$25	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$35	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$50	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$60	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$75	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$100	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$75	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$100	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.87)	(7.03)	(5.24)	(8.34)	(5.34)	(5.74)	(8.78)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.45)	(10.90)	(8.13)	(12.94)	(8.28)	(8.90)	(13.61)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.62)	(3.97)	(2.96)	(4.71)	(3.01)	(3.24)	(4.96)
$50	(1.78)	(4.36)	(3.25)	(5.17)	(3.31)	(3.56)	(5.45)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$15	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$20	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$25	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$60	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$75	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$100	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.12)	(7.64)	(5.70)	(9.07)	(5.80)	(6.24)	(9.54)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.83)	(11.83)	(8.82)	(14.04)	(8.98)	(9.66)	(14.77)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$50	(0.13)	(0.32)	(0.24)	(0.37)	(0.24)	(0.26)	(0.40)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.14)	(0.10)	(0.10)	(0.15)
$25	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$35	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
$60	(0.04)	(0.09)	(0.08)	(0.12)	(0.07)	(0.08)	(0.13)
$75	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.12)	(0.09)	(0.14)	(0.10)	(0.10)	(0.15)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$75	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.25)	(0.61)	(0.46)	(0.73)	(0.46)	(0.50)	(0.76)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.76)	(1.16)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.04)	(0.10)	(0.08)	(0.12)	(0.07)	(0.08)	(0.12)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	8.7%	8.8%	8.8%	8.8%	8.7%	8.7%	8.8%
$50	7.9%	7.9%	8.0%	7.7%	7.8%	7.9%	7.9%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$10	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
$15	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
$20	7.4%	7.2%	7.3%	7.1%	7.9%	7.4%	7.2%
$25	8.7%	8.9%	8.9%	9.0%	8.8%	8.7%	8.9%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$35	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
$50	9.7%	9.2%	8.8%	10.0%	8.6%	9.7%	9.5%
$60	10.3%	9.4%	11.3%	10.6%	9.6%	10.3%	10.9%
$75	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
$100	7.4%	7.2%	7.3%	7.1%	7.9%	7.4%	7.2%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$50	4.8%	5.9%	5.3%	4.9%	5.1%	4.8%	4.7%
$60	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
$75	11.4%	11.6%	10.9%	10.8%	12.3%	11.4%	11.2%
$100	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.7%	8.7%	8.8%	8.8%	8.6%	8.7%	8.7%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.5%	10.8%	11.6%	10.9%	9.9%	10.5%	10.3%
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copy same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.41	18.15	13.53	21.54	13.78	14.82	22.67
60	7.81	19.13	14.26	22.70	14.53	15.62	23.89
90	8.11	19.87	14.81	23.58	15.08	16.22	24.81
Unlimited	8.19	20.07	14.95	23.81	15.23	16.38	25.05
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copy same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits			**$0 Copay**				
20	8.28	20.29	15.12	24.07	15.40	16.56	25.33
30	9.12	22.34	16.65	26.51	16.96	18.24	27.90
40	9.63	23.59	17.58	27.99	17.91	19.26	29.46
60	10.15	24.87	18.53	29.51	18.88	20.30	31.05
Unlimited	10.23	25.06	18.68	29.74	19.03	20.46	31.29
LARGE GROUP			**$5 Copay**				
20	7.79	19.09	14.22	22.65	14.49	15.58	23.83
30	8.57	21.00	15.65	24.91	15.94	17.14	26.22
40	9.11	22.32	16.63	26.48	16.94	18.22	27.87
60	9.54	23.37	17.42	27.73	17.74	19.08	29.18
Unlimited	9.61	23.54	17.55	27.94	17.87	19.22	29.40
LARGE GROUP			**$10 Copay**				
20	7.29	17.86	13.31	21.19	13.56	14.58	22.30
30	8.03	19.67	14.66	23.34	14.94	16.06	24.56
40	8.49	20.80	15.50	24.68	15.79	16.98	25.97
60	8.95	21.93	16.34	26.02	16.65	17.90	27.38
Unlimited	9.02	22.10	16.47	26.22	16.78	18.04	27.59
LARGE GROUP			**$15 Copay**				
20	6.84	16.76	12.49	19.88	12.72	13.68	20.92
30	7.55	18.50	13.79	21.95	14.04	15.10	23.10
40	7.99	19.58	14.59	23.23	14.86	15.98	24.44
60	8.45	20.70	15.43	24.56	15.72	16.90	25.85
Unlimited	8.52	20.87	15.56	24.77	15.85	17.04	26.06
LARGE GROUP			**$20 Copay**				
20	6.44	15.78	11.76	18.72	11.98	12.88	19.70
30	7.07	17.32	12.91	20.55	13.15	14.14	21.63
40	7.45	18.25	13.60	21.66	13.86	14.90	22.79
60	7.92	19.40	14.46	23.02	14.73	15.84	24.23
Unlimited	7.98	19.55	14.57	23.20	14.84	15.96	24.41
LARGE GROUP			**$25 Copay**				
20	5.99	14.68	10.94	17.41	11.14	11.98	18.32
30	6.58	16.12	12.01	19.13	12.24	13.16	20.13
40	7.01	17.17	12.80	20.38	13.04	14.02	21.44
60	7.37	18.06	13.46	21.42	13.71	14.74	22.54
Unlimited	7.44	18.23	13.58	21.63	13.84	14.88	22.76
LARGE GROUP			**$30 Copay**				
20	5.71	13.99	10.43	16.60	10.62	11.42	17.47
30	6.19	15.17	11.30	17.99	11.51	12.38	18.93
40	6.60	16.17	12.05	19.19	12.28	13.20	20.19
60	6.92	16.95	12.64	20.12	12.87	13.84	21.17
Unlimited	6.96	17.05	12.71	20.23	12.95	13.92	21.29
LARGE GROUP			**$35 Copay**				
20	5.43	13.30	9.91	15.78	10.10	10.86	16.61
30	5.79	14.19	10.57	16.83	10.77	11.58	17.71
40	6.17	15.12	11.27	17.94	11.48	12.34	18.87
60	6.47	15.85	11.81	18.81	12.03	12.94	19.79
Unlimited	6.53	16.00	11.92	18.98	12.15	13.06	19.97
LARGE GROUP			**$40 Copay**				
20	5.28	12.94	9.64	15.35	9.82	10.56	16.15
30	5.64	13.82	10.30	16.40	10.49	11.28	17.25
40	6.01	14.72	10.97	17.47	11.18	12.02	18.38
60	6.33	15.51	11.56	18.40	11.77	12.66	19.36
Unlimited	6.38	15.63	11.65	18.55	11.87	12.76	19.52
LARGE GROUP			**$45 Copay**				
20	5.13	12.57	9.37	14.91	9.54	10.26	15.69
30	5.48	13.43	10.01	15.93	10.19	10.96	16.76
40	5.85	14.33	10.68	17.01	10.88	11.70	17.89
60	6.18	15.14	11.28	17.97	11.49	12.36	18.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.04	19.70	14.68	23.37	14.95	16.08	24.59
60	8.48	20.78	15.48	24.65	15.77	16.96	25.94
90	8.79	21.54	16.05	25.55	16.35	17.58	26.89
Unlimited	8.88	21.76	16.21	25.81	16.52	17.76	27.16
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits			**$0 Copay**				
20	8.98	22.00	16.40	26.10	16.70	17.96	27.47
30	9.89	24.23	18.06	28.75	18.40	19.78	30.25
40	10.44	25.58	19.06	30.35	19.42	20.88	31.94
60	11.01	26.97	20.10	32.01	20.48	22.02	33.68
Unlimited	11.09	27.17	20.25	32.24	20.63	22.18	33.92
LARGE GROUP			**$5 Copay**				
20	8.45	20.70	15.43	24.56	15.72	16.90	25.85
30	9.29	22.76	16.96	27.01	17.28	18.58	28.42
40	9.88	24.21	18.04	28.72	18.38	19.76	30.22
60	10.34	25.33	18.88	30.06	19.23	20.68	31.63
Unlimited	10.42	25.53	19.03	30.29	19.38	20.84	31.87
LARGE GROUP			**$10 Copay**				
20	7.90	19.36	14.43	22.97	14.69	15.80	24.17
30	8.71	21.34	15.90	25.32	16.20	17.42	26.64
40	9.21	22.56	16.82	26.77	17.13	18.42	28.17
60	9.71	23.79	17.73	28.23	18.06	19.42	29.70
Unlimited	9.78	23.96	17.86	28.43	18.19	19.56	29.92
LARGE GROUP			**$15 Copay**				
20	7.42	18.18	13.55	21.57	13.80	14.84	22.70
30	8.19	20.07	14.95	23.81	15.23	16.38	25.05
40	8.67	21.24	15.83	25.20	16.13	17.34	26.52
60	9.17	22.47	16.74	26.66	17.06	18.34	28.05
Unlimited	9.24	22.64	16.87	26.86	17.19	18.48	28.27
LARGE GROUP			**$20 Copay**				
20	6.99	17.13	12.76	20.32	13.00	13.98	21.38
30	7.66	18.77	13.99	22.27	14.25	15.32	23.43
40	8.08	19.80	14.75	23.49	15.03	16.16	24.72
60	8.59	21.05	15.69	24.97	15.98	17.18	26.28
Unlimited	8.65	21.19	15.79	25.15	16.09	17.30	26.46
LARGE GROUP			**$25 Copay**				
20	6.50	15.93	11.87	18.90	12.09	13.00	19.88
30	7.13	17.47	13.02	20.73	13.26	14.26	21.81
40	7.60	18.62	13.88	22.09	14.14	15.20	23.25
60	8.00	19.60	14.61	23.26	14.88	16.00	24.47
Unlimited	8.07	19.77	14.74	23.46	15.01	16.14	24.69
LARGE GROUP			**$30 Copay**				
20	6.19	15.17	11.30	17.99	11.51	12.38	18.94
30	6.72	16.46	12.27	19.54	12.50	13.44	20.56
40	7.15	17.52	13.06	20.79	13.30	14.30	21.87
60	7.51	18.40	13.71	21.83	13.97	15.02	22.97
Unlimited	7.55	18.50	13.79	21.95	14.04	15.10	23.10
LARGE GROUP			**$35 Copay**				
20	5.89	14.43	10.76	17.12	10.96	11.78	18.02
30	6.28	15.39	11.47	18.26	11.68	12.56	19.21
40	6.68	16.37	12.20	19.42	12.42	13.36	20.43
60	7.02	17.20	12.82	20.41	13.06	14.04	21.47
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP			**$40 Copay**				
20	5.72	14.01	10.44	16.63	10.64	11.44	17.50
30	6.11	14.97	11.16	17.76	11.36	12.22	18.69
40	6.52	15.97	11.91	18.95	12.13	13.04	19.94
60	6.87	16.83	12.54	19.97	12.78	13.74	21.02
Unlimited	6.92	16.95	12.64	20.12	12.87	13.84	21.17
LARGE GROUP			**$45 Copay**				
20	5.56	13.62	10.15	16.16	10.34	11.12	17.01
30	5.94	14.55	10.85	17.27	11.05	11.88	18.17
40	6.35	15.56	11.60	18.46	11.81	12.70	19.42
60	6.69	16.39	12.22	19.45	12.44	13.38	20.46

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.63	1.55	1.15	1.83	1.17	1.26	1.92
60	0.67	1.65	1.22	1.95	1.24	1.34	2.05
90	0.68	1.67	1.24	1.97	1.27	1.36	2.08
Unlimited	0.69	1.69	1.26	2.00	1.29	1.38	2.11
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits			**$0 Copay**				
20	0.70	1.71	1.28	2.03	1.30	1.40	2.14
30	0.77	1.89	1.41	2.24	1.44	1.54	2.35
40	0.81	1.99	1.48	2.36	1.51	1.62	2.48
60	0.86	2.10	1.57	2.50	1.60	1.72	2.63
Unlimited	0.86	2.11	1.57	2.50	1.60	1.72	2.63
LARGE GROUP			**$5 Copay**				
20	0.66	1.61	1.21	1.91	1.23	1.32	2.02
30	0.72	1.76	1.31	2.10	1.34	1.44	2.20
40	0.77	1.89	1.41	2.24	1.44	1.54	2.35
60	0.80	1.96	1.46	2.33	1.49	1.60	2.45
Unlimited	0.81	1.99	1.48	2.35	1.51	1.62	2.47
LARGE GROUP			**$10 Copay**				
20	0.61	1.50	1.12	1.78	1.13	1.22	1.87
30	0.68	1.67	1.24	1.98	1.26	1.36	2.08
40	0.72	1.76	1.32	2.09	1.34	1.44	2.20
60	0.76	1.86	1.39	2.21	1.41	1.52	2.32
Unlimited	0.76	1.86	1.39	2.21	1.41	1.52	2.33
LARGE GROUP			**$15 Copay**				
20	0.58	1.42	1.06	1.69	1.08	1.16	1.78
30	0.64	1.57	1.16	1.86	1.19	1.28	1.95
40	0.68	1.66	1.24	1.97	1.27	1.36	2.08
60	0.72	1.77	1.31	2.10	1.34	1.44	2.20
Unlimited	0.72	1.77	1.31	2.09	1.34	1.44	2.21
LARGE GROUP			**$20 Copay**				
20	0.55	1.35	1.00	1.60	1.02	1.10	1.68
30	0.59	1.45	1.08	1.72	1.10	1.18	1.80
40	0.63	1.55	1.15	1.83	1.17	1.26	1.93
60	0.67	1.65	1.23	1.95	1.25	1.34	2.05
Unlimited	0.67	1.64	1.22	1.95	1.25	1.34	2.05
LARGE GROUP			**$25 Copay**				
20	0.51	1.25	0.93	1.49	0.95	1.02	1.56
30	0.55	1.35	1.01	1.60	1.02	1.10	1.68
40	0.59	1.45	1.08	1.71	1.10	1.18	1.81
60	0.63	1.54	1.15	1.84	1.17	1.26	1.93
Unlimited	0.63	1.54	1.16	1.83	1.17	1.26	1.93
LARGE GROUP			**$30 Copay**				
20	0.48	1.18	0.87	1.39	0.89	0.96	1.47
30	0.53	1.29	0.97	1.55	0.99	1.06	1.63
40	0.55	1.35	1.01	1.60	1.02	1.10	1.68
60	0.59	1.45	1.07	1.71	1.10	1.18	1.80
Unlimited	0.59	1.45	1.08	1.72	1.09	1.18	1.81
LARGE GROUP			**$35 Copay**				
20	0.46	1.13	0.85	1.34	0.86	0.92	1.41
30	0.49	1.20	0.90	1.43	0.91	0.98	1.50
40	0.51	1.25	0.93	1.48	0.94	1.02	1.56
60	0.55	1.35	1.01	1.60	1.03	1.10	1.68
Unlimited	0.55	1.35	1.01	1.60	1.02	1.10	1.69
LARGE GROUP			**$40 Copay**				
20	0.44	1.07	0.80	1.28	0.82	0.88	1.35
30	0.47	1.15	0.86	1.36	0.87	0.94	1.44
40	0.51	1.25	0.94	1.48	0.95	1.02	1.56
60	0.54	1.32	0.98	1.57	1.01	1.08	1.66
Unlimited	0.54	1.32	0.99	1.57	1.00	1.08	1.65
LARGE GROUP			**$45 Copay**				
20	0.43	1.05	0.78	1.25	0.80	0.86	1.32
30	0.46	1.12	0.84	1.34	0.86	0.92	1.41
40	0.50	1.23	0.92	1.45	0.93	1.00	1.53
60	0.51	1.25	0.94	1.48	0.95	1.02	1.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%
90	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits			**$0 Copay**				
20	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%
30	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP			**$5 Copay**				
20	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP			**$10 Copay**				
20	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP			**$15 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP			**$20 Copay**				
20	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.3%	8.4%	8.4%	8.4%	8.4%	8.3%	8.3%
40	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP			**$25 Copay**				
20	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.3%
40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%	8.6%
Unlimited	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$30 Copay**				
20	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
30	8.6%	8.5%	8.6%	8.6%	8.6%	8.6%	8.6%
40	8.3%	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%
60	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
LARGE GROUP			**$35 Copay**				
20	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
40	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	8.3%
60	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
LARGE GROUP			**$40 Copay**				
20	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.4%
30	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%
40	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.6%
Unlimited	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%
LARGE GROUP			**$45 Copay**				
20	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.5%	8.6%	8.6%	8.5%	8.5%	8.5%	8.6%
60	8.3%	8.3%	8.3%	8.2%	8.3%	8.3%	8.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.21	15.21	11.34	18.05	11.55	12.42	19.00
LARGE GROUP			**$50 Copay**				
20	4.99	12.23	9.11	14.51	9.28	9.98	15.26
30	5.33	13.06	9.73	15.49	9.91	10.66	16.30
40	5.71	13.99	10.43	16.60	10.62	11.42	17.47
60	6.03	14.77	11.01	17.53	11.22	12.06	18.45
Unlimited	6.07	14.87	11.08	17.65	11.29	12.14	18.57

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.74	16.51	12.31	19.59	12.54	13.48	20.62
LARGE GROUP			**$50 Copay**				
20	5.41	13.25	9.88	15.73	10.06	10.82	16.55
30	5.79	14.19	10.57	16.83	10.77	11.58	17.71
40	6.19	15.17	11.30	17.99	11.51	12.38	18.94
60	6.54	16.02	11.94	19.01	12.16	13.08	20.01
Unlimited	6.58	16.12	12.02	19.13	12.24	13.16	20.13

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.62
LARGE GROUP			**$50 Copay**				
20	0.42	1.02	0.77	1.22	0.78	0.84	1.29
30	0.46	1.13	0.84	1.34	0.86	0.92	1.41
40	0.48	1.18	0.87	1.39	0.89	0.96	1.47
60	0.51	1.25	0.93	1.48	0.94	1.02	1.56
Unlimited	0.51	1.25	0.94	1.48	0.95	1.02	1.56

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP			**$50 Copay**				
20	8.4%	8.3%	8.5%	8.4%	8.4%	8.4%	8.5%
30	8.6%	8.7%	8.6%	8.7%	8.7%	8.6%	8.7%
40	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.12	10.09	7.52	11.98	7.66	8.24	12.60
$0/Max $5000	3.92	9.60	7.16	11.40	7.29	7.84	11.99
$0/Max $2500	3.66	8.97	6.68	10.64	6.81	7.32	11.20
$25	3.92	9.60	7.16	11.40	7.29	7.84	11.99
$50	3.66	8.97	6.68	10.64	6.81	7.32	11.20
$100	3.36	8.23	6.14	9.77	6.25	6.72	10.28
$500	1.61	3.94	2.94	4.68	2.99	3.22	4.92
$5,000	0.27	0.66	0.49	0.78	0.50	0.54	0.83
Coinsurance							
80%	3.30	8.08	6.03	9.59	6.14	6.60	10.09
75%	3.10	7.59	5.66	9.01	5.77	6.20	9.48
70%	2.90	7.10	5.30	8.43	5.39	5.80	8.87
Deductible			**Orthotics Riders**				
$0	0.70	1.71	1.28	2.03	1.30	1.40	2.14
$0/Max $5000	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$0/Max $2500	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$25	0.67	1.64	1.22	1.95	1.25	1.34	2.05
$50	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$100	0.57	1.40	1.04	1.66	1.06	1.14	1.74
$500	0.29	0.71	0.53	0.84	0.54	0.58	0.89
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
75%	0.54	1.32	0.99	1.57	1.00	1.08	1.65
70%	0.51	1.25	0.93	1.48	0.95	1.02	1.56
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.35	3.31	2.47	3.92	2.51	2.70	4.13
12 Months	2.15	5.27	3.93	6.25	4.00	4.30	6.58
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.10	5.14	3.83	6.10	3.91	4.20	6.42
12 Months	3.35	8.21	6.12	9.74	6.23	6.70	10.25
			Private Duty Nursing Riders				
In Full	0.49	1.20	0.89	1.42	0.91	0.98	1.50
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
			Dental Network Access				
	0.42	1.03	0.77	1.22	0.78	0.84	1.28
			Infertility Rider				
Limit							
2 IVF	8.72	21.36	15.92	25.35	16.22	17.44	26.67
3 IVF	10.54	25.82	19.25	30.64	19.60	21.08	32.24
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.59	6.35	4.73	7.53	4.82	5.18	7.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.46	10.93	8.14	12.97	8.30	8.92	13.64
$0/Max $5000	4.25	10.41	7.76	12.35	7.91	8.50	13.00
$0/Max $2500	3.96	9.70	7.23	11.51	7.37	7.92	12.11
$25	4.25	10.41	7.76	12.35	7.91	8.50	13.00
$50	3.96	9.70	7.23	11.51	7.37	7.92	12.11
$100	3.65	8.94	6.66	10.61	6.79	7.30	11.17
$500	1.74	4.26	3.18	5.06	3.24	3.48	5.32
$5,000	0.30	0.74	0.55	0.87	0.56	0.60	0.92
Coinsurance							
80%	3.59	8.80	6.56	10.44	6.68	7.18	10.98
75%	3.36	8.23	6.14	9.77	6.25	6.72	10.28
70%	3.15	7.72	5.75	9.16	5.86	6.30	9.64
Deductible			**Orthotics Riders**				
$0	0.75	1.84	1.37	2.18	1.40	1.50	2.29
$0/Max $5000	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$0/Max $2500	0.68	1.67	1.24	1.98	1.26	1.36	2.08
$25	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$50	0.68	1.67	1.24	1.98	1.26	1.36	2.08
$100	0.62	1.52	1.13	1.80	1.15	1.24	1.90
$500	0.32	0.78	0.58	0.93	0.60	0.64	0.98
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.62	1.52	1.13	1.80	1.15	1.24	1.90
75%	0.58	1.42	1.06	1.69	1.08	1.16	1.77
70%	0.55	1.35	1.00	1.60	1.02	1.10	1.68
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.53	1.30	0.97	1.54	0.99	1.06	1.62
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
			Infertility Rider				
Limit							
2 IVF	9.46	23.18	17.27	27.50	17.60	18.92	28.94
3 IVF	11.43	28.00	20.87	33.23	21.26	22.86	34.96
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.81	6.88	5.13	8.17	5.23	5.62	8.60

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.34	0.84	0.62	0.99	0.64	0.68	1.04
$0/Max $5000	0.33	0.81	0.60	0.95	0.62	0.66	1.01
$0/Max $2500	0.30	0.73	0.55	0.87	0.56	0.60	0.91
$25	0.33	0.81	0.60	0.95	0.62	0.66	1.01
$50	0.30	0.73	0.55	0.87	0.56	0.60	0.91
$100	0.29	0.71	0.52	0.84	0.54	0.58	0.89
$500	0.13	0.32	0.24	0.38	0.25	0.26	0.40
$5,000	0.03	0.08	0.06	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.29	0.72	0.53	0.85	0.54	0.58	0.89
75%	0.26	0.64	0.48	0.76	0.48	0.52	0.80
70%	0.25	0.62	0.45	0.73	0.47	0.50	0.77
Deductible			**Orthotics Riders**				
$0	0.05	0.13	0.09	0.15	0.10	0.10	0.15
$0/Max $5000	0.05	0.12	0.09	0.14	0.09	0.10	0.15
$0/Max $2500	0.05	0.13	0.09	0.15	0.09	0.10	0.15
$25	0.05	0.12	0.09	0.14	0.09	0.10	0.15
$50	0.05	0.13	0.09	0.15	0.09	0.10	0.15
$100	0.05	0.12	0.09	0.14	0.09	0.10	0.16
$500	0.03	0.07	0.05	0.09	0.06	0.06	0.09
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.05	0.12	0.09	0.14	0.09	0.10	0.16
75%	0.04	0.10	0.07	0.12	0.08	0.08	0.12
70%	0.04	0.10	0.07	0.12	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.35	0.22	0.24	0.37
12 Months	0.18	0.44	0.32	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.31	0.34	0.52
12 Months	0.29	0.71	0.53	0.84	0.54	0.58	0.88
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.08	0.12	0.08	0.08	0.12
80% hrs 73-504	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-504	0.01	0.03	0.01	0.03	0.02	0.02	0.03
			Dental Network Access				
	0.04	0.10	0.07	0.12	0.08	0.08	0.13
			Infertility Rider				
Limit							
2 IVF	0.74	1.82	1.35	2.15	1.38	1.48	2.27
3 IVF	0.89	2.18	1.62	2.59	1.66	1.78	2.72
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	0.22	0.53	0.40	0.64	0.41	0.44	0.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.3%	8.3%	8.2%	8.3%	8.4%	8.3%	8.3%
$0/Max $5000	8.4%	8.4%	8.4%	8.3%	8.5%	8.4%	8.4%
$0/Max $2500	8.2%	8.1%	8.2%	8.2%	8.2%	8.2%	8.1%
$25	8.4%	8.4%	8.4%	8.3%	8.5%	8.4%	8.4%
$50	8.2%	8.1%	8.2%	8.2%	8.2%	8.2%	8.1%
$100	8.6%	8.6%	8.5%	8.6%	8.6%	8.6%	8.7%
$500	8.1%	8.1%	8.2%	8.1%	8.4%	8.1%	8.1%
$5,000	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
Coinsurance							
80%	8.8%	8.9%	8.8%	8.9%	8.8%	8.8%	8.8%
75%	8.4%	8.4%	8.5%	8.4%	8.3%	8.4%	8.4%
70%	8.6%	8.7%	8.5%	8.7%	8.7%	8.6%	8.7%
Deductible			**Orthotics Riders**				
$0	7.1%	7.6%	7.0%	7.4%	7.7%	7.1%	7.0%
$0/Max $5000	7.5%	7.3%	7.4%	7.2%	7.2%	7.5%	7.3%
$0/Max $2500	7.9%	8.4%	7.8%	8.2%	7.7%	7.9%	7.8%
$25	7.5%	7.3%	7.4%	7.2%	7.2%	7.5%	7.3%
$50	7.9%	8.4%	7.8%	8.2%	7.7%	7.9%	7.8%
$100	8.8%	8.6%	8.7%	8.4%	8.5%	8.8%	9.2%
$500	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	8.8%	8.6%	8.7%	8.4%	8.5%	8.8%	9.2%
75%	7.4%	7.6%	7.1%	7.6%	8.0%	7.4%	7.3%
70%	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.9%	8.8%	8.5%	8.9%	8.8%	8.9%	9.0%
12 Months	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.1%	8.2%	8.4%	8.2%	7.9%	8.1%	8.1%
12 Months	8.7%	8.6%	8.7%	8.6%	8.7%	8.7%	8.6%
			Private Duty Nursing Riders				
In Full	8.2%	8.3%	9.0%	8.5%	8.8%	8.2%	8.0%
80% hrs 73-504	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-504	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
			Dental Network Access				
	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
			Infertility Rider				
Limit							
2 IVF	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
3 IVF	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	8.5%	8.3%	8.5%	8.5%	8.5%	8.5%	8.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
850.13	2,082.78	1,552.28	2,471.30	1,581.18	1,700.19	2,600.51
80% Coinsurance						
837.37	2,051.51	1,528.98	2,434.20	1,557.44	1,674.66	2,561.47
75% Coinsurance						
796.99	1,952.58	1,455.24	2,316.81	1,482.33	1,593.90	2,437.95
70% Coinsurance						
756.61	1,853.65	1,381.51	2,199.43	1,407.23	1,513.15	2,314.42
50% Coinsurance						
716.24	1,754.74	1,307.80	2,082.08	1,332.14	1,432.41	2,190.93

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
922.00	2,258.90	1,683.57	2,680.25	1,714.92	1,844.00	2,820.40
80% Coinsurance						
908.16	2,224.99	1,658.30	2,640.02	1,689.18	1,816.32	2,778.06
75% Coinsurance						
864.38	2,117.73	1,578.36	2,512.75	1,607.75	1,728.76	2,644.14
70% Coinsurance						
820.57	2,010.40	1,498.36	2,385.40	1,526.26	1,641.14	2,510.12
50% Coinsurance						
776.78	1,903.11	1,418.40	2,258.10	1,444.81	1,553.56	2,376.17

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
71.87	176.12	131.29	208.95	133.74	143.81	219.89
80% Coinsurance						
70.79	173.48	129.32	205.82	131.74	141.66	216.59
75% Coinsurance						
67.39	165.15	123.12	195.94	125.42	134.86	206.19
70% Coinsurance						
63.96	156.75	116.85	185.97	119.03	127.99	195.70
50% Coinsurance						
60.54	148.37	110.60	176.02	112.67	121.15	185.24

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
80% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
75% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
70% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
50% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(38.40)	(94.08)	(70.12)	(111.63)	(71.42)	(76.80)	(117.46)
$350	(50.83)	(124.53)	(92.81)	(147.76)	(94.54)	(101.66)	(155.49)
$500	(65.40)	(160.23)	(119.42)	(190.12)	(121.64)	(130.79)	(200.06)
$750	(84.97)	(208.17)	(155.15)	(247.01)	(158.04)	(169.93)	(259.92)
$1,000	(99.96)	(244.90)	(182.52)	(290.58)	(185.92)	(199.91)	(305.77)
$1,500	(122.93)	(301.17)	(224.46)	(357.35)	(228.64)	(245.85)	(376.04)
$2,500	(137.43)	(336.70)	(250.94)	(399.51)	(255.61)	(274.85)	(420.39)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(51.32)	(125.73)	(93.71)	(149.19)	(95.45)	(102.64)	(156.99)
$250	(61.22)	(149.99)	(111.78)	(177.96)	(113.86)	(122.43)	(187.27)
$300	(71.15)	(174.31)	(129.91)	(206.83)	(132.33)	(142.29)	(217.64)
$350	(81.07)	(198.62)	(148.03)	(235.67)	(150.78)	(162.13)	(247.99)
$400	(88.87)	(217.73)	(162.27)	(258.34)	(165.29)	(177.73)	(271.85)
$500	(104.46)	(255.92)	(190.74)	(303.66)	(194.29)	(208.91)	(319.54)
$750	(135.66)	(332.36)	(247.71)	(394.36)	(252.32)	(271.31)	(414.98)
$1,000	(159.68)	(391.21)	(291.56)	(464.19)	(296.99)	(319.35)	(488.45)
$1,500	(196.42)	(481.22)	(358.65)	(570.99)	(365.33)	(392.82)	(600.84)
$2,000	(211.45)	(518.04)	(386.09)	(614.68)	(393.28)	(422.88)	(646.82)
$2,500	(226.53)	(554.99)	(413.63)	(658.52)	(421.33)	(453.04)	(692.94)
$5,000	(266.31)	(652.45)	(486.26)	(774.16)	(495.32)	(532.60)	(814.63)
$10,000	(299.16)	(732.93)	(546.25)	(869.65)	(556.41)	(598.30)	(915.12)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(42.05)	(103.02)	(76.78)	(122.24)	(78.21)	(84.10)	(128.63)
$250	(50.15)	(122.87)	(91.57)	(145.78)	(93.28)	(100.30)	(153.41)
$300	(58.30)	(142.83)	(106.45)	(169.48)	(108.43)	(116.60)	(178.34)
$350	(66.41)	(162.70)	(121.26)	(193.05)	(123.52)	(132.81)	(203.15)
$400	(72.94)	(178.70)	(133.18)	(212.03)	(135.66)	(145.87)	(223.12)
$500	(86.02)	(210.75)	(157.07)	(250.06)	(159.99)	(172.03)	(263.13)
$750	(111.89)	(274.13)	(204.30)	(325.26)	(208.11)	(223.77)	(342.27)
$1,000	(132.03)	(323.47)	(241.08)	(383.81)	(245.57)	(264.05)	(403.87)
$1,500	(162.55)	(398.24)	(296.80)	(472.53)	(302.33)	(325.09)	(497.23)
$2,000	(176.39)	(432.15)	(322.08)	(512.76)	(328.07)	(352.77)	(539.57)
$2,500	(190.23)	(466.05)	(347.35)	(552.99)	(353.81)	(380.44)	(581.90)
$5,000	(229.83)	(563.07)	(419.65)	(668.11)	(427.47)	(459.64)	(703.04)
$10,000	(262.51)	(643.14)	(479.32)	(763.11)	(488.25)	(525.00)	(803.01)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(32.78)	(80.31)	(59.85)	(95.29)	(60.97)	(65.56)	(100.27)
$250	(39.11)	(95.82)	(71.41)	(113.69)	(72.74)	(78.22)	(119.64)
$300	(45.43)	(111.30)	(82.95)	(132.06)	(84.50)	(90.86)	(138.97)
$350	(51.74)	(126.76)	(94.47)	(150.41)	(96.23)	(103.48)	(158.27)
$400	(57.05)	(139.77)	(104.17)	(165.84)	(106.11)	(114.10)	(174.51)
$500	(67.53)	(165.45)	(123.31)	(196.31)	(125.60)	(135.05)	(206.57)
$750	(88.10)	(215.84)	(160.86)	(256.10)	(163.86)	(176.19)	(269.49)
$1,000	(104.33)	(255.60)	(190.50)	(303.28)	(194.05)	(208.65)	(319.14)
$1,500	(128.69)	(315.28)	(234.98)	(374.10)	(239.35)	(257.37)	(393.66)
$2,000	(141.33)	(346.25)	(258.06)	(410.84)	(262.86)	(282.65)	(432.32)
$2,500	(153.97)	(377.22)	(281.14)	(447.59)	(286.37)	(307.93)	(470.99)
$5,000	(193.36)	(473.72)	(353.06)	(562.09)	(359.63)	(386.70)	(591.48)
$10,000	(225.88)	(553.40)	(412.44)	(656.63)	(420.12)	(451.74)	(690.96)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(22.53)	(55.20)	(41.14)	(65.49)	(41.90)	(45.06)	(68.92)
$250	(27.00)	(66.15)	(49.30)	(78.49)	(50.22)	(54.00)	(82.59)
$300	(31.51)	(77.20)	(57.54)	(91.60)	(58.61)	(63.02)	(96.39)
$350	(35.96)	(88.10)	(65.66)	(104.53)	(66.88)	(71.92)	(110.00)
$400	(39.85)	(97.63)	(72.76)	(115.84)	(74.12)	(79.70)	(121.90)
$500	(47.61)	(116.64)	(86.93)	(138.40)	(88.55)	(95.22)	(145.64)
$750	(62.46)	(153.02)	(114.05)	(181.57)	(116.17)	(124.91)	(191.06)
$1,000	(74.54)	(182.62)	(136.10)	(216.69)	(138.64)	(149.07)	(228.01)
$1,500	(93.15)	(228.21)	(170.09)	(270.78)	(173.25)	(186.29)	(284.94)
$2,000	(103.06)	(252.49)	(188.18)	(299.59)	(191.68)	(206.11)	(315.26)
$2,500	(113.00)	(276.84)	(206.33)	(328.49)	(210.17)	(225.99)	(345.66)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(41.65)	(102.04)	(76.05)	(121.08)	(77.47)	(83.30)	(127.41)
$350	(55.13)	(135.07)	(100.67)	(160.26)	(102.54)	(110.26)	(168.64)
$500	(70.93)	(173.78)	(129.52)	(206.19)	(131.93)	(141.86)	(216.97)
$750	(92.16)	(225.79)	(168.28)	(267.91)	(171.42)	(184.32)	(281.92)
$1,000	(108.41)	(265.60)	(197.96)	(315.15)	(201.64)	(216.82)	(331.63)
$1,500	(133.33)	(326.66)	(243.46)	(387.59)	(247.99)	(266.66)	(407.86)
$2,500	(149.05)	(365.17)	(272.17)	(433.29)	(277.23)	(298.10)	(455.94)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(55.66)	(136.37)	(101.64)	(161.80)	(103.53)	(111.32)	(170.26)
$250	(66.39)	(162.66)	(121.23)	(193.00)	(123.49)	(132.78)	(203.09)
$300	(77.16)	(189.04)	(140.89)	(224.30)	(143.52)	(154.32)	(236.03)
$350	(87.93)	(215.43)	(160.56)	(255.61)	(163.55)	(175.86)	(268.98)
$400	(96.38)	(236.13)	(175.99)	(280.18)	(179.27)	(192.76)	(294.83)
$500	(113.29)	(277.56)	(206.87)	(329.33)	(210.72)	(226.58)	(346.55)
$750	(147.12)	(360.44)	(268.64)	(427.68)	(273.64)	(294.24)	(450.04)
$1,000	(173.18)	(424.29)	(316.23)	(503.43)	(322.11)	(346.36)	(529.76)
$1,500	(213.03)	(521.92)	(388.99)	(619.28)	(396.24)	(426.06)	(651.66)
$2,000	(229.33)	(561.86)	(418.76)	(666.66)	(426.55)	(458.66)	(701.52)
$2,500	(245.68)	(601.92)	(448.61)	(714.19)	(456.96)	(491.36)	(751.54)
$5,000	(288.82)	(707.61)	(527.39)	(839.60)	(537.21)	(577.64)	(883.50)
$10,000	(324.46)	(794.93)	(592.46)	(943.21)	(603.50)	(648.92)	(992.52)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(45.60)	(111.72)	(83.27)	(132.56)	(84.82)	(91.20)	(139.49)
$250	(54.39)	(133.26)	(99.32)	(158.11)	(101.17)	(108.78)	(166.38)
$300	(63.23)	(154.91)	(115.46)	(183.81)	(117.61)	(126.46)	(193.42)
$350	(72.02)	(176.45)	(131.51)	(209.36)	(133.96)	(144.04)	(220.31)
$400	(79.10)	(193.80)	(144.44)	(229.94)	(147.13)	(158.20)	(241.97)
$500	(93.30)	(228.59)	(170.37)	(271.22)	(173.54)	(186.60)	(285.40)
$750	(121.35)	(297.31)	(221.59)	(352.76)	(225.71)	(242.70)	(371.21)
$1,000	(143.19)	(350.82)	(261.46)	(416.25)	(266.33)	(286.38)	(438.02)
$1,500	(176.30)	(431.94)	(321.92)	(512.50)	(327.92)	(352.60)	(539.30)
$2,000	(191.30)	(468.69)	(349.31)	(556.11)	(355.82)	(382.60)	(585.19)
$2,500	(206.32)	(505.48)	(376.74)	(599.77)	(383.76)	(412.64)	(631.13)
$5,000	(249.26)	(610.69)	(455.15)	(724.60)	(463.62)	(498.52)	(762.49)
$10,000	(284.71)	(697.54)	(519.88)	(827.65)	(529.56)	(569.42)	(870.93)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(35.55)	(87.10)	(64.91)	(103.34)	(66.12)	(71.10)	(108.75)
$250	(42.42)	(103.93)	(77.46)	(123.31)	(78.90)	(84.84)	(129.76)
$300	(49.27)	(120.71)	(89.97)	(143.23)	(91.64)	(98.54)	(150.72)
$350	(56.12)	(137.49)	(102.48)	(163.14)	(104.38)	(112.24)	(171.67)
$400	(61.87)	(151.58)	(112.97)	(179.86)	(115.08)	(123.74)	(189.26)
$500	(73.24)	(179.44)	(133.74)	(212.91)	(136.23)	(146.48)	(224.04)
$750	(95.55)	(234.10)	(174.47)	(277.76)	(177.72)	(191.10)	(292.29)
$1,000	(113.15)	(277.22)	(206.61)	(328.93)	(210.46)	(226.30)	(346.13)
$1,500	(139.56)	(341.92)	(254.84)	(405.70)	(259.58)	(279.12)	(426.91)
$2,000	(153.28)	(375.54)	(279.89)	(445.58)	(285.10)	(306.56)	(468.88)
$2,500	(166.99)	(409.13)	(304.92)	(485.44)	(310.60)	(333.98)	(510.82)
$5,000	(209.71)	(513.79)	(382.93)	(609.63)	(390.06)	(419.42)	(641.50)
$10,000	(244.98)	(600.20)	(447.33)	(712.16)	(455.66)	(489.96)	(749.39)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(24.44)	(59.88)	(44.63)	(71.05)	(45.46)	(48.88)	(74.76)
$250	(29.29)	(71.76)	(53.48)	(85.15)	(54.48)	(58.58)	(89.60)
$300	(34.18)	(83.74)	(62.41)	(99.36)	(63.57)	(68.36)	(104.56)
$350	(39.00)	(95.55)	(71.21)	(113.37)	(72.54)	(78.00)	(119.30)
$400	(43.22)	(105.89)	(78.92)	(125.64)	(80.39)	(86.44)	(132.21)
$500	(51.63)	(126.49)	(94.28)	(150.09)	(96.03)	(103.26)	(157.94)
$750	(67.74)	(165.96)	(123.69)	(196.92)	(126.00)	(135.48)	(207.22)
$1,000	(80.85)	(198.08)	(147.63)	(235.03)	(150.38)	(161.70)	(247.32)
$1,500	(101.02)	(247.50)	(184.46)	(293.67)	(187.90)	(202.04)	(309.02)
$2,000	(111.77)	(273.84)	(204.09)	(324.92)	(207.89)	(223.54)	(341.90)
$2,500	(122.56)	(300.27)	(223.79)	(356.28)	(227.96)	(245.12)	(374.91)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(3.25)	(7.96)	(5.93)	(9.45)	(6.05)	(6.50)	(9.95)
$350	(4.30)	(10.54)	(7.86)	(12.50)	(8.00)	(8.60)	(13.15)
$500	(5.53)	(13.55)	(10.10)	(16.07)	(10.29)	(11.07)	(16.91)
$750	(7.19)	(17.62)	(13.13)	(20.90)	(13.38)	(14.39)	(22.00)
$1,000	(8.45)	(20.70)	(15.44)	(24.57)	(15.72)	(16.91)	(25.86)
$1,500	(10.40)	(25.49)	(19.00)	(30.24)	(19.35)	(20.81)	(31.82)
$2,500	(11.62)	(28.47)	(21.23)	(33.78)	(21.62)	(23.25)	(35.55)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(4.34)	(10.64)	(7.93)	(12.61)	(8.08)	(8.68)	(13.27)
$250	(5.17)	(12.67)	(9.45)	(15.04)	(9.63)	(10.35)	(15.82)
$300	(6.01)	(14.73)	(10.98)	(17.47)	(11.19)	(12.03)	(18.39)
$350	(6.86)	(16.81)	(12.53)	(19.94)	(12.77)	(13.73)	(20.99)
$400	(7.51)	(18.40)	(13.72)	(21.84)	(13.98)	(15.03)	(22.98)
$500	(8.83)	(21.64)	(16.13)	(25.67)	(16.43)	(17.67)	(27.01)
$750	(11.46)	(28.08)	(20.93)	(33.32)	(21.32)	(22.93)	(35.06)
$1,000	(13.50)	(33.08)	(24.67)	(39.24)	(25.12)	(27.01)	(41.31)
$1,500	(16.61)	(40.70)	(30.34)	(48.29)	(30.91)	(33.24)	(50.82)
$2,000	(17.88)	(43.82)	(32.67)	(51.98)	(33.27)	(35.78)	(54.70)
$2,500	(19.15)	(46.93)	(34.98)	(55.67)	(35.63)	(38.32)	(58.60)
$5,000	(22.51)	(55.16)	(41.13)	(65.44)	(41.89)	(45.04)	(68.87)
$10,000	(25.30)	(62.00)	(46.21)	(73.56)	(47.09)	(50.62)	(77.40)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(3.55)	(8.70)	(6.49)	(10.32)	(6.61)	(7.10)	(10.86)
$250	(4.24)	(10.39)	(7.75)	(12.33)	(7.89)	(8.48)	(12.97)
$300	(4.93)	(12.08)	(9.01)	(14.33)	(9.18)	(9.86)	(15.08)
$350	(5.61)	(13.75)	(10.25)	(16.31)	(10.44)	(11.23)	(17.16)
$400	(6.16)	(15.10)	(11.26)	(17.91)	(11.47)	(12.33)	(18.85)
$500	(7.28)	(17.84)	(13.30)	(21.16)	(13.55)	(14.57)	(22.27)
$750	(9.46)	(23.18)	(17.29)	(27.50)	(17.60)	(18.93)	(28.94)
$1,000	(11.16)	(27.35)	(20.38)	(32.44)	(20.76)	(22.33)	(34.15)
$1,500	(13.75)	(33.70)	(25.12)	(39.97)	(25.59)	(27.51)	(42.07)
$2,000	(14.91)	(36.54)	(27.23)	(43.35)	(27.75)	(29.83)	(45.62)
$2,500	(16.09)	(39.43)	(29.39)	(46.78)	(29.95)	(32.20)	(49.23)
$5,000	(19.43)	(47.62)	(35.50)	(56.49)	(36.15)	(38.88)	(59.45)
$10,000	(22.20)	(54.40)	(40.56)	(64.54)	(41.31)	(44.42)	(67.92)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(2.77)	(6.79)	(5.06)	(8.05)	(5.15)	(5.54)	(8.48)
$250	(3.31)	(8.11)	(6.05)	(9.62)	(6.16)	(6.62)	(10.12)
$300	(3.84)	(9.41)	(7.02)	(11.17)	(7.14)	(7.68)	(11.75)
$350	(4.38)	(10.73)	(8.01)	(12.73)	(8.15)	(8.76)	(13.40)
$400	(4.82)	(11.81)	(8.80)	(14.02)	(8.97)	(9.64)	(14.75)
$500	(5.71)	(13.99)	(10.43)	(16.60)	(10.63)	(11.43)	(17.47)
$750	(7.45)	(18.26)	(13.61)	(21.66)	(13.86)	(14.91)	(22.80)
$1,000	(8.82)	(21.62)	(16.11)	(25.65)	(16.41)	(17.65)	(26.99)
$1,500	(10.87)	(26.64)	(19.86)	(31.60)	(20.23)	(21.75)	(33.25)
$2,000	(11.95)	(29.29)	(21.83)	(34.74)	(22.24)	(23.91)	(36.56)
$2,500	(13.02)	(31.91)	(23.78)	(37.85)	(24.23)	(26.05)	(39.83)
$5,000	(16.35)	(40.07)	(29.87)	(47.54)	(30.43)	(32.72)	(50.02)
$10,000	(19.10)	(46.80)	(34.89)	(55.53)	(35.54)	(38.22)	(58.43)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(1.91)	(4.68)	(3.49)	(5.56)	(3.56)	(3.82)	(5.84)
$250	(2.29)	(5.61)	(4.18)	(6.66)	(4.26)	(4.58)	(7.01)
$300	(2.67)	(6.54)	(4.87)	(7.76)	(4.96)	(5.34)	(8.17)
$350	(3.04)	(7.45)	(5.55)	(8.84)	(5.66)	(6.08)	(9.30)
$400	(3.37)	(8.26)	(6.16)	(9.80)	(6.27)	(6.74)	(10.31)
$500	(4.02)	(9.85)	(7.35)	(11.69)	(7.48)	(8.04)	(12.30)
$750	(5.28)	(12.94)	(9.64)	(15.35)	(9.83)	(10.57)	(16.16)
$1,000	(6.31)	(15.46)	(11.53)	(18.34)	(11.74)	(12.63)	(19.31)
$1,500	(7.87)	(19.29)	(14.37)	(22.89)	(14.65)	(15.75)	(24.08)
$2,000	(8.71)	(21.35)	(15.91)	(25.33)	(16.21)	(17.43)	(26.64)
$2,500	(9.56)	(23.43)	(17.46)	(27.79)	(17.79)	(19.13)	(29.25)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
			LARGE GROUP				
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%
$300	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$400	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(151.85)	(372.03)	(277.27)	(441.42)	(282.43)	(303.69)	(464.50)
$10,000	(183.91)	(450.57)	(335.81)	(534.62)	(342.06)	(367.80)	(562.57)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(29.85)	(73.13)	(54.50)	(86.77)	(55.52)	(59.70)	(91.31)
$1,500	(32.55)	(79.75)	(59.43)	(94.62)	(60.54)	(65.10)	(99.57)
$2,000	(33.98)	(83.25)	(62.05)	(98.78)	(63.20)	(67.96)	(103.94)
$3,000	(35.21)	(86.26)	(64.29)	(102.35)	(65.49)	(70.42)	(107.71)
$4,000	(35.77)	(87.63)	(65.31)	(103.98)	(66.53)	(71.54)	(109.42)
$5,000	(36.06)	(88.35)	(65.84)	(104.83)	(67.07)	(72.12)	(110.31)
$7,000	(36.39)	(89.15)	(66.45)	(105.78)	(67.68)	(72.78)	(111.32)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(47.51)	(116.40)	(86.75)	(138.11)	(88.36)	(95.02)	(145.33)
$1,500	(51.83)	(126.98)	(94.64)	(150.67)	(96.40)	(103.66)	(158.55)
$2,000	(54.05)	(132.42)	(98.69)	(157.12)	(100.53)	(108.10)	(165.34)
$3,000	(56.11)	(137.47)	(102.45)	(163.11)	(104.36)	(112.22)	(171.64)
$4,000	(56.98)	(139.60)	(104.04)	(165.64)	(105.98)	(113.96)	(174.30)
$5,000	(57.43)	(140.70)	(104.86)	(166.95)	(106.82)	(114.86)	(175.68)
$7,000	(57.98)	(142.05)	(105.87)	(168.55)	(107.84)	(115.96)	(177.36)
$7,500	(58.45)	(143.20)	(106.73)	(169.91)	(108.71)	(116.90)	(178.80)
$10,000	(60.16)	(147.39)	(109.85)	(174.88)	(111.89)	(120.32)	(184.03)
$20,000	(62.60)	(153.37)	(114.30)	(181.98)	(116.43)	(125.19)	(191.49)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(45.91)	(112.48)	(83.83)	(133.46)	(85.39)	(91.82)	(140.44)
$1,500	(51.03)	(125.02)	(93.18)	(148.34)	(94.91)	(102.06)	(156.10)
$2,000	(53.87)	(131.98)	(98.36)	(156.60)	(100.19)	(107.74)	(164.79)
$3,000	(56.66)	(138.81)	(103.46)	(164.71)	(105.38)	(113.32)	(173.32)
$4,000	(57.93)	(141.93)	(105.78)	(168.40)	(107.75)	(115.86)	(177.21)
$5,000	(58.63)	(143.64)	(107.05)	(170.44)	(109.05)	(117.26)	(179.35)
$7,000	(59.31)	(145.31)	(108.30)	(172.41)	(110.31)	(118.62)	(181.43)
$7,500	(59.82)	(146.56)	(109.23)	(173.90)	(111.26)	(119.64)	(182.99)
$10,000	(61.92)	(151.70)	(113.06)	(180.00)	(115.17)	(123.83)	(189.41)
$20,000	(65.16)	(159.64)	(118.98)	(189.42)	(121.19)	(130.31)	(199.32)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(44.32)	(108.58)	(80.93)	(128.84)	(82.43)	(88.64)	(135.57)
$1,500	(50.26)	(123.13)	(91.77)	(146.10)	(93.48)	(100.52)	(153.74)
$2,000	(53.68)	(131.51)	(98.02)	(156.05)	(99.84)	(107.36)	(164.20)
$3,000	(57.23)	(140.21)	(104.50)	(166.37)	(106.44)	(114.46)	(175.06)
$4,000	(58.85)	(144.18)	(107.46)	(171.08)	(109.46)	(117.70)	(180.02)
$5,000	(59.80)	(146.51)	(109.19)	(173.84)	(111.22)	(119.60)	(182.93)
$7,000	(60.64)	(148.57)	(110.72)	(176.28)	(112.79)	(121.28)	(185.49)
$7,500	(61.18)	(149.89)	(111.71)	(177.85)	(113.79)	(122.35)	(187.15)
$10,000	(63.50)	(155.57)	(115.95)	(184.59)	(118.11)	(126.99)	(194.24)
$20,000	(67.62)	(165.67)	(123.47)	(196.57)	(125.77)	(135.23)	(206.85)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(50.15)	(122.87)	(91.57)	(145.78)	(93.28)	(100.30)	(153.41)
$1,500	(59.76)	(146.41)	(109.12)	(173.72)	(111.15)	(119.52)	(182.80)
$2,000	(65.96)	(161.60)	(120.44)	(191.74)	(122.68)	(131.91)	(201.77)
$3,000	(73.46)	(179.97)	(134.13)	(213.55)	(136.63)	(146.91)	(224.71)
$4,000	(77.58)	(190.07)	(141.66)	(225.52)	(144.29)	(155.15)	(237.31)
$5,000	(80.12)	(196.29)	(146.29)	(232.91)	(149.02)	(160.23)	(245.08)
$7,000	(82.74)	(202.71)	(151.08)	(240.52)	(153.89)	(165.47)	(253.10)
$7,500	(83.71)	(205.09)	(152.85)	(243.34)	(155.69)	(167.41)	(256.07)
$10,000	(87.60)	(214.62)	(159.95)	(254.65)	(162.93)	(175.19)	(267.96)
$20,000	(95.80)	(234.71)	(174.92)	(278.49)	(178.18)	(191.59)	(293.05)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.37	0.91	0.68	1.08	0.69	0.74	1.13
$1,000,000	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$50,000	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(164.68)	(403.47)	(300.71)	(478.72)	(306.30)	(329.36)	(503.76)
$10,000	(199.46)	(488.68)	(364.21)	(579.83)	(371.00)	(398.92)	(610.15)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(32.37)	(79.31)	(59.11)	(94.10)	(60.21)	(64.74)	(99.02)
$1,500	(35.31)	(86.51)	(64.48)	(102.65)	(65.68)	(70.62)	(108.01)
$2,000	(36.85)	(90.28)	(67.29)	(107.12)	(68.54)	(73.70)	(112.72)
$3,000	(38.19)	(93.57)	(69.73)	(111.02)	(71.03)	(76.38)	(116.82)
$4,000	(38.79)	(95.04)	(70.83)	(112.76)	(72.15)	(77.58)	(118.66)
$5,000	(39.11)	(95.82)	(71.41)	(113.69)	(72.74)	(78.22)	(119.64)
$7,000	(39.47)	(96.70)	(72.07)	(114.74)	(73.41)	(78.94)	(120.74)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(51.52)	(126.22)	(94.08)	(149.77)	(95.83)	(103.04)	(157.60)
$1,500	(56.22)	(137.74)	(102.66)	(163.43)	(104.57)	(112.44)	(171.98)
$2,000	(58.61)	(143.59)	(107.02)	(170.38)	(109.01)	(117.22)	(179.29)
$3,000	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$4,000	(61.79)	(151.39)	(112.83)	(179.62)	(114.93)	(123.58)	(189.02)
$5,000	(62.28)	(152.59)	(113.72)	(181.05)	(115.84)	(124.56)	(190.51)
$7,000	(62.88)	(154.06)	(114.82)	(182.79)	(116.96)	(125.76)	(192.35)
$7,500	(63.39)	(155.31)	(115.75)	(184.27)	(117.91)	(126.78)	(193.91)
$10,000	(65.25)	(159.86)	(119.15)	(189.68)	(121.37)	(130.50)	(199.60)
$20,000	(67.89)	(166.33)	(123.97)	(197.36)	(126.28)	(135.78)	(207.68)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(49.79)	(121.99)	(90.92)	(144.74)	(92.61)	(99.58)	(152.31)
$1,500	(55.34)	(135.58)	(101.05)	(160.87)	(102.93)	(110.68)	(169.29)
$2,000	(58.43)	(143.15)	(106.69)	(169.86)	(108.68)	(116.86)	(178.74)
$3,000	(61.45)	(150.55)	(112.21)	(178.64)	(114.30)	(122.90)	(187.98)
$4,000	(62.83)	(153.93)	(114.73)	(182.65)	(116.86)	(125.66)	(192.20)
$5,000	(63.59)	(155.80)	(116.12)	(184.86)	(118.28)	(127.18)	(194.52)
$7,000	(64.33)	(157.61)	(117.47)	(187.01)	(119.65)	(128.66)	(196.79)
$7,500	(64.88)	(158.96)	(118.47)	(188.61)	(120.68)	(129.76)	(198.47)
$10,000	(67.15)	(164.52)	(122.62)	(195.21)	(124.90)	(134.30)	(205.41)
$20,000	(70.67)	(173.14)	(129.04)	(205.44)	(131.45)	(141.34)	(216.18)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(48.07)	(117.77)	(87.78)	(139.74)	(89.41)	(96.14)	(147.05)
$1,500	(54.52)	(133.57)	(99.55)	(158.49)	(101.41)	(109.04)	(166.78)
$2,000	(58.23)	(142.66)	(106.33)	(169.27)	(108.31)	(116.46)	(178.13)
$3,000	(62.08)	(152.10)	(113.36)	(180.47)	(115.47)	(124.16)	(189.90)
$4,000	(63.83)	(156.38)	(116.55)	(185.55)	(118.72)	(127.66)	(195.26)
$5,000	(64.86)	(158.91)	(118.43)	(188.55)	(120.64)	(129.72)	(198.41)
$7,000	(65.77)	(161.14)	(120.10)	(191.19)	(122.33)	(131.54)	(201.19)
$7,500	(66.35)	(162.56)	(121.16)	(192.88)	(123.41)	(132.70)	(202.96)
$10,000	(68.86)	(168.71)	(125.74)	(200.18)	(128.08)	(137.72)	(210.64)
$20,000	(73.34)	(179.68)	(133.92)	(213.20)	(136.41)	(146.68)	(224.35)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(54.39)	(133.26)	(99.32)	(158.11)	(101.17)	(108.78)	(166.38)
$1,500	(64.82)	(158.81)	(118.36)	(188.43)	(120.57)	(129.64)	(198.28)
$2,000	(71.53)	(175.25)	(130.61)	(207.94)	(133.05)	(143.06)	(218.81)
$3,000	(79.68)	(195.22)	(145.50)	(231.63)	(148.20)	(159.36)	(243.74)
$4,000	(84.14)	(206.14)	(153.64)	(244.59)	(156.50)	(168.28)	(257.38)
$5,000	(86.89)	(212.88)	(158.66)	(252.59)	(161.62)	(173.78)	(265.80)
$7,000	(89.73)	(219.84)	(163.85)	(260.85)	(166.90)	(179.46)	(274.48)
$7,500	(90.78)	(222.41)	(165.76)	(263.90)	(168.85)	(181.56)	(277.70)
$10,000	(95.01)	(232.77)	(173.49)	(276.19)	(176.72)	(190.02)	(290.64)
$20,000	(103.90)	(254.56)	(189.72)	(302.04)	(193.25)	(207.80)	(317.83)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.41	1.00	0.75	1.19	0.76	0.82	1.25
$1,000,000	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$50,000	(5.34)	(13.08)	(9.75)	(15.52)	(9.93)	(10.68)	(16.34)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(12.83)	(31.44)	(23.44)	(37.30)	(23.87)	(25.67)	(39.26)
$10,000	(15.55)	(38.11)	(28.40)	(45.21)	(28.94)	(31.12)	(47.58)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(2.52)	(6.18)	(4.61)	(7.33)	(4.69)	(5.04)	(7.71)
$1,500	(2.76)	(6.76)	(5.05)	(8.03)	(5.14)	(5.52)	(8.44)
$2,000	(2.87)	(7.03)	(5.24)	(8.34)	(5.34)	(5.74)	(8.78)
$3,000	(2.98)	(7.31)	(5.44)	(8.67)	(5.54)	(5.96)	(9.11)
$4,000	(3.02)	(7.41)	(5.52)	(8.78)	(5.62)	(6.04)	(9.24)
$5,000	(3.05)	(7.47)	(5.57)	(8.86)	(5.67)	(6.10)	(9.33)
$7,000	(3.08)	(7.55)	(5.62)	(8.96)	(5.73)	(6.16)	(9.42)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(4.01)	(9.82)	(7.33)	(11.66)	(7.47)	(8.02)	(12.27)
$1,500	(4.39)	(10.76)	(8.02)	(12.76)	(8.17)	(8.78)	(13.43)
$2,000	(4.56)	(11.17)	(8.33)	(13.26)	(8.48)	(9.12)	(13.95)
$3,000	(4.74)	(11.61)	(8.66)	(13.78)	(8.82)	(9.48)	(14.50)
$4,000	(4.81)	(11.79)	(8.79)	(13.98)	(8.95)	(9.62)	(14.72)
$5,000	(4.85)	(11.89)	(8.86)	(14.10)	(9.02)	(9.70)	(14.83)
$7,000	(4.90)	(12.01)	(8.95)	(14.24)	(9.12)	(9.80)	(14.99)
$7,500	(4.94)	(12.11)	(9.02)	(14.36)	(9.20)	(9.88)	(15.11)
$10,000	(5.09)	(12.47)	(9.30)	(14.80)	(9.48)	(10.18)	(15.57)
$20,000	(5.29)	(12.96)	(9.67)	(15.38)	(9.85)	(10.59)	(16.19)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(3.88)	(9.51)	(7.09)	(11.28)	(7.22)	(7.76)	(11.87)
$1,500	(4.31)	(10.56)	(7.87)	(12.53)	(8.02)	(8.62)	(13.19)
$2,000	(4.56)	(11.17)	(8.33)	(13.26)	(8.49)	(9.12)	(13.95)
$3,000	(4.79)	(11.74)	(8.75)	(13.93)	(8.92)	(9.58)	(14.66)
$4,000	(4.90)	(12.00)	(8.95)	(14.25)	(9.11)	(9.80)	(14.99)
$5,000	(4.96)	(12.16)	(9.07)	(14.42)	(9.23)	(9.92)	(15.17)
$7,000	(5.02)	(12.30)	(9.17)	(14.60)	(9.34)	(10.04)	(15.36)
$7,500	(5.06)	(12.40)	(9.24)	(14.71)	(9.42)	(10.12)	(15.48)
$10,000	(5.23)	(12.82)	(9.56)	(15.21)	(9.73)	(10.47)	(16.00)
$20,000	(5.51)	(13.50)	(10.06)	(16.02)	(10.26)	(11.03)	(16.86)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(3.75)	(9.19)	(6.85)	(10.90)	(6.98)	(7.50)	(11.48)
$1,500	(4.26)	(10.44)	(7.78)	(12.39)	(7.93)	(8.52)	(13.04)
$2,000	(4.55)	(11.15)	(8.31)	(13.22)	(8.47)	(9.10)	(13.93)
$3,000	(4.85)	(11.89)	(8.86)	(14.10)	(9.03)	(9.70)	(14.84)
$4,000	(4.98)	(12.20)	(9.09)	(14.47)	(9.26)	(9.96)	(15.24)
$5,000	(5.06)	(12.40)	(9.24)	(14.71)	(9.42)	(10.12)	(15.48)
$7,000	(5.13)	(12.57)	(9.38)	(14.91)	(9.54)	(10.26)	(15.70)
$7,500	(5.17)	(12.67)	(9.45)	(15.03)	(9.62)	(10.35)	(15.81)
$10,000	(5.36)	(13.14)	(9.79)	(15.59)	(9.97)	(10.73)	(16.40)
$20,000	(5.72)	(14.01)	(10.45)	(16.63)	(10.64)	(11.45)	(17.50)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(4.24)	(10.39)	(7.75)	(12.33)	(7.89)	(8.48)	(12.97)
$1,500	(5.06)	(12.40)	(9.24)	(14.71)	(9.42)	(10.12)	(15.48)
$2,000	(5.57)	(13.65)	(10.17)	(16.20)	(10.37)	(11.15)	(17.04)
$3,000	(6.22)	(15.25)	(11.37)	(18.08)	(11.57)	(12.45)	(19.03)
$4,000	(6.56)	(16.07)	(11.98)	(19.07)	(12.21)	(13.13)	(20.07)
$5,000	(6.77)	(16.59)	(12.37)	(19.68)	(12.60)	(13.55)	(20.72)
$7,000	(6.99)	(17.13)	(12.77)	(20.33)	(13.01)	(13.99)	(21.38)
$7,500	(7.07)	(17.32)	(12.91)	(20.56)	(13.16)	(14.15)	(21.63)
$10,000	(7.41)	(18.15)	(13.54)	(21.54)	(13.79)	(14.83)	(22.68)
$20,000	(8.10)	(19.85)	(14.80)	(23.55)	(15.07)	(16.21)	(24.78)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.04	0.09	0.07	0.11	0.07	0.08	0.12
$1,000,000	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
$50,000	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.29)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$3,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$4,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$5,000	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$7,000	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$10,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$7,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$7,500	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	10.8%	9.9%	10.3%	10.2%	10.1%	10.8%	10.6%
$1,000,000	9.7%	9.2%	8.8%	10.0%	8.6%	9.7%	9.5%
$50,000	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.6%
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

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CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
75%	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
70%	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
75%	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
70%	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

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DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
75%	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
70%	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)

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PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	10.8%	9.9%	10.3%	10.2%	10.1%	10.8%	10.6%
75%	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
70%	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$10	(4.34)	(10.63)	(7.92)	(12.62)	(8.07)	(8.68)	(13.28)
$15	(7.22)	(17.69)	(13.18)	(20.99)	(13.43)	(14.44)	(22.09)
$20	(11.14)	(27.29)	(20.34)	(32.38)	(20.72)	(22.28)	(34.08)
$25	(14.67)	(35.94)	(26.79)	(42.65)	(27.29)	(29.34)	(44.87)
$30	(18.55)	(45.45)	(33.87)	(53.92)	(34.50)	(37.10)	(56.74)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
$10	(2.49)	(6.10)	(4.55)	(7.24)	(4.63)	(4.98)	(7.62)
$15	(4.14)	(10.14)	(7.56)	(12.03)	(7.70)	(8.28)	(12.66)
$20	(6.38)	(15.63)	(11.65)	(18.55)	(11.87)	(12.76)	(19.52)
$25	(8.40)	(20.58)	(15.34)	(24.42)	(15.62)	(16.80)	(25.70)
$30	(10.62)	(26.02)	(19.39)	(30.87)	(19.75)	(21.24)	(32.49)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.51)	(3.70)	(2.76)	(4.39)	(2.81)	(3.02)	(4.62)
$10	(3.12)	(7.64)	(5.70)	(9.07)	(5.80)	(6.24)	(9.54)
$15	(4.89)	(11.98)	(8.93)	(14.22)	(9.10)	(9.78)	(14.96)
$20	(6.89)	(16.88)	(12.58)	(20.03)	(12.81)	(13.78)	(21.08)
$25	(9.09)	(22.27)	(16.60)	(26.42)	(16.91)	(18.18)	(27.81)
$30	(11.59)	(28.39)	(21.16)	(33.69)	(21.56)	(23.18)	(35.45)
$35	(13.92)	(34.10)	(25.42)	(40.47)	(25.89)	(27.84)	(42.58)
$40	(16.34)	(40.03)	(29.84)	(47.50)	(30.39)	(32.68)	(49.98)
$45	(18.90)	(46.30)	(34.51)	(54.94)	(35.15)	(37.80)	(57.81)
$50	(21.57)	(52.85)	(39.39)	(62.70)	(40.12)	(43.14)	(65.98)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$10	(2.64)	(6.47)	(4.82)	(7.67)	(4.91)	(5.28)	(8.08)
$15	(4.14)	(10.14)	(7.56)	(12.03)	(7.70)	(8.28)	(12.66)
$20	(5.82)	(14.26)	(10.63)	(16.92)	(10.82)	(11.64)	(17.80)
$25	(7.69)	(18.84)	(14.04)	(22.35)	(14.30)	(15.38)	(23.52)
$30	(9.80)	(24.01)	(17.89)	(28.49)	(18.23)	(19.60)	(29.98)
$35	(11.79)	(28.88)	(21.53)	(34.27)	(21.93)	(23.58)	(36.07)
$40	(13.83)	(33.88)	(25.25)	(40.20)	(25.72)	(27.66)	(42.31)
$45	(15.98)	(39.15)	(29.18)	(46.45)	(29.72)	(31.96)	(48.88)
$50	(18.25)	(44.71)	(33.32)	(53.05)	(33.94)	(36.50)	(55.83)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.75)	(1.84)	(1.37)	(2.18)	(1.39)	(1.50)	(2.29)
$150	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$200	(1.76)	(4.31)	(3.21)	(5.12)	(3.27)	(3.52)	(5.38)
$250	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$500	(6.09)	(14.92)	(11.12)	(17.70)	(11.33)	(12.18)	(18.63)
$750	(10.44)	(25.58)	(19.06)	(30.35)	(19.42)	(20.88)	(31.94)
$1,000	(15.71)	(38.49)	(28.69)	(45.67)	(29.22)	(31.42)	(48.06)
Copay/Day							
$50 w/3 Day Max	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$50 w/5 Day Max	(1.25)	(3.06)	(2.28)	(3.63)	(2.32)	(2.50)	(3.82)
$100 w/3 Day Max	(2.28)	(5.59)	(4.16)	(6.63)	(4.24)	(4.56)	(6.97)
$100 w/5 Day Max	(3.29)	(8.06)	(6.01)	(9.56)	(6.12)	(6.58)	(10.06)
$250 w/3 Day Max	(7.58)	(18.57)	(13.84)	(22.03)	(14.10)	(15.16)	(23.19)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$75	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$100	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$125	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
$150	(1.50)	(3.67)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$35	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$50	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
$60	(1.09)	(2.67)	(1.99)	(3.17)	(2.03)	(2.18)	(3.33)
$75	(1.45)	(3.55)	(2.65)	(4.22)	(2.70)	(2.90)	(4.44)
$100	(2.06)	(5.05)	(3.76)	(5.99)	(3.83)	(4.12)	(6.30)
$125	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$150	(3.03)	(7.42)	(5.53)	(8.81)	(5.64)	(6.06)	(9.27)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.41	1.00	0.75	1.19	0.76	0.82	1.25
60	0.80	1.96	1.46	2.33	1.49	1.60	2.45
90	1.18	2.89	2.15	3.43	2.19	2.36	3.61
120	1.39	3.41	2.54	4.04	2.59	2.78	4.25
Unlimited	1.79	4.39	3.27	5.20	3.33	3.58	5.48
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.24)	(5.49)	(4.09)	(6.51)	(4.17)	(4.48)	(6.85)
$10	(4.71)	(11.54)	(8.60)	(13.69)	(8.76)	(9.42)	(14.41)
$15	(7.83)	(19.18)	(14.30)	(22.76)	(14.56)	(15.66)	(23.95)
$20	(12.09)	(29.62)	(22.08)	(35.15)	(22.49)	(24.18)	(36.98)
$25	(15.91)	(38.98)	(29.05)	(46.25)	(29.59)	(31.82)	(48.67)
$30	(20.13)	(49.32)	(36.76)	(58.52)	(37.44)	(40.26)	(61.58)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$10	(2.70)	(6.62)	(4.93)	(7.85)	(5.02)	(5.40)	(8.26)
$15	(4.48)	(10.98)	(8.18)	(13.02)	(8.33)	(8.96)	(13.70)
$20	(6.92)	(16.95)	(12.64)	(20.12)	(12.87)	(13.84)	(21.17)
$25	(9.11)	(22.32)	(16.63)	(26.48)	(16.94)	(18.22)	(27.87)
$30	(11.51)	(28.20)	(21.02)	(33.46)	(21.41)	(23.02)	(35.21)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$10	(3.38)	(8.28)	(6.17)	(9.83)	(6.29)	(6.76)	(10.34)
$15	(5.31)	(13.01)	(9.70)	(15.44)	(9.88)	(10.62)	(16.24)
$20	(7.48)	(18.33)	(13.66)	(21.74)	(13.91)	(14.96)	(22.88)
$25	(9.85)	(24.13)	(17.99)	(28.63)	(18.32)	(19.70)	(30.13)
$30	(12.57)	(30.80)	(22.95)	(36.54)	(23.38)	(25.14)	(38.45)
$35	(15.10)	(37.00)	(27.57)	(43.90)	(28.09)	(30.20)	(46.19)
$40	(17.72)	(43.41)	(32.36)	(51.51)	(32.96)	(35.44)	(54.21)
$45	(20.50)	(50.23)	(37.43)	(59.59)	(38.13)	(41.00)	(62.71)
$50	(23.40)	(57.33)	(42.73)	(68.02)	(43.52)	(46.80)	(71.58)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.40)	(3.43)	(2.56)	(4.07)	(2.60)	(2.80)	(4.28)
$10	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$15	(4.48)	(10.98)	(8.18)	(13.02)	(8.33)	(8.96)	(13.70)
$20	(6.32)	(15.48)	(11.54)	(18.37)	(11.76)	(12.64)	(19.33)
$25	(8.34)	(20.43)	(15.23)	(24.24)	(15.51)	(16.68)	(25.51)
$30	(10.63)	(26.04)	(19.41)	(30.90)	(19.77)	(21.26)	(32.52)
$35	(12.78)	(31.31)	(23.34)	(37.15)	(23.77)	(25.56)	(39.09)
$40	(15.00)	(36.75)	(27.39)	(43.61)	(27.90)	(30.00)	(45.89)
$45	(17.33)	(42.46)	(31.64)	(50.38)	(32.23)	(34.66)	(53.01)
$50	(19.79)	(48.49)	(36.14)	(57.53)	(36.81)	(39.58)	(60.54)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$150	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$200	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$250	(2.74)	(6.71)	(5.00)	(7.97)	(5.10)	(5.48)	(8.38)
$500	(6.60)	(16.17)	(12.05)	(19.19)	(12.28)	(13.20)	(20.19)
$750	(11.32)	(27.73)	(20.67)	(32.91)	(21.06)	(22.64)	(34.63)
$1,000	(17.04)	(41.75)	(31.12)	(49.54)	(31.69)	(34.08)	(52.13)
Copay/Day							
$50 w/3 Day Max	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$50 w/5 Day Max	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$100 w/3 Day Max	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)
$100 w/5 Day Max	(3.58)	(8.77)	(6.54)	(10.41)	(6.66)	(7.16)	(10.95)
$250 w/3 Day Max	(8.22)	(20.14)	(15.01)	(23.90)	(15.29)	(16.44)	(25.14)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$100	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$125	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$150	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$35	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$50	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$60	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$75	(1.57)	(3.85)	(2.87)	(4.56)	(2.92)	(3.14)	(4.80)
$100	(2.23)	(5.46)	(4.07)	(6.48)	(4.15)	(4.46)	(6.82)
$125	(2.74)	(6.71)	(5.00)	(7.97)	(5.10)	(5.48)	(8.38)
$150	(3.28)	(8.04)	(5.99)	(9.53)	(6.10)	(6.56)	(10.03)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.45	1.10	0.82	1.31	0.84	0.90	1.38
60	0.88	2.16	1.61	2.56	1.64	1.76	2.69
90	1.27	3.11	2.32	3.69	2.36	2.54	3.88
120	1.51	3.70	2.76	4.39	2.81	3.02	4.62
Unlimited	1.95	4.78	3.56	5.67	3.63	3.90	5.97
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$10	(0.37)	(0.91)	(0.68)	(1.07)	(0.69)	(0.74)	(1.13)
$15	(0.61)	(1.49)	(1.12)	(1.77)	(1.13)	(1.22)	(1.86)
$20	(0.95)	(2.33)	(1.74)	(2.77)	(1.77)	(1.90)	(2.90)
$25	(1.24)	(3.04)	(2.26)	(3.60)	(2.30)	(2.48)	(3.80)
$30	(1.58)	(3.87)	(2.89)	(4.60)	(2.94)	(3.16)	(4.84)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.27)
$10	(0.21)	(0.52)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.34)	(0.84)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$25	(0.71)	(1.74)	(1.29)	(2.06)	(1.32)	(1.42)	(2.17)
$30	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.23)	(0.38)	(0.24)	(0.26)	(0.40)
$10	(0.26)	(0.64)	(0.47)	(0.76)	(0.49)	(0.52)	(0.80)
$15	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$20	(0.59)	(1.45)	(1.08)	(1.71)	(1.10)	(1.18)	(1.80)
$25	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$30	(0.98)	(2.41)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$35	(1.18)	(2.90)	(2.15)	(3.43)	(2.20)	(2.36)	(3.61)
$40	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.23)
$45	(1.60)	(3.93)	(2.92)	(4.65)	(2.98)	(3.20)	(4.90)
$50	(1.83)	(4.48)	(3.34)	(5.32)	(3.40)	(3.66)	(5.60)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.34)	(0.84)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.50)	(1.22)	(0.91)	(1.45)	(0.94)	(1.00)	(1.53)
$25	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$30	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$35	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.02)
$40	(1.17)	(2.87)	(2.14)	(3.41)	(2.18)	(2.34)	(3.58)
$45	(1.35)	(3.31)	(2.46)	(3.93)	(2.51)	(2.70)	(4.13)
$50	(1.54)	(3.78)	(2.82)	(4.48)	(2.87)	(3.08)	(4.71)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.06)	(0.14)	(0.11)	(0.17)	(0.12)	(0.12)	(0.19)
$150	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$200	(0.15)	(0.37)	(0.28)	(0.43)	(0.28)	(0.30)	(0.46)
$250	(0.21)	(0.51)	(0.38)	(0.62)	(0.39)	(0.42)	(0.64)
$500	(0.51)	(1.25)	(0.93)	(1.49)	(0.95)	(1.02)	(1.56)
$750	(0.88)	(2.15)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$1,000	(1.33)	(3.26)	(2.43)	(3.87)	(2.47)	(2.66)	(4.07)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$50 w/5 Day Max	(0.11)	(0.27)	(0.20)	(0.32)	(0.21)	(0.22)	(0.34)
$100 w/3 Day Max	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.62)
$100 w/5 Day Max	(0.29)	(0.71)	(0.53)	(0.85)	(0.54)	(0.58)	(0.89)
$250 w/3 Day Max	(0.64)	(1.57)	(1.17)	(1.87)	(1.19)	(1.28)	(1.95)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
$75	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$100	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$125	(0.09)	(0.22)	(0.17)	(0.26)	(0.17)	(0.18)	(0.28)
$150	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.03)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)
$25	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.20)	(0.14)	(0.23)	(0.15)	(0.16)	(0.25)
$60	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)
$75	(0.12)	(0.30)	(0.22)	(0.34)	(0.22)	(0.24)	(0.36)
$100	(0.17)	(0.41)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$125	(0.21)	(0.51)	(0.38)	(0.62)	(0.39)	(0.42)	(0.64)
$150	(0.25)	(0.62)	(0.46)	(0.72)	(0.46)	(0.50)	(0.76)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.07	0.12	0.08	0.08	0.13
60	0.08	0.20	0.15	0.23	0.15	0.16	0.24
90	0.09	0.22	0.17	0.26	0.17	0.18	0.27
120	0.12	0.29	0.22	0.35	0.22	0.24	0.37
Unlimited	0.16	0.39	0.29	0.47	0.30	0.32	0.49
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	8.3%	8.2%	8.1%	8.3%	8.2%	8.2%
$10	8.5%	8.6%	8.6%	8.5%	8.6%	8.5%	8.5%
$15	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$20	8.5%	8.5%	8.6%	8.6%	8.5%	8.5%	8.5%
$25	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.7%	7.7%	7.5%	7.6%	7.3%	7.7%	7.5%
$10	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$15	8.2%	8.3%	8.2%	8.2%	8.2%	8.2%	8.2%
$20	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%
$25	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.6%	8.6%	8.3%	8.7%	8.5%	8.6%	8.7%
$10	8.3%	8.4%	8.2%	8.4%	8.4%	8.3%	8.4%
$15	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
$20	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.3%
$30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$35	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$40	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	9.4%	9.2%	9.4%	9.4%	9.2%	9.4%	9.2%
$10	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.3%
$15	8.2%	8.3%	8.2%	8.2%	8.2%	8.2%	8.2%
$20	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%	8.6%
$25	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$35	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%
$50	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	8.0%	7.6%	8.0%	7.8%	8.6%	8.0%	8.3%
$150	7.3%	7.3%	7.1%	7.3%	7.4%	7.3%	7.4%
$200	8.5%	8.6%	8.7%	8.4%	8.6%	8.5%	8.6%
$250	8.3%	8.2%	8.2%	8.4%	8.3%	8.3%	8.3%
$500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$750	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Day							
$50 w/3 Day Max	8.7%	8.9%	8.9%	9.0%	8.8%	8.7%	8.9%
$50 w/5 Day Max	8.8%	8.8%	8.8%	8.8%	9.1%	8.8%	8.9%
$100 w/3 Day Max	8.8%	8.8%	8.9%	8.7%	8.7%	8.8%	8.9%
$100 w/5 Day Max	8.8%	8.8%	8.8%	8.9%	8.8%	8.8%	8.8%
$250 w/3 Day Max	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.8%	10.0%	9.3%	10.1%	10.5%	9.8%	10.4%
$75	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.7%
$100	8.7%	8.9%	8.9%	9.0%	8.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
40/$15 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
40/$20 copay	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
40/$25 copay	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
60	0.18	0.44	0.33	0.52	0.33	0.36	0.55
100	0.46	1.13	0.84	1.34	0.86	0.92	1.41
200	1.21	2.96	2.21	3.52	2.25	2.42	3.70

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.55	1.35	1.00	1.60	1.02	1.10	1.68
90	1.12	2.74	2.05	3.26	2.08	2.24	3.43

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.48	1.18	0.88	1.40	0.89	0.96	1.47
90	0.89	2.18	1.63	2.59	1.66	1.78	2.72
120	1.44	3.53	2.63	4.19	2.68	2.88	4.40

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.19	0.47	0.35	0.55	0.35	0.38	0.58
30	0.33	0.81	0.60	0.96	0.61	0.66	1.01
Unlimited	0.48	1.18	0.88	1.40	0.89	0.96	1.47

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.13	5.22	3.89	6.19	3.96	4.26	6.52
60	2.51	6.15	4.58	7.30	4.67	5.02	7.68
90	2.99	7.33	5.46	8.69	5.56	5.98	9.15
Unlimited	3.03	7.42	5.53	8.81	5.64	6.06	9.27

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
60/$15 copay	(0.30)	(0.73)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
60/$20 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
60/$25 copay	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
120/$0 copay	0.43	1.05	0.79	1.25	0.80	0.86	1.32
120/$5 copay	0.33	0.81	0.60	0.96	0.61	0.66	1.01
120/$10 copay	0.18	0.44	0.33	0.52	0.33	0.36	0.55
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
120/$25 copay	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Unlimited/$0 copay	0.50	1.22	0.91	1.45	0.93	1.00	1.53
Unlimited/$5 copay	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited/$10 copay	0.23	0.56	0.42	0.67	0.43	0.46	0.70
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.12	0.29	0.22	0.35	0.22	0.24	0.37
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$25	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$15	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$20	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$25	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$30	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$35	(0.75)	(1.84)	(1.37)	(2.18)	(1.39)	(1.50)	(2.29)
$40	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$45	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$50	(1.10)	(2.69)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$20	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$25	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$20 copay	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
40/$25 copay	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.50	1.23	0.91	1.45	0.93	1.00	1.53
200	1.30	3.19	2.37	3.78	2.42	2.60	3.98

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.59	1.45	1.08	1.72	1.10	1.18	1.80
90	1.21	2.96	2.21	3.52	2.25	2.42	3.70

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.52	1.27	0.95	1.51	0.97	1.04	1.59
90	0.97	2.38	1.77	2.82	1.80	1.94	2.97
120	1.56	3.82	2.85	4.53	2.90	3.12	4.77

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited	0.52	1.27	0.95	1.51	0.97	1.04	1.59

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.30	5.64	4.20	6.69	4.28	4.60	7.04
60	2.72	6.66	4.97	7.91	5.06	5.44	8.32
90	3.24	7.94	5.92	9.42	6.03	6.48	9.91
Unlimited	3.28	8.04	5.99	9.53	6.10	6.56	10.03

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
60/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$25 copay	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
120/$0 copay	0.47	1.15	0.86	1.37	0.87	0.94	1.44
120/$5 copay	0.36	0.88	0.66	1.05	0.67	0.72	1.10
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$5 copay	0.42	1.03	0.77	1.22	0.78	0.84	1.28
Unlimited/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$20	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$25	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$30	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$35	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$40	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$45	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$50	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$25	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
40/$15 copay	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
40/$20 copay	(0.04)	(0.09)	(0.08)	(0.12)	(0.07)	(0.08)	(0.13)
40/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60	0.01	0.03	0.02	0.03	0.02	0.02	0.03
100	0.04	0.10	0.07	0.11	0.07	0.08	0.12
200	0.09	0.23	0.16	0.26	0.17	0.18	0.28

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	(0.08)	(0.19)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.08	0.12	0.08	0.08	0.12
90	0.09	0.22	0.16	0.26	0.17	0.18	0.27

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.09	0.07	0.11	0.08	0.08	0.12
90	0.08	0.20	0.14	0.23	0.14	0.16	0.25
120	0.12	0.29	0.22	0.34	0.22	0.24	0.37

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	(0.05)	(0.12)	(0.09)	(0.14)	(0.10)	(0.10)	(0.15)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.02	0.02	0.03	0.02	0.02	0.03
30	0.03	0.07	0.06	0.09	0.06	0.06	0.09
Unlimited	0.04	0.09	0.07	0.11	0.08	0.08	0.12

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.17	0.42	0.31	0.50	0.32	0.34	0.52
60	0.21	0.51	0.39	0.61	0.39	0.42	0.64
90	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited	0.25	0.62	0.46	0.72	0.46	0.50	0.76

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
60/$15 copay	(0.03)	(0.08)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.12
120/$5 copay	0.03	0.07	0.06	0.09	0.06	0.06	0.09
120/$10 copay	0.01	0.03	0.02	0.03	0.02	0.02	0.03
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
120/$25 copay	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
Unlimited/$0 copay	0.04	0.10	0.08	0.12	0.07	0.08	0.12
Unlimited/$5 copay	0.04	0.10	0.08	0.12	0.07	0.08	0.12
Unlimited/$10 copay	0.01	0.03	0.02	0.03	0.02	0.02	0.03
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)

Dialysis Treatment Copay [std: $10]

Copay							
$0	0.01	0.03	0.02	0.03	0.02	0.02	0.03
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$25	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)

Refractive Eye Exam Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$20	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$35	(0.06)	(0.14)	(0.11)	(0.17)	(0.12)	(0.12)	(0.19)
$40	(0.08)	(0.19)	(0.14)	(0.23)	(0.15)	(0.16)	(0.25)
$45	(0.08)	(0.20)	(0.14)	(0.23)	(0.15)	(0.16)	(0.24)
$50	(0.09)	(0.23)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)

Diabetic Supplies Copay [std: $0]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.02)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.05)	(0.13)	(0.10)	(0.15)	(0.10)	(0.10)	(0.15)

Chemotherapy [std: $0]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.6%	6.8%	6.1%	5.8%	6.1%	5.6%	5.5%
40/$15 copay	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
40/$20 copay	10.3%	9.4%	11.3%	10.6%	9.6%	10.3%	10.9%
40/$25 copay	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
60	5.6%	6.8%	6.1%	5.8%	6.1%	5.6%	5.5%
100	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
200	7.4%	7.8%	7.2%	7.4%	7.6%	7.4%	7.6%

** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*

Inpatient Therapies Limit [std: 30 days]

# Days							
0	9.5%	9.2%	9.8%	9.4%	9.6%	9.5%	9.3%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.3%	7.4%	8.0%	7.5%	7.8%	7.3%	7.1%
90	8.0%	8.0%	7.8%	8.0%	8.2%	8.0%	7.9%

Outpatient Therapies Limit [std: 30 visits]
[Copay same as Specialist Physician Office Visit]

# Visits							
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
90	9.0%	9.2%	8.6%	8.9%	8.4%	9.0%	9.2%
120	8.3%	8.2%	8.4%	8.1%	8.2%	8.3%	8.4%

Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]
[Copay same as Inpatient Facility]

# Days							
0	7.4%	7.2%	7.3%	7.1%	7.9%	7.4%	7.2%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
30	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
Unlimited	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%

Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]
[Copay same as Inpatient Facility]

# Days							
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.0%	8.0%	8.0%	8.1%	8.1%	8.0%	8.0%
60	8.4%	8.3%	8.5%	8.4%	8.4%	8.4%	8.3%
90	8.4%	8.3%	8.4%	8.4%	8.5%	8.4%	8.3%
Unlimited	8.3%	8.4%	8.3%	8.2%	8.2%	8.3%	8.2%

Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]

# Visits							
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.6%	6.8%	6.1%	5.8%	6.1%	5.6%	5.5%
60/$15 copay	10.0%	11.0%	9.1%	10.3%	8.9%	10.0%	9.8%
60/$20 copay	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
60/$25 copay	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
120/$0 copay	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
120/$5 copay	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
120/$10 copay	5.6%	6.8%	6.1%	5.8%	6.1%	5.6%	5.5%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	8.3%	10.3%	9.1%	8.6%	9.1%	8.3%	8.1%
120/$25 copay	4.3%	5.4%	4.8%	4.5%	4.7%	4.3%	4.3%
Unlimited/$0 copay	8.0%	8.2%	8.8%	8.3%	7.5%	8.0%	7.8%
Unlimited/$5 copay	10.5%	10.8%	11.6%	10.9%	9.9%	10.5%	10.3%
Unlimited/$10 copay	4.3%	5.4%	4.8%	4.5%	4.7%	4.3%	4.3%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copay	5.3%	4.3%	5.7%	5.5%	5.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$50	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$60	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
$75	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$100	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$60	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$75	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$100	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(1.92)	(4.70)	(3.51)	(5.58)	(3.57)	(3.84)	(5.87)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(2.99)	(7.33)	(5.46)	(8.69)	(5.56)	(5.98)	(9.15)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.01)	(0.02)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.03)	(0.08)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$75	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$75	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$100	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.17)	(0.42)	(0.31)	(0.50)	(0.32)	(0.34)	(0.52)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.03)	(0.08)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
$50	5.0%	4.1%	2.7%	5.2%	5.4%	5.0%	4.9%
$60	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
$75	11.4%	11.6%	10.9%	10.8%	12.3%	11.4%	11.2%
$100	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$60	5.6%	6.8%	6.1%	5.8%	6.1%	5.6%	5.5%
$75	4.5%	3.7%	5.0%	4.7%	4.9%	4.5%	4.5%
$100	9.7%	9.2%	8.8%	10.0%	8.6%	9.7%	9.5%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	8.9%	8.9%	8.8%	9.0%	9.0%	8.9%	8.9%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	8.4%	8.3%	8.4%	8.4%	8.5%	8.4%	8.3%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

				Grandchildren			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

				Grandchildren			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.78	19.06	14.21	22.62	14.47	15.56	23.80
60	8.21	20.11	14.99	23.87	15.27	16.42	25.11
90	8.51	20.85	15.54	24.74	15.83	17.02	26.03
Unlimited	8.60	21.07	15.70	25.00	16.00	17.20	26.31
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.70	21.31	15.89	25.29	16.18	17.40	26.61
30	9.57	23.45	17.47	27.82	17.80	19.14	29.27
40	10.10	24.74	18.44	29.36	18.79	20.20	30.90
60	10.65	26.09	19.45	30.96	19.81	21.30	32.58
Unlimited	10.74	26.31	19.61	31.22	19.98	21.48	32.85
LARGE GROUP			**$5 Copay**				
20	8.18	20.04	14.94	23.78	15.21	16.36	25.02
30	9.00	22.05	16.43	26.16	16.74	18.00	27.53
40	9.56	23.42	17.46	27.79	17.78	19.12	29.24
60	10.02	24.55	18.30	29.13	18.64	20.04	30.65
Unlimited	10.09	24.72	18.42	29.33	18.77	20.18	30.86
LARGE GROUP			**$10 Copay**				
20	7.66	18.77	13.99	22.27	14.25	15.32	23.43
30	8.44	20.68	15.41	24.53	15.70	16.88	25.82
40	8.91	21.83	16.27	25.90	16.57	17.82	27.26
60	9.39	23.01	17.15	27.30	17.46	18.78	28.72
Unlimited	9.47	23.20	17.29	27.53	17.61	18.94	28.97
LARGE GROUP			**$15 Copay**				
20	7.19	17.62	13.13	20.90	13.37	14.38	21.99
30	7.92	19.40	14.46	23.02	14.73	15.84	24.23
40	8.38	20.53	15.30	24.36	15.59	16.76	25.63
60	8.87	21.73	16.20	25.78	16.50	17.74	27.13
Unlimited	8.95	21.93	16.34	26.02	16.65	17.90	27.38
LARGE GROUP			**$20 Copay**				
20	6.76	16.56	12.34	19.65	12.57	13.52	20.68
30	7.42	18.18	13.55	21.57	13.80	14.84	22.70
40	7.82	19.16	14.28	22.73	14.54	15.64	23.92
60	8.31	20.36	15.17	24.16	15.46	16.62	25.42
Unlimited	8.37	20.51	15.28	24.33	15.57	16.74	25.60
LARGE GROUP			**$25 Copay**				
20	6.28	15.39	11.47	18.26	11.68	12.56	19.21
30	6.91	16.93	12.62	20.09	12.85	13.82	21.14
40	7.36	18.03	13.44	21.40	13.69	14.72	22.51
60	7.74	18.96	14.13	22.50	14.40	15.48	23.68
Unlimited	7.81	19.13	14.26	22.70	14.53	15.62	23.89
LARGE GROUP			**$30 Copay**				
20	6.00	14.70	10.96	17.44	11.16	12.00	18.35
30	6.51	15.95	11.89	18.92	12.11	13.02	19.91
40	6.93	16.98	12.65	20.15	12.89	13.86	21.20
60	7.26	17.79	13.26	21.10	13.50	14.52	22.21
Unlimited	7.30	17.88	13.33	21.22	13.58	14.60	22.33
LARGE GROUP			**$35 Copay**				
20	5.70	13.96	10.41	16.57	10.60	11.40	17.44
30	6.09	14.92	11.12	17.70	11.33	12.18	18.63
40	6.48	15.88	11.83	18.84	12.05	12.96	19.82
60	6.79	16.64	12.40	19.74	12.63	13.58	20.77
Unlimited	6.84	16.76	12.49	19.88	12.72	13.68	20.92
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.44	20.68	15.41	24.54	15.70	16.88	25.82
60	8.91	21.83	16.27	25.90	16.57	17.82	27.26
90	9.23	22.61	16.85	26.83	17.17	18.46	28.23
Unlimited	9.32	22.83	17.02	27.09	17.34	18.64	28.51
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.44	23.13	17.24	27.44	17.56	18.88	28.88
30	10.38	25.43	18.95	30.17	19.31	20.76	31.75
40	10.95	26.83	19.99	31.83	20.37	21.90	33.50
60	11.55	28.30	21.09	33.58	21.48	23.10	35.33
Unlimited	11.65	28.54	21.27	33.87	21.67	23.30	35.64
LARGE GROUP			**$5 Copay**				
20	8.87	21.73	16.20	25.79	16.50	17.74	27.13
30	9.76	23.91	17.82	28.37	18.15	19.52	29.86
40	10.37	25.41	18.94	30.15	19.29	20.74	31.72
60	10.87	26.63	19.85	31.60	20.22	21.74	33.25
Unlimited	10.94	26.80	19.98	31.80	20.35	21.88	33.47
LARGE GROUP			**$10 Copay**				
20	8.30	20.34	15.16	24.13	15.44	16.60	25.39
30	9.16	22.44	16.73	26.63	17.04	18.32	28.02
40	9.67	23.69	17.66	28.11	17.99	19.34	29.58
60	10.19	24.97	18.61	29.62	18.95	20.38	31.17
Unlimited	10.27	25.16	18.75	29.85	19.10	20.54	31.42
LARGE GROUP			**$15 Copay**				
20	7.80	19.11	14.24	22.67	14.51	15.60	23.86
30	8.59	21.05	15.69	24.97	15.98	17.18	26.28
40	9.09	22.27	16.60	26.42	16.91	18.18	27.81
60	9.62	23.57	17.57	27.97	17.89	19.24	29.43
Unlimited	9.71	23.79	17.73	28.23	18.06	19.42	29.70
LARGE GROUP			**$20 Copay**				
20	7.33	17.96	13.38	21.31	13.63	14.66	22.42
30	8.05	19.72	14.70	23.40	14.97	16.10	24.62
40	8.49	20.80	15.50	24.68	15.79	16.98	25.97
60	9.01	22.07	16.45	26.19	16.76	18.02	27.56
Unlimited	9.08	22.25	16.58	26.40	16.89	18.16	27.78
LARGE GROUP			**$25 Copay**				
20	6.81	16.68	12.44	19.80	12.67	13.62	20.83
30	7.50	18.38	13.70	21.80	13.95	15.00	22.94
40	7.99	19.58	14.59	23.23	14.86	15.98	24.44
60	8.39	20.56	15.32	24.39	15.61	16.78	25.67
Unlimited	8.48	20.78	15.48	24.65	15.77	16.96	25.94
LARGE GROUP			**$30 Copay**				
20	6.51	15.95	11.89	18.92	12.11	13.02	19.91
30	7.06	17.30	12.89	20.52	13.13	14.12	21.60
40	7.52	18.42	13.73	21.86	13.99	15.04	23.00
60	7.87	19.28	14.37	22.88	14.64	15.74	24.07
Unlimited	7.91	19.38	14.44	22.99	14.71	15.82	24.20
LARGE GROUP			**$35 Copay**				
20	6.18	15.14	11.28	17.97	11.49	12.36	18.90
30	6.60	16.17	12.05	19.19	12.28	13.20	20.19
40	7.03	17.22	12.84	20.44	13.08	14.06	21.50
60	7.36	18.03	13.44	21.40	13.69	14.72	22.51
Unlimited	7.42	18.18	13.55	21.57	13.80	14.84	22.70
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.66	1.62	1.20	1.92	1.23	1.32	2.02
60	0.70	1.72	1.28	2.03	1.30	1.40	2.15
90	0.72	1.76	1.31	2.09	1.34	1.44	2.20
Unlimited	0.72	1.76	1.32	2.09	1.34	1.44	2.20
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	0.74	1.82	1.35	2.15	1.38	1.48	2.27
30	0.81	1.98	1.48	2.35	1.51	1.62	2.48
40	0.85	2.09	1.55	2.47	1.58	1.70	2.60
60	0.90	2.21	1.64	2.62	1.67	1.80	2.75
Unlimited	0.91	2.23	1.66	2.65	1.69	1.82	2.79
LARGE GROUP			**$5 Copay**				
20	0.69	1.69	1.26	2.01	1.29	1.38	2.11
30	0.76	1.86	1.39	2.21	1.41	1.52	2.33
40	0.81	1.99	1.48	2.36	1.51	1.62	2.48
60	0.85	2.08	1.55	2.47	1.58	1.70	2.60
Unlimited	0.85	2.08	1.56	2.47	1.58	1.70	2.61
LARGE GROUP			**$10 Copay**				
20	0.64	1.57	1.17	1.86	1.19	1.28	1.96
30	0.72	1.76	1.32	2.10	1.34	1.44	2.20
40	0.76	1.86	1.39	2.21	1.42	1.52	2.32
60	0.80	1.96	1.46	2.32	1.49	1.60	2.45
Unlimited	0.80	1.96	1.46	2.32	1.49	1.60	2.45
LARGE GROUP			**$15 Copay**				
20	0.61	1.49	1.11	1.77	1.14	1.22	1.87
30	0.67	1.65	1.23	1.95	1.25	1.34	2.05
40	0.71	1.74	1.30	2.06	1.32	1.42	2.18
60	0.75	1.84	1.37	2.19	1.39	1.50	2.30
Unlimited	0.76	1.86	1.39	2.21	1.41	1.52	2.32
LARGE GROUP			**$20 Copay**				
20	0.57	1.40	1.04	1.66	1.06	1.14	1.74
30	0.63	1.54	1.15	1.83	1.17	1.26	1.92
40	0.67	1.64	1.22	1.95	1.25	1.34	2.05
60	0.70	1.71	1.28	2.03	1.30	1.40	2.14
Unlimited	0.71	1.74	1.30	2.07	1.32	1.42	2.18
LARGE GROUP			**$25 Copay**				
20	0.53	1.29	0.97	1.54	0.99	1.06	1.62
30	0.59	1.45	1.08	1.71	1.10	1.18	1.80
40	0.63	1.55	1.15	1.83	1.17	1.26	1.93
60	0.65	1.60	1.19	1.89	1.21	1.30	1.99
Unlimited	0.67	1.65	1.22	1.95	1.24	1.34	2.05
LARGE GROUP			**$30 Copay**				
20	0.51	1.25	0.93	1.48	0.95	1.02	1.56
30	0.55	1.35	1.00	1.60	1.02	1.10	1.69
40	0.59	1.44	1.08	1.71	1.10	1.18	1.80
60	0.61	1.49	1.11	1.78	1.14	1.22	1.86
Unlimited	0.61	1.50	1.11	1.77	1.13	1.22	1.87
LARGE GROUP			**$35 Copay**				
20	0.48	1.18	0.87	1.40	0.89	0.96	1.46
30	0.51	1.25	0.93	1.49	0.95	1.02	1.56
40	0.55	1.34	1.01	1.60	1.03	1.10	1.68
60	0.57	1.39	1.04	1.66	1.06	1.14	1.74
Unlimited	0.58	1.42	1.06	1.69	1.08	1.16	1.78
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.6%
90	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$5 Copay**				
20	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
30	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
LARGE GROUP			**$10 Copay**				
20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.6%	8.6%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
LARGE GROUP			**$15 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$20 Copay**				
20	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.5%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$25 Copay**				
20	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
30	8.5%	8.6%	8.6%	8.5%	8.6%	8.5%	8.5%
40	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%
LARGE GROUP			**$30 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.3%	8.3%	8.3%	8.4%	8.4%
LARGE GROUP			**$35 Copay**				
20	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd Quarter 2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	5.55	13.60	10.13	16.13	10.32	11.10	16.98
30	5.92	14.50	10.81	17.21	11.01	11.84	18.11
40	6.30	15.43	11.50	18.31	11.72	12.60	19.27
60	6.65	16.29	12.14	19.33	12.37	13.30	20.34
Unlimited	6.70	16.41	12.23	19.48	12.46	13.40	20.49
LARGE GROUP				**$45 Copay**			
20	5.39	13.21	9.84	15.67	10.02	10.78	16.49
30	5.74	14.06	10.48	16.69	10.68	11.48	17.56
40	6.15	15.07	11.23	17.88	11.44	12.30	18.81
60	6.49	15.90	11.85	18.87	12.07	12.98	19.85
Unlimited	6.53	16.00	11.92	18.98	12.15	13.06	19.97
LARGE GROUP				**$50 Copay**			
20	5.23	12.81	9.55	15.20	9.73	10.46	16.00
30	5.61	13.74	10.24	16.31	10.43	11.22	17.16
40	6.00	14.70	10.96	17.44	11.16	12.00	18.35
60	6.32	15.48	11.54	18.37	11.75	12.64	19.33
Unlimited	6.36	15.58	11.61	18.49	11.83	12.72	19.45

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.42	15.73	11.72	18.66	11.94	12.84	19.64
40	6.84	16.76	12.49	19.88	12.72	13.68	20.92
60	7.21	17.66	13.17	20.96	13.41	14.42	22.06
Unlimited	7.27	17.81	13.28	21.13	13.52	14.54	22.24
LARGE GROUP				**$45 Copay**			
20	5.85	14.33	10.68	17.01	10.88	11.70	17.90
30	6.23	15.26	11.38	18.11	11.59	12.46	19.06
40	6.66	16.32	12.16	19.36	12.39	13.32	20.37
60	7.04	17.25	12.86	20.47	13.09	14.08	21.54
Unlimited	7.08	17.35	12.93	20.58	13.17	14.16	21.66
LARGE GROUP				**$50 Copay**			
20	5.67	13.89	10.35	16.48	10.55	11.34	17.34
30	6.08	14.90	11.10	17.67	11.31	12.16	18.60
40	6.51	15.95	11.89	18.92	12.11	13.02	19.91
60	6.86	16.81	12.53	19.94	12.76	13.72	20.98
Unlimited	6.90	16.91	12.60	20.06	12.83	13.80	21.11

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	0.47	1.15	0.86	1.37	0.88	0.94	1.44
30	0.50	1.23	0.91	1.45	0.93	1.00	1.53
40	0.54	1.33	0.99	1.57	1.00	1.08	1.65
60	0.56	1.37	1.03	1.63	1.04	1.12	1.72
Unlimited	0.57	1.40	1.05	1.65	1.06	1.14	1.75
LARGE GROUP				**$45 Copay**			
20	0.46	1.12	0.84	1.34	0.86	0.92	1.41
30	0.49	1.20	0.90	1.42	0.91	0.98	1.50
40	0.51	1.25	0.93	1.48	0.95	1.02	1.56
60	0.55	1.35	1.01	1.60	1.02	1.10	1.69
Unlimited	0.55	1.35	1.01	1.60	1.02	1.10	1.69
LARGE GROUP				**$50 Copay**			
20	0.44	1.08	0.80	1.28	0.82	0.88	1.34
30	0.47	1.16	0.86	1.36	0.88	0.94	1.44
40	0.51	1.25	0.93	1.48	0.95	1.02	1.56
60	0.54	1.33	0.99	1.57	1.01	1.08	1.65
Unlimited	0.54	1.33	0.99	1.57	1.00	1.08	1.66

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
Unlimited	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$45 Copay**			
20	8.5%	8.5%	8.5%	8.6%	8.6%	8.5%	8.6%
30	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
40	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
LARGE GROUP				**$50 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.6%	8.6%	8.5%	8.6%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.17	15.12	11.27	17.94	11.48	12.34	18.87
$0/Max $5000	5.78	14.16	10.55	16.80	10.75	11.56	17.68
$0/Max $2500	5.45	13.35	9.95	15.84	10.14	10.90	16.67
$25	5.78	14.16	10.55	16.80	10.75	11.56	17.68
$50	5.45	13.35	9.95	15.84	10.14	10.90	16.67
$100	4.89	11.98	8.93	14.22	9.10	9.78	14.96
$500	2.41	5.90	4.40	7.01	4.48	4.82	7.37
$5,000	0.33	0.81	0.60	0.96	0.61	0.66	1.01
Coinsurance							
80%	4.90	12.00	8.95	14.24	9.11	9.80	14.99
75%	4.62	11.32	8.44	13.43	8.59	9.24	14.13
70%	4.29	10.51	7.83	12.47	7.98	8.58	13.12
			Orthotics Riders				
$0/Max $5000	6.40	15.68	11.69	18.60	11.90	12.80	19.58
$0/Max $2500	5.93	14.53	10.83	17.24	11.03	11.86	18.14
Deductible							
$0	1.05	2.57	1.92	3.05	1.95	2.10	3.21
$0/Max $5000	1.01	2.47	1.84	2.94	1.88	2.02	3.09
$0/Max $2500	0.96	2.35	1.75	2.79	1.79	1.92	2.94
$25	1.01	2.47	1.84	2.94	1.88	2.02	3.09
$50	0.96	2.35	1.75	2.79	1.79	1.92	2.94
$100	0.87	2.13	1.59	2.53	1.62	1.74	2.66
$500	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.87	2.13	1.59	2.53	1.62	1.74	2.66
75%	0.81	1.98	1.48	2.35	1.51	1.62	2.48
70%	0.74	1.81	1.35	2.15	1.38	1.48	2.26
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.35	3.31	2.47	3.92	2.51	2.70	4.13
12 Months	2.15	5.27	3.93	6.25	4.00	4.30	6.58
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.10	5.14	3.83	6.10	3.91	4.20	6.42
12 Months	3.35	8.21	6.12	9.74	6.23	6.70	10.25
			Private Duty Nursing Riders				
In Full	0.72	1.76	1.31	2.09	1.34	1.44	2.20
80% hrs 73-504	0.12	0.29	0.22	0.35	0.22	0.24	0.37
100% hrs 73-504	0.21	0.51	0.38	0.61	0.39	0.42	0.64
			Dental Network Access				
	0.42	1.03	0.77	1.22	0.78	0.84	1.28
Limit			**Infertility Rider**				
2 IVF	13.47	33.00	24.60	39.16	25.05	26.94	41.20
3 IVF	16.19	39.66	29.56	47.06	30.11	32.38	49.52

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.68	16.37	12.20	19.42	12.42	13.36	20.43
$0/Max $5000	6.27	15.36	11.45	18.23	11.66	12.54	19.18
$0/Max $2500	5.91	14.48	10.79	17.18	10.99	11.82	18.08
$25	6.27	15.36	11.45	18.23	11.66	12.54	19.18
$50	5.91	14.48	10.79	17.18	10.99	11.82	18.08
$100	5.31	13.01	9.70	15.44	9.88	10.62	16.24
$500	2.62	6.42	4.78	7.62	4.87	5.24	8.01
$5,000	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Coinsurance							
80%	5.32	13.03	9.71	15.47	9.90	10.64	16.27
75%	5.01	12.27	9.15	14.56	9.32	10.02	15.33
70%	4.66	11.42	8.51	13.55	8.67	9.32	14.25
			Orthotics Riders				
$0/Max $5000	6.94	17.00	12.67	20.17	12.91	13.88	21.23
$0/Max $2500	6.43	15.75	11.74	18.69	11.96	12.86	19.67
Deductible							
$0	1.14	2.79	2.08	3.31	2.12	2.28	3.49
$0/Max $5000	1.09	2.67	1.99	3.17	2.03	2.18	3.33
$0/Max $2500	1.04	2.55	1.90	3.02	1.93	2.08	3.18
$25	1.09	2.67	1.99	3.17	2.03	2.18	3.33
$50	1.04	2.55	1.90	3.02	1.93	2.08	3.18
$100	0.95	2.33	1.73	2.76	1.77	1.90	2.91
$500	0.46	1.13	0.84	1.34	0.86	0.92	1.41
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.95	2.33	1.73	2.76	1.77	1.90	2.91
75%	0.89	2.18	1.63	2.59	1.66	1.78	2.72
70%	0.79	1.94	1.44	2.30	1.47	1.58	2.42
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.77	1.89	1.41	2.24	1.43	1.54	2.36
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	14.61	35.79	26.68	42.47	27.17	29.22	44.69
3 IVF	17.56	43.02	32.06	51.05	32.66	35.12	53.72

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.51	1.25	0.93	1.48	0.94	1.02	1.56
$0/Max $5000	0.49	1.20	0.90	1.43	0.91	0.98	1.50
$0/Max $2500	0.46	1.13	0.84	1.34	0.85	0.92	1.41
$25	0.49	1.20	0.90	1.43	0.91	0.98	1.50
$50	0.46	1.13	0.84	1.34	0.85	0.92	1.41
$100	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$500	0.21	0.52	0.38	0.61	0.39	0.42	0.64
$5,000	0.03	0.07	0.06	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.42	1.03	0.76	1.23	0.79	0.84	1.28
75%	0.39	0.95	0.71	1.13	0.73	0.78	1.20
70%	0.37	0.91	0.68	1.08	0.69	0.74	1.13
			Orthotics Riders				
$0/Max $5000	0.54	1.32	0.98	1.57	1.01	1.08	1.65
$0/Max $2500	0.50	1.22	0.91	1.45	0.93	1.00	1.53
Deductible							
$0	0.09	0.22	0.16	0.26	0.17	0.18	0.28
$0/Max $5000	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$0/Max $2500	0.08	0.20	0.15	0.23	0.14	0.16	0.24
$25	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$50	0.08	0.20	0.15	0.23	0.14	0.16	0.24
$100	0.08	0.20	0.14	0.23	0.15	0.16	0.25
$500	0.04	0.10	0.07	0.12	0.08	0.08	0.13
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.08	0.20	0.14	0.23	0.15	0.16	0.25
75%	0.08	0.20	0.15	0.24	0.15	0.16	0.24
70%	0.05	0.13	0.09	0.15	0.09	0.10	0.16
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.35	0.22	0.24	0.37
12 Months	0.18	0.44	0.32	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.31	0.34	0.52
12 Months	0.29	0.71	0.53	0.84	0.54	0.58	0.88
			Private Duty Nursing Riders				
In Full	0.05	0.13	0.10	0.15	0.09	0.10	0.16
80% hrs 73-504	0.01	0.03	0.02	0.03	0.02	0.02	0.03
100% hrs 73-504	0.01	0.03	0.02	0.03	0.02	0.02	0.03
			Dental Network Access				
	0.04	0.10	0.07	0.12	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	1.14	2.79	2.08	3.31	2.12	2.28	3.49
3 IVF	1.37	3.36	2.50	3.99	2.55	2.74	4.20

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HIP POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	8.3%
$0/Max $5000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$0/Max $2500	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%
$25	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%
$100	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
$500	8.7%	8.8%	8.6%	8.7%	8.7%	8.7%	8.7%
$5,000	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
Coinsurance							
80%	8.6%	8.6%	8.5%	8.6%	8.7%	8.6%	8.5%
75%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
70%	8.6%	8.7%	8.7%	8.7%	8.6%	8.6%	8.6%
			Orthotics Riders				
$0/Max $5000	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$0/Max $2500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Deductible							
$0	8.6%	8.6%	8.3%	8.5%	8.7%	8.6%	8.7%
$0/Max $5000	7.9%	8.1%	8.2%	7.8%	8.0%	7.9%	7.8%
$0/Max $2500	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$25	7.9%	8.1%	8.2%	7.8%	8.0%	7.9%	7.8%
$50	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$100	9.2%	9.4%	8.8%	9.1%	9.3%	9.2%	9.4%
$500	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	9.2%	9.4%	8.8%	9.1%	9.3%	9.2%	9.4%
75%	9.9%	10.1%	10.1%	10.2%	9.9%	9.9%	9.7%
70%	6.8%	7.2%	6.7%	7.0%	6.5%	6.8%	7.1%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.9%	8.8%	8.5%	8.9%	8.8%	8.9%	9.0%
12 Months	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.1%	8.2%	8.4%	8.2%	7.9%	8.1%	8.1%
12 Months	8.7%	8.6%	8.7%	8.6%	8.7%	8.7%	8.6%
			Private Duty Nursing Riders				
In Full	6.9%	7.4%	7.6%	7.2%	6.7%	6.9%	7.3%
80% hrs 73-504	8.3%	10.3%	9.1%	8.6%	9.1%	8.3%	8.1%
100% hrs 73-504	4.8%	5.9%	5.3%	4.9%	5.1%	4.8%	4.7%
			Dental Network Access				
	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
Limit			**Infertility Rider**				
2 IVF	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
3 IVF	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	480.16	1,176.37	876.74	1,395.81	893.06	960.28	1,468.79

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	520.76	1,275.86	950.91	1,513.85	968.61	1,041.52	1,593.00

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	40.60	99.49	74.17	118.04	75.55	81.24	124.21

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

**** Base rates exclude premium component for mandatory mental health cove***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.21)	(7.86)	(5.86)	(9.33)	(5.97)	(6.42)	(9.82)
$10	(6.75)	(16.54)	(12.33)	(19.62)	(12.55)	(13.50)	(20.65)
$15	(11.24)	(27.54)	(20.52)	(32.67)	(20.91)	(22.48)	(34.38)
$20	(17.33)	(42.46)	(31.64)	(50.38)	(32.23)	(34.66)	(53.01)
$25	(22.83)	(55.93)	(41.69)	(66.37)	(42.46)	(45.66)	(69.84)
$30	(28.88)	(70.75)	(52.73)	(83.95)	(53.71)	(57.76)	(88.34)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$10	(3.87)	(9.48)	(7.07)	(11.25)	(7.20)	(7.74)	(11.84)
$15	(6.43)	(15.75)	(11.74)	(18.69)	(11.96)	(12.86)	(19.67)
$20	(9.92)	(24.30)	(18.11)	(28.84)	(18.45)	(19.84)	(30.34)
$25	(13.08)	(32.05)	(23.88)	(38.02)	(24.33)	(26.16)	(40.01)
$30	(16.55)	(40.55)	(30.22)	(48.11)	(30.78)	(33.10)	(50.63)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.35)	(5.76)	(4.29)	(6.83)	(4.37)	(4.70)	(7.19)
$10	(4.85)	(11.88)	(8.86)	(14.10)	(9.02)	(9.70)	(14.84)
$15	(7.62)	(18.67)	(13.91)	(22.15)	(14.17)	(15.24)	(23.31)
$20	(10.74)	(26.31)	(19.61)	(31.22)	(19.98)	(21.48)	(32.85)
$25	(14.16)	(34.69)	(25.86)	(41.16)	(26.34)	(28.32)	(43.31)
$30	(18.05)	(44.22)	(32.96)	(52.47)	(33.57)	(36.10)	(55.21)
$35	(21.69)	(53.14)	(39.60)	(63.05)	(40.34)	(43.38)	(66.35)
$40	(25.46)	(62.38)	(46.49)	(74.01)	(47.35)	(50.92)	(77.88)
$45	(29.44)	(72.13)	(53.76)	(85.58)	(54.76)	(58.88)	(90.06)
$50	(33.60)	(82.32)	(61.35)	(97.67)	(62.49)	(67.20)	(102.78)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$10	(4.10)	(10.04)	(7.49)	(11.92)	(7.63)	(8.20)	(12.54)
$15	(6.43)	(15.75)	(11.74)	(18.69)	(11.96)	(12.86)	(19.67)
$20	(9.08)	(22.25)	(16.58)	(26.40)	(16.89)	(18.16)	(27.78)
$25	(11.96)	(29.30)	(21.84)	(34.77)	(22.24)	(23.92)	(36.59)
$30	(15.25)	(37.36)	(27.85)	(44.33)	(28.36)	(30.50)	(46.65)
$35	(18.35)	(44.96)	(33.51)	(53.34)	(34.13)	(36.70)	(56.13)
$40	(21.52)	(52.72)	(39.29)	(62.56)	(40.03)	(43.04)	(65.83)
$45	(24.89)	(60.98)	(45.45)	(72.35)	(46.29)	(49.78)	(76.14)
$50	(28.42)	(69.63)	(51.89)	(82.62)	(52.86)	(56.84)	(86.94)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
$150	(1.94)	(4.75)	(3.54)	(5.64)	(3.61)	(3.88)	(5.93)
$200	(2.75)	(6.74)	(5.02)	(7.99)	(5.11)	(5.50)	(8.41)
$250	(3.96)	(9.70)	(7.23)	(11.51)	(7.37)	(7.92)	(12.11)
$500	(9.48)	(23.23)	(17.31)	(27.56)	(17.63)	(18.96)	(29.00)
$750	(16.26)	(39.84)	(29.69)	(47.27)	(30.24)	(32.52)	(49.74)
$1,000	(24.47)	(59.95)	(44.68)	(71.13)	(45.51)	(48.94)	(74.85)
Copay/Day							
$50 w/3 Day Max	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$50 w/5 Day Max	(1.96)	(4.80)	(3.58)	(5.70)	(3.65)	(3.92)	(6.00)
$100 w/3 Day Max	(3.56)	(8.72)	(6.50)	(10.35)	(6.62)	(7.12)	(10.89)
$100 w/5 Day Max	(5.13)	(12.57)	(9.37)	(14.91)	(9.54)	(10.26)	(15.69)
$250 w/3 Day Max	(11.79)	(28.88)	(21.53)	(34.27)	(21.93)	(23.58)	(36.07)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$75	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$100	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$125	(1.87)	(4.58)	(3.41)	(5.44)	(3.48)	(3.74)	(5.72)
$150	(2.33)	(5.71)	(4.25)	(6.77)	(4.33)	(4.66)	(7.13)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$25	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$35	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$50	(1.35)	(3.31)	(2.47)	(3.92)	(2.51)	(2.70)	(4.13)
$60	(1.71)	(4.19)	(3.12)	(4.97)	(3.18)	(3.42)	(5.23)
$75	(2.25)	(5.51)	(4.11)	(6.54)	(4.18)	(4.50)	(6.88)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.47)	(8.50)	(6.34)	(10.09)	(6.45)	(6.94)	(10.61)
$10	(7.32)	(17.93)	(13.37)	(21.28)	(13.62)	(14.64)	(22.39)
$15	(12.19)	(29.87)	(22.26)	(35.44)	(22.67)	(24.38)	(37.29)
$20	(18.79)	(46.04)	(34.31)	(54.62)	(34.95)	(37.58)	(57.48)
$25	(24.76)	(60.66)	(45.21)	(71.98)	(46.05)	(49.52)	(75.74)
$30	(31.31)	(76.71)	(57.17)	(91.02)	(58.24)	(62.62)	(95.78)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$10	(4.20)	(10.29)	(7.67)	(12.21)	(7.81)	(8.40)	(12.85)
$15	(6.98)	(17.10)	(12.75)	(20.29)	(12.98)	(13.96)	(21.35)
$20	(10.76)	(26.36)	(19.65)	(31.28)	(20.01)	(21.52)	(32.91)
$25	(14.18)	(34.74)	(25.89)	(41.22)	(26.37)	(28.36)	(43.38)
$30	(17.95)	(43.98)	(32.78)	(52.18)	(33.39)	(35.90)	(54.91)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.55)	(6.25)	(4.66)	(7.41)	(4.74)	(5.10)	(7.80)
$10	(5.27)	(12.91)	(9.62)	(15.32)	(9.80)	(10.54)	(16.12)
$15	(8.26)	(20.24)	(15.08)	(24.01)	(15.36)	(16.52)	(25.27)
$20	(11.65)	(28.54)	(21.27)	(33.87)	(21.67)	(23.30)	(35.64)
$25	(15.36)	(37.63)	(28.05)	(44.65)	(28.57)	(30.72)	(46.99)
$30	(19.57)	(47.95)	(35.73)	(56.89)	(36.40)	(39.14)	(59.86)
$35	(23.52)	(57.62)	(42.95)	(68.37)	(43.75)	(47.04)	(71.95)
$40	(27.61)	(67.64)	(50.42)	(80.26)	(51.35)	(55.22)	(84.46)
$45	(31.93)	(78.23)	(58.30)	(92.82)	(59.39)	(63.86)	(97.67)
$50	(36.44)	(89.28)	(66.54)	(105.93)	(67.78)	(72.88)	(111.47)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.16)	(5.29)	(3.94)	(6.28)	(4.02)	(4.32)	(6.61)
$10	(4.44)	(10.88)	(8.11)	(12.91)	(8.26)	(8.88)	(13.58)
$15	(6.98)	(17.10)	(12.75)	(20.29)	(12.98)	(13.96)	(21.35)
$20	(9.84)	(24.11)	(17.97)	(28.60)	(18.30)	(19.68)	(30.10)
$25	(12.97)	(31.78)	(23.68)	(37.70)	(24.12)	(25.94)	(39.68)
$30	(16.54)	(40.52)	(30.20)	(48.08)	(30.76)	(33.08)	(50.60)
$35	(19.90)	(48.76)	(36.34)	(57.85)	(37.01)	(39.80)	(60.87)
$40	(23.35)	(57.21)	(42.64)	(67.88)	(43.43)	(46.70)	(71.43)
$45	(26.99)	(66.13)	(49.28)	(78.46)	(50.20)	(53.98)	(82.56)
$50	(30.81)	(75.48)	(56.26)	(89.56)	(57.31)	(61.62)	(94.25)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$150	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$200	(2.98)	(7.30)	(5.44)	(8.66)	(5.54)	(5.96)	(9.12)
$250	(4.30)	(10.54)	(7.85)	(12.50)	(8.00)	(8.60)	(13.15)
$500	(10.28)	(25.19)	(18.77)	(29.88)	(19.12)	(20.56)	(31.45)
$750	(17.63)	(43.19)	(32.19)	(51.25)	(32.79)	(35.26)	(53.93)
$1,000	(26.54)	(65.02)	(48.46)	(77.15)	(49.36)	(53.08)	(81.19)
Copay/Day							
$50 w/3 Day Max	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$50 w/5 Day Max	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
$100 w/3 Day Max	(3.86)	(9.46)	(7.05)	(11.22)	(7.18)	(7.72)	(11.81)
$100 w/5 Day Max	(5.56)	(13.62)	(10.15)	(16.16)	(10.34)	(11.12)	(17.01)
$250 w/3 Day Max	(12.78)	(31.31)	(23.34)	(37.15)	(23.77)	(25.56)	(39.09)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$75	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$100	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$125	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$150	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$25	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$35	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$50	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$60	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$75	(2.44)	(5.98)	(4.46)	(7.09)	(4.54)	(4.88)	(7.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.64)	(0.48)	(0.76)	(0.48)	(0.52)	(0.79)
$10	(0.57)	(1.39)	(1.04)	(1.66)	(1.07)	(1.14)	(1.74)
$15	(0.95)	(2.33)	(1.74)	(2.77)	(1.76)	(1.90)	(2.91)
$20	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$25	(1.93)	(4.73)	(3.52)	(5.61)	(3.59)	(3.86)	(5.90)
$30	(2.43)	(5.96)	(4.44)	(7.07)	(4.53)	(4.86)	(7.44)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.49)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.55)	(1.35)	(1.01)	(1.60)	(1.02)	(1.10)	(1.68)
$20	(0.84)	(2.06)	(1.54)	(2.44)	(1.56)	(1.68)	(2.57)
$25	(1.10)	(2.69)	(2.01)	(3.20)	(2.04)	(2.20)	(3.37)
$30	(1.40)	(3.43)	(2.56)	(4.07)	(2.61)	(2.80)	(4.28)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$10	(0.42)	(1.03)	(0.76)	(1.22)	(0.78)	(0.84)	(1.28)
$15	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$20	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.79)
$25	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.40)	(3.68)
$30	(1.52)	(3.73)	(2.77)	(4.42)	(2.83)	(3.04)	(4.65)
$35	(1.83)	(4.48)	(3.35)	(5.32)	(3.41)	(3.66)	(5.60)
$40	(2.15)	(5.26)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$45	(2.49)	(6.10)	(4.54)	(7.24)	(4.63)	(4.98)	(7.61)
$50	(2.84)	(6.96)	(5.19)	(8.26)	(5.29)	(5.68)	(8.69)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.41)	(0.31)	(0.50)	(0.32)	(0.34)	(0.52)
$10	(0.34)	(0.84)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.55)	(1.35)	(1.01)	(1.60)	(1.02)	(1.10)	(1.68)
$20	(0.76)	(1.86)	(1.39)	(2.20)	(1.41)	(1.52)	(2.32)
$25	(1.01)	(2.48)	(1.84)	(2.93)	(1.88)	(2.02)	(3.09)
$30	(1.29)	(3.16)	(2.35)	(3.75)	(2.40)	(2.58)	(3.95)
$35	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$40	(1.83)	(4.49)	(3.35)	(5.32)	(3.40)	(3.66)	(5.60)
$45	(2.10)	(5.15)	(3.83)	(6.11)	(3.91)	(4.20)	(6.42)
$50	(2.39)	(5.85)	(4.37)	(6.94)	(4.45)	(4.78)	(7.31)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.27)
$150	(0.17)	(0.42)	(0.31)	(0.49)	(0.31)	(0.34)	(0.52)
$200	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.71)
$250	(0.34)	(0.84)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$500	(0.80)	(1.96)	(1.46)	(2.32)	(1.49)	(1.60)	(2.45)
$750	(1.37)	(3.35)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$1,000	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.34)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$50 w/5 Day Max	(0.17)	(0.42)	(0.31)	(0.49)	(0.31)	(0.34)	(0.52)
$100 w/3 Day Max	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$100 w/5 Day Max	(0.43)	(1.05)	(0.78)	(1.25)	(0.80)	(0.86)	(1.32)
$250 w/3 Day Max	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.02)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.13)	(0.10)	(0.15)	(0.10)	(0.10)	(0.15)
$75	(0.08)	(0.20)	(0.14)	(0.23)	(0.15)	(0.16)	(0.24)
$100	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$125	(0.16)	(0.39)	(0.30)	(0.46)	(0.30)	(0.32)	(0.49)
$150	(0.20)	(0.49)	(0.37)	(0.58)	(0.38)	(0.40)	(0.61)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.09)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$35	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$50	(0.12)	(0.29)	(0.21)	(0.35)	(0.22)	(0.24)	(0.37)
$60	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$75	(0.19)	(0.47)	(0.35)	(0.55)	(0.36)	(0.38)	(0.58)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.1%	8.1%	8.2%	8.1%	8.0%	8.1%	8.0%
$10	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
$15	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$25	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%	8.7%
$10	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$15	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.5%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
$10	8.7%	8.7%	8.6%	8.7%	8.6%	8.7%	8.6%
$15	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$40	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$45	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%
$50	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.4%	8.5%	8.7%	8.6%	8.5%	8.5%
$10	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%	8.3%
$15	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.5%
$20	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%	8.4%
$25	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
$30	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$35	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	7.7%	7.7%	7.5%	7.6%	7.3%	7.7%	7.5%
$150	8.8%	8.8%	8.8%	8.7%	8.6%	8.8%	8.8%
$200	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%
$250	8.6%	8.7%	8.6%	8.6%	8.5%	8.6%	8.6%
$500	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$750	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Day							
$50 w/3 Day Max	8.4%	8.6%	8.4%	8.4%	8.3%	8.4%	8.5%
$50 w/5 Day Max	8.7%	8.8%	8.7%	8.6%	8.5%	8.7%	8.7%
$100 w/3 Day Max	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
$100 w/5 Day Max	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
$250 w/3 Day Max	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.2%	8.7%	9.0%	8.5%	8.8%	8.2%	8.0%
$75	8.0%	8.2%	7.7%	7.9%	8.1%	8.0%	7.8%
$100	8.4%	8.6%	8.4%	8.4%	8.3%	8.4%	8.5%
$125	8.6%	8.5%	8.8%	8.5%	8.6%	8.6%	8.6%
$150	8.6%	8.6%	8.7%	8.6%	8.8%	8.6%	8.6%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
$25	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
$35	10.0%	10.2%	10.3%	9.9%	10.1%	10.0%	9.8%
$50	8.9%	8.8%	8.5%	8.9%	8.8%	8.9%	9.0%
$60	8.2%	8.1%	8.3%	8.2%	8.2%	8.2%	8.2%
$75	8.4%	8.5%	8.5%	8.4%	8.6%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.20)	(7.84)	(5.84)	(9.30)	(5.95)	(6.40)	(9.79)
$125	(3.96)	(9.70)	(7.23)	(11.51)	(7.37)	(7.92)	(12.11)
$150	(4.71)	(11.54)	(8.60)	(13.69)	(8.76)	(9.42)	(14.41)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.55	1.35	1.00	1.60	1.02	1.10	1.68
60	1.07	2.62	1.95	3.11	1.99	2.14	3.27
90	1.61	3.94	2.94	4.68	2.99	3.22	4.92
120	1.89	4.63	3.45	5.49	3.52	3.78	5.78
Unlimited	2.44	5.98	4.46	7.09	4.54	4.88	7.46
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
40/$15 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$20 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
40/$25 copay	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
60	0.29	0.71	0.53	0.84	0.54	0.58	0.89
100	0.71	1.74	1.30	2.06	1.32	1.42	2.17
200	1.89	4.63	3.45	5.49	3.52	3.78	5.78
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.74	1.81	1.35	2.15	1.38	1.48	2.26
90	1.54	3.77	2.81	4.48	2.86	3.08	4.71
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.66	1.62	1.21	1.92	1.23	1.32	2.02
90	1.21	2.96	2.21	3.52	2.25	2.42	3.70
120	1.96	4.80	3.58	5.70	3.65	3.92	6.00
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.94)	(2.30)	(1.72)	(2.73)	(1.75)	(1.88)	(2.88)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.28	0.69	0.51	0.81	0.52	0.56	0.86
30	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Unlimited	0.66	1.62	1.21	1.92	1.23	1.32	2.02
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.32	8.13	6.06	9.65	6.17	6.64	10.16
60	3.89	9.53	7.10	11.31	7.24	7.78	11.90
90	4.64	11.37	8.47	13.49	8.63	9.28	14.19
Unlimited	4.71	11.54	8.60	13.69	8.76	9.42	14.41
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.24)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
60/$15 copay	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
60/$20 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
60/$25 copay	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
120/$0 copay	0.58	1.42	1.06	1.69	1.08	1.16	1.77
120/$5 copay	0.45	1.10	0.82	1.31	0.84	0.90	1.38
120/$10 copay	0.27	0.66	0.49	0.78	0.50	0.54	0.83
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Unlimited/$0 copay	0.67	1.64	1.22	1.95	1.25	1.34	2.05
Unlimited/$5 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.56
Unlimited/$10 copa	0.33	0.81	0.60	0.96	0.61	0.66	1.01
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.24)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.46)	(8.48)	(6.32)	(10.06)	(6.44)	(6.92)	(10.58)
$125	(4.30)	(10.54)	(7.85)	(12.50)	(8.00)	(8.60)	(13.15)
$150	(5.11)	(12.52)	(9.33)	(14.85)	(9.50)	(10.22)	(15.63)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.59	1.45	1.08	1.72	1.10	1.18	1.80
60	1.16	2.84	2.12	3.37	2.16	2.32	3.55
90	1.74	4.26	3.18	5.06	3.24	3.48	5.32
120	2.05	5.02	3.74	5.96	3.81	4.10	6.27
Unlimited	2.65	6.49	4.84	7.70	4.93	5.30	8.11
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$15 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
40/$20 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
40/$25 copay	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
60	0.32	0.78	0.58	0.93	0.60	0.64	0.98
100	0.76	1.86	1.39	2.21	1.41	1.52	2.32
200	2.05	5.02	3.74	5.96	3.81	4.10	6.27
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.79	1.94	1.44	2.30	1.47	1.58	2.42
90	1.67	4.09	3.05	4.85	3.11	3.34	5.11
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.71	1.74	1.30	2.06	1.32	1.42	2.17
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98
120	2.13	5.22	3.89	6.19	3.96	4.26	6.52
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.31	0.76	0.57	0.90	0.58	0.62	0.95
30	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Unlimited	0.71	1.74	1.30	2.06	1.32	1.42	2.17
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.61	8.84	6.59	10.49	6.71	7.22	11.04
60	4.22	10.34	7.71	12.27	7.85	8.44	12.91
90	5.03	12.32	9.18	14.62	9.36	10.06	15.39
Unlimited	5.11	12.52	9.33	14.85	9.50	10.22	15.63
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
60/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$20 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
60/$25 copay	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
120/$0 copay	0.63	1.54	1.15	1.83	1.17	1.26	1.93
120/$5 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$10 copay	0.30	0.74	0.55	0.87	0.56	0.60	0.92
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
Unlimited/$0 copay	0.72	1.76	1.31	2.09	1.34	1.44	2.20
Unlimited/$5 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$10 copa	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(0.26)	(0.64)	(0.48)	(0.76)	(0.49)	(0.52)	(0.79)
$125	(0.34)	(0.84)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$150	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.08	0.12	0.08	0.08	0.12
60	0.09	0.22	0.17	0.26	0.17	0.18	0.28
90	0.13	0.32	0.24	0.38	0.25	0.26	0.40
120	0.16	0.39	0.29	0.47	0.29	0.32	0.49
Unlimited	0.21	0.51	0.38	0.61	0.39	0.42	0.65
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
40/$10 copay	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
40/$15 copay	(0.04)	(0.10)	(0.08)	(0.12)	(0.07)	(0.08)	(0.12)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
40/$25 copay	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.24)
60	0.03	0.07	0.05	0.09	0.06	0.06	0.09
100	0.05	0.12	0.09	0.15	0.09	0.10	0.15
200	0.16	0.39	0.29	0.47	0.29	0.32	0.49
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.27)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.13	0.09	0.15	0.09	0.10	0.16
90	0.13	0.32	0.24	0.37	0.25	0.26	0.40
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.14	0.09	0.10	0.15
90	0.09	0.23	0.16	0.26	0.17	0.18	0.28
120	0.17	0.42	0.31	0.49	0.31	0.34	0.52
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.08)	(0.20)	(0.14)	(0.24)	(0.15)	(0.16)	(0.24)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.07	0.06	0.09	0.06	0.06	0.09
30	0.04	0.10	0.07	0.11	0.07	0.08	0.12
Unlimited	0.05	0.12	0.09	0.14	0.09	0.10	0.15
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.29	0.71	0.53	0.84	0.54	0.58	0.88
60	0.33	0.81	0.61	0.96	0.61	0.66	1.01
90	0.39	0.95	0.71	1.13	0.73	0.78	1.20
Unlimited	0.40	0.98	0.73	1.16	0.74	0.80	1.22
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.03)	(0.08)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
60/$15 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
60/$20 copay	(0.04)	(0.10)	(0.08)	(0.11)	(0.08)	(0.08)	(0.13)
60/$25 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.10)	(0.10)	(0.15)
120/$0 copay	0.05	0.12	0.09	0.14	0.09	0.10	0.16
120/$5 copay	0.04	0.10	0.07	0.11	0.07	0.08	0.12
120/$10 copay	0.03	0.08	0.06	0.09	0.06	0.06	0.09
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.03)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)
120/$25 copay	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
Unlimited/$0 copay	0.05	0.12	0.09	0.14	0.09	0.10	0.15
Unlimited/$5 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.12
Unlimited/$10 copa	0.03	0.07	0.06	0.09	0.06	0.06	0.09
Unlimited/$15 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copa	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.01	0.02	0.02	0.03	0.01	0.02	0.03
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	8.1%	8.2%	8.2%	8.2%	8.2%	8.1%	8.1%
$125	8.6%	8.7%	8.6%	8.6%	8.5%	8.6%	8.6%
$150	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.3%	7.4%	8.0%	7.5%	7.8%	7.3%	7.1%
60	8.4%	8.4%	8.7%	8.4%	8.5%	8.4%	8.6%
90	8.1%	8.1%	8.2%	8.1%	8.4%	8.1%	8.1%
120	8.5%	8.4%	8.4%	8.6%	8.2%	8.5%	8.5%
Unlimited	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%	8.7%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
40/$10 copay	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
40/$15 copay	9.1%	9.3%	10.0%	9.4%	8.5%	9.1%	8.9%
40/$20 copay	8.3%	8.2%	8.2%	8.6%	8.0%	8.3%	8.2%
40/$25 copay	9.9%	10.1%	10.1%	10.2%	9.9%	9.9%	9.7%
60	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
100	7.0%	6.9%	6.9%	7.3%	6.8%	7.0%	6.9%
200	8.5%	8.4%	8.4%	8.6%	8.2%	8.5%	8.5%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	8.0%	8.0%	7.8%	8.0%	8.2%	8.0%	7.9%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	6.8%	7.2%	6.7%	7.0%	6.5%	6.8%	7.1%
90	8.4%	8.5%	8.5%	8.3%	8.7%	8.4%	8.5%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.6%	7.4%	7.4%	7.3%	7.3%	7.6%	7.4%
90	7.4%	7.8%	7.2%	7.4%	7.6%	7.4%	7.6%
120	8.7%	8.8%	8.7%	8.6%	8.5%	8.7%	8.7%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.5%	8.7%	8.1%	8.8%	8.6%	8.5%	8.3%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
30	8.9%	9.1%	8.5%	8.4%	8.3%	8.9%	8.7%
Unlimited	7.6%	7.4%	7.4%	7.3%	7.3%	7.6%	7.4%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.7%	8.7%	8.7%	8.7%	8.8%	8.7%	8.7%
60	8.5%	8.5%	8.6%	8.5%	8.4%	8.5%	8.5%
90	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
60/$15 copay	9.8%	10.0%	9.3%	10.1%	10.5%	9.8%	10.4%
60/$20 copay	7.1%	7.3%	7.8%	6.7%	7.7%	7.1%	7.6%
60/$25 copay	7.4%	7.2%	7.3%	7.1%	7.9%	7.4%	7.2%
120/$0 copay	8.6%	8.5%	8.5%	8.3%	8.3%	8.6%	9.0%
120/$5 copay	8.9%	9.1%	8.5%	8.4%	8.3%	8.9%	8.7%
120/$10 copay	11.1%	12.1%	12.2%	11.5%	12.0%	11.1%	10.8%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.3%	7.7%	6.9%	4.3%	6.7%	6.3%	6.1%
120/$25 copay	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
Unlimited/$0 copay	7.5%	7.3%	7.4%	7.2%	7.2%	7.5%	7.3%
Unlimited/$5 copay	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
Unlimited/$10 copa	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
Unlimited/$15 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copa	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	5.9%	4.8%	6.5%	6.1%	3.1%	5.9%	5.8%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.30)	(0.73)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$15	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$20	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$25	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$30	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$35	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$40	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$45	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$50	(1.72)	(4.21)	(3.14)	(5.00)	(3.20)	(3.44)	(5.26)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$20	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$25	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$60	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$75	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$100	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$75	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$100	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.99)	(7.33)	(5.46)	(8.69)	(5.56)	(5.98)	(9.15)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.63)	(11.34)	(8.45)	(13.46)	(8.61)	(9.26)	(14.16)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$25	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
$30	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$35	(1.27)	(3.11)	(2.32)	(3.69)	(2.36)	(2.54)	(3.88)
$40	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$45	(1.68)	(4.12)	(3.07)	(4.88)	(3.12)	(3.36)	(5.14)
$50	(1.86)	(4.56)	(3.40)	(5.41)	(3.46)	(3.72)	(5.69)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$15	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$20	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$25	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$60	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$100	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(5.02)	(12.30)	(9.17)	(14.59)	(9.34)	(10.04)	(15.36)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$25	(0.03)	(0.08)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$25	(0.08)	(0.20)	(0.14)	(0.24)	(0.15)	(0.16)	(0.24)
$30	(0.08)	(0.20)	(0.14)	(0.23)	(0.15)	(0.16)	(0.24)
$35	(0.09)	(0.22)	(0.17)	(0.26)	(0.17)	(0.18)	(0.27)
$40	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$45	(0.13)	(0.32)	(0.24)	(0.37)	(0.24)	(0.26)	(0.40)
$50	(0.14)	(0.35)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$15	(0.04)	(0.09)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$25	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$35	(0.01)	(0.02)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
$60	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
$75	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$75	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(0.39)	(0.96)	(0.72)	(1.13)	(0.73)	(0.78)	(1.20)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	4.8%	5.9%	5.3%	4.9%	5.1%	4.8%	4.7%
$25	10.0%	11.0%	9.1%	10.3%	8.9%	10.0%	9.8%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$10	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
$15	8.9%	9.1%	8.5%	8.4%	8.3%	8.9%	8.7%
$20	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.7%
$25	9.6%	9.9%	9.2%	10.0%	9.7%	9.6%	9.4%
$30	8.0%	8.2%	7.7%	7.9%	8.1%	8.0%	7.8%
$35	7.6%	7.6%	7.9%	7.6%	7.8%	7.6%	7.5%
$40	8.8%	8.6%	8.8%	8.8%	8.6%	8.8%	8.8%
$45	8.4%	8.4%	8.5%	8.2%	8.3%	8.4%	8.4%
$50	8.1%	8.3%	8.3%	8.2%	8.1%	8.1%	8.2%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
$10	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
$15	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
$20	7.0%	6.9%	6.9%	7.3%	6.8%	7.0%	6.9%
$25	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
$35	5.0%	4.1%	2.7%	5.2%	5.4%	5.0%	4.9%
$50	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
$60	9.8%	10.0%	9.3%	10.1%	10.5%	9.8%	10.4%
$75	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
$100	7.0%	6.9%	6.9%	7.3%	6.8%	7.0%	6.9%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
$50	4.5%	3.7%	5.0%	4.7%	4.9%	4.5%	4.5%
$60	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%
$75	11.1%	11.4%	10.6%	10.5%	10.4%	11.1%	10.9%
$100	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	8.4%	8.3%	8.4%	8.4%	8.5%	8.4%	8.3%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	10.0%	10.2%	9.6%	10.3%	10.8%	10.0%	10.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
19	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
19	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.73	18.94	14.11	22.47	14.38	15.46	23.65
60	8.15	19.97	14.88	23.69	15.16	16.30	24.93
90	8.45	20.70	15.43	24.56	15.72	16.90	25.85
Unlimited	8.54	20.92	15.59	24.83	15.88	17.08	26.12
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.64	21.17	15.78	25.12	16.07	17.28	26.43
30	9.51	23.30	17.36	27.65	17.69	19.02	29.09
40	10.04	24.60	18.33	29.19	18.67	20.08	30.71
60	10.58	25.92	19.32	30.76	19.68	21.16	32.36
Unlimited	10.67	26.14	19.48	31.02	19.85	21.34	32.64
LARGE GROUP				**$5 Copay**			
20	8.13	19.92	14.84	23.63	15.12	16.26	24.87
30	8.94	21.90	16.32	25.99	16.63	17.88	27.35
40	9.50	23.27	17.35	27.62	17.67	19.00	29.06
60	9.95	24.38	18.17	28.92	18.51	19.90	30.44
Unlimited	10.03	24.57	18.31	29.16	18.66	20.06	30.68
LARGE GROUP				**$10 Copay**			
20	7.61	18.64	13.90	22.12	14.15	15.22	23.28
30	8.37	20.51	15.28	24.33	15.57	16.74	25.60
40	8.85	21.68	16.16	25.73	16.46	17.70	27.07
60	9.33	22.86	17.04	27.12	17.35	18.66	28.54
Unlimited	9.40	23.03	17.16	27.33	17.48	18.80	28.75
LARGE GROUP				**$15 Copay**			
20	7.14	17.49	13.04	20.76	13.28	14.28	21.84
30	7.86	19.26	14.35	22.85	14.62	15.72	24.04
40	8.33	20.41	15.21	24.22	15.49	16.66	25.48
60	8.81	21.58	16.09	25.61	16.39	17.62	26.95
Unlimited	8.88	21.76	16.21	25.81	16.52	17.76	27.16
LARGE GROUP				**$20 Copay**			
20	6.72	16.46	12.27	19.53	12.50	13.44	20.56
30	7.36	18.03	13.44	21.40	13.69	14.72	22.51
40	7.77	19.04	14.19	22.59	14.45	15.54	23.77
60	8.26	20.24	15.08	24.01	15.36	16.52	25.27
Unlimited	8.32	20.38	15.19	24.19	15.47	16.64	25.45
LARGE GROUP				**$25 Copay**			
20	6.24	15.29	11.39	18.14	11.61	12.48	19.09
30	6.85	16.78	12.51	19.91	12.74	13.70	20.95
40	7.31	17.91	13.35	21.25	13.60	14.62	22.36
60	7.69	18.84	14.04	22.35	14.30	15.38	23.52
Unlimited	7.76	19.01	14.17	22.56	14.43	15.52	23.74
LARGE GROUP				**$30 Copay**			
20	5.96	14.60	10.88	17.33	11.09	11.92	18.23
30	6.46	15.83	11.80	18.78	12.02	12.92	19.76
40	6.87	16.83	12.54	19.97	12.78	13.74	21.02
60	7.22	17.69	13.18	20.99	13.43	14.44	22.09
Unlimited	7.26	17.79	13.26	21.10	13.50	14.52	22.21
LARGE GROUP				**$35 Copay**			
20	5.66	13.87	10.33	16.45	10.53	11.32	17.31
30	6.05	14.82	11.05	17.59	11.25	12.10	18.51
40	6.43	15.75	11.74	18.69	11.96	12.86	19.67
60	6.75	16.54	12.33	19.62	12.55	13.50	20.65
Unlimited	6.80	16.66	12.42	19.77	12.65	13.60	20.80
LARGE GROUP				**$40 Copay**			
20	5.52	13.52	10.08	16.05	10.27	11.04	16.89
30	5.88	14.41	10.74	17.09	10.94	11.76	17.99
40	6.26	15.34	11.43	18.20	11.64	12.52	19.15
60	6.61	16.19	12.07	19.22	12.29	13.22	20.22
Unlimited	6.65	16.29	12.14	19.33	12.37	13.30	20.34
LARGE GROUP				**$45 Copay**			
20	5.34	13.08	9.75	15.52	9.93	10.68	16.33
30	5.71	13.99	10.43	16.60	10.62	11.42	17.47
40	6.11	14.97	11.16	17.76	11.36	12.22	18.69
60	6.45	15.80	11.78	18.75	12.00	12.90	19.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.38	20.53	15.30	24.36	15.59	16.76	25.63
60	8.83	21.63	16.12	25.67	16.42	17.66	27.01
90	9.17	22.47	16.74	26.66	17.06	18.34	28.05
Unlimited	9.26	22.69	16.91	26.92	17.22	18.52	28.33
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.36	22.93	17.09	27.21	17.41	18.72	28.63
30	10.31	25.26	18.83	29.97	19.18	20.62	31.54
40	10.89	26.68	19.89	31.66	20.26	21.78	33.31
60	11.47	28.10	20.94	33.34	21.33	22.94	35.09
Unlimited	11.57	28.35	21.13	33.63	21.52	23.14	35.39
LARGE GROUP				**$5 Copay**			
20	8.81	21.58	16.09	25.61	16.39	17.62	26.95
30	9.70	23.77	17.71	28.20	18.04	19.40	29.67
40	10.30	25.24	18.81	29.94	19.16	20.60	31.51
60	10.79	26.44	19.70	31.37	20.07	21.58	33.01
Unlimited	10.88	26.66	19.87	31.63	20.24	21.76	33.28
LARGE GROUP				**$10 Copay**			
20	8.25	20.21	15.06	23.98	15.35	16.50	25.24
30	9.08	22.25	16.58	26.40	16.89	18.16	27.78
40	9.60	23.52	17.53	27.91	17.86	19.20	29.37
60	10.12	24.79	18.48	29.42	18.82	20.24	30.96
Unlimited	10.20	24.99	18.63	29.65	18.97	20.40	31.20
LARGE GROUP				**$15 Copay**			
20	7.74	18.96	14.13	22.50	14.40	15.48	23.68
30	8.53	20.90	15.58	24.80	15.87	17.06	26.09
40	9.04	22.15	16.51	26.28	16.81	18.08	27.65
60	9.55	23.40	17.44	27.76	17.76	19.10	29.21
Unlimited	9.63	23.59	17.58	27.99	17.91	19.26	29.46
LARGE GROUP				**$20 Copay**			
20	7.29	17.86	13.31	21.19	13.56	14.58	22.30
30	7.99	19.58	14.59	23.23	14.86	15.98	24.44
40	8.43	20.65	15.39	24.51	15.68	16.86	25.79
60	8.96	21.95	16.36	26.05	16.67	17.92	27.41
Unlimited	9.03	22.12	16.49	26.25	16.80	18.06	27.62
LARGE GROUP				**$25 Copay**			
20	6.77	16.59	12.36	19.68	12.59	13.54	20.71
30	7.43	18.20	13.57	21.60	13.82	14.86	22.73
40	7.94	19.45	14.50	23.08	14.77	15.88	24.29
60	8.34	20.43	15.23	24.24	15.51	16.68	25.51
Unlimited	8.42	20.63	15.37	24.48	15.66	16.84	25.76
LARGE GROUP				**$30 Copay**			
20	6.47	15.85	11.81	18.81	12.03	12.94	19.79
30	7.01	17.17	12.80	20.38	13.04	14.02	21.44
40	7.46	18.28	13.62	21.69	13.88	14.92	22.82
60	7.83	19.18	14.30	22.76	14.56	15.66	23.95
Unlimited	7.87	19.28	14.37	22.88	14.64	15.74	24.07
LARGE GROUP				**$35 Copay**			
20	6.13	15.02	11.19	17.82	11.40	12.26	18.75
30	6.56	16.07	11.98	19.07	12.20	13.12	20.07
40	6.98	17.10	12.75	20.29	12.98	13.96	21.35
60	7.32	17.93	13.37	21.28	13.62	14.64	22.39
Unlimited	7.37	18.06	13.46	21.42	13.71	14.74	22.54
LARGE GROUP				**$40 Copay**			
20	5.99	14.68	10.94	17.41	11.14	11.98	18.32
30	6.38	15.63	11.65	18.55	11.87	12.76	19.52
40	6.79	16.64	12.40	19.74	12.63	13.58	20.77
60	7.16	17.54	13.07	20.81	13.32	14.32	21.90
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP				**$45 Copay**			
20	5.80	14.21	10.59	16.86	10.79	11.60	17.74
30	6.19	15.17	11.30	17.99	11.51	12.38	18.94
40	6.62	16.22	12.09	19.24	12.31	13.24	20.25
60	7.00	17.15	12.78	20.35	13.02	14.00	21.41

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.65	1.59	1.19	1.89	1.21	1.30	1.98
60	0.68	1.66	1.24	1.98	1.26	1.36	2.08
90	0.72	1.77	1.31	2.10	1.34	1.44	2.20
Unlimited	0.72	1.77	1.32	2.09	1.34	1.44	2.21
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.72	1.76	1.31	2.09	1.34	1.44	2.20
30	0.80	1.96	1.47	2.32	1.49	1.60	2.45
40	0.85	2.08	1.56	2.47	1.59	1.70	2.60
60	0.89	2.18	1.62	2.58	1.65	1.78	2.73
Unlimited	0.90	2.21	1.65	2.61	1.67	1.80	2.75
LARGE GROUP				**$5 Copay**			
20	0.68	1.66	1.25	1.98	1.27	1.36	2.08
30	0.76	1.87	1.39	2.21	1.41	1.52	2.32
40	0.80	1.97	1.46	2.32	1.49	1.60	2.45
60	0.84	2.06	1.53	2.45	1.56	1.68	2.57
Unlimited	0.85	2.09	1.56	2.47	1.58	1.70	2.60
LARGE GROUP				**$10 Copay**			
20	0.64	1.57	1.16	1.86	1.20	1.28	1.96
30	0.71	1.74	1.30	2.07	1.32	1.42	2.18
40	0.75	1.84	1.37	2.18	1.40	1.50	2.30
60	0.79	1.93	1.44	2.30	1.47	1.58	2.42
Unlimited	0.80	1.96	1.47	2.32	1.49	1.60	2.45
LARGE GROUP				**$15 Copay**			
20	0.60	1.47	1.09	1.74	1.12	1.20	1.84
30	0.67	1.64	1.23	1.95	1.25	1.34	2.05
40	0.71	1.74	1.30	2.06	1.32	1.42	2.17
60	0.74	1.82	1.35	2.15	1.37	1.48	2.26
Unlimited	0.75	1.83	1.37	2.18	1.39	1.50	2.30
LARGE GROUP				**$20 Copay**			
20	0.57	1.40	1.04	1.66	1.06	1.14	1.74
30	0.63	1.55	1.15	1.83	1.17	1.26	1.93
40	0.66	1.61	1.20	1.92	1.23	1.32	2.02
60	0.70	1.71	1.28	2.04	1.31	1.40	2.14
Unlimited	0.71	1.74	1.30	2.06	1.33	1.42	2.17
LARGE GROUP				**$25 Copay**			
20	0.53	1.30	0.97	1.54	0.98	1.06	1.62
30	0.58	1.42	1.06	1.69	1.08	1.16	1.78
40	0.63	1.54	1.15	1.83	1.17	1.26	1.93
60	0.65	1.59	1.19	1.89	1.21	1.30	1.99
Unlimited	0.66	1.62	1.20	1.92	1.23	1.32	2.02
LARGE GROUP				**$30 Copay**			
20	0.51	1.25	0.93	1.48	0.94	1.02	1.56
30	0.55	1.34	1.00	1.60	1.02	1.10	1.68
40	0.59	1.45	1.08	1.72	1.10	1.18	1.80
60	0.61	1.49	1.12	1.77	1.13	1.22	1.86
Unlimited	0.61	1.49	1.11	1.78	1.14	1.22	1.86
LARGE GROUP				**$35 Copay**			
20	0.47	1.15	0.86	1.37	0.87	0.94	1.44
30	0.51	1.25	0.93	1.48	0.95	1.02	1.56
40	0.55	1.35	1.01	1.60	1.02	1.10	1.68
60	0.57	1.39	1.04	1.66	1.07	1.14	1.74
Unlimited	0.57	1.40	1.04	1.65	1.06	1.14	1.74
LARGE GROUP				**$40 Copay**			
20	0.47	1.16	0.86	1.36	0.87	0.94	1.43
30	0.50	1.22	0.91	1.46	0.93	1.00	1.53
40	0.53	1.30	0.97	1.54	0.99	1.06	1.62
60	0.55	1.35	1.00	1.59	1.03	1.10	1.68
Unlimited	0.56	1.37	1.03	1.63	1.04	1.12	1.72
LARGE GROUP				**$45 Copay**			
20	0.46	1.13	0.84	1.34	0.86	0.92	1.41
30	0.48	1.18	0.87	1.39	0.89	0.96	1.47
40	0.51	1.25	0.93	1.48	0.95	1.02	1.56
60	0.55	1.35	1.00	1.60	1.02	1.10	1.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.3%	8.3%	8.3%	8.4%	8.3%	8.3%	8.3%
90	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%
30	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$5 Copay**			
20	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$10 Copay**			
20	8.4%	8.4%	8.3%	8.4%	8.5%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$15 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
LARGE GROUP				**$20 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP				**$25 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
60	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$30 Copay**			
20	8.6%	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$35 Copay**			
20	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.5%
60	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%
LARGE GROUP				**$40 Copay**			
20	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.3%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
LARGE GROUP				**$45 Copay**			
20	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%	8.6%
30	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
40	8.3%	8.4%	8.3%	8.3%	8.4%	8.3%	8.3%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.48	15.88	11.83	18.84	12.05	12.96	19.82
LARGE GROUP			**$50 Copay**				
20	5.20	12.74	9.49	15.12	9.67	10.40	15.91
30	5.57	13.65	10.17	16.19	10.36	11.14	17.04
40	5.96	14.60	10.88	17.33	11.09	11.92	18.23
60	6.28	15.39	11.47	18.26	11.68	12.56	19.21
Unlimited	6.32	15.48	11.54	18.37	11.75	12.64	19.33

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	7.03	17.22	12.84	20.44	13.08	14.06	21.50
LARGE GROUP			**$50 Copay**				
20	5.64	13.82	10.30	16.40	10.49	11.28	17.25
30	6.04	14.80	11.03	17.56	11.23	12.08	18.48
40	6.47	15.85	11.81	18.81	12.03	12.94	19.79
60	6.81	16.68	12.44	19.80	12.67	13.62	20.83
Unlimited	6.86	16.81	12.53	19.94	12.76	13.72	20.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.55	1.34	1.01	1.60	1.03	1.10	1.68
LARGE GROUP			**$50 Copay**				
20	0.44	1.08	0.81	1.28	0.82	0.88	1.34
30	0.47	1.15	0.86	1.37	0.87	0.94	1.44
40	0.51	1.25	0.93	1.48	0.94	1.02	1.56
60	0.53	1.29	0.97	1.54	0.99	1.06	1.62
Unlimited	0.54	1.33	0.99	1.57	1.01	1.08	1.65

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$50 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
30	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%
40	8.6%	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%
60	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.5%	8.6%	8.6%	8.5%	8.6%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.29	10.51	7.83	12.47	7.98	8.58	13.12
$25	4.08	10.00	7.45	11.86	7.59	8.16	12.48
$50	3.81	9.33	6.96	11.08	7.09	7.62	11.65
$100	3.51	8.60	6.41	10.20	6.53	7.02	10.74
$500	1.68	4.12	3.07	4.88	3.12	3.36	5.14
Coinsurance							
80%	3.46	8.48	6.32	10.06	6.44	6.92	10.58
75%	3.23	7.91	5.90	9.39	6.01	6.46	9.88
70%	3.02	7.40	5.51	8.78	5.62	6.04	9.24
Deductible			**Orthotics Riders**				
$0	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$25	0.70	1.71	1.28	2.03	1.30	1.40	2.14
$50	0.66	1.62	1.21	1.92	1.23	1.32	2.02
$100	0.59	1.45	1.08	1.72	1.10	1.18	1.80
$500	0.30	0.73	0.55	0.87	0.56	0.60	0.92
Coinsurance							
80%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
75%	0.56	1.37	1.02	1.63	1.04	1.12	1.71
70%	0.53	1.30	0.97	1.54	0.99	1.06	1.62
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.35	3.31	2.47	3.92	2.51	2.70	4.13
12 Months	2.15	5.27	3.93	6.25	4.00	4.30	6.58
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.10	5.14	3.83	6.10	3.91	4.20	6.42
12 Months	3.35	8.21	6.12	9.74	6.23	6.70	10.25
			Private Duty Nursing Riders				
In Full	0.51	1.25	0.93	1.48	0.95	1.02	1.56
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.42	1.03	0.77	1.22	0.78	0.84	1.28
Limit			**Infertility Rider**				
2 IVF	9.09	22.27	16.60	26.42	16.91	18.18	27.81
3 IVF	11.00	26.95	20.09	31.98	20.46	22.00	33.65

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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.66	11.42	8.51	13.55	8.67	9.32	14.25
$25	4.42	10.83	8.07	12.85	8.22	8.84	13.52
$50	4.14	10.14	7.56	12.03	7.70	8.28	12.66
$100	3.81	9.33	6.96	11.08	7.09	7.62	11.65
$500	1.81	4.43	3.31	5.26	3.37	3.62	5.54
Coinsurance							
80%	3.75	9.19	6.85	10.90	6.98	7.50	11.47
75%	3.50	8.58	6.39	10.17	6.51	7.00	10.71
70%	3.27	8.01	5.97	9.51	6.08	6.54	10.00
Deductible			**Orthotics Riders**				
$0	0.78	1.91	1.42	2.27	1.45	1.56	2.39
$25	0.75	1.84	1.37	2.18	1.40	1.50	2.29
$50	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$100	0.64	1.57	1.17	1.86	1.19	1.28	1.96
$500	0.33	0.81	0.60	0.96	0.61	0.66	1.01
Coinsurance							
80%	0.64	1.57	1.17	1.86	1.19	1.28	1.96
75%	0.60	1.47	1.10	1.74	1.12	1.20	1.84
70%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.55	1.35	1.00	1.60	1.02	1.10	1.68
80% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	9.85	24.13	17.99	28.63	18.32	19.70	30.13
3 IVF	11.93	29.23	21.78	34.68	22.19	23.86	36.49

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.37	0.91	0.68	1.08	0.69	0.74	1.13
$25	0.34	0.83	0.62	0.99	0.63	0.68	1.04
$50	0.33	0.81	0.60	0.95	0.61	0.66	1.01
$100	0.30	0.73	0.55	0.88	0.56	0.60	0.91
$500	0.13	0.31	0.24	0.38	0.25	0.26	0.40
Coinsurance							
80%	0.29	0.71	0.53	0.84	0.54	0.58	0.89
75%	0.27	0.67	0.49	0.78	0.50	0.54	0.83
70%	0.25	0.61	0.46	0.73	0.46	0.50	0.76
Deductible			**Orthotics Riders**				
$0	0.05	0.12	0.09	0.15	0.09	0.10	0.16
$25	0.05	0.13	0.09	0.15	0.10	0.10	0.15
$50	0.05	0.12	0.09	0.14	0.09	0.10	0.15
$100	0.05	0.12	0.09	0.14	0.09	0.10	0.16
$500	0.03	0.08	0.05	0.09	0.05	0.06	0.09
Coinsurance							
80%	0.05	0.12	0.09	0.14	0.09	0.10	0.16
75%	0.04	0.10	0.08	0.11	0.08	0.08	0.13
70%	0.04	0.10	0.07	0.12	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.35	0.22	0.24	0.37
12 Months	0.18	0.44	0.32	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.31	0.34	0.52
12 Months	0.29	0.71	0.53	0.84	0.54	0.58	0.88
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.12	0.07	0.08	0.12
80% hrs 73-50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-50	0.01	0.02	0.02	0.03	0.02	0.02	0.03
			Dental Network Access				
	0.04	0.10	0.07	0.12	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	0.76	1.86	1.39	2.21	1.41	1.52	2.32
3 IVF	0.93	2.28	1.69	2.70	1.73	1.86	2.84

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.6%	8.7%	8.7%	8.7%	8.6%	8.6%	8.6%
$25	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%
$50	8.7%	8.7%	8.6%	8.6%	8.6%	8.7%	8.7%
$100	8.5%	8.5%	8.6%	8.6%	8.6%	8.5%	8.5%
$500	7.7%	7.5%	7.8%	7.8%	8.0%	7.7%	7.8%
Coinsurance							
80%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%
75%	8.4%	8.5%	8.3%	8.3%	8.3%	8.4%	8.4%
70%	8.3%	8.2%	8.3%	8.3%	8.2%	8.3%	8.2%
Deductible			**Orthotics Riders**				
$0	6.8%	6.7%	6.8%	7.1%	6.6%	6.8%	7.2%
$25	7.1%	7.6%	7.0%	7.4%	7.7%	7.1%	7.0%
$50	7.6%	7.4%	7.4%	7.3%	7.3%	7.6%	7.4%
$100	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.9%
$500	10.0%	11.0%	9.1%	10.3%	8.9%	10.0%	9.8%
Coinsurance							
80%	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.9%
75%	7.1%	7.3%	7.8%	6.7%	7.7%	7.1%	7.6%
70%	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.9%	8.8%	8.5%	8.9%	8.8%	8.9%	9.0%
12 Months	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.1%	8.2%	8.4%	8.2%	7.9%	8.1%	8.1%
12 Months	8.7%	8.6%	8.7%	8.6%	8.7%	8.7%	8.6%
			Private Duty Nursing Riders				
In Full	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.7%
80% hrs 73-50	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-50	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
			Dental Network Access				
	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
Limit			**Infertility Rider**				
2 IVF	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.3%
3 IVF	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
873.77	2,140.71	1,595.44	2,540.03	1,625.15	1,747.48	2,672.83
75% Coinsurance						
831.07	2,036.08	1,517.48	2,415.89	1,545.72	1,662.07	2,542.21
70% Coinsurance						
789.41	1,934.01	1,441.40	2,294.79	1,468.24	1,578.76	2,414.76
50% Coinsurance						
746.72	1,829.42	1,363.45	2,170.68	1,388.84	1,493.37	2,284.17

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
947.64	2,321.72	1,730.39	2,754.79	1,762.61	1,895.28	2,898.83
75% Coinsurance						
901.33	2,208.26	1,645.83	2,620.17	1,676.47	1,802.66	2,757.17
70% Coinsurance						
856.15	2,097.57	1,563.33	2,488.83	1,592.44	1,712.30	2,618.96
50% Coinsurance						
809.85	1,984.13	1,478.79	2,354.23	1,506.32	1,619.70	2,477.33

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
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HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
73.87	181.01	134.95	214.76	137.46	147.80	226.00
75% Coinsurance						
70.26	172.18	128.35	204.28	130.75	140.59	214.96
70% Coinsurance						
66.74	163.56	121.93	194.04	124.20	133.54	204.20
50% Coinsurance						
63.13	154.71	115.34	183.55	117.48	126.33	193.16

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
75% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
70% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
50% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(53.52)	(131.12)	(97.72)	(155.58)	(99.54)	(107.04)	(163.72)
$250	(63.85)	(156.43)	(116.59)	(185.61)	(118.76)	(127.69)	(195.31)
$300	(74.21)	(181.81)	(135.50)	(215.73)	(138.02)	(148.41)	(227.00)
$350	(84.56)	(207.17)	(154.40)	(245.81)	(157.28)	(169.11)	(258.67)
$400	(92.69)	(227.09)	(169.25)	(269.45)	(172.40)	(185.37)	(283.53)
$500	(108.95)	(266.92)	(198.94)	(316.71)	(202.64)	(217.89)	(333.27)
$750	(141.49)	(346.64)	(258.35)	(411.31)	(263.16)	(282.97)	(432.81)
$1,000	(166.55)	(408.04)	(304.11)	(484.16)	(309.77)	(333.09)	(509.47)
$1,500	(204.87)	(501.92)	(374.08)	(595.55)	(381.04)	(409.72)	(626.69)
$2,000	(220.54)	(540.31)	(402.69)	(641.10)	(410.19)	(441.06)	(674.62)
$2,500	(236.27)	(578.85)	(431.41)	(686.83)	(439.44)	(472.52)	(722.74)
$5,000	(277.77)	(680.52)	(507.19)	(807.47)	(516.63)	(555.52)	(849.69)
$10,000	(312.02)	(764.43)	(569.73)	(907.03)	(580.33)	(624.01)	(954.45)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(43.86)	(107.46)	(80.09)	(127.50)	(81.58)	(87.72)	(134.17)
$250	(52.32)	(128.18)	(95.53)	(152.09)	(97.31)	(104.64)	(160.04)
$300	(60.81)	(148.98)	(111.03)	(176.77)	(113.10)	(121.62)	(186.01)
$350	(69.26)	(169.68)	(126.46)	(201.34)	(128.82)	(138.51)	(211.86)
$400	(76.07)	(186.37)	(138.90)	(221.13)	(141.48)	(152.13)	(232.69)
$500	(89.72)	(219.81)	(163.82)	(260.81)	(166.87)	(179.43)	(274.45)
$750	(116.70)	(285.91)	(213.09)	(339.24)	(217.05)	(233.39)	(356.98)
$1,000	(137.71)	(337.38)	(251.45)	(400.32)	(256.13)	(275.41)	(421.25)
$1,500	(169.54)	(415.37)	(309.57)	(492.85)	(315.33)	(339.07)	(518.62)
$2,000	(183.98)	(450.74)	(335.93)	(534.82)	(342.19)	(367.94)	(562.79)
$2,500	(198.40)	(486.07)	(362.26)	(576.74)	(369.01)	(396.78)	(606.90)
$5,000	(239.71)	(587.28)	(437.69)	(696.83)	(445.84)	(479.40)	(733.26)
$10,000	(273.79)	(670.77)	(499.92)	(795.90)	(509.23)	(547.56)	(837.51)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(34.19)	(83.76)	(62.43)	(99.39)	(63.59)	(68.38)	(104.59)
$250	(40.79)	(99.93)	(74.48)	(118.58)	(75.87)	(81.58)	(124.77)
$300	(47.39)	(116.10)	(86.53)	(137.76)	(88.14)	(94.78)	(144.96)
$350	(53.98)	(132.25)	(98.56)	(156.92)	(100.40)	(107.96)	(165.12)
$400	(59.50)	(145.77)	(108.64)	(172.96)	(110.67)	(119.00)	(182.01)
$500	(70.43)	(172.55)	(128.60)	(204.74)	(130.99)	(140.85)	(215.44)
$750	(91.89)	(225.13)	(167.78)	(267.12)	(170.91)	(183.77)	(281.09)
$1,000	(108.80)	(266.56)	(198.66)	(316.28)	(202.36)	(217.59)	(332.81)
$1,500	(134.23)	(328.86)	(245.09)	(390.20)	(249.66)	(268.45)	(410.60)
$2,000	(147.40)	(361.12)	(269.14)	(428.49)	(274.15)	(294.79)	(450.89)
$2,500	(160.59)	(393.44)	(293.23)	(466.83)	(298.69)	(321.17)	(491.24)
$5,000	(201.67)	(494.08)	(368.24)	(586.25)	(375.09)	(403.32)	(616.90)
$10,000	(235.60)	(577.21)	(430.19)	(684.88)	(438.20)	(471.18)	(720.69)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(23.50)	(57.57)	(42.91)	(68.31)	(43.71)	(47.00)	(71.89)
$250	(28.16)	(68.99)	(51.42)	(81.86)	(52.38)	(56.32)	(86.14)
$300	(32.85)	(80.48)	(59.98)	(95.49)	(61.10)	(65.70)	(100.49)
$350	(37.51)	(91.90)	(68.49)	(109.04)	(69.77)	(75.02)	(114.74)
$400	(41.57)	(101.84)	(75.90)	(120.84)	(77.32)	(83.14)	(127.16)
$500	(49.65)	(121.64)	(90.66)	(144.33)	(92.35)	(99.30)	(151.88)
$750	(65.15)	(159.61)	(118.96)	(189.39)	(121.17)	(130.29)	(199.29)
$1,000	(77.74)	(190.46)	(141.95)	(225.99)	(144.59)	(155.47)	(237.80)
$1,500	(97.16)	(238.04)	(177.41)	(282.44)	(180.71)	(194.31)	(297.21)
$2,000	(107.50)	(263.37)	(196.29)	(312.50)	(199.94)	(214.99)	(328.84)
$2,500	(117.86)	(288.75)	(215.20)	(342.62)	(219.21)	(235.71)	(360.53)
$5,000	(158.38)	(388.02)	(289.19)	(460.41)	(294.57)	(316.75)	(484.48)
$10,000	(191.81)	(469.93)	(350.23)	(557.59)	(356.75)	(383.60)	(586.74)
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(49.55)	(121.40)	(90.47)	(144.04)	(92.16)	(99.10)	(151.57)
$1,500	(54.05)	(132.42)	(98.69)	(157.12)	(100.53)	(108.10)	(165.34)
$2,000	(56.37)	(138.10)	(102.93)	(163.87)	(104.84)	(112.74)	(172.43)
$3,000	(58.53)	(143.40)	(106.87)	(170.15)	(108.86)	(117.06)	(179.04)
$4,000	(59.42)	(145.58)	(108.50)	(172.73)	(110.52)	(118.84)	(181.76)
$5,000	(59.89)	(146.73)	(109.35)	(174.10)	(111.39)	(119.78)	(183.20)
$7,000	(60.48)	(148.17)	(110.43)	(175.81)	(112.49)	(120.96)	(185.01)
$7,500	(60.97)	(149.37)	(111.33)	(177.24)	(113.40)	(121.93)	(186.50)
$10,000	(62.75)	(153.73)	(114.58)	(182.41)	(116.71)	(125.49)	(191.95)
$20,000	(65.30)	(159.98)	(119.23)	(189.83)	(121.45)	(130.59)	(199.75)

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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(58.04)	(142.20)	(105.98)	(168.72)	(107.95)	(116.08)	(177.54)
$250	(69.25)	(169.66)	(126.45)	(201.31)	(128.81)	(138.50)	(211.84)
$300	(80.48)	(197.18)	(146.96)	(233.96)	(149.69)	(160.96)	(246.19)
$350	(91.71)	(224.69)	(167.46)	(266.60)	(170.58)	(183.42)	(280.54)
$400	(100.52)	(246.27)	(183.55)	(292.21)	(186.97)	(201.04)	(307.49)
$500	(118.16)	(289.49)	(215.76)	(343.49)	(219.78)	(236.32)	(361.45)
$750	(153.45)	(375.95)	(280.20)	(446.08)	(285.42)	(306.90)	(469.40)
$1,000	(180.64)	(442.57)	(329.85)	(525.12)	(335.99)	(361.28)	(552.58)
$1,500	(222.19)	(544.37)	(405.72)	(645.91)	(413.27)	(444.38)	(679.68)
$2,000	(239.19)	(586.02)	(436.76)	(695.33)	(444.89)	(478.38)	(731.68)
$2,500	(256.25)	(627.81)	(467.91)	(744.92)	(476.63)	(512.50)	(783.87)
$5,000	(301.25)	(738.06)	(550.08)	(875.73)	(560.33)	(602.50)	(921.52)
$10,000	(338.40)	(829.08)	(617.92)	(983.73)	(629.42)	(676.80)	(1,035.17)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(47.57)	(116.55)	(86.86)	(138.29)	(88.48)	(95.14)	(145.52)
$250	(56.75)	(139.04)	(103.63)	(164.97)	(105.56)	(113.50)	(173.60)
$300	(65.95)	(161.58)	(120.42)	(191.72)	(122.67)	(131.90)	(201.74)
$350	(75.11)	(184.02)	(137.15)	(218.34)	(139.70)	(150.22)	(229.76)
$400	(82.50)	(202.13)	(150.65)	(239.83)	(153.45)	(165.00)	(252.37)
$500	(97.30)	(238.39)	(177.67)	(282.85)	(180.98)	(194.60)	(297.64)
$750	(126.57)	(310.10)	(231.12)	(367.94)	(235.42)	(253.14)	(387.18)
$1,000	(149.34)	(365.88)	(272.69)	(434.13)	(277.77)	(298.68)	(456.83)
$1,500	(183.87)	(450.48)	(335.75)	(534.51)	(342.00)	(367.74)	(562.46)
$2,000	(199.53)	(488.85)	(364.34)	(580.03)	(371.13)	(399.06)	(610.36)
$2,500	(215.17)	(527.17)	(392.90)	(625.50)	(400.22)	(430.34)	(658.21)
$5,000	(259.98)	(636.95)	(474.72)	(755.76)	(483.56)	(519.96)	(795.28)
$10,000	(296.94)	(727.50)	(542.21)	(863.20)	(552.31)	(593.88)	(908.34)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(37.08)	(90.85)	(67.71)	(107.79)	(68.97)	(74.16)	(113.43)
$250	(44.23)	(108.36)	(80.76)	(128.58)	(82.27)	(88.46)	(135.30)
$300	(51.40)	(125.93)	(93.86)	(149.42)	(95.60)	(102.80)	(157.23)
$350	(58.54)	(143.42)	(106.89)	(170.18)	(108.88)	(117.08)	(179.07)
$400	(64.53)	(158.10)	(117.83)	(187.59)	(120.03)	(129.06)	(197.40)
$500	(76.38)	(187.13)	(139.47)	(222.04)	(142.07)	(152.76)	(233.65)
$750	(99.66)	(244.17)	(181.98)	(289.71)	(185.37)	(199.32)	(304.86)
$1,000	(118.00)	(289.10)	(215.47)	(343.03)	(219.48)	(236.00)	(360.96)
$1,500	(145.57)	(356.65)	(265.81)	(423.17)	(270.76)	(291.14)	(445.30)
$2,000	(159.87)	(391.68)	(291.92)	(464.74)	(297.36)	(319.74)	(489.04)
$2,500	(174.17)	(426.72)	(318.03)	(506.31)	(323.96)	(348.34)	(532.79)
$5,000	(218.72)	(535.86)	(399.38)	(635.82)	(406.82)	(437.44)	(669.06)
$10,000	(255.52)	(626.02)	(466.58)	(742.80)	(475.27)	(511.04)	(781.64)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(25.50)	(62.48)	(46.56)	(74.13)	(47.43)	(51.00)	(78.00)
$250	(30.54)	(74.82)	(55.77)	(88.78)	(56.80)	(61.08)	(93.42)
$300	(35.62)	(87.27)	(65.04)	(103.55)	(66.25)	(71.24)	(108.96)
$350	(40.68)	(99.67)	(74.28)	(118.26)	(75.66)	(81.36)	(124.44)
$400	(45.08)	(110.45)	(82.32)	(131.05)	(83.85)	(90.16)	(137.90)
$500	(53.85)	(131.93)	(98.33)	(156.54)	(100.16)	(107.70)	(164.73)
$750	(70.66)	(173.12)	(129.03)	(205.41)	(131.43)	(141.32)	(216.15)
$1,000	(84.31)	(206.56)	(153.95)	(245.09)	(156.82)	(168.62)	(257.90)
$1,500	(105.37)	(258.16)	(192.41)	(306.31)	(195.99)	(210.74)	(322.33)
$2,000	(116.58)	(285.62)	(212.88)	(338.90)	(216.84)	(233.16)	(356.62)
$2,500	(127.82)	(313.16)	(233.40)	(371.57)	(237.75)	(255.64)	(391.00)
$5,000	(171.76)	(420.81)	(313.63)	(499.31)	(319.47)	(343.52)	(525.41)
$10,000	(208.03)	(509.67)	(379.86)	(604.74)	(386.94)	(416.06)	(636.36)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(53.73)	(131.64)	(98.11)	(156.19)	(99.94)	(107.46)	(164.36)
$1,500	(58.61)	(143.59)	(107.02)	(170.38)	(109.01)	(117.22)	(179.29)
$2,000	(61.14)	(149.79)	(111.64)	(177.73)	(113.72)	(122.28)	(187.03)
$3,000	(63.47)	(155.50)	(115.90)	(184.51)	(118.05)	(126.94)	(194.15)
$4,000	(64.44)	(157.88)	(117.67)	(187.33)	(119.86)	(128.88)	(197.12)
$5,000	(64.95)	(159.13)	(118.60)	(188.81)	(120.81)	(129.90)	(198.68)
$7,000	(65.59)	(160.70)	(119.77)	(190.67)	(122.00)	(131.18)	(200.64)
$7,500	(66.12)	(161.99)	(120.74)	(192.21)	(122.98)	(132.24)	(202.26)
$10,000	(68.06)	(166.75)	(124.28)	(197.85)	(126.59)	(136.12)	(208.20)
$20,000	(70.82)	(173.51)	(129.32)	(205.87)	(131.73)	(141.64)	(216.64)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(4.52)	(11.08)	(8.26)	(13.14)	(8.41)	(9.04)	(13.82)
$250	(5.40)	(13.23)	(9.86)	(15.70)	(10.05)	(10.81)	(16.53)
$300	(6.27)	(15.37)	(11.46)	(18.23)	(11.67)	(12.55)	(19.19)
$350	(7.15)	(17.52)	(13.06)	(20.79)	(13.30)	(14.31)	(21.87)
$400	(7.83)	(19.18)	(14.30)	(22.76)	(14.57)	(15.67)	(23.96)
$500	(9.21)	(22.57)	(16.82)	(26.78)	(17.14)	(18.43)	(28.18)
$750	(11.96)	(29.31)	(21.85)	(34.77)	(22.26)	(23.93)	(36.59)
$1,000	(14.09)	(34.53)	(25.74)	(40.96)	(26.22)	(28.19)	(43.11)
$1,500	(17.32)	(42.45)	(31.64)	(50.36)	(32.23)	(34.66)	(52.99)
$2,000	(18.65)	(45.71)	(34.07)	(54.23)	(34.70)	(37.32)	(57.06)
$2,500	(19.98)	(48.96)	(36.50)	(58.09)	(37.19)	(39.98)	(61.13)
$5,000	(23.48)	(57.54)	(42.89)	(68.26)	(43.70)	(46.98)	(71.83)
$10,000	(26.38)	(64.65)	(48.19)	(76.70)	(49.09)	(52.79)	(80.72)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(3.71)	(9.09)	(6.77)	(10.79)	(6.90)	(7.42)	(11.35)
$250	(4.43)	(10.86)	(8.10)	(12.88)	(8.25)	(8.86)	(13.56)
$300	(5.14)	(12.60)	(9.39)	(14.95)	(9.57)	(10.28)	(15.73)
$350	(5.85)	(14.34)	(10.69)	(17.00)	(10.88)	(11.71)	(17.90)
$400	(6.43)	(15.76)	(11.75)	(18.70)	(11.97)	(12.87)	(19.68)
$500	(7.58)	(18.58)	(13.85)	(22.04)	(14.11)	(15.17)	(23.19)
$750	(9.87)	(24.19)	(18.03)	(28.70)	(18.37)	(19.75)	(30.20)
$1,000	(11.63)	(28.50)	(21.24)	(33.81)	(21.64)	(23.27)	(35.58)
$1,500	(14.33)	(35.11)	(26.18)	(41.66)	(26.67)	(28.67)	(43.84)
$2,000	(15.55)	(38.11)	(28.41)	(45.21)	(28.94)	(31.12)	(47.57)
$2,500	(16.77)	(41.10)	(30.64)	(48.76)	(31.21)	(33.56)	(51.31)
$5,000	(20.27)	(49.67)	(37.03)	(58.93)	(37.72)	(40.56)	(62.02)
$10,000	(23.15)	(56.73)	(42.29)	(67.30)	(43.08)	(46.32)	(70.83)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(2.89)	(7.09)	(5.28)	(8.40)	(5.38)	(5.78)	(8.84)
$250	(3.44)	(8.43)	(6.28)	(10.00)	(6.40)	(6.88)	(10.53)
$300	(4.01)	(9.83)	(7.33)	(11.66)	(7.46)	(8.02)	(12.27)
$350	(4.56)	(11.17)	(8.33)	(13.26)	(8.48)	(9.12)	(13.95)
$400	(5.03)	(12.33)	(9.19)	(14.63)	(9.36)	(10.06)	(15.39)
$500	(5.95)	(14.58)	(10.87)	(17.30)	(11.08)	(11.91)	(18.21)
$750	(7.77)	(19.04)	(14.20)	(22.59)	(14.46)	(15.55)	(23.77)
$1,000	(9.20)	(22.54)	(16.81)	(26.75)	(17.12)	(18.41)	(28.15)
$1,500	(11.34)	(27.79)	(20.72)	(32.97)	(21.10)	(22.69)	(34.70)
$2,000	(12.47)	(30.56)	(22.78)	(36.25)	(23.21)	(24.95)	(38.15)
$2,500	(13.58)	(33.28)	(24.80)	(39.48)	(25.27)	(27.17)	(41.55)
$5,000	(17.05)	(41.78)	(31.14)	(49.57)	(31.73)	(34.12)	(52.16)
$10,000	(19.92)	(48.81)	(36.39)	(57.92)	(37.07)	(39.86)	(60.95)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(2.00)	(4.91)	(3.65)	(5.82)	(3.72)	(4.00)	(6.11)
$250	(2.38)	(5.83)	(4.35)	(6.92)	(4.42)	(4.76)	(7.28)
$300	(2.77)	(6.79)	(5.06)	(8.06)	(5.15)	(5.54)	(8.47)
$350	(3.17)	(7.77)	(5.79)	(9.22)	(5.89)	(6.34)	(9.70)
$400	(3.51)	(8.61)	(6.42)	(10.21)	(6.53)	(7.02)	(10.74)
$500	(4.20)	(10.29)	(7.67)	(12.21)	(7.81)	(8.40)	(12.85)
$750	(5.51)	(13.51)	(10.07)	(16.02)	(10.26)	(11.03)	(16.86)
$1,000	(6.57)	(16.10)	(12.00)	(19.10)	(12.23)	(13.15)	(20.10)
$1,500	(8.21)	(20.12)	(15.00)	(23.87)	(15.28)	(16.43)	(25.12)
$2,000	(9.08)	(22.25)	(16.59)	(26.40)	(16.90)	(18.17)	(27.78)
$2,500	(9.96)	(24.41)	(18.20)	(28.95)	(18.54)	(19.93)	(30.47)
$5,000	(13.38)	(32.79)	(24.44)	(38.90)	(24.90)	(26.77)	(40.93)
$10,000	(16.22)	(39.74)	(29.63)	(47.15)	(30.19)	(32.46)	(49.62)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(4.18)	(10.24)	(7.64)	(12.15)	(7.78)	(8.36)	(12.79)
$1,500	(4.56)	(11.17)	(8.33)	(13.26)	(8.48)	(9.12)	(13.95)
$2,000	(4.77)	(11.69)	(8.71)	(13.86)	(8.88)	(9.54)	(14.60)
$3,000	(4.94)	(12.10)	(9.03)	(14.36)	(9.19)	(9.88)	(15.11)
$4,000	(5.02)	(12.30)	(9.17)	(14.60)	(9.34)	(10.04)	(15.36)
$5,000	(5.06)	(12.40)	(9.25)	(14.71)	(9.42)	(10.12)	(15.48)
$7,000	(5.11)	(12.53)	(9.34)	(14.86)	(9.51)	(10.22)	(15.63)
$7,500	(5.15)	(12.62)	(9.41)	(14.97)	(9.58)	(10.31)	(15.76)
$10,000	(5.31)	(13.02)	(9.70)	(15.44)	(9.88)	(10.63)	(16.25)
$20,000	(5.52)	(13.53)	(10.09)	(16.04)	(10.28)	(11.05)	(16.89)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%	8.4%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$300	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$350	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$400	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$2,500	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$5,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$4,000	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%
$5,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
$7,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%
$7,500	8.4%	8.4%	8.5%	8.4%	8.4%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(47.89)	(117.33)	(87.44)	(139.21)	(89.07)	(95.78)	(146.49)
$1,500	(53.22)	(130.39)	(97.18)	(154.71)	(98.99)	(106.44)	(162.80)
$2,000	(56.18)	(137.64)	(102.58)	(163.31)	(104.49)	(112.36)	(171.85)
$3,000	(59.10)	(144.79)	(107.91)	(171.80)	(109.92)	(118.20)	(180.78)
$4,000	(60.41)	(148.00)	(110.30)	(175.61)	(112.36)	(120.82)	(184.79)
$5,000	(61.15)	(149.81)	(111.66)	(177.76)	(113.73)	(122.29)	(187.06)
$7,000	(61.86)	(151.55)	(112.95)	(179.83)	(115.05)	(123.71)	(189.23)
$7,500	(62.39)	(152.85)	(113.92)	(181.37)	(116.04)	(124.77)	(190.85)
$10,000	(64.59)	(158.24)	(117.94)	(187.76)	(120.13)	(129.17)	(197.58)
$20,000	(67.96)	(166.50)	(124.09)	(197.56)	(126.40)	(135.91)	(207.89)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(46.23)	(113.26)	(84.41)	(134.39)	(85.98)	(92.46)	(141.42)
$1,500	(52.42)	(128.43)	(95.72)	(152.38)	(97.50)	(104.84)	(160.35)
$2,000	(56.00)	(137.20)	(102.25)	(162.79)	(104.16)	(112.00)	(171.30)
$3,000	(59.70)	(146.26)	(109.01)	(173.55)	(111.04)	(119.40)	(182.62)
$4,000	(61.38)	(150.38)	(112.08)	(178.43)	(114.16)	(122.75)	(187.76)
$5,000	(62.37)	(152.80)	(113.88)	(181.31)	(116.00)	(124.73)	(190.79)
$7,000	(63.25)	(154.96)	(115.49)	(183.87)	(117.64)	(126.49)	(193.48)
$7,500	(63.81)	(156.33)	(116.51)	(185.49)	(118.68)	(127.61)	(195.19)
$10,000	(66.22)	(162.24)	(120.91)	(192.50)	(123.16)	(132.43)	(202.56)
$20,000	(70.52)	(172.77)	(128.76)	(205.00)	(131.16)	(141.03)	(215.72)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(52.32)	(128.18)	(95.53)	(152.09)	(97.31)	(104.64)	(160.04)
$1,500	(62.33)	(152.71)	(113.81)	(181.19)	(115.93)	(124.65)	(190.66)
$2,000	(68.80)	(168.56)	(125.62)	(200.00)	(127.96)	(137.59)	(210.46)
$3,000	(76.62)	(187.72)	(139.90)	(222.73)	(142.51)	(153.23)	(234.38)
$4,000	(80.93)	(198.27)	(147.77)	(235.26)	(150.52)	(161.85)	(247.56)
$5,000	(83.57)	(204.74)	(152.59)	(242.94)	(155.43)	(167.13)	(255.64)
$7,000	(86.30)	(211.43)	(157.58)	(250.87)	(160.51)	(172.59)	(263.99)
$7,500	(87.31)	(213.91)	(159.42)	(253.81)	(162.39)	(174.61)	(267.08)
$10,000	(91.37)	(223.85)	(166.84)	(265.61)	(169.94)	(182.73)	(279.50)
$20,000	(99.92)	(244.80)	(182.45)	(290.46)	(185.84)	(199.83)	(305.65)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.39	0.96	0.71	1.13	0.73	0.78	1.19
$1,000,000	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$50,000	(5.13)	(12.57)	(9.37)	(14.91)	(9.54)	(10.26)	(15.69)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
75%	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
70%	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(51.94)	(127.25)	(94.84)	(150.99)	(96.61)	(103.88)	(158.88)
$1,500	(57.73)	(141.44)	(105.41)	(167.82)	(107.38)	(115.46)	(176.60)
$2,000	(60.93)	(149.28)	(111.26)	(177.12)	(113.33)	(121.86)	(186.38)
$3,000	(64.10)	(157.05)	(117.05)	(186.34)	(119.23)	(128.20)	(196.08)
$4,000	(65.52)	(160.52)	(119.64)	(190.47)	(121.87)	(131.04)	(200.43)
$5,000	(66.32)	(162.48)	(121.10)	(192.79)	(123.36)	(132.64)	(202.87)
$7,000	(67.09)	(164.37)	(122.51)	(195.03)	(124.79)	(134.18)	(205.23)
$7,500	(67.66)	(165.77)	(123.55)	(196.69)	(125.85)	(135.32)	(206.97)
$10,000	(70.05)	(171.62)	(127.91)	(203.64)	(130.29)	(140.10)	(214.28)
$20,000	(73.70)	(180.57)	(134.58)	(214.25)	(137.08)	(147.40)	(225.45)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(50.14)	(122.84)	(91.56)	(145.76)	(93.26)	(100.28)	(153.38)
$1,500	(56.85)	(139.28)	(103.81)	(165.26)	(105.74)	(113.70)	(173.90)
$2,000	(60.73)	(148.79)	(110.89)	(176.54)	(112.96)	(121.46)	(185.77)
$3,000	(64.75)	(158.64)	(118.23)	(188.23)	(120.44)	(129.50)	(198.07)
$4,000	(66.57)	(163.10)	(121.56)	(193.52)	(123.82)	(133.14)	(203.64)
$5,000	(67.64)	(165.72)	(123.51)	(196.63)	(125.81)	(135.28)	(206.91)
$7,000	(68.60)	(168.07)	(125.26)	(199.42)	(127.60)	(137.20)	(209.85)
$7,500	(69.21)	(169.56)	(126.38)	(201.19)	(128.73)	(138.42)	(211.71)
$10,000	(71.82)	(175.96)	(131.14)	(208.78)	(133.59)	(143.64)	(219.70)
$20,000	(76.49)	(187.40)	(139.67)	(222.36)	(142.27)	(152.98)	(233.98)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(56.75)	(139.04)	(103.63)	(164.97)	(105.56)	(113.50)	(173.60)
$1,500	(67.60)	(165.62)	(123.44)	(196.51)	(125.74)	(135.20)	(206.79)
$2,000	(74.62)	(182.82)	(136.26)	(216.92)	(138.79)	(149.24)	(228.26)
$3,000	(83.10)	(203.60)	(151.74)	(241.57)	(154.57)	(166.20)	(254.20)
$4,000	(87.78)	(215.06)	(160.29)	(255.18)	(163.27)	(175.56)	(268.52)
$5,000	(90.64)	(222.07)	(165.51)	(263.49)	(168.59)	(181.28)	(277.27)
$7,000	(93.60)	(229.32)	(170.91)	(272.10)	(174.10)	(187.20)	(286.32)
$7,500	(94.69)	(231.99)	(172.90)	(275.26)	(176.12)	(189.38)	(289.66)
$10,000	(99.09)	(242.77)	(180.94)	(288.05)	(184.31)	(198.18)	(303.12)
$20,000	(108.36)	(265.48)	(197.87)	(315.00)	(201.55)	(216.72)	(331.47)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.43	1.05	0.79	1.25	0.80	0.86	1.32
$1,000,000	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$50,000	(5.56)	(13.62)	(10.15)	(16.16)	(10.34)	(11.12)	(17.01)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
75%	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
70%	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(4.05)	(9.92)	(7.40)	(11.78)	(7.54)	(8.10)	(12.39)
$1,500	(4.51)	(11.05)	(8.23)	(13.11)	(8.39)	(9.02)	(13.80)
$2,000	(4.75)	(11.64)	(8.68)	(13.81)	(8.84)	(9.50)	(14.53)
$3,000	(5.00)	(12.26)	(9.14)	(14.54)	(9.31)	(10.00)	(15.30)
$4,000	(5.11)	(12.52)	(9.34)	(14.86)	(9.51)	(10.22)	(15.64)
$5,000	(5.17)	(12.67)	(9.44)	(15.03)	(9.63)	(10.35)	(15.81)
$7,000	(5.23)	(12.82)	(9.56)	(15.20)	(9.74)	(10.47)	(16.00)
$7,500	(5.27)	(12.92)	(9.63)	(15.32)	(9.81)	(10.55)	(16.12)
$10,000	(5.46)	(13.38)	(9.97)	(15.88)	(10.16)	(10.93)	(16.70)
$20,000	(5.74)	(14.07)	(10.49)	(16.69)	(10.68)	(11.49)	(17.56)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(3.91)	(9.58)	(7.15)	(11.37)	(7.28)	(7.82)	(11.96)
$1,500	(4.43)	(10.85)	(8.09)	(12.88)	(8.24)	(8.86)	(13.55)
$2,000	(4.73)	(11.59)	(8.64)	(13.75)	(8.80)	(9.46)	(14.47)
$3,000	(5.05)	(12.38)	(9.22)	(14.68)	(9.40)	(10.10)	(15.45)
$4,000	(5.19)	(12.72)	(9.48)	(15.09)	(9.66)	(10.39)	(15.88)
$5,000	(5.27)	(12.92)	(9.63)	(15.32)	(9.81)	(10.55)	(16.12)
$7,000	(5.35)	(13.11)	(9.77)	(15.55)	(9.96)	(10.71)	(16.37)
$7,500	(5.40)	(13.23)	(9.87)	(15.70)	(10.05)	(10.81)	(16.52)
$10,000	(5.60)	(13.72)	(10.23)	(16.28)	(10.43)	(11.21)	(17.14)
$20,000	(5.97)	(14.63)	(10.91)	(17.36)	(11.11)	(11.95)	(18.26)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(4.43)	(10.86)	(8.10)	(12.88)	(8.25)	(8.86)	(13.56)
$1,500	(5.27)	(12.91)	(9.63)	(15.32)	(9.81)	(10.55)	(16.13)
$2,000	(5.82)	(14.26)	(10.64)	(16.92)	(10.83)	(11.65)	(17.80)
$3,000	(6.48)	(15.88)	(11.84)	(18.84)	(12.06)	(12.97)	(19.82)
$4,000	(6.85)	(16.79)	(12.52)	(19.92)	(12.75)	(13.71)	(20.96)
$5,000	(7.07)	(17.33)	(12.92)	(20.55)	(13.16)	(14.15)	(21.63)
$7,000	(7.30)	(17.89)	(13.33)	(21.23)	(13.59)	(14.61)	(22.33)
$7,500	(7.38)	(18.08)	(13.48)	(21.45)	(13.73)	(14.77)	(22.58)
$10,000	(7.72)	(18.92)	(14.10)	(22.44)	(14.37)	(15.45)	(23.62)
$20,000	(8.44)	(20.68)	(15.42)	(24.54)	(15.71)	(16.89)	(25.82)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.04	0.09	0.08	0.12	0.07	0.08	0.13
$1,000,000	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
$50,000	(0.43)	(1.05)	(0.78)	(1.25)	(0.80)	(0.86)	(1.32)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	(0.04)	(0.09)	(0.08)	(0.12)	(0.07)	(0.08)	(0.13)
75%	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
70%	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%	8.4%
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$20,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	10.3%	9.4%	11.3%	10.6%	9.6%	10.3%	10.9%
$1,000,000	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
$50,000	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						
80%	10.3%	9.4%	11.3%	10.6%	9.6%	10.3%	10.9%
75%	9.1%	8.6%	10.0%	9.4%	9.8%	9.1%	8.9%
70%	10.3%	9.9%	9.4%	10.7%	11.1%	10.3%	10.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2010 RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2010 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed]

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.16)	(5.29)	(3.94)	(6.28)	(4.02)	(4.32)	(6.61)
$10	(4.53)	(11.10)	(8.27)	(13.17)	(8.43)	(9.06)	(13.86)
$15	(7.53)	(18.45)	(13.75)	(21.89)	(14.01)	(15.06)	(23.03)
$20	(11.62)	(28.47)	(21.22)	(33.78)	(21.61)	(23.24)	(35.55)
$25	(15.30)	(37.48)	(27.94)	(44.48)	(28.46)	(30.60)	(46.80)
$30	(19.35)	(47.41)	(35.33)	(56.25)	(35.99)	(38.70)	(59.19)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$10	(2.59)	(6.35)	(4.73)	(7.53)	(4.82)	(5.18)	(7.92)
$15	(4.31)	(10.56)	(7.87)	(12.53)	(8.02)	(8.62)	(13.18)
$20	(6.65)	(16.29)	(12.14)	(19.33)	(12.37)	(13.30)	(20.34)
$25	(8.77)	(21.49)	(16.01)	(25.49)	(16.31)	(17.54)	(26.83)
$30	(11.08)	(27.15)	(20.23)	(32.21)	(20.61)	(22.16)	(33.89)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.57)	(3.85)	(2.87)	(4.56)	(2.92)	(3.14)	(4.80)
$10	(3.25)	(7.96)	(5.93)	(9.45)	(6.04)	(6.50)	(9.94)
$15	(5.10)	(12.49)	(9.31)	(14.83)	(9.49)	(10.20)	(15.60)
$20	(7.18)	(17.59)	(13.11)	(20.87)	(13.35)	(14.36)	(21.96)
$25	(9.49)	(23.25)	(17.33)	(27.59)	(17.65)	(18.98)	(29.03)
$30	(12.09)	(29.62)	(22.08)	(35.15)	(22.49)	(24.18)	(36.98)
$35	(14.52)	(35.57)	(26.51)	(42.21)	(27.01)	(29.04)	(44.42)
$40	(17.05)	(41.77)	(31.13)	(49.56)	(31.71)	(34.10)	(52.16)
$45	(19.72)	(48.31)	(36.01)	(57.33)	(36.68)	(39.44)	(60.32)
$50	(22.50)	(55.12)	(41.08)	(65.41)	(41.85)	(45.00)	(68.83)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.34)	(3.28)	(2.45)	(3.90)	(2.49)	(2.68)	(4.10)
$10	(2.75)	(6.74)	(5.02)	(7.99)	(5.11)	(5.50)	(8.41)
$15	(4.31)	(10.56)	(7.87)	(12.53)	(8.02)	(8.62)	(13.18)
$20	(6.08)	(14.90)	(11.10)	(17.67)	(11.31)	(12.16)	(18.60)
$25	(8.02)	(19.65)	(14.64)	(23.31)	(14.92)	(16.04)	(24.53)
$30	(10.23)	(25.06)	(18.68)	(29.74)	(19.03)	(20.46)	(31.29)
$35	(12.30)	(30.13)	(22.46)	(35.76)	(22.88)	(24.60)	(37.63)
$40	(14.42)	(35.33)	(26.33)	(41.92)	(26.82)	(28.84)	(44.11)
$45	(16.67)	(40.84)	(30.44)	(48.46)	(31.00)	(33.34)	(50.99)
$50	(19.03)	(46.62)	(34.75)	(55.32)	(35.39)	(38.06)	(58.21)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$150	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$200	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$250	(2.63)	(6.44)	(4.80)	(7.65)	(4.89)	(5.26)	(8.05)
$500	(6.34)	(15.53)	(11.58)	(18.43)	(11.79)	(12.68)	(19.39)
$750	(10.89)	(26.68)	(19.88)	(31.66)	(20.25)	(21.78)	(33.31)
$1,000	(16.39)	(40.15)	(29.93)	(47.65)	(30.48)	(32.78)	(50.14)
Copay/Day							
$50 w/3 Day Max	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$50 w/5 Day Max	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$100 w/3 Day Max	(2.39)	(5.86)	(4.36)	(6.95)	(4.45)	(4.78)	(7.31)
$100 w/5 Day Max	(3.45)	(8.45)	(6.30)	(10.03)	(6.42)	(6.90)	(10.55)
$250 w/3 Day Max	(7.89)	(19.33)	(14.41)	(22.94)	(14.67)	(15.78)	(24.14)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$75	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$100	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$125	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$150	(1.56)	(3.82)	(2.85)	(4.53)	(2.90)	(3.12)	(4.77)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$35	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$50	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
$60	(1.14)	(2.79)	(2.08)	(3.31)	(2.12)	(2.28)	(3.49)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.34)	(5.73)	(4.27)	(6.80)	(4.35)	(4.68)	(7.16)
$10	(4.91)	(12.03)	(8.97)	(14.27)	(9.13)	(9.82)	(15.02)
$15	(8.16)	(19.99)	(14.90)	(23.72)	(15.18)	(16.32)	(24.96)
$20	(12.61)	(30.89)	(23.03)	(36.66)	(23.45)	(25.22)	(38.57)
$25	(16.59)	(40.65)	(30.29)	(48.23)	(30.86)	(33.18)	(50.75)
$30	(20.98)	(51.40)	(38.31)	(60.99)	(39.02)	(41.96)	(64.18)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.01)
$10	(2.81)	(6.88)	(5.13)	(8.17)	(5.23)	(5.62)	(8.60)
$15	(4.68)	(11.47)	(8.55)	(13.60)	(8.70)	(9.36)	(14.32)
$20	(7.21)	(17.66)	(13.17)	(20.96)	(13.41)	(14.42)	(22.06)
$25	(9.51)	(23.30)	(17.37)	(27.65)	(17.69)	(19.02)	(29.09)
$30	(12.01)	(29.42)	(21.93)	(34.91)	(22.34)	(24.02)	(36.74)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$10	(3.52)	(8.62)	(6.43)	(10.23)	(6.55)	(7.04)	(10.77)
$15	(5.53)	(13.55)	(10.10)	(16.08)	(10.29)	(11.06)	(16.92)
$20	(7.79)	(19.09)	(14.22)	(22.65)	(14.49)	(15.58)	(23.83)
$25	(10.29)	(25.21)	(18.79)	(29.91)	(19.14)	(20.58)	(31.48)
$30	(13.11)	(32.12)	(23.94)	(38.11)	(24.38)	(26.22)	(40.10)
$35	(15.75)	(38.59)	(28.76)	(45.79)	(29.30)	(31.50)	(48.18)
$40	(18.49)	(45.30)	(33.76)	(53.75)	(34.39)	(36.98)	(56.56)
$45	(21.39)	(52.41)	(39.06)	(62.18)	(39.79)	(42.78)	(65.43)
$50	(24.41)	(59.80)	(44.57)	(70.96)	(45.40)	(48.82)	(74.67)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$10	(2.98)	(7.30)	(5.44)	(8.66)	(5.54)	(5.96)	(9.12)
$15	(4.68)	(11.47)	(8.55)	(13.60)	(8.70)	(9.36)	(14.32)
$20	(6.59)	(16.15)	(12.03)	(19.16)	(12.26)	(13.18)	(20.16)
$25	(8.70)	(21.32)	(15.89)	(25.29)	(16.18)	(17.40)	(26.61)
$30	(11.09)	(27.17)	(20.25)	(32.24)	(20.63)	(22.18)	(33.92)
$35	(13.34)	(32.68)	(24.36)	(38.78)	(24.81)	(26.68)	(40.81)
$40	(15.64)	(38.32)	(28.56)	(45.47)	(29.09)	(31.28)	(47.84)
$45	(18.08)	(44.30)	(33.01)	(52.56)	(33.63)	(36.16)	(55.31)
$50	(20.64)	(50.57)	(37.69)	(60.00)	(38.39)	(41.28)	(63.14)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$150	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$200	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$250	(2.85)	(6.98)	(5.20)	(8.28)	(5.30)	(5.70)	(8.72)
$500	(6.88)	(16.86)	(12.56)	(20.00)	(12.80)	(13.76)	(21.05)
$750	(11.81)	(28.93)	(21.57)	(34.33)	(21.97)	(23.62)	(36.13)
$1,000	(17.78)	(43.56)	(32.47)	(51.69)	(33.07)	(35.56)	(54.39)
Copay/Day							
$50 w/3 Day Max	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$50 w/5 Day Max	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$100 w/3 Day Max	(2.60)	(6.37)	(4.75)	(7.56)	(4.84)	(5.20)	(7.95)
$100 w/5 Day Max	(3.74)	(9.16)	(6.83)	(10.87)	(6.96)	(7.48)	(11.44)
$250 w/3 Day Max	(8.56)	(20.97)	(15.63)	(24.88)	(15.92)	(17.12)	(26.19)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$100	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$125	(1.35)	(3.31)	(2.47)	(3.92)	(2.51)	(2.70)	(4.13)
$150	(1.69)	(4.14)	(3.09)	(4.91)	(3.14)	(3.38)	(5.17)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$35	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$50	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$60	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)

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DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$10	(0.38)	(0.93)	(0.70)	(1.10)	(0.70)	(0.76)	(1.16)
$15	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
$20	(0.99)	(2.42)	(1.81)	(2.88)	(1.84)	(1.98)	(3.02)
$25	(1.29)	(3.17)	(2.35)	(3.75)	(2.40)	(2.58)	(3.95)
$30	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.68)
$15	(0.37)	(0.91)	(0.68)	(1.07)	(0.68)	(0.74)	(1.14)
$20	(0.56)	(1.37)	(1.03)	(1.63)	(1.04)	(1.12)	(1.72)
$25	(0.74)	(1.81)	(1.36)	(2.16)	(1.38)	(1.48)	(2.26)
$30	(0.93)	(2.27)	(1.70)	(2.70)	(1.73)	(1.86)	(2.85)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.23)	(0.38)	(0.24)	(0.26)	(0.40)
$10	(0.27)	(0.66)	(0.50)	(0.78)	(0.51)	(0.54)	(0.83)
$15	(0.43)	(1.06)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$20	(0.61)	(1.50)	(1.11)	(1.78)	(1.14)	(1.22)	(1.87)
$25	(0.80)	(1.96)	(1.46)	(2.32)	(1.49)	(1.60)	(2.45)
$30	(1.02)	(2.50)	(1.86)	(2.96)	(1.89)	(2.04)	(3.12)
$35	(1.23)	(3.02)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$40	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$45	(1.67)	(4.10)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$50	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.30)	(0.22)	(0.34)	(0.23)	(0.24)	(0.37)
$10	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.71)
$15	(0.37)	(0.91)	(0.68)	(1.07)	(0.68)	(0.74)	(1.14)
$20	(0.51)	(1.25)	(0.93)	(1.49)	(0.95)	(1.02)	(1.56)
$25	(0.68)	(1.67)	(1.25)	(1.98)	(1.26)	(1.36)	(2.08)
$30	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$35	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$40	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$45	(1.41)	(3.46)	(2.57)	(4.10)	(2.63)	(2.82)	(4.32)
$50	(1.61)	(3.95)	(2.94)	(4.68)	(3.00)	(3.22)	(4.93)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$150	(0.12)	(0.29)	(0.21)	(0.35)	(0.22)	(0.24)	(0.36)
$200	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.49)
$250	(0.22)	(0.54)	(0.40)	(0.63)	(0.41)	(0.44)	(0.67)
$500	(0.54)	(1.33)	(0.98)	(1.57)	(1.01)	(1.08)	(1.66)
$750	(0.92)	(2.25)	(1.69)	(2.67)	(1.72)	(1.84)	(2.82)
$1,000	(1.39)	(3.41)	(2.54)	(4.04)	(2.59)	(2.78)	(4.25)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
$50 w/5 Day Max	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)
$100 w/3 Day Max	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
$100 w/5 Day Max	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$250 w/3 Day Max	(0.67)	(1.64)	(1.22)	(1.94)	(1.25)	(1.34)	(2.05)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$75	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.15)
$100	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
$125	(0.11)	(0.27)	(0.21)	(0.32)	(0.20)	(0.22)	(0.34)
$150	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.02)	(0.02)	(0.03)	(0.01)	(0.02)	(0.03)
$25	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.25)
$60	(0.09)	(0.22)	(0.17)	(0.27)	(0.17)	(0.18)	(0.27)

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PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.3%	8.4%	8.3%	8.2%	8.3%	8.3%
$10	8.4%	8.4%	8.5%	8.4%	8.3%	8.4%	8.4%
$15	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.4%	7.4%	7.2%	7.3%	7.5%	7.4%	7.5%
$10	8.5%	8.3%	8.5%	8.5%	8.5%	8.5%	8.6%
$15	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%
$20	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
$25	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.3%	8.0%	8.3%	8.2%	8.3%	8.3%
$10	8.3%	8.3%	8.4%	8.3%	8.4%	8.3%	8.4%
$15	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$40	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	9.0%	9.1%	9.0%	8.7%	9.2%	9.0%	9.0%
$10	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%
$15	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%
$20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$25	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$50	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	10.0%	10.2%	10.3%	9.9%	10.1%	10.0%	9.8%
$150	9.3%	9.2%	8.9%	9.3%	9.2%	9.3%	9.1%
$200	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%	8.7%
$250	8.4%	8.4%	8.3%	8.2%	8.4%	8.4%	8.3%
$500	8.5%	8.6%	8.5%	8.5%	8.6%	8.5%	8.6%
$750	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Day							
$50 w/3 Day Max	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$50 w/5 Day Max	9.1%	9.3%	9.1%	9.1%	8.9%	9.1%	8.9%
$100 w/3 Day Max	8.8%	8.7%	8.9%	8.8%	8.8%	8.8%	8.8%
$100 w/5 Day Max	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$250 w/3 Day Max	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
$75	7.5%	7.3%	7.4%	7.2%	7.2%	7.5%	7.3%
$100	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.2%
$125	8.9%	8.9%	9.3%	8.9%	8.7%	8.9%	9.0%
$150	8.3%	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	5.9%	4.8%	6.5%	6.1%	3.1%	5.9%	5.8%
$25	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
$35	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
$50	8.8%	9.0%	9.0%	8.7%	8.9%	8.8%	9.0%
$60	7.9%	7.9%	8.2%	8.2%	8.0%	7.9%	7.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd Quarter 2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.51)	(3.70)	(2.76)	(4.39)	(2.81)	(3.02)	(4.62)
$100	(2.15)	(5.27)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$125	(2.63)	(6.44)	(4.80)	(7.65)	(4.89)	(5.26)	(8.05)
$150	(3.16)	(7.74)	(5.77)	(9.19)	(5.88)	(6.32)	(9.67)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.43	1.05	0.79	1.25	0.80	0.86	1.32
60	0.83	2.03	1.52	2.41	1.54	1.66	2.54
90	1.23	3.01	2.25	3.58	2.29	2.46	3.76
120	1.45	3.55	2.65	4.22	2.70	2.90	4.44
Unlimited	1.87	4.58	3.41	5.44	3.48	3.74	5.72
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.30)	(0.73)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
40/$20 copay	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
40/$25 copay	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.48	1.18	0.88	1.40	0.89	0.96	1.47
200	1.26	3.09	2.30	3.66	2.34	2.52	3.85
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.57	1.40	1.04	1.66	1.06	1.14	1.74
90	1.17	2.87	2.14	3.40	2.18	2.34	3.58
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.50	1.22	0.91	1.45	0.93	1.00	1.53
90	0.93	2.28	1.70	2.70	1.73	1.86	2.84
120	1.50	3.67	2.74	4.36	2.79	3.00	4.59
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Unlimited	0.50	1.22	0.91	1.45	0.93	1.00	1.53
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.22	5.44	4.05	6.45	4.13	4.44	6.79
60	2.61	6.39	4.77	7.59	4.85	5.22	7.98
90	3.11	7.62	5.68	9.04	5.78	6.22	9.51
Unlimited	3.16	7.74	5.77	9.19	5.88	6.32	9.67
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
60/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
60/$25 copay	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
120/$0 copay	0.45	1.10	0.82	1.31	0.84	0.90	1.38
120/$5 copay	0.34	0.83	0.62	0.99	0.63	0.68	1.04
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copay	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited/$5 copay	0.40	0.98	0.73	1.16	0.74	0.80	1.22
Unlimited/$10 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$100	(2.33)	(5.71)	(4.25)	(6.77)	(4.33)	(4.66)	(7.13)
$125	(2.85)	(6.98)	(5.20)	(8.28)	(5.30)	(5.70)	(8.72)
$150	(3.42)	(8.38)	(6.24)	(9.94)	(6.36)	(6.84)	(10.46)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.47	1.15	0.86	1.37	0.87	0.94	1.44
60	0.91	2.23	1.66	2.65	1.69	1.82	2.78
90	1.32	3.23	2.41	3.84	2.46	2.64	4.04
120	1.57	3.85	2.87	4.56	2.92	3.14	4.80
Unlimited	2.03	4.97	3.71	5.90	3.78	4.06	6.21
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.52	1.27	0.95	1.51	0.97	1.04	1.59
200	1.38	3.38	2.52	4.01	2.57	2.76	4.22
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.62	1.52	1.13	1.80	1.15	1.24	1.90
90	1.26	3.09	2.30	3.66	2.34	2.52	3.85
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.54	1.32	0.99	1.57	1.00	1.08	1.65
90	1.01	2.47	1.84	2.94	1.88	2.02	3.09
120	1.63	3.99	2.98	4.74	3.03	3.26	4.99
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited	0.54	1.32	0.99	1.57	1.00	1.08	1.65
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.40	5.88	4.38	6.98	4.46	4.80	7.34
60	2.83	6.93	5.17	8.23	5.26	5.66	8.66
90	3.37	8.26	6.15	9.80	6.27	6.74	10.31
Unlimited	3.42	8.38	6.24	9.94	6.36	6.84	10.46
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
60/$20 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
60/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
120/$0 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$5 copay	0.38	0.93	0.69	1.10	0.71	0.76	1.16
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
Unlimited/$0 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$5 copay	0.44	1.08	0.80	1.28	0.82	0.88	1.35
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

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HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(0.13)	(0.32)	(0.23)	(0.38)	(0.24)	(0.26)	(0.40)
$100	(0.18)	(0.44)	(0.32)	(0.52)	(0.33)	(0.36)	(0.55)
$125	(0.22)	(0.54)	(0.40)	(0.63)	(0.41)	(0.44)	(0.67)
$150	(0.26)	(0.64)	(0.47)	(0.75)	(0.48)	(0.52)	(0.79)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.07	0.12	0.07	0.08	0.12
60	0.08	0.20	0.14	0.24	0.15	0.16	0.24
90	0.09	0.22	0.16	0.26	0.17	0.18	0.28
120	0.12	0.30	0.22	0.34	0.22	0.24	0.36
Unlimited	0.16	0.39	0.30	0.46	0.30	0.32	0.49
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
40/$15 copay	(0.03)	(0.08)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
40/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.13)
40/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60	0.01	0.02	0.02	0.03	0.02	0.02	0.03
100	0.04	0.09	0.07	0.11	0.08	0.08	0.12
200	0.12	0.29	0.22	0.35	0.23	0.24	0.37
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.08)	(0.20)	(0.14)	(0.23)	(0.15)	(0.16)	(0.25)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.14	0.09	0.10	0.16
90	0.09	0.22	0.16	0.26	0.16	0.18	0.27
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.08	0.12	0.07	0.08	0.12
90	0.08	0.19	0.14	0.24	0.15	0.16	0.25
120	0.13	0.32	0.24	0.38	0.24	0.26	0.40
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.02	0.01	0.03	0.02	0.02	0.03
30	0.04	0.10	0.07	0.11	0.08	0.08	0.12
Unlimited	0.04	0.10	0.08	0.12	0.07	0.08	0.12
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.18	0.44	0.33	0.53	0.33	0.36	0.55
60	0.22	0.54	0.40	0.64	0.41	0.44	0.68
90	0.26	0.64	0.47	0.76	0.49	0.52	0.80
Unlimited	0.26	0.64	0.47	0.75	0.48	0.52	0.79
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
60/$15 copay	(0.03)	(0.07)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
60/$20 copay	(0.04)	(0.10)	(0.08)	(0.12)	(0.07)	(0.08)	(0.12)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.10	0.07	0.11	0.07	0.08	0.12
120/$5 copay	0.04	0.10	0.07	0.11	0.08	0.08	0.12
120/$10 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
120/$25 copay	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
Unlimited/$0 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.12
Unlimited/$5 copay	0.04	0.10	0.07	0.12	0.08	0.08	0.13
Unlimited/$10 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copay	(0.01)	(0.02)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.01	0.02	0.02	0.03	0.02	0.02	0.03
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	8.6%	8.6%	8.3%	8.7%	8.5%	8.6%	8.7%
$100	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
$125	8.4%	8.4%	8.3%	8.2%	8.4%	8.4%	8.3%
$150	8.2%	8.3%	8.1%	8.2%	8.2%	8.2%	8.2%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	9.3%	9.5%	8.9%	9.6%	8.7%	9.3%	9.1%
60	9.6%	9.9%	9.2%	10.0%	9.7%	9.6%	9.4%
90	7.3%	7.3%	7.1%	7.3%	7.4%	7.3%	7.4%
120	8.3%	8.5%	8.3%	8.1%	8.1%	8.3%	8.1%
Unlimited	8.6%	8.5%	8.8%	8.5%	8.6%	8.6%	8.6%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
40/$15 copay	10.0%	11.0%	9.1%	10.3%	8.9%	10.0%	9.8%
40/$20 copay	9.8%	10.0%	9.3%	10.1%	10.5%	9.8%	10.4%
40/$25 copay	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
60	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
100	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
200	9.5%	9.4%	9.6%	9.6%	9.8%	9.5%	9.6%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	9.2%	9.4%	8.8%	9.1%	9.3%	9.2%	9.4%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.8%	8.6%	8.7%	8.4%	8.5%	8.8%	9.2%
90	7.7%	7.7%	7.5%	7.6%	7.3%	7.7%	7.5%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.0%	8.2%	8.8%	8.3%	7.5%	8.0%	7.8%
90	8.6%	8.3%	8.2%	8.9%	8.7%	8.6%	8.8%
120	8.7%	8.7%	8.8%	8.7%	8.6%	8.7%	8.7%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	7.0%	6.9%	6.9%	7.3%	6.8%	7.0%	6.9%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.0%	4.1%	2.7%	5.2%	5.4%	5.0%	4.9%
30	11.8%	12.0%	11.3%	11.1%	12.7%	11.8%	11.5%
Unlimited	8.0%	8.2%	8.8%	8.3%	7.5%	8.0%	7.8%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.1%	8.1%	8.1%	8.2%	8.0%	8.1%	8.1%
60	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%	8.5%
90	8.4%	8.4%	8.3%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.2%	8.3%	8.1%	8.2%	8.2%	8.2%	8.2%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
60/$15 copay	9.7%	9.2%	8.8%	10.0%	8.6%	9.7%	9.5%
60/$20 copay	9.1%	9.3%	10.0%	9.4%	8.5%	9.1%	8.9%
60/$25 copay	7.5%	7.7%	7.2%	7.8%	7.1%	7.5%	7.4%
120/$0 copay	8.9%	9.1%	8.5%	8.4%	8.3%	8.9%	8.7%
120/$5 copay	11.8%	12.0%	11.3%	11.1%	12.7%	11.8%	11.5%
120/$10 copay	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
120/$25 copay	4.2%	3.4%	4.5%	4.3%	4.4%	4.2%	4.1%
Unlimited/$0 copay	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
Unlimited/$5 copay	10.0%	10.2%	9.6%	10.3%	10.8%	10.0%	10.7%
Unlimited/$10 copay	4.2%	3.4%	4.5%	4.3%	4.4%	4.2%	4.1%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copay	5.0%	4.1%	2.7%	5.2%	5.4%	5.0%	4.9%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.30)	(0.73)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$20	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$25	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$30	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$35	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$40	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$45	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$50	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
Copay	**Chemotherapy [std: $0]** **[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$75	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$100	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
Copay	**Ambulance Copay [std: $0]** **[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
	Surgery [std: $0 copay] **Copay per procedure of minimum of [20%, $300]**						
	(2.00)	(4.90)	(3.65)	(5.81)	(3.72)	(4.00)	(6.12)
	Diagnostic and Therapeutic Radiology [std: $0] **Copay per procedure of minimum (20%, $100); $500 annual maximum**						
	(3.11)	(7.62)	(5.68)	(9.04)	(5.78)	(6.22)	(9.51)
	Diagnostic Testing [std: $0] **Copay per procedure minimum of [20%, $100], $500 annual maximum**						
	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$30	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$35	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
$40	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$45	(1.13)	(2.77)	(2.06)	(3.28)	(2.10)	(2.26)	(3.46)
$50	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$25	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
Copay	**Chemotherapy [std: $0]** **[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
Copay	**Ambulance Copay [std: $0]** **[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
	Surgery [std: $0 copay] **Copay per procedure of minimum of [20%, $300]**						
	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
	Diagnostic and Therapeutic Radiology [std: $0] **Copay per procedure of minimum (20%, $100); $500 annual maximum**						
	(3.37)	(8.26)	(6.15)	(9.80)	(6.27)	(6.74)	(10.31)
	Diagnostic Testing [std: $0] **Copay per procedure minimum of [20%, $100], $500 annual maximum**						
	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.03)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)
$25	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.03)	(0.08)	(0.05)	(0.09)	(0.05)	(0.06)	(0.09)
$20	(0.04)	(0.10)	(0.08)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.15)
$35	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$40	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$45	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.27)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
$20	(0.04)	(0.09)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$25	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
Copay	**Chemotherapy [std: $0]** **[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	(0.01)	(0.03)	(0.01)	(0.03)	(0.02)	(0.02)	(0.03)
$50	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)
$75	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
Copay	**Ambulance Copay [std: $0]** **[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$60	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$75	(0.01)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$100	(0.03)	(0.08)	(0.06)	(0.09)	(0.05)	(0.06)	(0.09)
	Surgery [std: $0 copay] **Copay per procedure of minimum of [20%, $300]**						
	(0.17)	(0.42)	(0.31)	(0.50)	(0.32)	(0.34)	(0.52)
	Diagnostic and Therapeutic Radiology [std: $0] **Copay per procedure of minimum (20%, $100); $500 annual maximum**						
	(0.26)	(0.64)	(0.47)	(0.76)	(0.49)	(0.52)	(0.80)
	Diagnostic Testing [std: $0] **Copay per procedure minimum of [20%, $100], $500 annual maximum**						
	(0.03)	(0.07)	(0.06)	(0.09)	(0.06)	(0.06)	(0.09)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	6.3%	7.7%	6.9%	4.3%	6.7%	6.3%	6.1%
$25	4.5%	3.7%	5.0%	4.7%	4.9%	4.5%	4.5%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
$15	10.0%	11.0%	9.1%	10.3%	8.9%	10.0%	9.8%
$20	9.1%	9.3%	10.0%	9.4%	8.5%	9.1%	8.9%
$25	7.3%	7.4%	8.0%	7.5%	7.8%	7.3%	7.1%
$30	7.5%	7.3%	7.4%	7.2%	7.2%	7.5%	7.3%
$35	10.0%	10.2%	10.3%	9.9%	10.1%	10.0%	9.8%
$40	8.7%	8.9%	8.9%	9.0%	8.8%	8.7%	8.9%
$45	8.7%	8.6%	8.4%	8.6%	8.8%	8.7%	8.8%
$50	7.8%	7.8%	7.6%	7.8%	7.9%	7.8%	7.7%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	4.8%	5.9%	5.3%	4.9%	5.1%	4.8%	4.7%
$15	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
$20	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
$25	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.7%
Copay	**Chemotherapy [std: $0]** **[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	7.1%	8.8%	3.8%	7.3%	7.7%	7.1%	7.0%
$50	4.8%	5.9%	5.3%	4.9%	5.1%	4.8%	4.7%
$60	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%
$75	11.1%	11.4%	10.6%	10.5%	10.4%	11.1%	10.9%
$100	8.3%	7.6%	8.0%	7.9%	9.0%	8.3%	8.2%
Copay	**Ambulance Copay [std: $0]** **[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	6.7%	5.4%	7.4%	6.8%	7.1%	6.7%	6.5%
$60	5.3%	4.3%	5.7%	5.5%	5.7%	5.3%	5.2%
$75	4.3%	5.4%	4.8%	4.5%	4.7%	4.3%	4.3%
$100	9.4%	10.3%	10.3%	9.7%	8.3%	9.4%	9.2%
	Surgery [std: $0 copay] **Copay per procedure of minimum of [20%, $300]**						
	8.5%	8.6%	8.5%	8.6%	8.6%	8.5%	8.5%
	Diagnostic and Therapeutic Radiology [std: $0] **Copay per procedure of minimum (20%, $100); $500 annual maximum**						
	8.4%	8.4%	8.3%	8.4%	8.5%	8.4%	8.4%
	Diagnostic Testing [std: $0] **Copay per procedure minimum of [20%, $100], $500 annual maximum**						
	10.7%	10.1%	11.8%	11.1%	11.5%	10.7%	10.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	8.12	19.89	14.83	23.60	15.10	16.24	24.84
60	8.56	20.97	15.63	24.88	15.92	17.12	26.18
90	8.87	21.73	16.20	25.78	16.50	17.74	27.13
Unlimited	8.97	21.98	16.38	26.08	16.68	17.94	27.44
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	9.07	22.22	16.56	26.37	16.87	18.14	27.74
30	9.99	24.48	18.24	29.04	18.58	19.98	30.56
40	10.54	25.82	19.25	30.64	19.60	21.08	32.24
60	11.11	27.22	20.29	32.30	20.66	22.22	33.98
Unlimited	11.20	27.44	20.45	32.56	20.83	22.40	34.26
LARGE GROUP	**$5 Copay**						
20	8.53	20.90	15.58	24.80	15.87	17.06	26.09
30	9.38	22.98	17.13	27.27	17.45	18.76	28.69
40	9.98	24.45	18.22	29.01	18.56	19.96	30.53
60	10.44	25.58	19.06	30.35	19.42	20.88	31.94
Unlimited	10.53	25.80	19.23	30.61	19.58	21.06	32.21
LARGE GROUP	**$10 Copay**						
20	7.99	19.58	14.59	23.23	14.86	15.98	24.44
30	8.80	21.56	16.07	25.58	16.37	17.60	26.92
40	9.30	22.78	16.98	27.03	17.30	18.60	28.45
60	9.80	24.01	17.89	28.49	18.23	19.60	29.98
Unlimited	9.87	24.18	18.02	28.69	18.36	19.74	30.19
LARGE GROUP	**$15 Copay**						
20	7.50	18.37	13.69	21.80	13.95	15.00	22.94
30	8.26	20.24	15.08	24.01	15.36	16.52	25.27
40	8.75	21.44	15.98	25.44	16.27	17.50	26.77
60	9.26	22.69	16.91	26.92	17.22	18.52	28.33
Unlimited	9.33	22.86	17.04	27.12	17.35	18.66	28.54
LARGE GROUP	**$20 Copay**						
20	7.06	17.30	12.89	20.52	13.13	14.12	21.60
30	7.74	18.96	14.13	22.50	14.40	15.48	23.68
40	8.16	19.99	14.90	23.72	15.18	16.32	24.96
60	8.67	21.24	15.83	25.20	16.13	17.34	26.52
Unlimited	8.74	21.41	15.96	25.41	16.26	17.48	26.74
LARGE GROUP	**$25 Copay**						
20	6.56	16.07	11.98	19.07	12.20	13.12	20.07
30	7.21	17.66	13.16	20.96	13.41	14.42	22.06
40	7.68	18.82	14.02	22.33	14.28	15.36	23.49
60	8.08	19.80	14.75	23.49	15.03	16.16	24.72
Unlimited	8.15	19.97	14.88	23.69	15.16	16.30	24.93
LARGE GROUP	**$30 Copay**						
20	6.25	15.31	11.41	18.17	11.62	12.50	19.12
30	6.78	16.61	12.38	19.71	12.61	13.56	20.74
40	7.23	17.71	13.20	21.02	13.45	14.46	22.12
60	7.58	18.57	13.84	22.03	14.10	15.16	23.19
Unlimited	7.62	18.67	13.91	22.15	14.17	15.24	23.31
LARGE GROUP	**$35 Copay**						
20	5.95	14.58	10.86	17.30	11.07	11.90	18.20
30	6.34	15.53	11.58	18.43	11.79	12.68	19.39
40	6.76	16.56	12.34	19.65	12.57	13.52	20.68
60	7.09	17.37	12.95	20.61	13.19	14.18	21.69
Unlimited	7.14	17.49	13.04	20.76	13.28	14.28	21.84
LARGE GROUP	**$40 Copay**						
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.17	15.12	11.27	17.94	11.48	12.34	18.87
40	6.58	16.12	12.01	19.13	12.24	13.16	20.13
60	6.93	16.98	12.65	20.15	12.89	13.86	21.20
Unlimited	6.99	17.13	12.76	20.32	13.00	13.98	21.38
LARGE GROUP	**$45 Copay**						
20	5.62	13.77	10.26	16.34	10.45	11.24	17.19

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	8.80	21.56	16.07	25.58	16.37	17.60	26.92
60	9.28	22.74	16.95	26.98	17.26	18.56	28.39
90	9.62	23.57	17.57	27.97	17.89	19.24	29.43
Unlimited	9.73	23.84	17.77	28.29	18.10	19.46	29.76
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	9.83	24.08	17.95	28.58	18.28	19.66	30.07
30	10.83	26.53	19.78	31.48	20.14	21.66	33.13
40	11.43	28.00	20.87	33.23	21.26	22.86	34.96
60	12.04	29.50	21.99	35.00	22.39	24.08	36.83
Unlimited	12.15	29.77	22.19	35.32	22.60	24.30	37.17
LARGE GROUP	**$5 Copay**						
20	9.25	22.66	16.89	26.89	17.21	18.50	28.30
30	10.18	24.94	18.59	29.59	18.93	20.36	31.14
40	10.82	26.51	19.76	31.45	20.13	21.64	33.10
60	11.32	27.73	20.67	32.91	21.06	22.64	34.63
Unlimited	11.42	27.98	20.85	33.20	21.24	22.84	34.93
LARGE GROUP	**$10 Copay**						
20	8.67	21.24	15.83	25.20	16.13	17.34	26.52
30	9.54	23.37	17.42	27.73	17.74	19.08	29.18
40	10.08	24.70	18.41	29.30	18.75	20.16	30.83
60	10.63	26.04	19.41	30.90	19.77	21.26	32.52
Unlimited	10.71	26.24	19.56	31.13	19.92	21.42	32.76
LARGE GROUP	**$15 Copay**						
20	8.13	19.92	14.85	23.63	15.12	16.26	24.87
30	8.96	21.95	16.36	26.05	16.67	17.92	27.41
40	9.49	23.25	17.33	27.59	17.65	18.98	29.03
60	10.04	24.60	18.33	29.19	18.67	20.08	30.71
Unlimited	10.12	24.79	18.48	29.42	18.82	20.24	30.96
LARGE GROUP	**$20 Copay**						
20	7.65	18.74	13.97	22.24	14.23	15.30	23.40
30	8.39	20.56	15.32	24.39	15.61	16.78	25.67
40	8.84	21.66	16.14	25.70	16.44	17.68	27.04
60	9.41	23.05	17.18	27.35	17.50	18.82	28.79
Unlimited	9.48	23.23	17.31	27.56	17.63	18.96	29.00
LARGE GROUP	**$25 Copay**						
20	7.11	17.42	12.98	20.67	13.22	14.22	21.75
30	7.82	19.16	14.28	22.73	14.55	15.64	23.92
40	8.33	20.41	15.21	24.22	15.49	16.66	25.48
60	8.76	21.46	16.00	25.47	16.29	17.52	26.80
Unlimited	8.83	21.63	16.12	25.67	16.42	17.66	27.01
LARGE GROUP	**$30 Copay**						
20	6.78	16.61	12.38	19.71	12.61	13.56	20.74
30	7.35	18.01	13.42	21.37	13.67	14.70	22.48
40	7.84	19.21	14.32	22.79	14.58	15.68	23.98
60	8.22	20.14	15.01	23.90	15.29	16.44	25.14
Unlimited	8.26	20.24	15.08	24.01	15.36	16.52	25.27
LARGE GROUP	**$35 Copay**						
20	6.45	15.80	11.78	18.75	12.00	12.90	19.73
30	6.88	16.86	12.56	20.00	12.80	13.76	21.05
40	7.33	17.96	13.38	21.31	13.63	14.66	22.42
60	7.69	18.84	14.04	22.35	14.30	15.38	23.52
Unlimited	7.74	18.96	14.13	22.50	14.40	15.48	23.68
LARGE GROUP	**$40 Copay**						
20	6.27	15.36	11.45	18.23	11.66	12.54	19.18
30	6.68	16.37	12.20	19.42	12.42	13.36	20.43
40	7.13	17.47	13.02	20.73	13.26	14.26	21.81
60	7.52	18.42	13.73	21.86	13.99	15.04	23.00
Unlimited	7.58	18.57	13.84	22.04	14.10	15.16	23.19
LARGE GROUP	**$45 Copay**						
20	6.09	14.92	11.12	17.70	11.33	12.18	18.63

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	0.68	1.67	1.24	1.98	1.27	1.36	2.08
60	0.72	1.77	1.32	2.10	1.34	1.44	2.21
90	0.75	1.84	1.37	2.19	1.39	1.50	2.30
Unlimited	0.76	1.86	1.39	2.21	1.42	1.52	2.32
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	0.76	1.86	1.39	2.21	1.41	1.52	2.33
30	0.84	2.05	1.54	2.44	1.56	1.68	2.57
40	0.89	2.18	1.62	2.59	1.66	1.78	2.72
60	0.93	2.28	1.70	2.70	1.73	1.86	2.85
Unlimited	0.95	2.33	1.74	2.76	1.77	1.90	2.91
LARGE GROUP	**$5 Copay**						
20	0.72	1.76	1.31	2.09	1.34	1.44	2.21
30	0.80	1.96	1.46	2.32	1.48	1.60	2.45
40	0.84	2.06	1.54	2.44	1.57	1.68	2.57
60	0.88	2.15	1.61	2.56	1.64	1.76	2.69
Unlimited	0.89	2.18	1.62	2.59	1.66	1.78	2.72
LARGE GROUP	**$10 Copay**						
20	0.68	1.66	1.24	1.97	1.27	1.36	2.08
30	0.74	1.81	1.35	2.15	1.37	1.48	2.26
40	0.78	1.92	1.43	2.27	1.45	1.56	2.38
60	0.83	2.03	1.52	2.41	1.54	1.66	2.54
Unlimited	0.84	2.06	1.54	2.44	1.56	1.68	2.57
LARGE GROUP	**$15 Copay**						
20	0.63	1.55	1.16	1.83	1.17	1.26	1.93
30	0.70	1.71	1.28	2.04	1.31	1.40	2.14
40	0.74	1.81	1.35	2.15	1.38	1.48	2.26
60	0.78	1.91	1.42	2.27	1.45	1.56	2.38
Unlimited	0.79	1.93	1.44	2.30	1.47	1.58	2.42
LARGE GROUP	**$20 Copay**						
20	0.59	1.44	1.08	1.72	1.10	1.18	1.80
30	0.65	1.60	1.19	1.89	1.21	1.30	1.99
40	0.68	1.67	1.24	1.98	1.26	1.36	2.08
60	0.74	1.81	1.35	2.15	1.37	1.48	2.27
Unlimited	0.74	1.82	1.35	2.15	1.37	1.48	2.26
LARGE GROUP	**$25 Copay**						
20	0.55	1.35	1.00	1.60	1.02	1.10	1.68
30	0.61	1.50	1.12	1.77	1.14	1.22	1.86
40	0.65	1.59	1.19	1.89	1.21	1.30	1.99
60	0.68	1.66	1.25	1.98	1.26	1.36	2.08
Unlimited	0.68	1.66	1.24	1.98	1.26	1.36	2.08
LARGE GROUP	**$30 Copay**						
20	0.53	1.30	0.97	1.54	0.99	1.06	1.62
30	0.57	1.40	1.04	1.66	1.06	1.14	1.74
40	0.61	1.50	1.12	1.77	1.13	1.22	1.86
60	0.64	1.57	1.17	1.87	1.19	1.28	1.95
Unlimited	0.64	1.57	1.17	1.86	1.19	1.28	1.96
LARGE GROUP	**$35 Copay**						
20	0.50	1.22	0.92	1.45	0.93	1.00	1.53
30	0.54	1.33	0.98	1.57	1.01	1.08	1.66
40	0.57	1.40	1.04	1.66	1.06	1.14	1.74
60	0.60	1.47	1.09	1.74	1.11	1.20	1.83
Unlimited	0.60	1.47	1.09	1.74	1.12	1.20	1.84
LARGE GROUP	**$40 Copay**						
20	0.49	1.20	0.90	1.43	0.91	0.98	1.50
30	0.51	1.25	0.93	1.48	0.94	1.02	1.56
40	0.55	1.35	1.01	1.60	1.02	1.10	1.68
60	0.59	1.44	1.08	1.71	1.10	1.18	1.80
Unlimited	0.59	1.44	1.08	1.72	1.10	1.18	1.81
LARGE GROUP	**$45 Copay**						
20	0.47	1.15	0.86	1.36	0.88	0.94	1.44

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage							
LARGE GROUP	**[minimum mandatory coverage: 30 days with unlimited BIO and CSED]**						
# Days	**[Copay same as Inpatient Facility]**						
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
90	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage							
# Visits	**[minimum mandatory coverage: 20 visits with unlimited Bio and CSED]**						
	[Copay same or less than Specialist Physician Office Visit]						
LARGE GROUP	**$0 Copay**						
20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP	**$5 Copay**						
20	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
LARGE GROUP	**$10 Copay**						
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP	**$15 Copay**						
20	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP	**$20 Copay**						
20	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%	8.3%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%	8.3%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.6%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
LARGE GROUP	**$25 Copay**						
20	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
40	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.3%	8.3%	8.3%	8.4%	8.3%	8.3%	8.3%
LARGE GROUP	**$30 Copay**						
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
60	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP	**$35 Copay**						
20	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.6%	8.5%	8.5%	8.6%	8.5%	8.6%
40	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP	**$40 Copay**						
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.3%	8.3%	8.3%	8.2%	8.2%	8.3%	8.3%
40	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.3%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%
LARGE GROUP	**$45 Copay**						
20	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.00	14.70	10.96	17.44	11.16	12.00	18.35
40	6.41	15.70	11.70	18.63	11.92	12.82	19.61
60	6.77	16.59	12.36	19.68	12.59	13.54	20.71
Unlimited	6.80	16.66	12.42	19.77	12.65	13.60	20.80
LARGE GROUP				**$50 Copay**			
20	5.47	13.40	9.99	15.90	10.17	10.94	16.73
30	5.84	14.31	10.66	16.98	10.86	11.68	17.86
40	6.25	15.31	11.41	18.17	11.62	12.50	19.12
60	6.60	16.17	12.05	19.19	12.28	13.20	20.19
Unlimited	6.64	16.27	12.12	19.30	12.35	13.28	20.31

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.51	15.95	11.89	18.92	12.11	13.02	19.91
40	6.96	17.05	12.71	20.23	12.95	13.92	21.29
60	7.34	17.98	13.40	21.34	13.65	14.68	22.45
Unlimited	7.37	18.06	13.46	21.42	13.71	14.74	22.54
LARGE GROUP				**$50 Copay**			
20	5.93	14.53	10.83	17.24	11.03	11.86	18.14
30	6.34	15.53	11.58	18.43	11.79	12.68	19.39
40	6.78	16.61	12.38	19.71	12.61	13.56	20.74
60	7.15	17.52	13.06	20.79	13.30	14.30	21.87
Unlimited	7.20	17.64	13.15	20.93	13.39	14.40	22.02

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	0.51	1.25	0.93	1.48	0.95	1.02	1.56
40	0.55	1.35	1.01	1.60	1.03	1.10	1.68
60	0.57	1.39	1.04	1.66	1.06	1.14	1.74
Unlimited	0.57	1.40	1.04	1.65	1.06	1.14	1.74
LARGE GROUP				**$50 Copay**			
20	0.46	1.13	0.84	1.34	0.86	0.92	1.41
30	0.50	1.22	0.92	1.45	0.93	1.00	1.53
40	0.53	1.30	0.97	1.54	0.99	1.06	1.62
60	0.55	1.35	1.01	1.60	1.02	1.10	1.68
Unlimited	0.56	1.37	1.03	1.63	1.04	1.12	1.71

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HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%
LARGE GROUP				**$50 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
30	8.6%	8.5%	8.6%	8.5%	8.6%	8.6%	8.6%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.3%	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individua	Family	Two Persons	Family	Employee Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.43	15.75	11.74	18.69	11.96	12.86	19.67
$25	6.04	14.80	11.03	17.56	11.23	12.08	18.48
$50	5.69	13.94	10.39	16.54	10.58	11.38	17.41
$100	5.10	12.49	9.31	14.83	9.49	10.20	15.60
$500	2.51	6.15	4.58	7.30	4.67	5.02	7.68
Coinsurance							
80%	5.11	12.52	9.33	14.85	9.50	10.22	15.63
75%	4.81	11.78	8.78	13.98	8.95	9.62	14.71
70%	4.49	11.00	8.20	13.05	8.35	8.98	13.73
Deductible			**Orthotics Riders**				
$0	1.09	2.67	1.99	3.17	2.03	2.18	3.33
$25	1.05	2.57	1.92	3.05	1.95	2.10	3.21
$50	1.00	2.45	1.83	2.91	1.86	2.00	3.06
$100	0.91	2.23	1.66	2.65	1.69	1.82	2.78
$500	0.44	1.08	0.80	1.28	0.82	0.88	1.35
Coinsurance							
80%	0.91	2.23	1.66	2.65	1.69	1.82	2.78
75%	0.84	2.06	1.53	2.44	1.56	1.68	2.57
70%	0.79	1.94	1.44	2.30	1.47	1.58	2.42
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.35	3.31	2.47	3.92	2.51	2.70	4.13
12 Months	2.15	5.27	3.93	6.25	4.00	4.30	6.58
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.10	5.14	3.83	6.10	3.91	4.20	6.42
12 Months	3.35	8.21	6.12	9.74	6.23	6.70	10.25
			Private Duty Nursing Riders				
In Full	0.75	1.84	1.37	2.18	1.39	1.50	2.29
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.42	1.03	0.77	1.22	0.78	0.84	1.28
Limit			**Infertility Rider**				
2 IVF	14.06	34.45	25.67	40.87	26.15	28.12	43.01
3 IVF	16.88	41.36	30.82	49.07	31.40	33.76	51.64

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.98	17.10	12.75	20.29	12.98	13.96	21.35
$25	6.55	16.05	11.96	19.04	12.18	13.10	20.04
$50	6.16	15.09	11.25	17.91	11.46	12.32	18.84
$100	5.53	13.55	10.10	16.08	10.29	11.06	16.92
$500	2.72	6.66	4.97	7.91	5.06	5.44	8.32
Coinsurance							
80%	5.54	13.57	10.12	16.10	10.30	11.08	16.95
75%	5.22	12.79	9.53	15.17	9.71	10.44	15.97
70%	4.87	11.93	8.89	14.16	9.06	9.74	14.90
Deductible			**Orthotics Riders**				
$0	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$25	1.14	2.79	2.08	3.31	2.12	2.28	3.49
$50	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$100	0.99	2.43	1.81	2.88	1.84	1.98	3.03
$500	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Coinsurance							
80%	0.99	2.43	1.81	2.88	1.84	1.98	3.03
75%	0.92	2.25	1.68	2.67	1.71	1.84	2.81
70%	0.87	2.13	1.59	2.53	1.62	1.74	2.66
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.47	3.60	2.68	4.27	2.73	2.94	4.50
12 Months	2.33	5.71	4.25	6.77	4.33	4.66	7.13
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	5.56	4.15	6.60	4.22	4.54	6.94
12 Months	3.64	8.92	6.65	10.58	6.77	7.28	11.13
			Private Duty Nursing Riders				
In Full	0.81	1.98	1.48	2.35	1.51	1.62	2.48
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Limit			**Infertility Rider**				
2 IVF	15.25	37.36	27.85	44.33	28.37	30.50	46.65
3 IVF	18.30	44.84	33.42	53.20	34.04	36.60	55.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.55	1.35	1.01	1.60	1.02	1.10	1.68
$25	0.51	1.25	0.93	1.48	0.95	1.02	1.56
$50	0.47	1.15	0.86	1.37	0.88	0.94	1.43
$100	0.43	1.06	0.79	1.25	0.80	0.86	1.32
$500	0.21	0.51	0.39	0.61	0.39	0.42	0.64
Coinsurance							
80%	0.43	1.05	0.79	1.25	0.80	0.86	1.32
75%	0.41	1.01	0.75	1.19	0.76	0.82	1.26
70%	0.38	0.93	0.69	1.11	0.71	0.76	1.17
Deductible			**Orthotics Riders**				
$0	0.09	0.22	0.16	0.26	0.16	0.18	0.28
$25	0.09	0.22	0.16	0.26	0.17	0.18	0.28
$50	0.08	0.20	0.14	0.23	0.15	0.16	0.24
$100	0.08	0.20	0.15	0.23	0.15	0.16	0.25
$500	0.04	0.10	0.08	0.12	0.07	0.08	0.12
Coinsurance							
80%	0.08	0.20	0.15	0.23	0.15	0.16	0.25
75%	0.08	0.19	0.15	0.23	0.15	0.16	0.24
70%	0.08	0.19	0.15	0.23	0.15	0.16	0.24
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.35	0.22	0.24	0.37
12 Months	0.18	0.44	0.32	0.52	0.33	0.36	0.55
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.31	0.34	0.52
12 Months	0.29	0.71	0.53	0.84	0.54	0.58	0.88
			Private Duty Nursing Riders				
In Full	0.06	0.14	0.11	0.17	0.12	0.12	0.19
80% hrs 73-504	0.01	0.02	0.02	0.03	0.02	0.02	0.03
100% hrs 73-504	0.01	0.02	0.02	0.03	0.02	0.02	0.03
			Dental Network Access				
	0.04	0.10	0.07	0.12	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	1.19	2.91	2.18	3.46	2.22	2.38	3.64
3 IVF	1.42	3.48	2.60	4.13	2.64	2.84	4.34

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$50	8.3%	8.2%	8.3%	8.3%	8.3%	8.3%	8.2%
$100	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%
$500	8.4%	8.3%	8.5%	8.4%	8.4%	8.4%	8.3%
Coinsurance							
80%	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
75%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.6%
70%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
Deductible			**Orthotics Riders**				
$0	8.3%	8.2%	8.0%	8.2%	7.9%	8.3%	8.4%
$25	8.6%	8.6%	8.3%	8.5%	8.7%	8.6%	8.7%
$50	8.0%	8.2%	7.7%	7.9%	8.1%	8.0%	7.8%
$100	8.8%	9.0%	9.0%	8.7%	8.9%	8.8%	9.0%
$500	9.1%	9.3%	10.0%	9.4%	8.5%	9.1%	8.9%
Coinsurance							
80%	8.8%	9.0%	9.0%	8.7%	8.9%	8.8%	9.0%
75%	9.5%	9.2%	9.8%	9.4%	9.6%	9.5%	9.3%
70%	10.1%	9.8%	10.4%	10.0%	10.2%	10.1%	9.9%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.9%	8.8%	8.5%	8.9%	8.8%	8.9%	9.0%
12 Months	8.4%	8.3%	8.1%	8.3%	8.3%	8.4%	8.4%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	8.1%	8.2%	8.4%	8.2%	7.9%	8.1%	8.1%
12 Months	8.7%	8.6%	8.7%	8.6%	8.7%	8.7%	8.6%
			Private Duty Nursing Riders				
In Full	8.0%	7.6%	8.0%	7.8%	8.6%	8.0%	8.3%
80% hrs 73-504	7.7%	6.3%	8.3%	7.9%	8.3%	7.7%	7.5%
100% hrs 73-504	4.5%	3.7%	5.0%	4.7%	4.9%	4.5%	4.5%
			Dental Network Access				
	9.5%	9.7%	9.1%	9.8%	10.3%	9.5%	10.2%
Limit			**Infertility Rider**				
2 IVF	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
3 IVF	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter 2011 Rate Manual
LARGE GROUP HMO
VHLI - LGRP - 01
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	550.71	1,433.05
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.07	5.07
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.29	3.15
Outpatient Mental Health: 20 Visits	5.72	14.03
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.05	2.56
Other Riders		
Durable Medical Equipment	1.52	3.59
Chiropractic: $5 Copay	4.04	10.62
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	134.90	350.74
Infertility Drug Coverage: $7 Brand Copay	3.15	8.24
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.08
Inpatient Substance Abuse Rehab: Unlimited days	4.34	10.63
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.61	1.49
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.47	1.15

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	571.83	1,488.03
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.15	5.27
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.33	3.27
Outpatient Mental Health: 20 Visits	5.72	14.03
	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.09	2.66
Other Riders		
Durable Medical Equipment	1.58	3.73
Chiropractic: $5 Copay	4.20	11.03
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	140.07	364.19
Infertility Drug Coverage: $7 Brand Copay	3.27	8.56
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.89
Inpatient Substance Abuse Rehab: Unlimited days	4.50	11.04
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.63	1.55
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.49	1.19

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
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	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	21.12	54.98
Mental Health Coverage		
Inpatient Mental Health: 30 Days	0.08	0.20
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.04	0.12
Outpatient Mental Health: 20 Visits	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.04	0.10
Other Riders		
Durable Medical Equipment	0.06	0.14
Chiropractic: $5 Copay	0.16	0.41
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	5.17	13.45
Infertility Drug Coverage: $7 Brand Copay	0.12	0.32
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	0.81
Inpatient Substance Abuse Rehab: Unlimited days	0.16	0.41
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.02	0.06
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.02	0.04

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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LARGE GROUP HMO
VHLI - LGRP - 01
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	3.8%	3.8%
Mental Health Coverage		
Inpatient Mental Health: 30 Days	3.9%	3.9%
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	3.1%	3.8%
Outpatient Mental Health: 20 Visits	0.0%	0.0%
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	3.8%	3.9%
Other Riders		
Durable Medical Equipment	3.9%	3.9%
Chiropractic: $5 Copay	4.0%	3.9%
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	3.8%	3.8%
Infertility Drug Coverage: $7 Brand Copay	3.8%	3.9%
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	N/A
Inpatient Substance Abuse Rehab: Unlimited days	3.7%	3.9%
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	3.3%	4.0%
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	4.3%	3.5%

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	#DIV/0!	0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
2nd QUARTER 2012 LARGE GROUP RATE MANUAL

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2nd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
April 1, 2012 - June 30, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter 2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS *

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2010 1st QUARTER

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
2nd QUARTER 2012 LARGE GROUP RATE MANUAL

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.00	0.00	0.00
$750 *	0.00	0.00	0.00
$1,000	0.00	0.00	0.00
$2,000	0.00	0.00	0.00
$2,500	0.00	0.00	0.00
$3,000	0.00	0.00	0.00
$4,000	0.00	0.00	0.00
$5,000	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	#DIV/0!	0.0%
$1,000	0.0%	0.0%	#DIV/0!	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.0%	#DIV/0!	0.0%	#DIV/0!
$750 *	0.0%	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	2.5%

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	0.0000
Family	1.2179
Three Tier	
Individual EE	0.0000
Two Persons	1.2179
Family	2.2238
Four Tier	
Individual EE	0.0000
EE + Child(ren)	1.2179
EE + Spouse	2.2652
Family	2.4357

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	**2.5%**
3Q2011	**1.9%**
4Q2011	**1.9%**
1Q2012-2Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.00
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.00
$2,000 (Brand & Generic)	0.00
$2,500 (Brand & Generic)	0.00
$3,000 (Brand & Generic)	0.00
$4,000 (Brand & Generic)	0.00
$5,000 (Brand & Generic)	0.00
[c] Non Formulary Coverage, Generic Only Plans	0.00
[d] PICA Adjustm Applies only to New York City account	0.00
[e] IC Adjustme Applies only to New York City account	0.00
[f] Product Fact HMO, Access I, and EPO	0.00
POS, Access II, and PPO	0.00
[g] Trend per Quarter	(0.03)
2Q2010-2Q2011	0.03
3Q2011	0.02
4Q2011	0.02
1Q2012-2Q2012	0.02

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.22
Family	1.77
Three Tier	
Individual EE	1.22
Two Persons	1.01
Family	1.32
Four Tier	
Individual EE	1.22
EE + Child(ren)	1.05
EE + Spouse	0.17
Family	1.29

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.0%
$2,000 (Brand & Generic)	0.0%
$2,500 (Brand & Generic)	0.0%
$3,000 (Brand & Generic)	0.0%
$4,000 (Brand & Generic)	0.0%
$5,000 (Brand & Generic)	0.0%
[c] Non Formulary Coverage, Generic Only Plans	0.0%
[d] PICA Adjustm Applies only to New York City account	0.0%
[e] IC Adjustme Applies only to New York City account	0.0%
[f] Product Fact HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
2Q2010-2Q2011	#DIV/0!
3Q2011	#DIV/0!
4Q2011	#DIV/0!
1Q2012-2Q2012	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	#DIV/0!
Family	145.0%
Three Tier	
Individual EE	#DIV/0!
Two Persons	82.6%
Family	59.2%
Four Tier	
Individual EE	#DIV/0!
EE + Child(ren)	86.0%
EE + Spouse	7.5%
Family	53.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - BASE BENEFITS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	469.13	1,149.34	856.59	1,363.74	872.55	938.21	1,435.04

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	508.80	1,246.56	929.07	1,479.08	946.37	1,017.60	1,556.42

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	39.67	97.22	72.48	115.34	73.82	79.39	121.38

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.14)	(7.69)	(5.73)	(9.12)	(5.84)	(6.28)	(9.60)
$10	(6.59)	(16.15)	(12.03)	(19.17)	(12.26)	(13.19)	(20.17)
$15	(10.97)	(26.89)	(20.04)	(31.90)	(20.41)	(21.95)	(33.57)
$20	(16.94)	(41.49)	(30.93)	(49.23)	(31.50)	(33.87)	(51.81)
$25	(22.31)	(54.65)	(40.73)	(64.84)	(41.48)	(44.61)	(68.23)
$30	(28.21)	(69.10)	(51.50)	(81.99)	(52.46)	(56.41)	(86.28)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.79)	(4.39)	(3.27)	(5.22)	(3.33)	(3.59)	(5.48)
$10	(3.78)	(9.26)	(6.90)	(10.98)	(7.03)	(7.56)	(11.57)
$15	(6.29)	(15.41)	(11.48)	(18.28)	(11.70)	(12.57)	(19.23)
$20	(9.70)	(23.76)	(17.71)	(28.20)	(18.05)	(19.40)	(29.67)
$25	(12.78)	(31.30)	(23.34)	(37.14)	(23.76)	(25.56)	(39.09)
$30	(16.17)	(39.62)	(29.53)	(47.01)	(30.08)	(32.34)	(49.47)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.28)	(5.59)	(4.17)	(6.63)	(4.25)	(4.57)	(6.98)
$10	(4.74)	(11.61)	(8.65)	(13.78)	(8.81)	(9.48)	(14.49)
$15	(7.44)	(18.22)	(13.58)	(21.62)	(13.84)	(14.88)	(22.75)
$20	(10.49)	(25.69)	(19.15)	(30.48)	(19.50)	(20.97)	(32.08)
$25	(13.84)	(33.90)	(25.27)	(40.23)	(25.74)	(27.68)	(42.33)
$30	(17.63)	(43.19)	(32.19)	(51.25)	(32.79)	(35.26)	(53.93)
$35	(21.19)	(51.90)	(38.68)	(61.59)	(39.40)	(42.37)	(64.81)
$40	(24.87)	(60.94)	(45.42)	(72.31)	(46.26)	(49.75)	(76.09)
$45	(28.75)	(70.42)	(52.49)	(83.57)	(53.47)	(57.49)	(87.93)
$50	(32.82)	(80.41)	(59.93)	(95.41)	(61.05)	(65.64)	(100.40)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.95)	(4.77)	(3.56)	(5.66)	(3.62)	(3.89)	(5.95)
$10	(4.01)	(9.83)	(7.33)	(11.67)	(7.47)	(8.03)	(12.28)
$15	(6.29)	(15.41)	(11.48)	(18.28)	(11.70)	(12.57)	(19.23)
$20	(8.88)	(21.75)	(16.20)	(25.80)	(16.51)	(17.75)	(27.15)
$25	(11.70)	(28.66)	(21.36)	(34.00)	(21.76)	(23.40)	(35.79)
$30	(14.91)	(36.52)	(27.22)	(43.34)	(27.73)	(29.82)	(45.60)
$35	(17.93)	(43.94)	(32.75)	(52.13)	(33.35)	(35.87)	(54.86)
$40	(21.03)	(51.53)	(38.41)	(61.14)	(39.12)	(42.06)	(64.34)
$45	(24.31)	(59.57)	(44.40)	(70.68)	(45.22)	(48.63)	(74.38)
$50	(27.75)	(67.98)	(50.66)	(80.66)	(51.61)	(55.49)	(84.88)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.14)	(2.79)	(2.09)	(3.32)	(2.12)	(2.28)	(3.50)
$150	(1.90)	(4.65)	(3.46)	(5.51)	(3.53)	(3.79)	(5.80)
$200	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$250	(3.85)	(9.44)	(7.03)	(11.20)	(7.16)	(7.70)	(11.78)
$500	(9.25)	(22.67)	(16.90)	(26.90)	(17.21)	(18.51)	(28.31)
$750	(15.90)	(38.95)	(29.02)	(46.21)	(29.56)	(31.79)	(48.63)
$1,000	(23.91)	(58.57)	(43.65)	(69.50)	(44.46)	(47.81)	(73.12)
Copay/Day							
$50 w/3 Day Max	(1.40)	(3.42)	(2.55)	(4.06)	(2.60)	(2.79)	(4.27)
$50 w/5 Day Max	(1.92)	(4.70)	(3.50)	(5.57)	(3.57)	(3.83)	(5.86)
$100 w/3 Day Max	(3.48)	(8.54)	(6.36)	(10.13)	(6.48)	(6.97)	(10.66)
$100 w/5 Day Max	(5.01)	(12.28)	(9.15)	(14.57)	(9.32)	(10.03)	(15.34)
$250 w/3 Day Max	(11.51)	(28.21)	(21.02)	(33.47)	(21.42)	(23.03)	(35.23)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.60)	(1.48)	(1.10)	(1.75)	(1.12)	(1.20)	(1.83)
$75	(0.98)	(2.39)	(1.78)	(2.84)	(1.82)	(1.96)	(3.00)
$100	(1.40)	(3.42)	(2.55)	(4.06)	(2.60)	(2.79)	(4.27)
$125	(1.82)	(4.47)	(3.33)	(5.30)	(3.39)	(3.65)	(5.58)
$150	(2.27)	(5.56)	(4.15)	(6.60)	(4.23)	(4.54)	(6.95)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.28)	(0.67)	(0.50)	(0.79)	(0.51)	(0.55)	(0.85)
$25	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$35	(0.76)	(1.87)	(1.40)	(2.22)	(1.42)	(1.53)	(2.33)
$50	(1.31)	(3.22)	(2.40)	(3.82)	(2.45)	(2.63)	(4.03)
$60	(1.67)	(4.10)	(3.05)	(4.86)	(3.11)	(3.34)	(5.12)
$75	(2.20)	(5.39)	(4.01)	(6.40)	(4.10)	(4.40)	(6.74)
$100	(3.13)	(7.66)	(5.72)	(9.09)	(5.82)	(6.26)	(9.57)
$125	(3.85)	(9.44)	(7.03)	(11.20)	(7.16)	(7.70)	(11.78)
$150	(4.61)	(11.28)	(8.41)	(13.39)	(8.57)	(9.21)	(14.09)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.54	1.32	0.99	1.57	1.01	1.08	1.65
60	1.05	2.57	1.92	3.05	1.96	2.10	3.21

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
$10	(7.15)	(17.52)	(13.06)	(20.79)	(13.30)	(14.30)	(21.87)
$15	(11.90)	(29.16)	(21.73)	(34.59)	(22.13)	(23.80)	(36.40)
$20	(18.37)	(45.01)	(33.54)	(53.40)	(34.17)	(36.74)	(56.19)
$25	(24.18)	(59.24)	(44.15)	(70.29)	(44.97)	(48.36)	(73.97)
$30	(30.59)	(74.95)	(55.86)	(88.93)	(56.90)	(61.18)	(93.57)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$10	(4.11)	(10.07)	(7.50)	(11.95)	(7.64)	(8.22)	(12.57)
$15	(6.81)	(16.68)	(12.44)	(19.80)	(12.67)	(13.62)	(20.83)
$20	(10.52)	(25.77)	(19.21)	(30.58)	(19.57)	(21.04)	(32.18)
$25	(13.86)	(33.96)	(25.31)	(40.29)	(25.78)	(27.72)	(42.40)
$30	(17.55)	(43.00)	(32.05)	(51.02)	(32.64)	(35.10)	(53.69)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.48)	(6.08)	(4.53)	(7.21)	(4.61)	(4.96)	(7.59)
$10	(5.14)	(12.59)	(9.39)	(14.94)	(9.56)	(10.28)	(15.72)
$15	(8.06)	(19.75)	(14.72)	(23.43)	(14.99)	(16.12)	(24.66)
$20	(11.37)	(27.86)	(20.76)	(33.05)	(21.15)	(22.74)	(34.78)
$25	(15.00)	(36.75)	(27.39)	(43.61)	(27.90)	(30.00)	(45.89)
$30	(19.12)	(46.84)	(34.91)	(55.58)	(35.56)	(38.24)	(58.49)
$35	(22.97)	(56.28)	(41.94)	(66.77)	(42.72)	(45.94)	(70.27)
$40	(26.97)	(66.08)	(49.25)	(78.40)	(50.16)	(53.94)	(82.50)
$45	(31.17)	(76.37)	(56.92)	(90.61)	(57.98)	(62.34)	(95.35)
$50	(35.59)	(87.20)	(64.99)	(103.46)	(66.20)	(71.18)	(108.87)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(6.81)	(16.68)	(12.44)	(19.80)	(12.67)	(13.62)	(20.83)
$20	(9.63)	(23.59)	(17.58)	(27.99)	(17.91)	(19.26)	(29.46)
$25	(12.69)	(31.09)	(23.17)	(36.89)	(23.60)	(25.38)	(38.82)
$30	(16.17)	(39.62)	(29.53)	(47.01)	(30.08)	(32.34)	(49.46)
$35	(19.45)	(47.65)	(35.52)	(56.54)	(36.18)	(38.90)	(59.50)
$40	(22.82)	(55.91)	(41.67)	(66.34)	(42.45)	(45.64)	(69.81)
$45	(26.36)	(64.58)	(48.13)	(76.63)	(49.03)	(52.72)	(80.64)
$50	(30.09)	(73.72)	(54.94)	(87.47)	(55.97)	(60.18)	(92.05)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$150	(2.06)	(5.05)	(3.76)	(5.99)	(3.83)	(4.12)	(6.30)
$200	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$250	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$500	(10.03)	(24.57)	(18.31)	(29.16)	(18.66)	(20.06)	(30.68)
$750	(17.24)	(42.24)	(31.48)	(50.12)	(32.07)	(34.48)	(52.74)
$1,000	(25.92)	(63.50)	(47.33)	(75.35)	(48.21)	(51.84)	(79.29)
Copay/Day							
$50 w/3 Day Max	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$50 w/5 Day Max	(2.08)	(5.10)	(3.80)	(6.05)	(3.87)	(4.16)	(6.36)
$100 w/3 Day Max	(3.78)	(9.26)	(6.90)	(10.99)	(7.03)	(7.56)	(11.56)
$100 w/5 Day Max	(5.44)	(13.33)	(9.93)	(15.81)	(10.12)	(10.88)	(16.64)
$250 w/3 Day Max	(12.48)	(30.58)	(22.79)	(36.28)	(23.21)	(24.96)	(38.18)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$75	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$100	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$125	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$150	(2.47)	(6.05)	(4.51)	(7.18)	(4.59)	(4.94)	(7.56)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$25	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$35	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$50	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$60	(1.80)	(4.41)	(3.29)	(5.23)	(3.35)	(3.60)	(5.51)
$75	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$100	(3.39)	(8.31)	(6.19)	(9.85)	(6.31)	(6.78)	(10.37)
$125	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$150	(4.99)	(12.23)	(9.11)	(14.51)	(9.28)	(9.98)	(15.26)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.58	1.42	1.06	1.69	1.08	1.16	1.77
60	1.14	2.79	2.08	3.31	2.12	2.28	3.49

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.64)	(0.48)	(0.76)	(0.48)	(0.52)	(0.80)
$10	(0.56)	(1.37)	(1.03)	(1.62)	(1.04)	(1.11)	(1.70)
$15	(0.93)	(2.27)	(1.69)	(2.69)	(1.72)	(1.85)	(2.83)
$20	(1.43)	(3.52)	(2.61)	(4.17)	(2.67)	(2.87)	(4.38)
$25	(1.87)	(4.59)	(3.42)	(5.45)	(3.49)	(3.75)	(5.74)
$30	(2.38)	(5.85)	(4.36)	(6.94)	(4.44)	(4.77)	(7.29)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.45)	(0.30)	(0.31)	(0.49)
$10	(0.33)	(0.81)	(0.60)	(0.97)	(0.61)	(0.66)	(1.00)
$15	(0.52)	(1.27)	(0.96)	(1.52)	(0.97)	(1.05)	(1.60)
$20	(0.82)	(2.01)	(1.50)	(2.38)	(1.52)	(1.64)	(2.51)
$25	(1.08)	(2.66)	(1.97)	(3.15)	(2.02)	(2.16)	(3.31)
$30	(1.38)	(3.38)	(2.52)	(4.01)	(2.56)	(2.76)	(4.22)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.20)	(0.49)	(0.36)	(0.58)	(0.36)	(0.39)	(0.61)
$10	(0.40)	(0.98)	(0.74)	(1.16)	(0.75)	(0.80)	(1.23)
$15	(0.62)	(1.53)	(1.14)	(1.81)	(1.15)	(1.24)	(1.91)
$20	(0.88)	(2.17)	(1.61)	(2.57)	(1.65)	(1.77)	(2.70)
$25	(1.16)	(2.85)	(2.12)	(3.38)	(2.16)	(2.32)	(3.56)
$30	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$35	(1.78)	(4.38)	(3.26)	(5.18)	(3.32)	(3.57)	(5.46)
$40	(2.10)	(5.14)	(3.83)	(6.09)	(3.90)	(4.19)	(6.41)
$45	(2.42)	(5.95)	(4.43)	(7.04)	(4.51)	(4.85)	(7.42)
$50	(2.77)	(6.79)	(5.06)	(8.05)	(5.15)	(5.54)	(8.47)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.40)	(0.29)	(0.47)	(0.30)	(0.33)	(0.50)
$10	(0.35)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.06)
$15	(0.52)	(1.27)	(0.96)	(1.52)	(0.97)	(1.05)	(1.60)
$20	(0.75)	(1.84)	(1.38)	(2.19)	(1.40)	(1.51)	(2.31)
$25	(0.99)	(2.43)	(1.81)	(2.89)	(1.84)	(1.98)	(3.03)
$30	(1.26)	(3.10)	(2.31)	(3.67)	(2.35)	(2.52)	(3.86)
$35	(1.52)	(3.71)	(2.77)	(4.41)	(2.83)	(3.03)	(4.64)
$40	(1.79)	(4.38)	(3.26)	(5.20)	(3.33)	(3.58)	(5.47)
$45	(2.05)	(5.01)	(3.73)	(5.95)	(3.81)	(4.09)	(6.26)
$50	(2.34)	(5.74)	(4.28)	(6.81)	(4.36)	(4.69)	(7.17)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.26)
$150	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$200	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$250	(0.34)	(0.83)	(0.62)	(0.98)	(0.63)	(0.68)	(1.04)
$500	(0.78)	(1.90)	(1.41)	(2.26)	(1.45)	(1.55)	(2.37)
$750	(1.34)	(3.29)	(2.46)	(3.91)	(2.51)	(2.69)	(4.11)
$1,000	(2.01)	(4.93)	(3.68)	(5.85)	(3.75)	(4.03)	(6.17)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.30)	(0.23)	(0.36)	(0.23)	(0.25)	(0.38)
$50 w/5 Day Max	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$100 w/3 Day Max	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.90)
$100 w/5 Day Max	(0.43)	(1.05)	(0.78)	(1.24)	(0.80)	(0.85)	(1.30)
$250 w/3 Day Max	(0.97)	(2.37)	(1.77)	(2.81)	(1.79)	(1.93)	(2.95)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.11)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
$75	(0.08)	(0.21)	(0.16)	(0.24)	(0.15)	(0.16)	(0.24)
$100	(0.12)	(0.30)	(0.23)	(0.36)	(0.23)	(0.25)	(0.38)
$125	(0.17)	(0.41)	(0.30)	(0.48)	(0.31)	(0.33)	(0.51)
$150	(0.20)	(0.49)	(0.36)	(0.58)	(0.36)	(0.40)	(0.61)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.10)
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.07)	(0.16)	(0.12)	(0.19)	(0.12)	(0.13)	(0.21)
$50	(0.13)	(0.31)	(0.23)	(0.37)	(0.23)	(0.25)	(0.37)
$60	(0.13)	(0.31)	(0.24)	(0.37)	(0.24)	(0.26)	(0.39)
$75	(0.18)	(0.44)	(0.34)	(0.52)	(0.33)	(0.36)	(0.54)
$100	(0.26)	(0.65)	(0.47)	(0.76)	(0.49)	(0.52)	(0.80)
$125	(0.34)	(0.83)	(0.62)	(0.98)	(0.63)	(0.68)	(1.04)
$150	(0.38)	(0.95)	(0.70)	(1.12)	(0.71)	(0.77)	(1.17)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.07	0.12	0.07	0.08	0.12
60	0.09	0.22	0.16	0.26	0.16	0.18	0.28

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.3%	8.4%	8.3%	8.2%	8.3%	8.3%
$10	8.5%	8.5%	8.6%	8.5%	8.5%	8.4%	8.4%
$15	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$20	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.9%	8.9%	8.9%	8.6%	9.0%	8.6%	8.9%
$10	8.7%	8.7%	8.7%	8.8%	8.7%	8.7%	8.6%
$15	8.3%	8.2%	8.4%	8.3%	8.3%	8.4%	8.3%
$20	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$25	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.8%	8.8%	8.6%	8.7%	8.5%	8.5%	8.7%
$10	8.4%	8.4%	8.6%	8.4%	8.5%	8.4%	8.5%
$15	8.3%	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%
$20	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.5%	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%
$35	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$45	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	8.4%	8.1%	8.3%	8.3%	8.5%	8.4%
$10	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
$15	8.3%	8.2%	8.4%	8.3%	8.3%	8.4%	8.3%
$20	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$35	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	7.9%	7.9%	7.7%	7.8%	8.0%	7.9%	7.4%
$150	8.4%	8.6%	8.7%	8.7%	8.5%	8.7%	8.6%
$200	8.2%	8.2%	8.1%	8.2%	8.2%	8.2%	8.1%
$250	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%
$500	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
$750	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay/Day							
$50 w/3 Day Max	8.6%	8.8%	9.0%	8.9%	8.8%	9.0%	8.9%
$50 w/5 Day Max	8.3%	8.5%	8.6%	8.6%	8.4%	8.6%	8.5%
$100 w/3 Day Max	8.6%	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%
$100 w/5 Day Max	8.6%	8.6%	8.5%	8.5%	8.6%	8.5%	8.5%
$250 w/3 Day Max	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.3%	7.4%	8.2%	8.0%	8.0%	8.3%	8.7%
$75	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$100	8.6%	8.8%	9.0%	8.9%	8.8%	9.0%	8.9%
$125	9.3%	9.2%	9.0%	9.1%	9.1%	9.0%	9.1%
$150	8.8%	8.8%	8.7%	8.8%	8.5%	8.8%	8.8%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
$25	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$35	9.2%	8.6%	8.6%	8.6%	8.5%	8.5%	9.0%
$50	9.9%	9.6%	9.6%	9.7%	9.4%	9.5%	9.2%
$60	7.8%	7.6%	7.9%	7.6%	7.7%	7.8%	7.6%
$75	8.2%	8.2%	8.5%	8.1%	8.0%	8.2%	8.0%
$100	8.3%	8.5%	8.2%	8.4%	8.4%	8.3%	8.4%
$125	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%
$150	8.2%	8.4%	8.3%	8.4%	8.3%	8.4%	8.3%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
60	8.6%	8.6%	8.3%	8.5%	8.2%	8.6%	8.7%

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.58	3.87	2.88	4.60	2.93	3.16	4.83
120	1.84	4.51	3.36	5.36	3.43	3.69	5.65
Unlimited	2.37	5.82	4.33	6.90	4.41	4.75	7.27
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.26)	(0.41)
40/$10 copay	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
40/$15 copay	(0.43)	(1.05)	(0.78)	(1.24)	(0.79)	(0.86)	(1.30)
40/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
40/$25 copay	(0.78)	(1.93)	(1.44)	(2.28)	(1.46)	(1.57)	(2.40)
60	0.29	0.70	0.52	0.83	0.53	0.57	0.88
100	0.69	1.70	1.26	2.02	1.28	1.39	2.12
200	1.84	4.51	3.36	5.36	3.43	3.69	5.65
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.72	1.77	1.32	2.10	1.35	1.45	2.21
90	1.51	3.70	2.75	4.38	2.80	3.02	4.62
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.64	1.57	1.17	1.86	1.19	1.28	1.97
90	1.18	2.89	2.16	3.43	2.20	2.36	3.62
120	1.92	4.70	3.50	5.57	3.57	3.83	5.86
visits for all other	(Verizon Benefit)						
	1.49	3.65	2.72	4.32	2.77	2.98	4.55
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.92)	(2.24)	(1.67)	(2.67)	(1.70)	(1.83)	(2.80)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.28	0.67	0.50	0.79	0.51	0.55	0.85
30	0.44	1.07	0.81	1.27	0.82	0.88	1.35
Unlimited	0.64	1.57	1.17	1.86	1.19	1.28	1.97
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.24	7.94	5.92	9.42	6.02	6.48	9.91
60	3.80	9.31	6.94	11.05	7.07	7.60	11.63
90	4.54	11.14	8.29	13.22	8.46	9.09	13.90
Unlimited	4.61	11.28	8.41	13.39	8.57	9.21	14.09
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.24)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
60/$10 copay	(0.24)	(0.60)	(0.45)	(0.71)	(0.46)	(0.49)	(0.74)
60/$15 copay	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.79)	(1.21)
60/$20 copay	(0.55)	(1.35)	(1.01)	(1.60)	(1.02)	(1.10)	(1.68)
60/$25 copay	(0.66)	(1.62)	(1.21)	(1.93)	(1.23)	(1.32)	(2.03)
120/$0 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
120/$5 copay	0.44	1.07	0.81	1.27	0.82	0.88	1.35
120/$10 copay	0.24	0.60	0.45	0.71	0.46	0.49	0.74
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
120/$25 copay	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
Unlimited/$0 copay	0.65	1.60	1.19	1.90	1.21	1.30	2.00
Unlimited/$5 copay	0.50	1.22	0.91	1.45	0.93	1.00	1.53
Unlimited/$10 copay	0.33	0.79	0.59	0.95	0.61	0.65	1.00
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
Unlimited/$25 copay	(0.28)	(0.67)	(0.50)	(0.79)	(0.51)	(0.55)	(0.85)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.16	0.40	0.30	0.48	0.31	0.33	0.50
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.24)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
$20	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$25	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.26)	(0.41)
$10	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
$15	(0.44)	(1.07)	(0.81)	(1.27)	(0.82)	(0.88)	(1.35)
$20	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.91)
$25	(0.82)	(2.00)	(1.49)	(2.37)	(1.52)	(1.63)	(2.50)
$30	(0.98)	(2.39)	(1.78)	(2.84)	(1.82)	(1.96)	(3.00)
$35	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.53)
$40	(1.35)	(3.29)	(2.46)	(3.91)	(2.51)	(2.69)	(4.12)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.71	4.19	3.12	4.97	3.18	3.42	5.23
120	2.01	4.92	3.67	5.84	3.74	4.02	6.15
Unlimited	2.58	6.32	4.71	7.50	4.80	5.16	7.89
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$20 copay	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
40/$25 copay	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
60	0.32	0.78	0.58	0.93	0.60	0.64	0.98
100	0.74	1.81	1.35	2.15	1.38	1.48	2.26
200	2.01	4.92	3.67	5.84	3.74	4.02	6.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.77	1.89	1.41	2.24	1.43	1.54	2.36
90	1.64	4.02	2.99	4.77	3.05	3.28	5.02
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.69	1.69	1.26	2.01	1.28	1.38	2.11
90	1.27	3.11	2.32	3.69	2.36	2.54	3.88
120	2.08	5.10	3.80	6.05	3.87	4.16	6.36
visits for all other	(Verizon Benefit)						
	1.61	3.94	2.94	4.68	2.99	3.22	4.92
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.31	0.76	0.57	0.90	0.58	0.62	0.95
30	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Unlimited	0.69	1.69	1.26	2.01	1.28	1.38	2.11
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.51	8.60	6.41	10.20	6.53	7.02	10.74
60	4.13	10.12	7.54	12.01	7.68	8.26	12.63
90	4.93	12.08	9.00	14.33	9.17	9.86	15.08
Unlimited	4.99	12.23	9.11	14.51	9.28	9.98	15.26
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
60/$20 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60/$25 copay	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
120/$0 copay	0.61	1.49	1.11	1.77	1.13	1.22	1.87
120/$5 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
Unlimited/$0 copay	0.70	1.72	1.28	2.03	1.30	1.40	2.14
Unlimited/$5 copay	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Unlimited/$10 copay	0.36	0.88	0.66	1.05	0.67	0.72	1.10
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$20	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$25	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$30	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$35	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
$40	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	0.13	0.32	0.24	0.37	0.25	0.26	0.40
120	0.17	0.41	0.31	0.48	0.31	0.33	0.50
Unlimited	0.21	0.50	0.38	0.60	0.39	0.41	0.62
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
40/$10 copay	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
40/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.14)	(0.09)	(0.10)	(0.16)
40/$25 copay	(0.08)	(0.18)	(0.13)	(0.22)	(0.14)	(0.15)	(0.23)
60	0.03	0.08	0.06	0.10	0.07	0.07	0.10
100	0.05	0.11	0.09	0.13	0.10	0.09	0.14
200	0.17	0.41	0.31	0.48	0.31	0.33	0.50
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.14	0.08	0.09	0.15
90	0.13	0.32	0.24	0.39	0.25	0.26	0.40
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.12	0.09	0.15	0.09	0.10	0.14
90	0.09	0.22	0.16	0.26	0.16	0.18	0.26
120	0.16	0.40	0.30	0.48	0.30	0.33	0.50
visits for all other	(Verizon Benefit)						
	0.12	0.29	0.22	0.36	0.22	0.24	0.37
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.26)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.09	0.07	0.11	0.07	0.07	0.10
30	0.04	0.11	0.07	0.13	0.07	0.08	0.12
Unlimited	0.05	0.12	0.09	0.15	0.09	0.10	0.14
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.27	0.66	0.49	0.78	0.51	0.54	0.83
60	0.33	0.81	0.60	0.96	0.61	0.66	1.00
90	0.39	0.94	0.71	1.11	0.71	0.77	1.18
Unlimited	0.38	0.95	0.70	1.12	0.71	0.77	1.17
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	(0.01)	0.00	0.01	0.00	0.00	0.01
60/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.12)
60/$25 copay	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.10)	(0.14)
120/$0 copay	0.04	0.09	0.07	0.11	0.07	0.08	0.13
120/$5 copay	0.04	0.11	0.07	0.13	0.07	0.08	0.12
120/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
120/$25 copay	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
Unlimited/$0 copay	0.05	0.12	0.09	0.13	0.09	0.10	0.14
Unlimited/$5 copay	0.04	0.10	0.08	0.12	0.07	0.08	0.12
Unlimited/$10 copay	0.03	0.09	0.07	0.10	0.06	0.07	0.10
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.01
Unlimited/$25 copay	(0.03)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.10)
Copay	Dialysis Treatment Copay [std: $10]						
$0	0.01	0.02	0.01	0.01	0.01	0.01	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	(0.01)	0.00	0.01	0.00	0.00	0.01
$20	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
$10	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
$15	(0.04)	(0.11)	(0.07)	(0.13)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.15)	(0.10)	(0.10)	(0.14)
$25	(0.08)	(0.21)	(0.15)	(0.25)	(0.15)	(0.17)	(0.25)
$30	(0.08)	(0.21)	(0.16)	(0.24)	(0.15)	(0.16)	(0.24)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.26)
$40	(0.12)	(0.31)	(0.22)	(0.36)	(0.22)	(0.25)	(0.38)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	8.2%	8.3%	8.3%	8.0%	8.5%	8.2%	8.3%
120	9.2%	9.1%	9.2%	9.0%	9.0%	8.9%	8.8%
Unlimited	8.9%	8.6%	8.8%	8.7%	8.8%	8.6%	8.5%
# Visits	Home Health Care Limit [std: 40 visits]						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
40/$10 copay	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
40/$15 copay	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
40/$20 copay	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.9%
40/$25 copay	10.3%	9.3%	9.0%	9.6%	9.6%	9.6%	9.6%
60	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
100	7.2%	6.5%	7.1%	6.4%	7.8%	6.5%	6.6%
200	9.2%	9.1%	9.2%	9.0%	9.0%	8.9%	8.8%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	Inpatient Therapies Limit [std: 30 days]						
0	8.2%	8.1%	8.0%	8.1%	7.8%	8.2%	8.3%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	6.9%	6.8%	6.8%	6.7%	5.9%	6.2%	6.8%
90	8.6%	8.6%	8.7%	8.9%	8.9%	8.6%	8.7%
# Visits	Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.1%
90	7.6%	7.6%	7.4%	7.6%	7.3%	7.6%	7.2%
120	8.3%	8.5%	8.6%	8.6%	8.4%	8.6%	8.5%
visits for all other	(Verizon Benefit)						
	8.1%	7.9%	8.1%	8.3%	7.9%	8.1%	8.1%
# Days	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]						
0	8.7%	9.4%	9.6%	9.0%	9.4%	9.3%	9.3%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
30	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
Unlimited	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.1%
# Days	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.3%	8.3%	8.3%	8.3%	8.5%	8.3%	8.4%
60	8.7%	8.7%	8.6%	8.7%	8.6%	8.7%	8.6%
90	8.6%	8.4%	8.6%	8.4%	8.4%	8.5%	8.5%
Unlimited	8.2%	8.4%	8.3%	8.4%	8.3%	8.4%	8.3%
# Visits	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	4.2%	0.0%	-3.3%	0.0%	0.0%	-3.1%
60/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
60/$15 copay	10.0%	10.2%	11.1%	11.3%	10.8%	11.4%	11.6%
60/$20 copay	7.3%	7.4%	6.9%	7.5%	7.8%	7.3%	7.1%
60/$25 copay	7.6%	7.4%	7.4%	6.7%	7.3%	7.6%	6.9%
120/$0 copay	7.0%	6.4%	6.7%	6.6%	6.6%	7.0%	7.5%
120/$5 copay	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
120/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
120/$25 copay	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
Unlimited/$0 copay	7.7%	7.5%	7.6%	6.8%	7.4%	7.7%	7.0%
Unlimited/$5 copay	8.0%	8.2%	8.8%	8.3%	7.5%	8.0%	7.8%
Unlimited/$10 copay	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
Unlimited/$25 copay	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
Copay	Dialysis Treatment Copay [std: $10]						
$0	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	4.2%	0.0%	-3.3%	0.0%	0.0%	-3.1%
$20	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$25	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
Copay	Refractive Eye Exam Copay [std: $0]						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
$10	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
$15	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
$20	8.1%	7.9%	8.0%	8.3%	8.7%	8.1%	7.3%
$25	9.8%	10.5%	10.1%	10.5%	9.9%	10.4%	10.0%
$30	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$35	7.8%	7.8%	7.6%	7.8%	7.9%	7.8%	7.4%
$40	8.9%	9.4%	8.9%	9.2%	8.8%	9.3%	9.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.52)	(3.72)	(2.77)	(4.41)	(2.82)	(3.04)	(4.65)
$50	(1.68)	(4.12)	(3.07)	(4.89)	(3.13)	(3.36)	(5.15)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$10	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
$15	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$20	(0.69)	(1.70)	(1.26)	(2.02)	(1.28)	(1.39)	(2.12)
$25	(0.94)	(2.29)	(1.71)	(2.72)	(1.74)	(1.87)	(2.86)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$25	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$35	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$50	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
$60	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.79)	(1.21)
$75	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$100	(0.69)	(1.70)	(1.26)	(2.02)	(1.28)	(1.39)	(2.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
$35	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$50	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$60	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
$75	(0.36)	(0.88)	(0.65)	(1.04)	(0.66)	(0.71)	(1.09)
$100	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.92)	(7.16)	(5.34)	(8.50)	(5.44)	(5.85)	(8.95)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.53)	(11.11)	(8.28)	(13.19)	(8.44)	(9.07)	(13.87)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.39)	(0.95)	(0.70)	(1.12)	(0.72)	(0.77)	(1.18)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
$50	(1.81)	(4.43)	(3.31)	(5.26)	(3.37)	(3.62)	(5.54)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$25	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$60	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$75	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$100	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.73)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(0.13)	(0.32)	(0.24)	(0.39)	(0.25)	(0.26)	(0.40)
$50	(0.13)	(0.31)	(0.24)	(0.37)	(0.24)	(0.26)	(0.39)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$10	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.11)	(0.09)	(0.13)	(0.10)	(0.09)	(0.14)
$25	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.26)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$25	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$35	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$60	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
$75	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.11)	(0.09)	(0.13)	(0.10)	(0.09)	(0.14)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$50	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.26)	(0.63)	(0.47)	(0.74)	(0.47)	(0.51)	(0.78)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(0.39)	(0.94)	(0.70)	(1.11)	(0.71)	(0.77)	(1.18)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.04)	(0.10)	(0.09)	(0.13)	(0.08)	(0.09)	(0.14)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	8.6%	8.6%	8.7%	8.8%	8.9%	8.6%	8.6%
$50	7.7%	7.5%	7.8%	7.6%	7.7%	7.7%	7.6%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$10	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
$15	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$20	7.2%	6.5%	7.1%	6.4%	7.8%	6.5%	6.6%
$25	8.5%	9.2%	8.8%	9.2%	9.2%	9.1%	9.1%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$25	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$35	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$50	9.4%	11.7%	10.3%	10.9%	10.2%	11.1%	10.3%
$60	10.0%	10.2%	11.1%	11.3%	10.8%	11.4%	11.6%
$75	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
$100	7.2%	6.5%	7.1%	6.4%	7.8%	6.5%	6.6%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
$35	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$50	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$60	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
$75	11.1%	11.4%	12.3%	11.5%	12.1%	12.7%	11.9%
$100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.9%	8.8%	8.8%	8.7%	8.6%	8.7%	8.7%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	8.6%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.3%	10.5%	12.9%	11.6%	11.1%	11.7%	11.9%
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copy same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.55	18.49	13.79	21.95	14.04	15.10	23.10
60	7.96	19.49	14.53	23.13	14.81	15.92	24.34
90	8.26	20.25	15.09	24.03	15.37	16.53	25.28
Unlimited	8.35	20.45	15.23	24.26	15.52	16.69	25.53
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copy same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.44	20.68	15.41	24.53	15.69	16.87	25.81
30	9.29	22.76	16.97	27.01	17.28	18.59	28.43
40	9.81	24.04	17.91	28.52	18.25	19.63	30.02
60	10.34	25.34	18.88	30.07	19.24	20.69	31.64
Unlimited	10.42	25.54	19.03	30.31	19.39	20.85	31.88
LARGE GROUP				**$5 Copay**			
20	7.94	19.45	14.49	23.08	14.77	15.88	24.28
30	8.73	21.40	15.95	25.38	16.24	17.47	26.72
40	9.28	22.74	16.95	26.98	17.26	18.57	28.40
60	9.72	23.81	17.75	28.26	18.08	19.44	29.73
Unlimited	9.79	23.99	17.88	28.47	18.21	19.59	29.96
LARGE GROUP				**$10 Copay**			
20	7.43	18.20	13.56	21.59	13.82	14.86	22.72
30	8.18	20.04	14.94	23.78	15.22	16.37	25.03
40	8.65	21.20	15.79	25.15	16.09	17.30	26.46
60	9.12	22.35	16.65	26.51	16.97	18.24	27.90
Unlimited	9.19	22.52	16.78	26.72	17.10	18.38	28.11
LARGE GROUP				**$15 Copay**			
20	6.97	17.08	12.73	20.26	12.96	13.94	21.32
30	7.69	18.85	14.05	22.37	14.31	15.39	23.54
40	8.14	19.95	14.87	23.67	15.14	16.28	24.90
60	8.61	21.09	15.72	25.03	16.02	17.22	26.34
Unlimited	8.68	21.27	15.86	25.24	16.15	17.36	26.56
LARGE GROUP				**$20 Copay**			
20	6.56	16.08	11.98	19.08	12.21	13.12	20.07
30	7.20	17.65	13.16	20.94	13.40	14.41	22.04
40	7.59	18.60	13.86	22.07	14.12	15.18	23.22
60	8.07	19.77	14.73	23.46	15.01	16.14	24.69
Unlimited	8.13	19.92	14.85	23.64	15.12	16.26	24.87
LARGE GROUP				**$25 Copay**			
20	6.10	14.96	11.15	17.74	11.35	12.21	18.67
30	6.71	16.43	12.24	19.49	12.47	13.41	20.51
40	7.14	17.50	13.04	20.77	13.29	14.29	21.85
60	7.51	18.40	13.72	21.83	13.97	15.02	22.97
Unlimited	7.58	18.58	13.84	22.04	14.10	15.16	23.19
LARGE GROUP				**$30 Copay**			
20	5.82	14.26	10.63	16.92	10.82	11.64	17.80
30	6.31	15.46	11.51	18.33	11.73	12.62	19.29
40	6.73	16.48	12.28	19.55	12.51	13.45	20.57
60	7.05	17.27	12.88	20.50	13.11	14.10	21.57
Unlimited	7.09	17.37	12.95	20.61	13.20	14.18	21.69
LARGE GROUP				**$35 Copay**			
20	5.53	13.55	10.10	16.08	10.29	11.07	16.93
30	5.90	14.46	10.77	17.15	10.97	11.80	18.05
40	6.29	15.41	11.48	18.28	11.70	12.57	19.23
60	6.59	16.15	12.03	19.17	12.26	13.19	20.17
Unlimited	6.65	16.30	12.15	19.34	12.38	13.31	20.35
LARGE GROUP				**$40 Copay**			
20	5.38	13.19	9.82	15.64	10.01	10.76	16.46
30	5.75	14.08	10.50	16.71	10.69	11.49	17.58
40	6.12	15.00	11.18	17.80	11.39	12.25	18.73
60	6.45	15.80	11.78	18.75	11.99	12.90	19.73
Unlimited	6.50	15.93	11.87	18.90	12.10	13.00	19.89
LARGE GROUP				**$45 Copay**			
20	5.23	12.81	9.55	15.19	9.72	10.45	15.99
30	5.58	13.69	10.20	16.23	10.38	11.17	17.08
40	5.96	14.60	10.88	17.33	11.09	11.92	18.23
60	6.30	15.43	11.49	18.31	11.71	12.59	19.26

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.19	20.07	14.95	23.81	15.23	16.38	25.05
60	8.64	21.17	15.78	25.12	16.07	17.28	26.43
90	8.96	21.95	16.36	26.05	16.67	17.92	27.41
Unlimited	9.05	22.17	16.53	26.31	16.83	18.10	27.68
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.15	22.42	16.71	26.60	17.02	18.30	27.99
30	10.08	24.70	18.41	29.30	18.75	20.16	30.83
40	10.64	26.07	19.43	30.93	19.79	21.28	32.55
60	11.22	27.49	20.49	32.62	20.87	22.44	34.32
Unlimited	11.30	27.69	20.63	32.85	21.02	22.60	34.57
LARGE GROUP				**$5 Copay**			
20	8.61	21.09	15.72	25.03	16.01	17.22	26.34
30	9.47	23.20	17.29	27.53	17.61	18.94	28.97
40	10.07	24.67	18.39	29.27	18.73	20.14	30.80
60	10.54	25.82	19.25	30.64	19.60	21.08	32.24
Unlimited	10.62	26.02	19.39	30.87	19.75	21.24	32.49
LARGE GROUP				**$10 Copay**			
20	8.05	19.72	14.70	23.40	14.97	16.10	24.62
30	8.88	21.76	16.21	25.81	16.52	17.76	27.16
40	9.38	22.98	17.13	27.27	17.45	18.76	28.69
60	9.89	24.23	18.06	28.75	18.40	19.78	30.25
Unlimited	9.97	24.43	18.21	28.98	18.54	19.94	30.50
LARGE GROUP				**$15 Copay**			
20	7.56	18.52	13.80	21.98	14.06	15.12	23.13
30	8.35	20.46	15.25	24.27	15.53	16.70	25.54
40	8.83	21.63	16.12	25.67	16.42	17.66	27.01
60	9.34	22.88	17.05	27.15	17.37	18.68	28.57
Unlimited	9.42	23.08	17.20	27.38	17.52	18.84	28.82
LARGE GROUP				**$20 Copay**			
20	7.12	17.44	13.00	20.70	13.24	14.24	21.78
30	7.81	19.13	14.26	22.70	14.53	15.62	23.89
40	8.23	20.16	15.03	23.92	15.31	16.46	25.18
60	8.75	21.44	15.98	25.44	16.28	17.50	26.77
Unlimited	8.81	21.58	16.09	25.61	16.39	17.62	26.95
LARGE GROUP				**$25 Copay**			
20	6.62	16.22	12.09	19.24	12.31	13.24	20.25
30	7.27	17.81	13.28	21.13	13.52	14.54	22.24
40	7.74	18.96	14.13	22.50	14.40	15.48	23.68
60	8.15	19.97	14.88	23.69	15.16	16.30	24.93
Unlimited	8.22	20.14	15.01	23.90	15.29	16.44	25.14
LARGE GROUP				**$30 Copay**			
20	6.31	15.46	11.52	18.34	11.74	12.62	19.30
30	6.85	16.78	12.51	19.91	12.74	13.70	20.95
40	7.29	17.86	13.31	21.19	13.56	14.58	22.30
60	7.65	18.74	13.97	22.24	14.23	15.30	23.40
Unlimited	7.69	18.84	14.04	22.35	14.30	15.38	23.52
LARGE GROUP				**$35 Copay**			
20	6.00	14.70	10.96	17.44	11.16	12.00	18.35
30	6.40	15.68	11.69	18.60	11.90	12.80	19.58
40	6.81	16.68	12.44	19.80	12.67	13.62	20.83
60	7.15	17.52	13.06	20.79	13.30	14.30	21.87
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP				**$40 Copay**			
20	5.83	14.28	10.65	16.95	10.84	11.66	17.83
30	6.23	15.26	11.38	18.11	11.59	12.46	19.06
40	6.64	16.27	12.12	19.30	12.35	13.28	20.31
60	7.00	17.15	12.78	20.35	13.02	14.00	21.41
Unlimited	7.05	17.27	12.87	20.49	13.11	14.10	21.57
LARGE GROUP				**$45 Copay**			
20	5.67	13.89	10.35	16.48	10.55	11.34	17.34
30	6.05	14.82	11.05	17.59	11.25	12.10	18.51
40	6.47	15.85	11.81	18.81	12.03	12.94	19.79
60	6.82	16.71	12.45	19.83	12.69	13.64	20.86

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.64	1.58	1.16	1.86	1.19	1.28	1.95
60	0.68	1.68	1.25	1.99	1.26	1.36	2.09
90	0.70	1.70	1.27	2.02	1.30	1.39	2.13
Unlimited	0.70	1.72	1.30	2.05	1.31	1.41	2.15
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.71	1.74	1.30	2.07	1.33	1.43	2.18
30	0.79	1.94	1.44	2.29	1.47	1.57	2.40
40	0.83	2.03	1.52	2.41	1.54	1.65	2.53
60	0.88	2.15	1.61	2.55	1.63	1.75	2.68
Unlimited	0.88	2.15	1.60	2.54	1.63	1.75	2.69
LARGE GROUP				**$5 Copay**			
20	0.67	1.64	1.23	1.95	1.24	1.34	2.06
30	0.74	1.80	1.34	2.15	1.37	1.47	2.25
40	0.79	1.93	1.44	2.29	1.47	1.57	2.40
60	0.82	2.01	1.50	2.38	1.52	1.64	2.51
Unlimited	0.83	2.03	1.51	2.40	1.54	1.65	2.53
LARGE GROUP				**$10 Copay**			
20	0.62	1.52	1.14	1.81	1.15	1.24	1.90
30	0.70	1.72	1.27	2.03	1.30	1.39	2.13
40	0.73	1.78	1.34	2.12	1.36	1.46	2.23
60	0.77	1.88	1.41	2.24	1.43	1.54	2.35
Unlimited	0.78	1.91	1.43	2.26	1.44	1.56	2.39
LARGE GROUP				**$15 Copay**			
20	0.59	1.44	1.07	1.72	1.10	1.18	1.81
30	0.66	1.61	1.20	1.90	1.22	1.31	2.00
40	0.69	1.68	1.25	2.00	1.28	1.38	2.11
60	0.73	1.79	1.33	2.12	1.35	1.46	2.23
Unlimited	0.74	1.81	1.34	2.14	1.37	1.48	2.26
LARGE GROUP				**$20 Copay**			
20	0.56	1.36	1.02	1.62	1.03	1.12	1.71
30	0.61	1.48	1.10	1.76	1.13	1.21	1.85
40	0.64	1.56	1.17	1.85	1.19	1.28	1.96
60	0.68	1.67	1.25	1.98	1.27	1.36	2.08
Unlimited	0.68	1.66	1.24	1.97	1.27	1.36	2.08
LARGE GROUP				**$25 Copay**			
20	0.52	1.26	0.94	1.50	0.96	1.03	1.58
30	0.56	1.38	1.04	1.64	1.05	1.13	1.73
40	0.60	1.46	1.09	1.73	1.11	1.19	1.83
60	0.64	1.57	1.16	1.86	1.19	1.28	1.96
Unlimited	0.64	1.56	1.17	1.86	1.19	1.28	1.95
LARGE GROUP				**$30 Copay**			
20	0.49	1.20	0.89	1.42	0.92	0.98	1.50
30	0.54	1.32	1.00	1.58	1.01	1.08	1.66
40	0.56	1.38	1.03	1.64	1.05	1.13	1.73
60	0.60	1.47	1.09	1.74	1.12	1.20	1.83
Unlimited	0.60	1.47	1.09	1.74	1.10	1.20	1.83
LARGE GROUP				**$35 Copay**			
20	0.47	1.15	0.86	1.36	0.87	0.93	1.42
30	0.50	1.22	0.92	1.45	0.93	1.00	1.53
40	0.52	1.27	0.96	1.52	0.97	1.05	1.60
60	0.56	1.37	1.03	1.62	1.04	1.11	1.70
Unlimited	0.56	1.36	1.02	1.62	1.03	1.11	1.71
LARGE GROUP				**$40 Copay**			
20	0.45	1.09	0.83	1.31	0.83	0.90	1.37
30	0.48	1.18	0.88	1.40	0.90	0.97	1.48
40	0.52	1.27	0.94	1.50	0.96	1.03	1.58
60	0.55	1.35	1.00	1.60	1.03	1.10	1.68
Unlimited	0.55	1.34	1.00	1.59	1.01	1.10	1.68
LARGE GROUP				**$45 Copay**			
20	0.44	1.08	0.80	1.29	0.83	0.89	1.35
30	0.47	1.13	0.85	1.36	0.87	0.93	1.43
40	0.51	1.25	0.93	1.48	0.94	1.02	1.56
60	0.52	1.28	0.96	1.52	0.98	1.05	1.60

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%
60	8.5%	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%
90	8.5%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%
40	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$5 Copay**			
20	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
30	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
LARGE GROUP				**$10 Copay**			
20	8.3%	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%
30	8.6%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
LARGE GROUP				**$15 Copay**			
20	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%
30	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$20 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
30	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.3%	8.4%	8.3%	8.4%	8.4%	8.4%
LARGE GROUP				**$25 Copay**			
20	8.5%	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%
30	8.3%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.3%	8.4%	8.3%	8.4%	8.3%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$30 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
30	8.6%	8.5%	8.7%	8.6%	8.6%	8.6%	8.6%
40	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.4%	8.4%	8.3%	8.5%	8.4%
LARGE GROUP				**$35 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%
30	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.3%	8.2%	8.4%	8.3%	8.3%	8.4%	8.3%
60	8.5%	8.5%	8.6%	8.5%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.3%	8.4%	8.4%	8.3%	8.3%	8.4%
LARGE GROUP				**$40 Copay**			
20	8.4%	8.3%	8.5%	8.4%	8.3%	8.4%	8.3%
30	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
Unlimited	8.5%	8.4%	8.4%	8.4%	8.3%	8.5%	8.4%
LARGE GROUP				**$45 Copay**			
20	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
30	8.4%	8.3%	8.3%	8.4%	8.4%	8.3%	8.4%
40	8.6%	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%
60	8.3%	8.3%	8.4%	8.3%	8.4%	8.3%	8.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.33	15.50	11.56	18.39	11.77	12.66	19.36
LARGE GROUP			**$50 Copay**				
20	5.08	12.46	9.28	14.79	9.46	10.17	15.55
30	5.43	13.31	9.91	15.78	10.10	10.86	16.61
40	5.82	14.26	10.63	16.92	10.82	11.64	17.80
60	6.14	15.05	11.22	17.86	11.43	12.29	18.80
Unlimited	6.19	15.15	11.29	17.99	11.50	12.37	18.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.87	16.83	12.54	19.97	12.78	13.74	21.02
LARGE GROUP			**$50 Copay**				
20	5.51	13.50	10.06	16.02	10.25	11.02	16.86
30	5.90	14.46	10.77	17.15	10.97	11.80	18.05
40	6.31	15.46	11.52	18.34	11.74	12.62	19.30
60	6.66	16.32	12.16	19.36	12.39	13.32	20.37
Unlimited	6.71	16.44	12.25	19.51	12.48	13.42	20.53

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.54	1.33	0.98	1.58	1.01	1.08	1.66
LARGE GROUP			**$50 Copay**				
20	0.43	1.04	0.78	1.23	0.79	0.85	1.31
30	0.47	1.15	0.86	1.37	0.87	0.94	1.44
40	0.49	1.20	0.89	1.42	0.92	0.98	1.50
60	0.52	1.27	0.94	1.50	0.96	1.03	1.57
Unlimited	0.52	1.29	0.96	1.52	0.98	1.05	1.61

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	8.5%	8.6%	8.5%	8.6%	8.6%	8.5%	8.6%
LARGE GROUP			**$50 Copay**				
20	8.5%	8.3%	8.4%	8.3%	8.4%	8.4%	8.4%
30	8.7%	8.6%	8.7%	8.7%	8.6%	8.7%	8.7%
40	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
60	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - RIDERS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.20	10.28	7.66	12.21	7.81	8.40	12.84
$0/Max $5000	3.99	9.78	7.30	11.62	7.43	7.99	12.22
$0/Max $2500	3.73	9.14	6.81	10.84	6.94	7.46	11.41
$25	3.99	9.78	7.30	11.62	7.43	7.99	12.22
$50	3.73	9.14	6.81	10.84	6.94	7.46	11.41
$100	3.42	8.39	6.26	9.96	6.37	6.85	10.48
$500	1.64	4.01	3.00	4.77	3.05	3.28	5.01
$5,000	0.28	0.67	0.50	0.79	0.51	0.55	0.85
Coinsurance							
80%	3.36	8.23	6.14	9.77	6.26	6.73	10.28
75%	3.16	7.73	5.77	9.18	5.88	6.32	9.66
70%	2.96	7.23	5.40	8.59	5.49	5.91	9.04
Deductible			**Orthotics Riders**				
$0	0.71	1.74	1.30	2.07	1.32	1.43	2.18
$0/Max $5000	0.68	1.67	1.24	1.99	1.27	1.37	2.09
$0/Max $2500	0.64	1.57	1.17	1.86	1.19	1.28	1.97
$25	0.68	1.67	1.24	1.99	1.27	1.37	2.09
$50	0.64	1.57	1.17	1.86	1.19	1.28	1.97
$100	0.58	1.43	1.06	1.69	1.08	1.16	1.77
$500	0.30	0.72	0.54	0.86	0.55	0.59	0.91
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.58	1.43	1.06	1.69	1.08	1.16	1.77
75%	0.55	1.35	1.01	1.60	1.02	1.10	1.68
70%	0.52	1.27	0.95	1.51	0.97	1.04	1.59
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.38	3.37	2.52	3.99	2.56	2.75	4.21
12 Months	2.19	5.37	4.00	6.37	4.08	4.38	6.71
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.14	5.24	3.90	6.22	3.98	4.28	6.54
12 Months	3.41	8.37	6.24	9.93	6.35	6.83	10.44
			Private Duty Nursing Riders				
In Full	0.50	1.22	0.91	1.45	0.93	1.00	1.53
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.14	0.35	0.26	0.42	0.26	0.29	0.44
			Dental Network Access				
	0.43	1.05	0.78	1.24	0.79	0.86	1.30
			Infertility Rider				
Limit							
2 IVF	8.89	21.77	16.22	25.83	16.53	17.77	27.18
3 IVF	10.74	26.31	19.62	31.22	19.97	21.48	32.85
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.64	6.47	4.82	7.67	4.91	5.28	8.07

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.54	11.12	8.29	13.20	8.44	9.08	13.89
$0/Max $5000	4.33	10.61	7.91	12.59	8.05	8.66	13.25
$0/Max $2500	4.04	9.90	7.38	11.74	7.51	8.08	12.36
$25	4.33	10.61	7.91	12.59	8.05	8.66	13.25
$50	4.04	9.90	7.38	11.74	7.51	8.08	12.36
$100	3.72	9.11	6.79	10.81	6.92	7.44	11.38
$500	1.77	4.34	3.23	5.15	3.29	3.54	5.41
$5,000	0.31	0.76	0.57	0.90	0.58	0.62	0.95
Coinsurance							
80%	3.66	8.97	6.68	10.64	6.81	7.32	11.20
75%	3.42	8.38	6.24	9.94	6.36	6.84	10.46
70%	3.21	7.86	5.86	9.33	5.97	6.42	9.82
Deductible			**Orthotics Riders**				
$0	0.76	1.86	1.39	2.21	1.41	1.52	2.32
$0/Max $5000	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$0/Max $2500	0.69	1.69	1.26	2.01	1.28	1.38	2.11
$25	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$50	0.69	1.69	1.26	2.01	1.28	1.38	2.11
$100	0.63	1.54	1.15	1.83	1.17	1.26	1.93
$500	0.33	0.81	0.60	0.96	0.61	0.66	1.01
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.63	1.54	1.15	1.83	1.17	1.26	1.93
75%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
70%	0.56	1.37	1.02	1.63	1.04	1.12	1.71
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.54	1.32	0.99	1.57	1.00	1.08	1.65
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
			Infertility Rider				
Limit							
2 IVF	9.64	23.62	17.60	28.02	17.93	19.28	29.49
3 IVF	11.65	28.54	21.27	33.87	21.67	23.30	35.64
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.86	7.01	5.22	8.31	5.32	5.72	8.75

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.34	0.84	0.63	0.99	0.63	0.68	1.05
$0/Max $5000	0.34	0.83	0.61	0.97	0.62	0.67	1.03
$0/Max $2500	0.31	0.76	0.57	0.90	0.57	0.62	0.95
$25	0.34	0.83	0.61	0.97	0.62	0.67	1.03
$50	0.31	0.76	0.57	0.90	0.57	0.62	0.95
$100	0.30	0.72	0.53	0.85	0.55	0.59	0.90
$500	0.13	0.33	0.23	0.38	0.24	0.26	0.40
$5,000	0.03	0.09	0.07	0.11	0.07	0.07	0.10
Coinsurance							
80%	0.30	0.74	0.54	0.87	0.55	0.59	0.92
75%	0.26	0.65	0.47	0.76	0.48	0.52	0.80
70%	0.25	0.63	0.46	0.74	0.48	0.51	0.78
Deductible			**Orthotics Riders**				
$0	0.05	0.12	0.09	0.14	0.09	0.09	0.14
$0/Max $5000	0.05	0.12	0.09	0.13	0.09	0.09	0.14
$0/Max $2500	0.05	0.12	0.09	0.15	0.09	0.10	0.14
$25	0.05	0.12	0.09	0.13	0.09	0.09	0.14
$50	0.05	0.12	0.09	0.15	0.09	0.10	0.14
$100	0.05	0.11	0.09	0.14	0.09	0.10	0.16
$500	0.03	0.09	0.06	0.10	0.06	0.07	0.10
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.05	0.11	0.09	0.14	0.09	0.10	0.16
75%	0.04	0.10	0.07	0.12	0.08	0.08	0.12
70%	0.04	0.10	0.07	0.12	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.37	0.23	0.25	0.38
12 Months	0.18	0.44	0.33	0.52	0.33	0.36	0.54
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.32	0.34	0.53
12 Months	0.30	0.72	0.53	0.85	0.55	0.59	0.91
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.08	0.12	0.07	0.08	0.12
80% hrs 73-504	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-504	0.01	0.02	0.01	0.02	0.02	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.14
			Infertility Rider				
Limit							
2 IVF	0.75	1.85	1.38	2.19	1.40	1.51	2.31
3 IVF	0.91	2.23	1.65	2.65	1.70	1.82	2.79
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	0.22	0.54	0.40	0.64	0.41	0.44	0.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.1%	8.2%	8.2%	8.1%	8.1%	8.1%	8.2%
$0/Max $5000	8.5%	8.5%	8.4%	8.3%	8.3%	8.4%	8.4%
$0/Max $2500	8.3%	8.3%	8.4%	8.3%	8.2%	8.3%	8.3%
$25	8.5%	8.5%	8.4%	8.3%	8.3%	8.4%	8.4%
$50	8.3%	8.3%	8.4%	8.3%	8.2%	8.3%	8.3%
$100	8.8%	8.6%	8.5%	8.5%	8.6%	8.6%	8.6%
$500	7.9%	8.2%	7.7%	8.0%	7.9%	7.9%	8.0%
$5,000	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
Coinsurance							
80%	8.9%	9.0%	8.8%	8.9%	8.8%	8.8%	8.9%
75%	8.2%	8.4%	8.1%	8.3%	8.2%	8.2%	8.3%
70%	8.4%	8.7%	8.5%	8.6%	8.7%	8.6%	8.6%
Deductible			**Orthotics Riders**				
$0	7.0%	6.9%	6.9%	6.8%	6.8%	6.3%	6.4%
$0/Max $5000	7.4%	7.2%	7.3%	6.5%	7.1%	6.6%	6.7%
$0/Max $2500	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.1%
$25	7.4%	7.2%	7.3%	6.5%	7.1%	6.6%	6.7%
$50	7.8%	7.6%	7.7%	8.1%	7.6%	7.8%	7.1%
$100	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
$500	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
75%	7.3%	7.4%	6.9%	7.5%	7.8%	7.3%	7.1%
70%	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.7%	9.2%	8.7%	9.3%	9.0%	9.1%	9.0%
12 Months	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.0%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.9%	8.0%	8.2%	8.0%	8.0%	7.9%	8.1%
12 Months	8.8%	8.6%	8.5%	8.6%	8.7%	8.6%	8.7%
			Private Duty Nursing Riders				
In Full	8.0%	8.2%	8.8%	8.3%	7.5%	8.0%	7.8%
80% hrs 73-504	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-504	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
			Dental Network Access				
	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
			Infertility Rider				
Limit							
2 IVF	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
3 IVF	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.4%

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JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
866.28	2,122.35	1,581.77	2,518.25	1,611.22	1,732.49	2,649.92
80% Coinsurance						
853.28	2,090.49	1,558.03	2,480.45	1,587.03	1,706.48	2,610.14
75% Coinsurance						
812.13	1,989.68	1,482.89	2,360.83	1,510.49	1,624.18	2,484.27
70% Coinsurance						
770.99	1,888.87	1,407.76	2,241.22	1,433.97	1,541.90	2,358.39
50% Coinsurance						
729.85	1,788.08	1,332.65	2,121.64	1,357.45	1,459.63	2,232.56

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**
**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
939.52	2,301.82	1,715.56	2,731.18	1,747.51	1,879.04	2,873.99
80% Coinsurance						
925.42	2,267.28	1,689.82	2,690.20	1,721.28	1,850.84	2,830.86
75% Coinsurance						
880.80	2,157.96	1,608.34	2,560.49	1,638.29	1,761.60	2,694.37
70% Coinsurance						
836.16	2,048.59	1,526.83	2,430.72	1,555.26	1,672.32	2,557.81
50% Coinsurance						
791.54	1,939.27	1,445.35	2,301.01	1,472.26	1,583.08	2,421.32

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**
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HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
73.24	179.47	133.79	212.93	136.29	146.55	224.07
80% Coinsurance						
72.14	176.79	131.79	209.75	134.25	144.36	220.72
75% Coinsurance						
68.67	168.28	125.45	199.66	127.80	137.42	210.10
70% Coinsurance						
65.17	159.72	119.07	189.50	121.29	130.42	199.42
50% Coinsurance						
61.69	151.19	112.70	179.37	114.81	123.45	188.76

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**
**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

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HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
80% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
75% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
70% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
50% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

***Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max**
**** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component**

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HIP POS LARGE GROUP CONTRACT
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LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(39.13)	(95.87)	(71.45)	(113.75)	(72.78)	(78.26)	(119.69)
$350	(51.80)	(126.90)	(94.57)	(150.57)	(96.34)	(103.59)	(158.44)
$500	(66.64)	(163.27)	(121.69)	(193.73)	(123.95)	(133.28)	(203.86)
$750	(86.58)	(212.13)	(158.10)	(251.70)	(161.04)	(173.16)	(264.86)
$1,000	(101.86)	(249.55)	(185.99)	(296.10)	(189.45)	(203.71)	(311.58)
$1,500	(125.27)	(306.89)	(228.72)	(364.14)	(232.98)	(250.52)	(383.18)
$2,500	(140.04)	(343.10)	(255.71)	(407.10)	(260.47)	(280.07)	(428.38)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(52.30)	(128.12)	(95.49)	(152.02)	(97.26)	(104.59)	(159.97)
$250	(62.38)	(152.84)	(113.90)	(181.34)	(116.02)	(124.76)	(190.83)
$300	(72.50)	(177.62)	(132.38)	(210.76)	(134.84)	(144.99)	(221.78)
$350	(82.61)	(202.39)	(150.84)	(240.15)	(153.64)	(165.21)	(252.70)
$400	(90.56)	(221.87)	(165.35)	(263.25)	(168.43)	(181.11)	(277.02)
$500	(106.44)	(260.78)	(194.36)	(309.43)	(197.98)	(212.88)	(325.61)
$750	(138.24)	(338.67)	(252.42)	(401.85)	(257.11)	(276.46)	(422.86)
$1,000	(162.71)	(398.64)	(297.10)	(473.01)	(302.63)	(325.42)	(497.73)
$1,500	(200.15)	(490.36)	(365.46)	(581.84)	(372.27)	(400.28)	(612.26)
$2,000	(215.47)	(527.88)	(393.43)	(626.36)	(400.75)	(430.91)	(659.11)
$2,500	(230.83)	(565.53)	(421.49)	(671.03)	(429.34)	(461.65)	(706.11)
$5,000	(271.37)	(664.85)	(495.50)	(788.87)	(504.73)	(542.72)	(830.11)
$10,000	(304.84)	(746.86)	(556.63)	(886.17)	(566.98)	(609.67)	(932.51)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(42.85)	(104.98)	(78.24)	(124.56)	(79.70)	(85.70)	(131.07)
$250	(51.10)	(125.20)	(93.31)	(148.55)	(95.05)	(102.21)	(156.32)
$300	(59.41)	(145.54)	(108.47)	(172.70)	(110.49)	(118.82)	(181.73)
$350	(67.67)	(165.79)	(123.56)	(196.72)	(125.87)	(135.33)	(207.01)
$400	(74.33)	(182.10)	(135.71)	(216.06)	(138.24)	(148.64)	(227.36)
$500	(87.65)	(214.75)	(160.05)	(254.81)	(163.03)	(175.30)	(268.13)
$750	(114.02)	(279.34)	(208.18)	(331.44)	(212.06)	(228.02)	(348.77)
$1,000	(134.54)	(329.62)	(245.66)	(391.10)	(250.24)	(269.07)	(411.54)
$1,500	(165.64)	(405.81)	(302.44)	(481.51)	(308.07)	(331.27)	(506.68)
$2,000	(179.74)	(440.36)	(328.20)	(522.50)	(334.30)	(359.47)	(549.82)
$2,500	(193.84)	(474.90)	(353.95)	(563.50)	(360.53)	(387.67)	(592.96)
$5,000	(234.20)	(573.77)	(427.62)	(680.80)	(435.59)	(468.37)	(716.40)
$10,000	(267.50)	(655.36)	(488.43)	(777.61)	(497.53)	(534.98)	(818.27)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(33.40)	(81.84)	(60.99)	(97.10)	(62.13)	(66.81)	(102.18)
$250	(39.85)	(97.64)	(72.77)	(115.85)	(74.12)	(79.71)	(121.91)
$300	(46.29)	(113.41)	(84.53)	(134.57)	(86.11)	(92.59)	(141.61)
$350	(52.72)	(129.17)	(96.26)	(153.27)	(98.06)	(105.45)	(161.28)
$400	(58.13)	(142.43)	(106.15)	(168.99)	(108.13)	(116.27)	(177.83)
$500	(68.81)	(168.59)	(125.65)	(200.04)	(127.99)	(137.62)	(210.49)
$750	(89.77)	(219.94)	(163.92)	(260.97)	(166.97)	(179.54)	(274.61)
$1,000	(106.31)	(260.46)	(194.12)	(309.04)	(197.74)	(212.61)	(325.20)
$1,500	(131.14)	(321.27)	(239.44)	(381.21)	(243.90)	(262.26)	(401.14)
$2,000	(144.02)	(352.83)	(262.96)	(418.65)	(267.85)	(288.02)	(440.53)
$2,500	(156.90)	(384.39)	(286.48)	(456.09)	(291.81)	(313.78)	(479.94)
$5,000	(197.03)	(482.72)	(359.77)	(572.77)	(366.46)	(394.05)	(602.72)
$10,000	(230.17)	(563.91)	(420.28)	(669.11)	(428.10)	(460.32)	(704.09)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(22.96)	(56.25)	(41.92)	(66.73)	(42.70)	(45.92)	(70.23)
$250	(27.51)	(67.41)	(50.24)	(79.98)	(51.17)	(55.03)	(84.16)
$300	(32.11)	(78.67)	(58.63)	(93.34)	(59.72)	(64.22)	(98.22)
$350	(36.64)	(89.77)	(66.91)	(106.52)	(68.15)	(73.29)	(112.09)
$400	(40.61)	(99.48)	(74.14)	(118.04)	(75.53)	(81.21)	(124.22)
$500	(48.51)	(118.86)	(88.58)	(141.03)	(90.23)	(97.03)	(148.41)
$750	(63.65)	(155.93)	(116.22)	(185.02)	(118.38)	(127.28)	(194.69)
$1,000	(75.96)	(186.09)	(138.69)	(220.81)	(141.27)	(151.90)	(232.34)
$1,500	(94.92)	(232.55)	(173.32)	(275.92)	(176.54)	(189.83)	(290.35)
$2,000	(105.02)	(257.29)	(191.76)	(305.28)	(195.32)	(210.03)	(321.25)
$2,500	(115.15)	(282.10)	(210.25)	(334.73)	(214.16)	(230.28)	(352.23)

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LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(42.44)	(103.98)	(77.50)	(123.37)	(78.94)	(84.88)	(129.82)
$350	(56.18)	(137.64)	(102.58)	(163.32)	(104.49)	(112.36)	(171.85)
$500	(72.28)	(177.09)	(131.98)	(210.12)	(134.44)	(144.56)	(221.10)
$750	(93.91)	(230.08)	(171.48)	(273.00)	(174.67)	(187.82)	(287.27)
$1,000	(110.47)	(270.65)	(201.72)	(321.14)	(205.47)	(220.94)	(337.93)
$1,500	(135.86)	(332.86)	(248.08)	(394.95)	(252.70)	(271.72)	(415.60)
$2,500	(151.88)	(372.11)	(277.33)	(441.52)	(282.50)	(303.76)	(464.60)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(56.72)	(138.96)	(103.57)	(164.89)	(105.50)	(113.44)	(173.51)
$250	(67.65)	(165.74)	(123.53)	(196.66)	(125.83)	(135.30)	(206.94)
$300	(78.63)	(192.64)	(143.58)	(228.58)	(146.25)	(157.26)	(240.53)
$350	(89.60)	(219.52)	(163.61)	(260.47)	(166.66)	(179.20)	(274.09)
$400	(98.21)	(240.61)	(179.33)	(285.50)	(182.67)	(196.42)	(300.42)
$500	(115.44)	(282.83)	(210.79)	(335.58)	(214.72)	(230.88)	(353.13)
$750	(149.92)	(367.30)	(273.75)	(435.82)	(278.85)	(299.84)	(458.61)
$1,000	(176.47)	(432.35)	(322.23)	(513.00)	(328.23)	(352.94)	(539.82)
$1,500	(217.08)	(531.85)	(396.39)	(631.05)	(403.77)	(434.16)	(664.05)
$2,000	(233.69)	(572.54)	(426.72)	(679.34)	(434.66)	(467.38)	(714.86)
$2,500	(250.35)	(613.36)	(457.14)	(727.77)	(465.65)	(500.70)	(765.82)
$5,000	(294.31)	(721.06)	(537.41)	(855.56)	(547.42)	(588.62)	(900.29)
$10,000	(330.62)	(810.02)	(603.71)	(961.11)	(614.95)	(661.24)	(1,011.37)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(46.47)	(113.85)	(84.85)	(135.09)	(86.43)	(92.94)	(142.15)
$250	(55.42)	(135.78)	(101.20)	(161.11)	(103.08)	(110.84)	(169.53)
$300	(64.43)	(157.85)	(117.65)	(187.30)	(119.84)	(128.86)	(197.09)
$350	(73.39)	(179.81)	(134.01)	(213.34)	(136.51)	(146.78)	(224.50)
$400	(80.60)	(197.47)	(147.18)	(234.30)	(149.92)	(161.20)	(246.56)
$500	(95.07)	(232.92)	(173.60)	(276.37)	(176.83)	(190.14)	(290.82)
$750	(123.66)	(302.97)	(225.80)	(359.48)	(230.01)	(247.32)	(378.28)
$1,000	(145.91)	(357.48)	(266.43)	(424.16)	(271.39)	(291.82)	(446.34)
$1,500	(179.65)	(440.14)	(328.04)	(522.24)	(334.15)	(359.30)	(549.55)
$2,000	(194.93)	(477.58)	(355.94)	(566.66)	(362.57)	(389.86)	(596.29)
$2,500	(210.24)	(515.09)	(383.90)	(611.17)	(391.05)	(420.48)	(643.12)
$5,000	(254.00)	(622.30)	(463.80)	(738.38)	(472.44)	(508.00)	(776.99)
$10,000	(290.12)	(710.79)	(529.76)	(843.38)	(539.62)	(580.24)	(887.48)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(36.23)	(88.76)	(66.16)	(105.32)	(67.39)	(72.46)	(110.83)
$250	(43.23)	(105.91)	(78.94)	(125.67)	(80.41)	(86.46)	(132.24)
$300	(50.21)	(123.01)	(91.68)	(145.96)	(93.39)	(100.42)	(153.59)
$350	(57.19)	(140.12)	(104.43)	(166.25)	(106.37)	(114.38)	(174.94)
$400	(63.05)	(154.47)	(115.13)	(183.29)	(117.27)	(126.10)	(192.87)
$500	(74.63)	(182.84)	(136.27)	(216.95)	(138.81)	(149.26)	(228.29)
$750	(97.37)	(238.56)	(177.80)	(283.05)	(181.11)	(194.74)	(297.85)
$1,000	(115.30)	(282.49)	(210.54)	(335.18)	(214.46)	(230.60)	(352.70)
$1,500	(142.21)	(348.41)	(259.68)	(413.40)	(264.51)	(284.42)	(435.02)
$2,000	(156.19)	(382.67)	(285.20)	(454.04)	(290.51)	(312.38)	(477.79)
$2,500	(170.16)	(416.89)	(310.71)	(494.66)	(316.50)	(340.32)	(520.52)
$5,000	(213.69)	(523.54)	(390.20)	(621.20)	(397.46)	(427.38)	(653.68)
$10,000	(249.63)	(611.59)	(455.82)	(725.67)	(464.31)	(499.26)	(763.62)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(24.90)	(61.01)	(45.47)	(72.38)	(46.31)	(49.80)	(76.17)
$250	(29.85)	(73.13)	(54.51)	(86.77)	(55.52)	(59.70)	(91.31)
$300	(34.83)	(85.33)	(63.60)	(101.25)	(64.78)	(69.66)	(106.54)
$350	(39.74)	(97.36)	(72.57)	(115.52)	(73.92)	(79.48)	(121.56)
$400	(44.04)	(107.90)	(80.42)	(128.02)	(81.91)	(88.08)	(134.72)
$500	(52.61)	(128.89)	(96.07)	(152.94)	(97.85)	(105.22)	(160.93)
$750	(69.03)	(169.12)	(126.05)	(200.67)	(128.40)	(138.06)	(211.16)
$1,000	(82.39)	(201.86)	(150.44)	(239.51)	(153.25)	(164.78)	(252.03)
$1,500	(102.94)	(252.20)	(187.97)	(299.25)	(191.47)	(205.88)	(314.89)
$2,000	(113.89)	(279.03)	(207.96)	(331.08)	(211.84)	(227.78)	(348.39)
$2,500	(124.89)	(305.98)	(228.05)	(363.06)	(232.30)	(249.78)	(382.04)

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DOLLAR CHANGE IN RATES

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(3.31)	(8.11)	(6.05)	(9.62)	(6.16)	(6.62)	(10.13)
$350	(4.38)	(10.74)	(8.01)	(12.75)	(8.15)	(8.77)	(13.41)
$500	(5.64)	(13.82)	(10.29)	(16.39)	(10.49)	(11.28)	(17.24)
$750	(7.33)	(17.95)	(13.38)	(21.30)	(13.63)	(14.66)	(22.41)
$1,000	(8.61)	(21.10)	(15.73)	(25.04)	(16.02)	(17.23)	(26.35)
$1,500	(10.59)	(25.97)	(19.36)	(30.81)	(19.72)	(21.20)	(32.42)
$2,500	(11.84)	(29.01)	(21.62)	(34.42)	(22.03)	(23.69)	(36.22)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(4.42)	(10.84)	(8.08)	(12.87)	(8.24)	(8.85)	(13.54)
$250	(5.27)	(12.90)	(9.63)	(15.32)	(9.81)	(10.54)	(16.11)
$300	(6.13)	(15.02)	(11.20)	(17.82)	(11.41)	(12.27)	(18.75)
$350	(6.99)	(17.13)	(12.77)	(20.32)	(13.02)	(13.99)	(21.39)
$400	(7.65)	(18.74)	(13.98)	(22.25)	(14.24)	(15.31)	(23.40)
$500	(9.00)	(22.05)	(16.43)	(26.15)	(16.74)	(18.00)	(27.52)
$750	(11.68)	(28.63)	(21.33)	(33.97)	(21.74)	(23.38)	(35.75)
$1,000	(13.76)	(33.71)	(25.13)	(39.99)	(25.60)	(27.52)	(42.09)
$1,500	(16.93)	(41.49)	(30.93)	(49.21)	(31.50)	(33.88)	(51.79)
$2,000	(18.22)	(44.66)	(33.29)	(52.98)	(33.91)	(36.47)	(55.75)
$2,500	(19.52)	(47.83)	(35.65)	(56.74)	(36.31)	(39.05)	(59.71)
$5,000	(22.94)	(56.21)	(41.91)	(66.69)	(42.69)	(45.90)	(70.18)
$10,000	(25.78)	(63.16)	(47.08)	(74.94)	(47.97)	(51.57)	(78.86)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(3.62)	(8.87)	(6.61)	(10.53)	(6.73)	(7.24)	(11.08)
$250	(4.32)	(10.58)	(7.89)	(12.56)	(8.03)	(8.63)	(13.21)
$300	(5.02)	(12.31)	(9.18)	(14.60)	(9.35)	(10.04)	(15.36)
$350	(5.72)	(14.02)	(10.45)	(16.62)	(10.64)	(11.45)	(17.49)
$400	(6.27)	(15.37)	(11.47)	(18.24)	(11.68)	(12.56)	(19.20)
$500	(7.42)	(18.17)	(13.55)	(21.56)	(13.80)	(14.84)	(22.69)
$750	(9.64)	(23.63)	(17.62)	(28.04)	(17.95)	(19.30)	(29.51)
$1,000	(11.37)	(27.86)	(20.77)	(33.06)	(21.15)	(22.75)	(34.80)
$1,500	(14.01)	(34.33)	(25.60)	(40.73)	(26.08)	(28.03)	(42.87)
$2,000	(15.19)	(37.22)	(27.74)	(44.16)	(28.27)	(30.39)	(46.47)
$2,500	(16.40)	(40.19)	(29.95)	(47.67)	(30.52)	(32.81)	(50.16)
$5,000	(19.80)	(48.53)	(36.18)	(57.58)	(36.85)	(39.63)	(60.59)
$10,000	(22.62)	(55.43)	(41.33)	(65.77)	(42.09)	(45.26)	(69.21)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(2.83)	(6.92)	(5.17)	(8.22)	(5.26)	(5.65)	(8.65)
$250	(3.38)	(8.27)	(6.17)	(9.82)	(6.29)	(6.75)	(10.33)
$300	(3.92)	(9.60)	(7.15)	(11.39)	(7.28)	(7.83)	(11.98)
$350	(4.47)	(10.95)	(8.17)	(12.98)	(8.31)	(8.93)	(13.66)
$400	(4.92)	(12.04)	(8.98)	(14.30)	(9.14)	(9.83)	(15.04)
$500	(5.82)	(14.25)	(10.62)	(16.91)	(10.82)	(11.64)	(17.80)
$750	(7.60)	(18.62)	(13.88)	(22.08)	(14.14)	(15.20)	(23.24)
$1,000	(8.99)	(22.03)	(16.42)	(26.14)	(16.72)	(17.99)	(27.50)
$1,500	(11.07)	(27.14)	(20.24)	(32.19)	(20.61)	(22.16)	(33.88)
$2,000	(12.17)	(29.84)	(22.24)	(35.39)	(22.66)	(24.36)	(37.26)
$2,500	(13.26)	(32.50)	(24.23)	(38.57)	(24.69)	(26.54)	(40.58)
$5,000	(16.66)	(40.82)	(30.43)	(48.43)	(31.00)	(33.33)	(50.96)
$10,000	(19.46)	(47.68)	(35.54)	(56.56)	(36.21)	(38.94)	(59.53)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(1.94)	(4.76)	(3.55)	(5.65)	(3.61)	(3.88)	(5.94)
$250	(2.34)	(5.72)	(4.27)	(6.79)	(4.35)	(4.67)	(7.15)
$300	(2.72)	(6.66)	(4.97)	(7.91)	(5.06)	(5.44)	(8.32)
$350	(3.10)	(7.59)	(5.66)	(9.00)	(5.77)	(6.19)	(9.47)
$400	(3.43)	(8.42)	(6.28)	(9.98)	(6.38)	(6.87)	(10.50)
$500	(4.10)	(10.03)	(7.49)	(11.91)	(7.62)	(8.19)	(12.52)
$750	(5.38)	(13.19)	(9.83)	(15.65)	(10.02)	(10.78)	(16.47)
$1,000	(6.43)	(15.77)	(11.75)	(18.70)	(11.98)	(12.88)	(19.69)
$1,500	(8.02)	(19.65)	(14.65)	(23.33)	(14.93)	(16.05)	(24.54)
$2,000	(8.87)	(21.74)	(16.20)	(25.80)	(16.52)	(17.75)	(27.14)
$2,500	(9.74)	(23.88)	(17.80)	(28.33)	(18.14)	(19.50)	(29.81)

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HIP POS LARGE GROUP CONTRACT
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PERCENTAGE CHANGE IN RATES

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
$300	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
$350	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$400	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
$400	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$500	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(154.74)	(379.10)	(282.54)	(449.81)	(287.80)	(309.46)	(473.33)
$10,000	(187.40)	(459.13)	(342.19)	(544.78)	(348.56)	(374.79)	(573.26)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(30.42)	(74.52)	(55.54)	(88.42)	(56.57)	(60.83)	(93.04)
$1,500	(33.17)	(81.27)	(60.56)	(96.42)	(61.69)	(66.34)	(101.46)
$2,000	(34.63)	(84.83)	(63.23)	(100.66)	(64.40)	(69.25)	(105.91)
$3,000	(35.88)	(87.90)	(65.51)	(104.29)	(66.73)	(71.76)	(109.76)
$4,000	(36.45)	(89.29)	(66.55)	(105.96)	(67.79)	(72.90)	(111.50)
$5,000	(36.75)	(90.03)	(67.09)	(106.82)	(68.34)	(73.49)	(112.41)
$7,000	(37.08)	(90.84)	(67.71)	(107.79)	(68.97)	(74.16)	(113.44)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(48.41)	(118.61)	(88.40)	(140.73)	(90.04)	(96.83)	(148.09)
$1,500	(52.81)	(129.39)	(96.44)	(153.53)	(98.23)	(105.63)	(161.56)
$2,000	(55.08)	(134.94)	(100.57)	(160.11)	(102.44)	(110.15)	(168.48)
$3,000	(57.18)	(140.08)	(104.40)	(166.21)	(106.34)	(114.35)	(174.90)
$4,000	(58.06)	(142.25)	(106.02)	(168.79)	(107.99)	(116.13)	(177.61)
$5,000	(58.52)	(143.37)	(106.85)	(170.12)	(108.85)	(117.04)	(179.02)
$7,000	(59.08)	(144.75)	(107.88)	(171.75)	(109.89)	(118.16)	(180.73)
$7,500	(59.56)	(145.92)	(108.76)	(173.14)	(110.78)	(119.12)	(182.20)
$10,000	(61.30)	(150.19)	(111.94)	(178.20)	(114.02)	(122.61)	(187.53)
$20,000	(63.79)	(156.28)	(116.47)	(185.44)	(118.64)	(127.57)	(195.13)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(46.78)	(114.62)	(85.42)	(136.00)	(87.01)	(93.56)	(143.11)
$1,500	(52.00)	(127.40)	(94.95)	(151.16)	(96.71)	(104.00)	(159.07)
$2,000	(54.89)	(134.49)	(100.23)	(159.58)	(102.09)	(109.79)	(167.92)
$3,000	(57.74)	(141.45)	(105.43)	(167.84)	(107.38)	(115.47)	(176.61)
$4,000	(59.03)	(144.63)	(107.79)	(171.60)	(109.80)	(118.06)	(180.58)
$5,000	(59.74)	(146.37)	(109.08)	(173.68)	(111.12)	(119.49)	(182.76)
$7,000	(60.44)	(148.07)	(110.36)	(175.69)	(112.41)	(120.87)	(184.88)
$7,500	(60.96)	(149.34)	(111.31)	(177.20)	(113.37)	(121.91)	(186.47)
$10,000	(63.10)	(154.58)	(115.21)	(183.42)	(117.36)	(126.18)	(193.01)
$20,000	(66.40)	(162.67)	(121.24)	(193.02)	(123.49)	(132.79)	(203.11)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(45.16)	(110.64)	(82.47)	(131.29)	(84.00)	(90.32)	(138.15)
$1,500	(51.21)	(125.47)	(93.51)	(148.88)	(95.26)	(102.43)	(156.66)
$2,000	(54.70)	(134.01)	(99.88)	(159.01)	(101.74)	(109.40)	(167.32)
$3,000	(58.32)	(142.87)	(106.49)	(169.53)	(108.46)	(116.63)	(178.39)
$4,000	(59.97)	(146.92)	(109.50)	(174.33)	(111.54)	(119.94)	(183.44)
$5,000	(60.94)	(149.29)	(111.26)	(177.14)	(113.33)	(121.87)	(186.41)
$7,000	(61.79)	(151.39)	(112.82)	(179.63)	(114.93)	(123.58)	(189.01)
$7,500	(62.34)	(152.74)	(113.83)	(181.23)	(115.95)	(124.67)	(190.71)
$10,000	(64.71)	(158.53)	(118.15)	(188.10)	(120.35)	(129.40)	(197.93)
$20,000	(68.90)	(168.82)	(125.82)	(200.30)	(128.16)	(137.80)	(210.78)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(51.10)	(125.20)	(93.31)	(148.55)	(95.05)	(102.21)	(156.32)
$1,500	(60.90)	(149.19)	(111.19)	(177.02)	(113.26)	(121.79)	(186.27)
$2,000	(67.21)	(164.67)	(122.73)	(195.38)	(125.01)	(134.42)	(205.60)
$3,000	(74.86)	(183.39)	(136.68)	(217.61)	(139.23)	(149.70)	(228.98)
$4,000	(79.05)	(193.68)	(144.35)	(229.80)	(147.03)	(158.10)	(241.82)
$5,000	(81.64)	(200.02)	(149.07)	(237.34)	(151.85)	(163.27)	(249.74)
$7,000	(84.31)	(206.56)	(153.95)	(245.09)	(156.81)	(168.61)	(257.91)
$7,500	(85.30)	(208.99)	(155.75)	(247.96)	(158.65)	(170.59)	(260.94)
$10,000	(89.26)	(218.70)	(162.99)	(259.49)	(166.03)	(178.52)	(273.05)
$20,000	(97.62)	(239.17)	(178.24)	(283.78)	(181.57)	(195.23)	(298.62)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.38	0.93	0.69	1.10	0.70	0.75	1.15
$1,000,000	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
$50,000	(5.01)	(12.28)	(9.15)	(14.57)	(9.32)	(10.03)	(15.34)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(167.81)	(411.13)	(306.42)	(487.82)	(312.13)	(335.62)	(513.33)
$10,000	(203.25)	(497.96)	(371.13)	(590.85)	(378.05)	(406.50)	(621.74)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(32.99)	(80.83)	(60.24)	(95.90)	(61.36)	(65.98)	(100.92)
$1,500	(35.98)	(88.15)	(65.70)	(104.59)	(66.92)	(71.96)	(110.06)
$2,000	(37.55)	(92.00)	(68.57)	(109.16)	(69.84)	(75.10)	(114.87)
$3,000	(38.92)	(95.35)	(71.07)	(113.14)	(72.39)	(77.84)	(119.06)
$4,000	(39.53)	(96.85)	(72.18)	(114.91)	(73.53)	(79.06)	(120.92)
$5,000	(39.85)	(97.63)	(72.77)	(115.84)	(74.12)	(79.70)	(121.90)
$7,000	(40.22)	(98.54)	(73.44)	(116.92)	(74.81)	(80.44)	(123.03)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(52.50)	(128.63)	(95.87)	(152.62)	(97.65)	(105.00)	(160.60)
$1,500	(57.29)	(140.36)	(104.61)	(166.54)	(106.56)	(114.58)	(175.25)
$2,000	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$3,000	(62.01)	(151.92)	(113.23)	(180.26)	(115.34)	(124.02)	(189.69)
$4,000	(62.96)	(154.25)	(114.96)	(183.02)	(117.11)	(125.92)	(192.59)
$5,000	(63.46)	(155.48)	(115.88)	(184.48)	(118.04)	(126.92)	(194.12)
$7,000	(64.07)	(156.97)	(116.99)	(186.25)	(119.17)	(128.14)	(195.99)
$7,500	(64.59)	(158.25)	(117.94)	(187.76)	(120.14)	(129.18)	(197.58)
$10,000	(66.49)	(162.90)	(121.41)	(193.29)	(123.67)	(132.98)	(203.39)
$20,000	(69.18)	(169.49)	(126.32)	(201.11)	(128.67)	(138.36)	(211.62)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(50.74)	(124.31)	(92.65)	(147.50)	(94.38)	(101.48)	(155.21)
$1,500	(56.39)	(138.16)	(102.97)	(163.93)	(104.89)	(112.78)	(172.50)
$2,000	(59.54)	(145.87)	(108.72)	(173.08)	(110.74)	(119.08)	(182.13)
$3,000	(62.62)	(153.42)	(114.34)	(182.04)	(116.47)	(125.24)	(191.55)
$4,000	(64.02)	(156.85)	(116.90)	(186.11)	(119.08)	(128.04)	(195.84)
$5,000	(64.80)	(158.76)	(118.32)	(188.37)	(120.53)	(129.60)	(198.22)
$7,000	(65.55)	(160.60)	(119.69)	(190.55)	(121.92)	(131.10)	(200.52)
$7,500	(66.11)	(161.97)	(120.72)	(192.18)	(122.96)	(132.22)	(202.23)
$10,000	(68.43)	(167.65)	(124.95)	(198.93)	(127.28)	(136.86)	(209.33)
$20,000	(72.01)	(176.42)	(131.49)	(209.33)	(133.94)	(144.02)	(220.28)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(48.98)	(120.00)	(89.44)	(142.38)	(91.10)	(97.96)	(149.83)
$1,500	(55.56)	(136.12)	(101.45)	(161.51)	(103.34)	(111.12)	(169.96)
$2,000	(59.34)	(145.38)	(108.35)	(172.50)	(110.37)	(118.68)	(181.52)
$3,000	(63.26)	(154.99)	(115.51)	(183.90)	(117.66)	(126.52)	(193.51)
$4,000	(65.04)	(159.35)	(118.76)	(189.07)	(120.97)	(130.08)	(198.96)
$5,000	(66.09)	(161.92)	(120.68)	(192.12)	(122.93)	(132.18)	(202.17)
$7,000	(67.02)	(164.20)	(122.38)	(194.83)	(124.66)	(134.04)	(205.01)
$7,500	(67.61)	(165.64)	(123.46)	(196.54)	(125.75)	(135.22)	(206.82)
$10,000	(70.17)	(171.92)	(128.13)	(203.98)	(130.52)	(140.34)	(214.65)
$20,000	(74.73)	(183.09)	(136.46)	(217.24)	(139.00)	(149.46)	(228.60)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(55.42)	(135.78)	(101.20)	(161.11)	(103.08)	(110.84)	(169.53)
$1,500	(66.05)	(161.82)	(120.61)	(192.01)	(122.85)	(132.10)	(202.05)
$2,000	(72.89)	(178.58)	(133.10)	(211.89)	(135.58)	(145.78)	(222.97)
$3,000	(81.19)	(198.92)	(148.25)	(236.02)	(151.01)	(162.38)	(248.36)
$4,000	(85.74)	(210.06)	(156.56)	(249.25)	(159.48)	(171.48)	(262.28)
$5,000	(88.54)	(216.92)	(161.67)	(257.39)	(164.68)	(177.08)	(270.84)
$7,000	(91.43)	(224.00)	(166.95)	(265.79)	(170.06)	(182.86)	(279.68)
$7,500	(92.50)	(226.63)	(168.91)	(268.90)	(172.05)	(185.00)	(282.96)
$10,000	(96.82)	(237.21)	(176.79)	(281.46)	(180.09)	(193.64)	(296.17)
$20,000	(105.87)	(259.38)	(193.32)	(307.76)	(196.92)	(211.74)	(323.86)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.42	1.03	0.77	1.22	0.78	0.84	1.28
$1,000,000	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$50,000	(5.44)	(13.33)	(9.93)	(15.81)	(10.12)	(10.88)	(16.64)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(13.07)	(32.03)	(23.88)	(38.01)	(24.33)	(26.16)	(40.00)
$10,000	(15.85)	(38.83)	(28.94)	(46.07)	(29.49)	(31.71)	(48.48)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(2.57)	(6.31)	(4.70)	(7.48)	(4.79)	(5.15)	(7.88)
$1,500	(2.81)	(6.88)	(5.14)	(8.17)	(5.23)	(5.62)	(8.60)
$2,000	(2.92)	(7.17)	(5.34)	(8.50)	(5.44)	(5.85)	(8.96)
$3,000	(3.04)	(7.45)	(5.56)	(8.85)	(5.66)	(6.08)	(9.30)
$4,000	(3.08)	(7.56)	(5.63)	(8.95)	(5.74)	(6.16)	(9.42)
$5,000	(3.10)	(7.60)	(5.68)	(9.02)	(5.78)	(6.21)	(9.49)
$7,000	(3.14)	(7.70)	(5.73)	(9.13)	(5.84)	(6.28)	(9.59)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(4.09)	(10.02)	(7.47)	(11.89)	(7.61)	(8.17)	(12.51)
$1,500	(4.48)	(10.97)	(8.17)	(13.01)	(8.33)	(8.95)	(13.69)
$2,000	(4.64)	(11.37)	(8.48)	(13.50)	(8.64)	(9.29)	(14.20)
$3,000	(4.83)	(11.84)	(8.83)	(14.05)	(9.00)	(9.67)	(14.79)
$4,000	(4.90)	(12.00)	(8.94)	(14.23)	(9.12)	(9.79)	(14.98)
$5,000	(4.94)	(12.11)	(9.03)	(14.36)	(9.19)	(9.88)	(15.10)
$7,000	(4.99)	(12.22)	(9.11)	(14.50)	(9.28)	(9.98)	(15.26)
$7,500	(5.03)	(12.33)	(9.18)	(14.62)	(9.36)	(10.06)	(15.38)
$10,000	(5.19)	(12.71)	(9.47)	(15.09)	(9.65)	(10.37)	(15.86)
$20,000	(5.39)	(13.21)	(9.85)	(15.67)	(10.03)	(10.79)	(16.49)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(3.96)	(9.69)	(7.23)	(11.50)	(7.37)	(7.92)	(12.10)
$1,500	(4.39)	(10.76)	(8.02)	(12.77)	(8.18)	(8.78)	(13.43)
$2,000	(4.65)	(11.38)	(8.49)	(13.50)	(8.65)	(9.29)	(14.21)
$3,000	(4.88)	(11.97)	(8.91)	(14.20)	(9.09)	(9.77)	(14.94)
$4,000	(4.99)	(12.22)	(9.11)	(14.51)	(9.28)	(9.98)	(15.26)
$5,000	(5.06)	(12.39)	(9.24)	(14.69)	(9.41)	(10.11)	(15.46)
$7,000	(5.11)	(12.53)	(9.33)	(14.86)	(9.51)	(10.23)	(15.64)
$7,500	(5.15)	(12.63)	(9.41)	(14.98)	(9.59)	(10.31)	(15.76)
$10,000	(5.33)	(13.07)	(9.74)	(15.51)	(9.92)	(10.68)	(16.32)
$20,000	(5.61)	(13.75)	(10.25)	(16.31)	(10.45)	(11.23)	(17.17)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(3.82)	(9.36)	(6.97)	(11.09)	(7.10)	(7.64)	(11.68)
$1,500	(4.35)	(10.65)	(7.94)	(12.63)	(8.08)	(8.69)	(13.30)
$2,000	(4.64)	(11.37)	(8.47)	(13.49)	(8.63)	(9.28)	(14.20)
$3,000	(4.94)	(12.12)	(9.02)	(14.37)	(9.20)	(9.89)	(15.12)
$4,000	(5.07)	(12.43)	(9.26)	(14.74)	(9.43)	(10.14)	(15.52)
$5,000	(5.15)	(12.63)	(9.42)	(14.98)	(9.60)	(10.31)	(15.76)
$7,000	(5.23)	(12.81)	(9.56)	(15.20)	(9.73)	(10.46)	(16.00)
$7,500	(5.27)	(12.90)	(9.63)	(15.31)	(9.80)	(10.55)	(16.11)
$10,000	(5.46)	(13.39)	(9.98)	(15.88)	(10.17)	(10.94)	(16.72)
$20,000	(5.83)	(14.27)	(10.64)	(16.94)	(10.84)	(11.66)	(17.82)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(4.32)	(10.58)	(7.89)	(12.56)	(8.03)	(8.63)	(13.21)
$1,500	(5.15)	(12.63)	(9.42)	(14.99)	(9.59)	(10.31)	(15.78)
$2,000	(5.68)	(13.91)	(10.37)	(16.51)	(10.57)	(11.36)	(17.37)
$3,000	(6.33)	(15.53)	(11.57)	(18.41)	(11.78)	(12.68)	(19.38)
$4,000	(6.69)	(16.38)	(12.21)	(19.45)	(12.45)	(13.38)	(20.46)
$5,000	(6.90)	(16.90)	(12.60)	(20.05)	(12.83)	(13.81)	(21.10)
$7,000	(7.12)	(17.44)	(13.00)	(20.70)	(13.25)	(14.25)	(21.77)
$7,500	(7.20)	(17.64)	(13.16)	(20.94)	(13.40)	(14.41)	(22.02)
$10,000	(7.56)	(18.51)	(13.80)	(21.97)	(14.06)	(15.12)	(23.12)
$20,000	(8.25)	(20.21)	(15.08)	(23.98)	(15.35)	(16.51)	(25.24)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.04	0.10	0.08	0.12	0.08	0.09	0.13
$1,000,000	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$50,000	(0.43)	(1.05)	(0.78)	(1.24)	(0.80)	(0.85)	(1.30)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

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OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
$5,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$3,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$5,000	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$7,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$7,500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$10,000	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%
$7,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%
$7,500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
$1,000,000	9.4%	11.7%	10.3%	10.9%	10.2%	11.1%	10.3%
$50,000	8.6%	8.6%	8.5%	8.5%	8.6%	8.5%	8.5%
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
75%	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
70%	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
75%	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
70%	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
75%	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
70%	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	10.5%	10.8%	11.6%	10.9%	11.4%	12.0%	11.3%
75%	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
70%	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$10	(4.42)	(10.83)	(8.07)	(12.86)	(8.22)	(8.84)	(13.53)
$15	(7.36)	(18.03)	(13.43)	(21.39)	(13.69)	(14.71)	(22.51)
$20	(11.35)	(27.81)	(20.73)	(33.00)	(21.11)	(22.70)	(34.73)
$25	(14.95)	(36.62)	(27.30)	(43.46)	(27.81)	(29.90)	(45.72)
$30	(18.90)	(46.31)	(34.51)	(54.94)	(35.16)	(37.80)	(57.82)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.19)	(2.92)	(2.18)	(3.46)	(2.22)	(2.38)	(3.65)
$10	(2.54)	(6.22)	(4.64)	(7.38)	(4.72)	(5.07)	(7.76)
$15	(4.22)	(10.33)	(7.70)	(12.26)	(7.85)	(8.44)	(12.90)
$20	(6.50)	(15.93)	(11.87)	(18.90)	(12.10)	(13.00)	(19.89)
$25	(8.56)	(20.97)	(15.63)	(24.88)	(15.92)	(17.12)	(26.19)
$30	(10.82)	(26.51)	(19.76)	(31.46)	(20.13)	(21.64)	(33.11)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.54)	(3.77)	(2.81)	(4.47)	(2.86)	(3.08)	(4.71)
$10	(3.18)	(7.79)	(5.81)	(9.24)	(5.91)	(6.36)	(9.72)
$15	(4.98)	(12.21)	(9.10)	(14.49)	(9.27)	(9.97)	(15.24)
$20	(7.02)	(17.20)	(12.82)	(20.41)	(13.05)	(14.04)	(21.48)
$25	(9.26)	(22.69)	(16.92)	(26.92)	(17.23)	(18.53)	(28.34)
$30	(11.81)	(28.93)	(21.56)	(34.33)	(21.97)	(23.62)	(36.12)
$35	(14.18)	(34.75)	(25.90)	(41.24)	(26.38)	(28.37)	(43.39)
$40	(16.65)	(40.79)	(30.41)	(48.40)	(30.97)	(33.30)	(50.93)
$45	(19.26)	(47.18)	(35.17)	(55.98)	(35.82)	(38.52)	(58.91)
$50	(21.98)	(53.85)	(40.14)	(63.89)	(40.88)	(43.96)	(67.23)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.30)	(3.20)	(2.38)	(3.79)	(2.43)	(2.61)	(3.99)
$10	(2.69)	(6.59)	(4.91)	(7.82)	(5.00)	(5.38)	(8.23)
$15	(4.22)	(10.33)	(7.70)	(12.26)	(7.85)	(8.44)	(12.90)
$20	(5.93)	(14.53)	(10.83)	(17.24)	(11.03)	(11.86)	(18.14)
$25	(7.84)	(19.20)	(14.31)	(22.77)	(14.57)	(15.67)	(23.97)
$30	(9.99)	(24.47)	(18.23)	(29.03)	(18.58)	(19.97)	(30.55)
$35	(12.01)	(29.43)	(21.94)	(34.92)	(22.35)	(24.03)	(36.76)
$40	(14.09)	(34.52)	(25.73)	(40.96)	(26.21)	(28.19)	(43.11)
$45	(16.28)	(39.89)	(29.73)	(47.33)	(30.28)	(32.57)	(49.81)
$50	(18.60)	(45.56)	(33.95)	(54.06)	(34.58)	(37.19)	(56.89)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.76)	(1.87)	(1.40)	(2.22)	(1.42)	(1.53)	(2.33)
$150	(1.25)	(3.07)	(2.29)	(3.65)	(2.33)	(2.51)	(3.83)
$200	(1.79)	(4.39)	(3.27)	(5.22)	(3.33)	(3.59)	(5.48)
$250	(2.58)	(6.32)	(4.71)	(7.49)	(4.80)	(5.16)	(7.89)
$500	(6.21)	(15.20)	(11.33)	(18.04)	(11.55)	(12.41)	(18.98)
$750	(10.64)	(26.07)	(19.42)	(30.93)	(19.79)	(21.28)	(32.55)
$1,000	(16.01)	(39.22)	(29.24)	(46.54)	(29.78)	(32.02)	(48.97)
Copay/Day							
$50 w/3 Day Max	(0.94)	(2.29)	(1.71)	(2.72)	(1.74)	(1.87)	(2.86)
$50 w/5 Day Max	(1.27)	(3.12)	(2.32)	(3.70)	(2.36)	(2.55)	(3.89)
$100 w/3 Day Max	(2.32)	(5.70)	(4.24)	(6.76)	(4.32)	(4.65)	(7.10)
$100 w/5 Day Max	(3.35)	(8.21)	(6.12)	(9.74)	(6.24)	(6.71)	(10.25)
$250 w/3 Day Max	(7.72)	(18.92)	(14.10)	(22.45)	(14.37)	(15.45)	(23.63)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.42)	(1.02)	(0.76)	(1.21)	(0.77)	(0.84)	(1.27)
$75	(0.65)	(1.60)	(1.19)	(1.90)	(1.21)	(1.30)	(2.00)
$100	(0.94)	(2.29)	(1.71)	(2.72)	(1.74)	(1.87)	(2.86)
$125	(1.21)	(2.98)	(2.21)	(3.53)	(2.25)	(2.43)	(3.71)
$150	(1.53)	(3.74)	(2.79)	(4.44)	(2.84)	(3.06)	(4.68)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
$25	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
$35	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$50	(0.89)	(2.17)	(1.62)	(2.58)	(1.65)	(1.77)	(2.71)
$60	(1.11)	(2.72)	(2.03)	(3.23)	(2.07)	(2.22)	(3.39)
$75	(1.48)	(3.62)	(2.70)	(4.30)	(2.75)	(2.96)	(4.52)
$100	(2.10)	(5.15)	(3.83)	(6.10)	(3.90)	(4.20)	(6.42)
$125	(2.58)	(6.32)	(4.71)	(7.49)	(4.80)	(5.16)	(7.89)
$150	(3.09)	(7.56)	(5.64)	(8.98)	(5.75)	(6.18)	(9.45)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.42	1.02	0.76	1.21	0.77	0.84	1.27
60	0.82	2.00	1.49	2.37	1.52	1.63	2.50
90	1.20	2.94	2.19	3.50	2.23	2.40	3.68
120	1.42	3.47	2.59	4.12	2.64	2.83	4.33
Unlimited	1.82	4.47	3.33	5.30	3.39	3.65	5.58
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.28)	(5.59)	(4.16)	(6.63)	(4.24)	(4.56)	(6.97)
$10	(4.80)	(11.76)	(8.76)	(13.95)	(8.93)	(9.60)	(14.68)
$15	(7.98)	(19.55)	(14.57)	(23.20)	(14.84)	(15.96)	(24.41)
$20	(12.32)	(30.18)	(22.50)	(35.81)	(22.92)	(24.64)	(37.69)
$25	(16.21)	(39.71)	(29.60)	(47.12)	(30.15)	(32.42)	(49.59)
$30	(20.51)	(50.25)	(37.45)	(59.62)	(38.15)	(41.02)	(62.74)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$10	(2.75)	(6.74)	(5.02)	(7.99)	(5.12)	(5.50)	(8.41)
$15	(4.57)	(11.20)	(8.34)	(13.28)	(8.50)	(9.14)	(13.98)
$20	(7.05)	(17.27)	(12.87)	(20.49)	(13.11)	(14.10)	(21.57)
$25	(9.28)	(22.74)	(16.95)	(26.98)	(17.26)	(18.56)	(28.39)
$30	(11.73)	(28.74)	(21.42)	(34.10)	(21.82)	(23.46)	(35.88)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$10	(3.44)	(8.43)	(6.28)	(10.00)	(6.40)	(6.88)	(10.52)
$15	(5.41)	(13.25)	(9.88)	(15.73)	(10.06)	(10.82)	(16.55)
$20	(7.62)	(18.67)	(13.91)	(22.15)	(14.17)	(15.24)	(23.31)
$25	(10.04)	(24.60)	(18.33)	(29.19)	(18.67)	(20.08)	(30.71)
$30	(12.81)	(31.38)	(23.39)	(37.24)	(23.83)	(25.62)	(39.19)
$35	(15.39)	(37.71)	(28.10)	(44.74)	(28.63)	(30.78)	(47.08)
$40	(18.06)	(44.25)	(32.98)	(52.50)	(33.59)	(36.12)	(55.25)
$45	(20.89)	(51.18)	(38.15)	(60.73)	(38.86)	(41.78)	(63.90)
$50	(23.84)	(58.41)	(43.53)	(69.30)	(44.34)	(47.68)	(72.93)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$10	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$15	(4.57)	(11.20)	(8.34)	(13.28)	(8.50)	(9.14)	(13.98)
$20	(6.44)	(15.78)	(11.76)	(18.72)	(11.98)	(12.88)	(19.70)
$25	(8.50)	(20.83)	(15.52)	(24.71)	(15.81)	(17.00)	(26.00)
$30	(10.83)	(26.53)	(19.78)	(31.48)	(20.14)	(21.66)	(33.13)
$35	(13.02)	(31.90)	(23.77)	(37.85)	(24.22)	(26.04)	(39.83)
$40	(15.29)	(37.46)	(27.92)	(44.45)	(28.44)	(30.58)	(46.77)
$45	(17.66)	(43.27)	(32.25)	(51.34)	(32.85)	(35.32)	(54.02)
$50	(20.17)	(49.42)	(36.83)	(58.63)	(37.52)	(40.34)	(61.70)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$150	(1.35)	(3.31)	(2.47)	(3.92)	(2.51)	(2.70)	(4.13)
$200	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.97)
$250	(2.79)	(6.84)	(5.09)	(8.11)	(5.19)	(5.58)	(8.53)
$500	(6.73)	(16.49)	(12.29)	(19.56)	(12.52)	(13.46)	(20.59)
$750	(11.54)	(28.27)	(21.07)	(33.55)	(21.46)	(23.08)	(35.30)
$1,000	(17.36)	(42.53)	(31.70)	(50.47)	(32.29)	(34.72)	(53.10)
Copay/Day							
$50 w/3 Day Max	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$50 w/5 Day Max	(1.39)	(3.41)	(2.54)	(4.04)	(2.59)	(2.78)	(4.25)
$100 w/3 Day Max	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$100 w/5 Day Max	(3.65)	(8.94)	(6.66)	(10.61)	(6.79)	(7.30)	(11.17)
$250 w/3 Day Max	(8.38)	(20.53)	(15.30)	(24.36)	(15.59)	(16.76)	(25.63)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$100	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$125	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$150	(1.66)	(4.07)	(3.03)	(4.83)	(3.09)	(3.32)	(5.08)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$35	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$50	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
$60	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.40)	(3.67)
$75	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
$100	(2.27)	(5.56)	(4.15)	(6.60)	(4.22)	(4.54)	(6.94)
$125	(2.79)	(6.84)	(5.09)	(8.11)	(5.19)	(5.58)	(8.53)
$150	(3.34)	(8.18)	(6.10)	(9.71)	(6.21)	(6.68)	(10.22)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.46	1.13	0.84	1.34	0.86	0.92	1.41
60	0.90	2.21	1.64	2.62	1.67	1.80	2.75
90	1.29	3.16	2.36	3.75	2.40	2.58	3.95
120	1.54	3.77	2.81	4.48	2.86	3.08	4.71
Unlimited	1.99	4.88	3.63	5.78	3.70	3.98	6.09
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.42)	(0.31)	(0.50)	(0.32)	(0.34)	(0.52)
$10	(0.38)	(0.93)	(0.69)	(1.09)	(0.71)	(0.76)	(1.15)
$15	(0.62)	(1.52)	(1.14)	(1.81)	(1.15)	(1.25)	(1.90)
$20	(0.97)	(2.37)	(1.77)	(2.81)	(1.81)	(1.94)	(2.96)
$25	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.87)
$30	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.27)
$10	(0.21)	(0.52)	(0.38)	(0.61)	(0.40)	(0.43)	(0.65)
$15	(0.35)	(0.87)	(0.64)	(1.02)	(0.65)	(0.70)	(1.08)
$20	(0.55)	(1.34)	(1.00)	(1.59)	(1.01)	(1.10)	(1.68)
$25	(0.72)	(1.77)	(1.32)	(2.10)	(1.34)	(1.44)	(2.20)
$30	(0.91)	(2.23)	(1.66)	(2.64)	(1.69)	(1.82)	(2.77)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.24)	(0.38)	(0.25)	(0.26)	(0.40)
$10	(0.26)	(0.64)	(0.47)	(0.76)	(0.49)	(0.52)	(0.80)
$15	(0.43)	(1.04)	(0.78)	(1.24)	(0.79)	(0.85)	(1.31)
$20	(0.60)	(1.47)	(1.09)	(1.74)	(1.12)	(1.20)	(1.83)
$25	(0.78)	(1.91)	(1.41)	(2.27)	(1.44)	(1.55)	(2.37)
$30	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.07)
$35	(1.21)	(2.96)	(2.20)	(3.50)	(2.25)	(2.41)	(3.69)
$40	(1.41)	(3.46)	(2.57)	(4.10)	(2.62)	(2.82)	(4.32)
$45	(1.63)	(4.00)	(2.98)	(4.75)	(3.04)	(3.26)	(4.99)
$50	(1.86)	(4.56)	(3.39)	(5.41)	(3.46)	(3.72)	(5.70)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.30)	(0.23)	(0.37)	(0.23)	(0.25)	(0.38)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.35)	(0.87)	(0.64)	(1.02)	(0.65)	(0.70)	(1.08)
$20	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$25	(0.66)	(1.63)	(1.21)	(1.94)	(1.24)	(1.33)	(2.03)
$30	(0.84)	(2.06)	(1.55)	(2.45)	(1.56)	(1.69)	(2.58)
$35	(1.01)	(2.47)	(1.83)	(2.93)	(1.87)	(2.01)	(3.07)
$40	(1.20)	(2.94)	(2.19)	(3.49)	(2.23)	(2.39)	(3.66)
$45	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.75)	(4.21)
$50	(1.57)	(3.86)	(2.88)	(4.57)	(2.94)	(3.15)	(4.81)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.07)	(0.16)	(0.12)	(0.19)	(0.12)	(0.13)	(0.21)
$150	(0.10)	(0.24)	(0.18)	(0.27)	(0.18)	(0.19)	(0.30)
$200	(0.16)	(0.39)	(0.29)	(0.45)	(0.30)	(0.31)	(0.49)
$250	(0.21)	(0.52)	(0.38)	(0.62)	(0.39)	(0.42)	(0.64)
$500	(0.52)	(1.29)	(0.96)	(1.52)	(0.97)	(1.05)	(1.61)
$750	(0.90)	(2.20)	(1.65)	(2.62)	(1.67)	(1.80)	(2.75)
$1,000	(1.35)	(3.31)	(2.46)	(3.93)	(2.51)	(2.70)	(4.13)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.26)
$50 w/5 Day Max	(0.12)	(0.29)	(0.22)	(0.34)	(0.23)	(0.23)	(0.36)
$100 w/3 Day Max	(0.21)	(0.50)	(0.38)	(0.59)	(0.39)	(0.41)	(0.64)
$100 w/5 Day Max	(0.30)	(0.73)	(0.54)	(0.87)	(0.55)	(0.59)	(0.92)
$250 w/3 Day Max	(0.66)	(1.61)	(1.20)	(1.91)	(1.22)	(1.31)	(2.00)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
$75	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.10)	(0.14)
$100	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.26)
$125	(0.09)	(0.21)	(0.16)	(0.25)	(0.17)	(0.17)	(0.27)
$150	(0.13)	(0.33)	(0.24)	(0.39)	(0.25)	(0.26)	(0.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.17)	(0.26)
$60	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)
$75	(0.12)	(0.30)	(0.22)	(0.35)	(0.23)	(0.24)	(0.37)
$100	(0.17)	(0.41)	(0.32)	(0.50)	(0.32)	(0.34)	(0.52)
$125	(0.21)	(0.52)	(0.38)	(0.62)	(0.39)	(0.42)	(0.64)
$150	(0.25)	(0.62)	(0.46)	(0.73)	(0.46)	(0.50)	(0.77)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.11	0.08	0.13	0.09	0.08	0.14
60	0.08	0.21	0.15	0.25	0.15	0.17	0.25
90	0.09	0.22	0.17	0.25	0.17	0.18	0.27
120	0.12	0.30	0.22	0.36	0.22	0.25	0.38
Unlimited	0.17	0.41	0.30	0.48	0.31	0.33	0.51
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.1%	8.1%	8.1%	8.2%	8.2%	8.1%	8.1%
$10	8.6%	8.6%	8.6%	8.5%	8.6%	8.6%	8.5%
$15	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%
$20	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.6%	7.5%	7.3%	7.5%	7.2%	7.6%	7.4%
$10	8.3%	8.4%	8.2%	8.3%	8.5%	8.5%	8.4%
$15	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%	8.4%
$20	8.5%	8.4%	8.4%	8.4%	8.3%	8.5%	8.4%
$25	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.5%	8.5%	8.5%	8.7%	8.4%	8.5%
$10	8.2%	8.2%	8.1%	8.2%	8.3%	8.2%	8.2%
$15	8.6%	8.5%	8.6%	8.6%	8.5%	8.5%	8.6%
$20	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
$25	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
$30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$35	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	10.0%	9.4%	9.7%	9.8%	9.5%	9.6%	9.5%
$10	8.2%	8.2%	8.1%	8.2%	8.2%	8.2%	8.1%
$15	8.3%	8.4%	8.3%	8.3%	8.3%	8.3%	8.4%
$20	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
$25	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$30	8.4%	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%
$35	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
$50	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	9.2%	8.6%	8.6%	8.6%	8.5%	8.5%	9.0%
$150	8.0%	7.8%	7.9%	7.4%	7.7%	7.6%	7.8%
$200	8.9%	8.9%	8.9%	8.6%	9.0%	8.6%	8.9%
$250	8.1%	8.2%	8.1%	8.3%	8.1%	8.1%	8.1%
$500	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$750	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay/Day							
$50 w/3 Day Max	8.5%	9.2%	8.8%	9.2%	9.2%	9.1%	9.1%
$50 w/5 Day Max	9.4%	9.3%	9.5%	9.2%	9.7%	9.0%	9.3%
$100 w/3 Day Max	9.1%	8.8%	9.0%	8.7%	9.0%	8.8%	9.0%
$100 w/5 Day Max	9.0%	8.9%	8.8%	8.9%	8.8%	8.8%	9.0%
$250 w/3 Day Max	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%
$75	7.7%	7.5%	7.6%	6.8%	7.4%	7.7%	7.0%
$100	8.5%	9.2%	8.8%	9.2%	9.2%	9.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
40/$15 copay	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
40/$20 copay	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.79)	(1.21)
40/$25 copay	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
60	0.18	0.45	0.34	0.53	0.34	0.37	0.56
100	0.47	1.15	0.86	1.37	0.88	0.94	1.44
200	1.23	3.02	2.25	3.59	2.29	2.47	3.77
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.86)	(2.10)	(1.56)	(2.49)	(1.59)	(1.71)	(2.62)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.56	1.38	1.02	1.63	1.04	1.12	1.71
90	1.14	2.79	2.09	3.32	2.12	2.28	3.50
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.49	1.20	0.90	1.43	0.91	0.98	1.50
90	0.91	2.22	1.66	2.64	1.69	1.81	2.77
120	1.47	3.60	2.68	4.27	2.73	2.93	4.48
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.69)	(1.70)	(1.26)	(2.02)	(1.28)	(1.39)	(2.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.19	0.48	0.36	0.56	0.36	0.39	0.59
30	0.34	0.83	0.61	0.98	0.62	0.67	1.03
Unlimited	0.49	1.20	0.90	1.43	0.91	0.98	1.50
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.17	5.32	3.96	6.31	4.04	4.34	6.64
60	2.56	6.27	4.67	7.44	4.76	5.12	7.83
90	3.05	7.47	5.56	8.86	5.67	6.09	9.32
Unlimited	3.09	7.56	5.64	8.98	5.75	6.18	9.45
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
60/$15 copay	(0.31)	(0.74)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
60/$20 copay	(0.43)	(1.05)	(0.78)	(1.24)	(0.79)	(0.86)	(1.30)
60/$25 copay	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
120/$0 copay	0.44	1.07	0.81	1.27	0.82	0.88	1.35
120/$5 copay	0.34	0.83	0.61	0.98	0.62	0.67	1.03
120/$10 copay	0.18	0.45	0.34	0.53	0.34	0.37	0.56
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.12)	(0.30)	(0.22)	(0.36)	(0.22)	(0.24)	(0.38)
120/$25 copay	(0.23)	(0.57)	(0.43)	(0.68)	(0.44)	(0.47)	(0.71)
)nlimited/$0 copa	0.51	1.24	0.93	1.48	0.95	1.02	1.56
)nlimited/$5 copa	0.39	0.95	0.70	1.12	0.72	0.77	1.18
nlimited/$10 copa	0.23	0.57	0.43	0.68	0.44	0.47	0.71
nlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
nlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
nlimited/$25 copa	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.12	0.30	0.22	0.36	0.22	0.24	0.38
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$25	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
$15	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$20	(0.43)	(1.05)	(0.78)	(1.24)	(0.79)	(0.86)	(1.30)
$25	(0.54)	(1.32)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
$30	(0.65)	(1.60)	(1.19)	(1.90)	(1.21)	(1.30)	(2.00)
$35	(0.76)	(1.87)	(1.40)	(2.22)	(1.42)	(1.53)	(2.33)
$40	(0.90)	(2.20)	(1.64)	(2.61)	(1.67)	(1.79)	(2.74)
$45	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$50	(1.12)	(2.74)	(2.05)	(3.26)	(2.09)	(2.24)	(3.42)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$10	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$15	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$25	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.91)
Copay	**Chemotherapy [std: $0] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.51	1.25	0.93	1.48	0.95	1.02	1.56
200	1.32	3.23	2.41	3.84	2.46	2.64	4.04
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.94)	(2.30)	(1.72)	(2.73)	(1.75)	(1.88)	(2.88)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.60	1.47	1.10	1.74	1.12	1.20	1.84
90	1.23	3.01	2.25	3.58	2.29	2.46	3.76
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.53	1.30	0.97	1.54	0.99	1.06	1.62
90	0.99	2.43	1.81	2.88	1.84	1.98	3.03
120	1.59	3.90	2.90	4.62	2.96	3.18	4.86
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.62
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.34	5.73	4.27	6.80	4.35	4.68	7.16
60	2.77	6.79	5.06	8.05	5.15	5.54	8.47
90	3.30	8.09	6.03	9.59	6.14	6.60	10.09
Unlimited	3.34	8.18	6.10	9.71	6.21	6.68	10.22
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
60/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
120/$0 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
120/$5 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copa	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$5 copa	0.43	1.05	0.79	1.25	0.80	0.86	1.32
Unlimited/$10 copa	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copa	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$20	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$25	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$30	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$35	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$40	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$45	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$50	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$25	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
Copay	**Chemotherapy [std: $0] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
40/$15 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
40/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
40/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60	0.01	0.02	0.01	0.02	0.01	0.01	0.02
100	0.04	0.10	0.07	0.11	0.07	0.08	0.12
200	0.09	0.21	0.16	0.25	0.17	0.17	0.27
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.08)	(0.20)	(0.16)	(0.24)	(0.16)	(0.17)	(0.26)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.09	0.08	0.11	0.08	0.08	0.13
90	0.09	0.22	0.16	0.26	0.17	0.18	0.26
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.07	0.11	0.08	0.08	0.12
90	0.08	0.21	0.15	0.24	0.15	0.17	0.26
120	0.12	0.30	0.22	0.35	0.23	0.25	0.38
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.05)	(0.11)	(0.09)	(0.13)	(0.10)	(0.09)	(0.14)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.01	0.01	0.02	0.01	0.01	0.02
30	0.03	0.08	0.07	0.10	0.07	0.07	0.10
Unlimited	0.04	0.10	0.07	0.11	0.08	0.08	0.12
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.17	0.41	0.31	0.49	0.31	0.34	0.52
60	0.21	0.52	0.39	0.61	0.39	0.42	0.64
90	0.25	0.62	0.47	0.73	0.47	0.51	0.77
Unlimited	0.25	0.62	0.46	0.73	0.46	0.50	0.77
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
60/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.11	0.07	0.13	0.07	0.08	0.12
120/$5 copay	0.03	0.08	0.07	0.10	0.07	0.07	0.10
120/$10 copay	0.01	0.02	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
120/$25 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Unlimited/$0 copa	0.04	0.11	0.07	0.12	0.07	0.08	0.12
Unlimited/$5 copa	0.04	0.10	0.09	0.13	0.08	0.09	0.14
Unlimited/$10 copa	0.01	0.02	0.01	0.02	0.01	0.01	0.02
Unlimited/$15 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copa	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.01	0.02	0.02	0.02	0.02	0.02	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.14)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.10)	(0.14)
$35	(0.07)	(0.16)	(0.12)	(0.19)	(0.12)	(0.13)	(0.21)
$40	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.17)	(0.26)
$45	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.28)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$10	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.05)	(0.12)	(0.09)	(0.15)	(0.10)	(0.10)	(0.14)
Copay	**Chemotherapy [std: $0] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
40/$15 copay	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
40/$20 copay	10.0%	10.2%	11.1%	11.3%	10.8%	11.4%	11.6%
40/$25 copay	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
60	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
200	7.3%	7.0%	7.1%	7.0%	7.4%	6.9%	7.2%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	9.3%	9.5%	10.3%	9.6%	10.1%	9.9%	9.9%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.1%	6.5%	7.8%	6.7%	7.7%	7.1%	7.6%
90	7.9%	7.9%	7.7%	7.8%	8.0%	7.9%	7.4%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
90	8.8%	9.5%	9.0%	9.1%	8.9%	9.4%	9.4%
120	8.2%	8.3%	8.2%	8.2%	8.4%	8.5%	8.5%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	7.2%	6.5%	7.1%	6.4%	7.8%	6.5%	6.6%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
30	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
Unlimited	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	7.8%	7.7%	7.8%	7.8%	7.7%	7.8%	7.8%
60	8.2%	8.3%	8.4%	8.2%	8.2%	8.2%	8.2%
90	8.2%	8.3%	8.5%	8.2%	8.3%	8.4%	8.3%
Unlimited	8.1%	8.2%	8.2%	8.1%	8.0%	8.1%	8.1%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
60/$15 copay	9.7%	12.2%	10.7%	11.2%	10.5%	11.5%	10.6%
60/$20 copay	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
60/$25 copay	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
120/$0 copay	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
120/$5 copay	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
120/$10 copay	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	8.3%	6.7%	9.1%	5.6%	9.1%	8.3%	5.3%
120/$25 copay	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
Unlimited/$0 copa	7.8%	8.9%	7.5%	8.1%	7.4%	7.8%	7.7%
Unlimited/$5 copa	10.3%	10.5%	12.9%	11.6%	11.1%	11.7%	11.9%
Unlimited/$10 copa	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
Unlimited/$15 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copa	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	8.3%	6.7%	9.1%	5.6%	9.1%	8.3%	5.3%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$25	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
$15	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$20	9.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$35	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.26)	(0.41)
$50	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$60	(0.28)	(0.67)	(0.50)	(0.79)	(0.51)	(0.55)	(0.85)
$75	(0.36)	(0.88)	(0.65)	(1.04)	(0.66)	(0.71)	(1.09)
$100	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$50	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$60	(0.18)	(0.45)	(0.34)	(0.53)	(0.34)	(0.37)	(0.56)
$75	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
$100	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(1.96)	(4.79)	(3.58)	(5.69)	(3.64)	(3.91)	(5.98)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.05)	(7.47)	(5.56)	(8.86)	(5.67)	(6.09)	(9.32)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.28)	(0.67)	(0.50)	(0.79)	(0.51)	(0.55)	(0.85)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$75	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$100	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.13)	(5.22)	(3.89)	(6.19)	(3.96)	(4.26)	(6.52)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.30)	(8.09)	(6.03)	(9.59)	(6.14)	(6.60)	(10.09)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$35	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
$50	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$50	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$60	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$75	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$100	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.17)	(0.43)	(0.31)	(0.50)	(0.32)	(0.35)	(0.54)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(0.25)	(0.62)	(0.47)	(0.73)	(0.47)	(0.51)	(0.77)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.03)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$35	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
$50	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$60	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
$75	11.1%	11.4%	12.3%	11.5%	12.1%	12.7%	11.9%
$100	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$50	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$60	5.6%	4.4%	2.9%	3.8%	2.9%	2.7%	3.6%
$75	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
$100	9.4%	11.7%	10.3%	10.9%	10.2%	11.1%	10.3%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.7%	9.0%	8.7%	8.8%	8.8%	9.0%	9.0%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	8.2%	8.3%	8.5%	8.2%	8.3%	8.4%	8.3%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

Dependent Coverage

				Grandchildren			
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
				Class II Dependents			
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

				Grandchildren			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

Dependent Coverage
Expressed as % add-on to each premium rate otherwise computed

Dependent Children [std: covered to 19 end of month]

Age							
				End of Month			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Year			
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Full-time Students [std: covered to 23 end of year]

Age							
				End of Year			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				End of Month			
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na

				Grandchildren			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.93	19.42	14.48	23.05	14.74	15.86	24.25
60	8.37	20.49	15.27	24.32	15.56	16.73	25.59
90	8.67	21.25	15.84	25.21	16.13	17.34	26.52
Unlimited	8.76	21.47	16.00	25.48	16.30	17.53	26.81
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.87	21.71	16.19	25.77	16.49	17.73	27.12
30	9.75	23.90	17.80	28.35	18.14	19.50	29.83
40	10.29	25.21	18.79	29.92	19.15	20.58	31.49
60	10.85	26.59	19.82	31.55	20.19	21.70	33.20
Unlimited	10.94	26.81	19.98	31.81	20.36	21.89	33.47
LARGE GROUP			**$5 Copay**				
20	8.34	20.42	15.22	24.23	15.50	16.67	25.50
30	9.17	22.47	16.74	26.66	17.06	18.34	28.05
40	9.74	23.86	17.79	28.32	18.12	19.48	29.80
60	10.21	25.02	18.65	29.68	18.99	20.42	31.23
Unlimited	10.28	25.19	18.77	29.89	19.13	20.56	31.45
LARGE GROUP			**$10 Copay**				
20	7.81	19.13	14.26	22.69	14.52	15.61	23.88
30	8.60	21.07	15.70	25.00	16.00	17.20	26.31
40	9.08	22.24	16.58	26.39	16.88	18.16	27.78
60	9.57	23.45	17.48	27.82	17.79	19.14	29.27
Unlimited	9.65	23.64	17.62	28.05	17.94	19.30	29.52
LARGE GROUP			**$15 Copay**				
20	7.33	17.95	13.38	21.30	13.62	14.65	22.41
30	8.07	19.77	14.73	23.46	15.01	16.14	24.69
40	8.54	20.92	15.59	24.82	15.89	17.08	26.12
60	9.04	22.14	16.51	26.27	16.81	18.08	27.65
Unlimited	9.12	22.35	16.65	26.51	16.97	18.24	27.90
LARGE GROUP			**$20 Copay**				
20	6.89	16.87	12.57	20.02	12.81	13.78	21.07
30	7.56	18.53	13.81	21.98	14.06	15.12	23.13
40	7.97	19.52	14.55	23.16	14.82	15.94	24.37
60	8.47	20.75	15.46	24.62	15.75	16.94	25.90
Unlimited	8.53	20.90	15.57	24.79	15.87	17.06	26.09
LARGE GROUP			**$25 Copay**				
20	6.40	15.68	11.69	18.61	11.90	12.80	19.57
30	7.04	17.25	12.86	20.47	13.09	14.08	21.54
40	7.50	18.37	13.70	21.81	13.95	15.00	22.94
60	7.89	19.32	14.40	22.93	14.67	15.77	24.13
Unlimited	7.96	19.49	14.53	23.13	14.81	15.92	24.34
LARGE GROUP			**$30 Copay**				
20	6.11	14.98	11.17	17.77	11.37	12.23	18.70
30	6.63	16.25	12.12	19.28	12.34	13.27	20.29
40	7.06	17.30	12.89	20.53	13.13	14.12	21.60
60	7.40	18.13	13.51	21.50	13.76	14.80	22.63
Unlimited	7.44	18.22	13.58	21.62	13.84	14.88	22.75
LARGE GROUP			**$35 Copay**				
20	5.81	14.23	10.61	16.88	10.80	11.62	17.77
30	6.21	15.20	11.33	18.04	11.55	12.41	18.98
40	6.60	16.18	12.05	19.20	12.28	13.21	20.20
60	6.92	16.96	12.64	20.12	12.87	13.84	21.16
Unlimited	6.97	17.08	12.73	20.26	12.96	13.94	21.32
LARGE GROUP			**$40 Copay**				

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HIP POS GROUP CONTRACT
MENTAL HEALTH
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Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.60	21.07	15.70	25.00	16.00	17.20	26.31
60	9.08	22.25	16.58	26.40	16.89	18.16	27.78
90	9.41	23.05	17.18	27.35	17.50	18.82	28.79
Unlimited	9.50	23.28	17.35	27.62	17.67	19.00	29.06
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.62	23.57	17.57	27.97	17.89	19.24	29.43
30	10.58	25.92	19.32	30.76	19.68	21.16	32.36
40	11.16	27.34	20.38	32.44	20.76	22.32	34.14
60	11.77	28.84	21.49	34.22	21.89	23.54	36.00
Unlimited	11.87	29.08	21.67	34.51	22.08	23.74	36.31
LARGE GROUP			**$5 Copay**				
20	9.04	22.15	16.51	26.28	16.81	18.08	27.65
30	9.95	24.38	18.17	28.92	18.51	19.90	30.44
40	10.57	25.90	19.30	30.73	19.66	21.14	32.33
60	11.08	27.15	20.23	32.21	20.61	22.16	33.89
Unlimited	11.15	27.32	20.36	32.41	20.74	22.30	34.11
LARGE GROUP			**$10 Copay**				
20	8.46	20.73	15.45	24.59	15.74	16.92	25.88
30	9.33	22.86	17.04	27.12	17.35	18.66	28.54
40	9.85	24.13	17.99	28.63	18.32	19.70	30.13
60	10.38	25.43	18.95	30.17	19.31	20.76	31.75
Unlimited	10.47	25.65	19.12	30.44	19.47	20.94	32.03
LARGE GROUP			**$15 Copay**				
20	7.95	19.48	14.52	23.11	14.79	15.90	24.32
30	8.75	21.44	15.98	25.44	16.28	17.50	26.77
40	9.26	22.69	16.91	26.92	17.22	18.52	28.33
60	9.80	24.01	17.89	28.49	18.23	19.60	29.98
Unlimited	9.89	24.23	18.06	28.75	18.40	19.78	30.25
LARGE GROUP			**$20 Copay**				
20	7.47	18.30	13.64	21.72	13.89	14.94	22.85
30	8.20	20.09	14.97	23.84	15.25	16.40	25.08
40	8.65	21.19	15.79	25.15	16.09	17.30	26.46
60	9.18	22.49	16.76	26.69	17.07	18.36	28.08
Unlimited	9.25	22.66	16.89	26.89	17.21	18.50	28.30
LARGE GROUP			**$25 Copay**				
20	6.94	17.00	12.67	20.17	12.91	13.88	21.23
30	7.64	18.72	13.95	22.21	14.21	15.28	23.37
40	8.14	19.94	14.86	23.66	15.14	16.28	24.90
60	8.55	20.95	15.61	24.85	15.90	17.10	26.15
Unlimited	8.64	21.17	15.78	25.12	16.07	17.28	26.43
LARGE GROUP			**$30 Copay**				
20	6.63	16.24	12.11	19.27	12.33	13.26	20.28
30	7.19	17.62	13.13	20.90	13.37	14.38	21.99
40	7.66	18.77	13.99	22.27	14.25	15.32	23.43
60	8.02	19.65	14.64	23.31	14.92	16.04	24.53
Unlimited	8.06	19.75	14.72	23.43	14.99	16.12	24.66
LARGE GROUP			**$35 Copay**				
20	6.30	15.44	11.50	18.31	11.72	12.60	19.27
30	6.73	16.49	12.29	19.56	12.52	13.46	20.59
40	7.16	17.54	13.07	20.81	13.32	14.32	21.90
60	7.50	18.38	13.70	21.80	13.95	15.00	22.94
Unlimited	7.56	18.52	13.80	21.98	14.06	15.12	23.13
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.67	1.65	1.22	1.95	1.26	1.34	2.06
60	0.71	1.76	1.31	2.08	1.33	1.43	2.19
90	0.74	1.80	1.34	2.14	1.37	1.48	2.27
Unlimited	0.74	1.81	1.35	2.14	1.37	1.47	2.25
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	0.75	1.86	1.38	2.20	1.40	1.51	2.31
30	0.83	2.02	1.52	2.41	1.54	1.66	2.53
40	0.87	2.13	1.59	2.52	1.61	1.74	2.65
60	0.92	2.25	1.67	2.67	1.70	1.84	2.80
Unlimited	0.93	2.27	1.69	2.70	1.72	1.85	2.84
LARGE GROUP			**$5 Copay**				
20	0.70	1.73	1.29	2.05	1.31	1.41	2.15
30	0.78	1.91	1.43	2.26	1.45	1.56	2.39
40	0.83	2.04	1.51	2.41	1.54	1.66	2.53
60	0.87	2.13	1.58	2.53	1.62	1.74	2.66
Unlimited	0.87	2.13	1.59	2.52	1.61	1.74	2.66
LARGE GROUP			**$10 Copay**				
20	0.65	1.60	1.19	1.90	1.22	1.31	2.00
30	0.73	1.79	1.34	2.12	1.35	1.46	2.23
40	0.77	1.89	1.41	2.24	1.44	1.54	2.35
60	0.81	1.98	1.47	2.35	1.52	1.62	2.48
Unlimited	0.82	2.01	1.50	2.39	1.53	1.64	2.51
LARGE GROUP			**$15 Copay**				
20	0.62	1.53	1.14	1.81	1.17	1.25	1.91
30	0.68	1.67	1.25	1.98	1.27	1.36	2.08
40	0.72	1.77	1.32	2.10	1.33	1.44	2.21
60	0.76	1.87	1.38	2.22	1.42	1.52	2.33
Unlimited	0.77	1.88	1.41	2.24	1.43	1.54	2.35
LARGE GROUP			**$20 Copay**				
20	0.58	1.43	1.07	1.70	1.08	1.16	1.78
30	0.64	1.56	1.16	1.86	1.19	1.28	1.95
40	0.68	1.67	1.24	1.99	1.27	1.36	2.09
60	0.71	1.74	1.30	2.07	1.32	1.42	2.18
Unlimited	0.72	1.76	1.32	2.10	1.34	1.44	2.21
LARGE GROUP			**$25 Copay**				
20	0.54	1.32	0.98	1.56	1.01	1.08	1.66
30	0.60	1.47	1.09	1.74	1.12	1.20	1.83
40	0.64	1.57	1.16	1.85	1.19	1.28	1.96
60	0.66	1.63	1.21	1.92	1.23	1.33	2.02
Unlimited	0.68	1.68	1.25	1.99	1.26	1.36	2.09
LARGE GROUP			**$30 Copay**				
20	0.52	1.26	0.94	1.50	0.96	1.03	1.58
30	0.56	1.37	1.01	1.62	1.03	1.11	1.70
40	0.60	1.47	1.10	1.74	1.12	1.20	1.83
60	0.62	1.52	1.13	1.81	1.16	1.24	1.90
Unlimited	0.62	1.53	1.14	1.81	1.15	1.24	1.91
LARGE GROUP			**$35 Copay**				
20	0.49	1.21	0.89	1.43	0.92	0.98	1.50
30	0.52	1.29	0.96	1.52	0.97	1.05	1.61
40	0.56	1.36	1.02	1.61	1.04	1.11	1.70
60	0.58	1.42	1.06	1.68	1.08	1.16	1.78
Unlimited	0.59	1.44	1.07	1.72	1.10	1.18	1.81
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
60	8.5%	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%
90	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.6%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%
60	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
LARGE GROUP			**$5 Copay**				
20	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
LARGE GROUP			**$10 Copay**				
20	8.3%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$15 Copay**				
20	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
30	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
40	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
60	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP			**$20 Copay**				
20	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.4%
30	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
40	8.5%	8.6%	8.5%	8.6%	8.6%	8.5%	8.6%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%
LARGE GROUP			**$25 Copay**				
20	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%
LARGE GROUP			**$30 Copay**				
20	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.3%	8.4%	8.3%	8.4%	8.4%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.3%	8.4%	8.4%	8.4%	8.3%	8.3%	8.4%
LARGE GROUP			**$35 Copay**				
20	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%
30	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
40	8.5%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP			**$40 Copay**				

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	5.66	13.86	10.32	16.44	10.52	11.31	17.30
30	6.03	14.78	11.02	17.54	11.22	12.06	18.45
40	6.42	15.72	11.72	18.66	11.94	12.84	19.64
60	6.78	16.60	12.37	19.70	12.61	13.55	20.73
Unlimited	6.83	16.72	12.46	19.85	12.70	13.65	20.88
LARGE GROUP				**$45 Copay**			
20	5.49	13.46	10.03	15.97	10.21	10.98	16.80
30	5.85	14.33	10.68	17.01	10.88	11.70	17.89
40	6.27	15.36	11.44	18.22	11.66	12.53	19.17
60	6.61	16.20	12.08	19.23	12.30	13.23	20.23
Unlimited	6.65	16.30	12.15	19.34	12.38	13.31	20.35
LARGE GROUP				**$50 Copay**			
20	5.33	13.05	9.73	15.49	9.91	10.66	16.30
30	5.72	14.00	10.43	16.62	10.63	11.43	17.49
40	6.11	14.98	11.17	17.77	11.37	12.23	18.70
60	6.44	15.77	11.76	18.72	11.97	12.88	19.70
Unlimited	6.48	15.88	11.83	18.84	12.05	12.96	19.82

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	6.13	15.02	11.19	17.82	11.40	12.26	18.75
30	6.54	16.02	11.94	19.01	12.16	13.08	20.01
40	6.97	17.08	12.73	20.26	12.96	13.94	21.32
60	7.35	18.01	13.42	21.37	13.67	14.70	22.48
Unlimited	7.41	18.15	13.53	21.54	13.78	14.82	22.67
LARGE GROUP				**$45 Copay**			
20	5.96	14.60	10.88	17.33	11.09	11.92	18.23
30	6.35	15.56	11.60	18.46	11.81	12.70	19.42
40	6.79	16.64	12.40	19.74	12.63	13.58	20.77
60	7.17	17.57	13.09	20.84	13.34	14.34	21.93
Unlimited	7.21	17.66	13.17	20.96	13.41	14.42	22.06
LARGE GROUP				**$50 Copay**			
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.20	15.19	11.32	18.02	11.53	12.40	18.97
40	6.63	16.24	12.11	19.27	12.33	13.26	20.28
60	6.99	17.13	12.76	20.32	13.00	13.98	21.38
Unlimited	7.03	17.22	12.84	20.44	13.08	14.06	21.50

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	0.47	1.16	0.87	1.38	0.88	0.95	1.45
30	0.51	1.24	0.92	1.47	0.94	1.02	1.56
40	0.55	1.36	1.01	1.60	1.02	1.10	1.68
60	0.57	1.41	1.05	1.67	1.06	1.15	1.75
Unlimited	0.58	1.43	1.07	1.69	1.08	1.17	1.79
LARGE GROUP				**$45 Copay**			
20	0.47	1.14	0.85	1.36	0.88	0.94	1.43
30	0.50	1.23	0.92	1.45	0.93	1.00	1.53
40	0.52	1.28	0.96	1.52	0.97	1.05	1.60
60	0.56	1.37	1.01	1.61	1.04	1.11	1.70
Unlimited	0.56	1.36	1.02	1.62	1.03	1.11	1.71
LARGE GROUP				**$50 Copay**			
20	0.45	1.11	0.82	1.31	0.84	0.90	1.38
30	0.48	1.19	0.89	1.40	0.90	0.97	1.48
40	0.52	1.26	0.94	1.50	0.96	1.03	1.58
60	0.55	1.36	1.00	1.60	1.03	1.10	1.68
Unlimited	0.55	1.34	1.01	1.60	1.03	1.10	1.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.4%	8.3%	8.4%	8.4%	8.5%	8.5%
40	8.6%	8.7%	8.6%	8.6%	8.5%	8.6%	8.6%
60	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.6%	8.6%	8.5%	8.5%	8.6%	8.6%
LARGE GROUP				**$45 Copay**			
20	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%	8.5%
30	8.5%	8.6%	8.6%	8.5%	8.5%	8.5%	8.6%
40	8.3%	8.3%	8.4%	8.3%	8.3%	8.4%	8.3%
60	8.5%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.3%	8.4%	8.4%	8.3%	8.3%	8.4%
LARGE GROUP				**$50 Copay**			
20	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
30	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
40	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.6%	8.5%	8.5%	8.6%	8.5%	8.5%
Unlimited	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - RIDERS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.29	15.41	11.48	18.28	11.70	12.57	19.23
$0/Max $5000	5.89	14.43	10.75	17.12	10.95	11.78	18.02
$0/Max $2500	5.55	13.60	10.14	16.14	10.33	11.11	16.99
$25	5.89	14.43	10.75	17.12	10.95	11.78	18.02
$50	5.55	13.60	10.14	16.14	10.33	11.11	16.99
$100	4.98	12.21	9.10	14.49	9.27	9.97	15.24
$500	2.46	6.01	4.48	7.14	4.57	4.91	7.51
$5,000	0.34	0.83	0.61	0.98	0.62	0.67	1.03
Coinsurance							
80%	4.99	12.23	9.12	14.51	9.28	9.99	15.27
75%	4.71	11.54	8.60	13.69	8.75	9.42	14.40
70%	4.37	10.71	7.98	12.71	8.13	8.74	13.37
			Orthotics Riders				
$0/Max $5000	6.52	15.98	11.91	18.95	12.13	13.04	19.95
$0/Max $2500	6.04	14.81	11.04	17.57	11.24	12.09	18.48
Deductible							
$0	1.07	2.62	1.96	3.11	1.99	2.14	3.27
$0/Max $5000	1.03	2.52	1.87	3.00	1.92	2.06	3.15
$0/Max $2500	0.98	2.39	1.78	2.84	1.82	1.96	3.00
$25	1.03	2.52	1.87	3.00	1.92	2.06	3.15
$50	0.98	2.39	1.78	2.84	1.82	1.96	3.00
$100	0.89	2.17	1.62	2.58	1.65	1.77	2.71
$500	0.43	1.05	0.78	1.24	0.79	0.86	1.30
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.89	2.17	1.62	2.58	1.65	1.77	2.71
75%	0.83	2.02	1.51	2.39	1.54	1.65	2.53
70%	0.75	1.84	1.38	2.19	1.41	1.51	2.30
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.38	3.37	2.52	3.99	2.56	2.75	4.21
12 Months	2.19	5.37	4.00	6.37	4.08	4.38	6.71
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.14	5.24	3.90	6.22	3.98	4.28	6.54
12 Months	3.41	8.37	6.24	9.93	6.35	6.83	10.44
			Private Duty Nursing Riders				
In Full	0.73	1.79	1.33	2.13	1.37	1.47	2.24
80% hrs 73-504	0.12	0.30	0.22	0.36	0.22	0.24	0.38
100% hrs 73-504	0.21	0.52	0.39	0.62	0.40	0.43	0.65
			Dental Network Access				
	0.43	1.05	0.78	1.24	0.79	0.86	1.30
Limit			**Infertility Rider**				
2 IVF	13.73	33.63	25.07	39.90	25.53	27.45	41.98
3 IVF	16.50	40.41	30.12	47.95	30.68	33.00	50.46

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.81	16.68	12.44	19.80	12.67	13.62	20.83
$0/Max $5000	6.39	15.66	11.67	18.58	11.89	12.78	19.55
$0/Max $2500	6.02	14.75	10.99	17.50	11.20	12.04	18.42
$25	6.39	15.66	11.67	18.58	11.89	12.78	19.55
$50	6.02	14.75	10.99	17.50	11.20	12.04	18.42
$100	5.41	13.25	9.88	15.73	10.06	10.82	16.55
$500	2.67	6.54	4.88	7.76	4.97	5.34	8.17
$5,000	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Coinsurance							
80%	5.42	13.28	9.90	15.76	10.08	10.84	16.58
75%	5.11	12.52	9.33	14.85	9.50	10.22	15.63
70%	4.75	11.64	8.67	13.81	8.84	9.50	14.53
			Orthotics Riders				
$0/Max $5000	7.07	17.32	12.91	20.55	13.15	14.14	21.63
$0/Max $2500	6.55	16.05	11.96	19.04	12.18	13.10	20.04
Deductible							
$0	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$0/Max $5000	1.11	2.72	2.03	3.23	2.06	2.22	3.40
$0/Max $2500	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$25	1.11	2.72	2.03	3.23	2.06	2.22	3.40
$50	1.06	2.60	1.94	3.08	1.97	2.12	3.24
$100	0.97	2.38	1.77	2.82	1.80	1.94	2.97
$500	0.47	1.15	0.86	1.37	0.87	0.94	1.44
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.97	2.38	1.77	2.82	1.80	1.94	2.97
75%	0.91	2.23	1.66	2.65	1.69	1.82	2.78
70%	0.81	1.98	1.48	2.35	1.51	1.62	2.48
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.78	1.91	1.42	2.27	1.45	1.56	2.39
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	14.89	36.48	27.19	43.29	27.70	29.78	45.55
3 IVF	17.89	43.83	32.67	52.01	33.28	35.78	54.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.52	1.27	0.96	1.52	0.97	1.05	1.60
$0/Max $5000	0.50	1.23	0.92	1.46	0.94	1.00	1.53
$0/Max $2500	0.47	1.15	0.85	1.36	0.87	0.93	1.43
$25	0.50	1.23	0.92	1.46	0.94	1.00	1.53
$50	0.47	1.15	0.85	1.36	0.87	0.93	1.43
$100	0.43	1.04	0.78	1.24	0.79	0.85	1.31
$500	0.21	0.53	0.40	0.62	0.40	0.43	0.66
$5,000	0.03	0.08	0.07	0.10	0.07	0.07	0.10
Coinsurance							
80%	0.43	1.05	0.78	1.25	0.80	0.85	1.31
75%	0.40	0.98	0.73	1.16	0.75	0.80	1.23
70%	0.38	0.93	0.69	1.10	0.71	0.76	1.16
			Orthotics Riders				
$0/Max $5000	0.55	1.34	1.00	1.60	1.02	1.10	1.68
$0/Max $2500	0.51	1.24	0.92	1.47	0.94	1.01	1.56
Deductible							
$0	0.09	0.22	0.16	0.26	0.17	0.18	0.28
$0/Max $5000	0.08	0.20	0.16	0.23	0.14	0.16	0.25
$0/Max $2500	0.08	0.21	0.16	0.24	0.15	0.16	0.24
$25	0.08	0.20	0.16	0.23	0.14	0.16	0.25
$50	0.08	0.21	0.16	0.24	0.15	0.16	0.24
$100	0.08	0.21	0.15	0.24	0.15	0.17	0.26
$500	0.04	0.10	0.08	0.13	0.08	0.08	0.14
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.08	0.21	0.15	0.24	0.15	0.17	0.26
75%	0.08	0.21	0.15	0.26	0.15	0.17	0.25
70%	0.06	0.14	0.10	0.16	0.10	0.11	0.18
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.37	0.23	0.25	0.38
12 Months	0.18	0.44	0.33	0.52	0.33	0.36	0.54
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.32	0.34	0.53
12 Months	0.30	0.72	0.53	0.85	0.55	0.59	0.91
			Private Duty Nursing Riders				
In Full	0.05	0.12	0.09	0.14	0.08	0.09	0.15
80% hrs 73-504	0.01	0.02	0.02	0.02	0.02	0.02	0.02
100% hrs 73-504	0.01	0.02	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	1.16	2.85	2.12	3.39	2.17	2.33	3.57
3 IVF	1.39	3.42	2.55	4.06	2.60	2.78	4.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.3%	8.2%	8.4%	8.3%	8.3%	8.4%	8.3%
$0/Max $5000	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
$0/Max $2500	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$25	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
$50	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$100	8.6%	8.5%	8.6%	8.6%	8.5%	8.5%	8.6%
$500	8.5%	8.8%	8.9%	8.7%	8.8%	8.8%	8.8%
$5,000	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
Coinsurance							
80%	8.6%	8.6%	8.6%	8.6%	8.6%	8.5%	8.6%
75%	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
70%	8.7%	8.7%	8.6%	8.7%	8.7%	8.7%	8.7%
			Orthotics Riders				
$0/Max $5000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$0/Max $2500	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
Deductible							
$0	8.4%	8.4%	8.2%	8.4%	8.5%	8.4%	8.6%
$0/Max $5000	7.8%	7.9%	8.6%	7.7%	7.3%	7.8%	7.9%
$0/Max $2500	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$25	7.8%	7.9%	8.6%	7.7%	7.3%	7.8%	7.9%
$50	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$100	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
$500	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
75%	9.6%	10.4%	9.9%	10.9%	9.7%	10.3%	9.9%
70%	8.0%	7.6%	7.2%	7.3%	7.1%	7.3%	7.8%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.7%	9.2%	8.7%	9.3%	9.0%	9.1%	9.0%
12 Months	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.0%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.9%	8.0%	8.2%	8.0%	8.0%	7.9%	8.1%
12 Months	8.8%	8.6%	8.5%	8.6%	8.7%	8.6%	8.7%
			Private Duty Nursing Riders				
In Full	6.8%	6.7%	6.8%	6.6%	5.8%	6.1%	6.7%
80% hrs 73-504	8.3%	6.7%	9.1%	5.6%	9.1%	8.3%	5.3%
100% hrs 73-504	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
			Dental Network Access				
	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
Limit			**Infertility Rider**				
2 IVF	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
3 IVF	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	489.28	1,198.72	893.40	1,422.33	910.03	978.53	1,496.70

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	530.65	1,300.09	968.97	1,542.60	987.01	1,061.30	1,623.26

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	41.37	101.37	75.57	120.27	76.98	82.77	126.56

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

**** Base rates exclude premium component for mandatory mental health cove***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.27)	(8.01)	(5.97)	(9.51)	(6.08)	(6.54)	(10.01)
$10	(6.88)	(16.85)	(12.56)	(19.99)	(12.79)	(13.76)	(21.04)
$15	(11.45)	(28.06)	(20.91)	(33.29)	(21.31)	(22.91)	(35.03)
$20	(17.66)	(43.27)	(32.24)	(51.34)	(32.84)	(35.32)	(54.02)
$25	(23.26)	(56.99)	(42.48)	(67.63)	(43.27)	(46.53)	(71.17)
$30	(29.43)	(72.09)	(53.73)	(85.55)	(54.73)	(58.86)	(90.02)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.89)	(4.62)	(3.44)	(5.48)	(3.51)	(3.77)	(5.77)
$10	(3.94)	(9.66)	(7.20)	(11.46)	(7.34)	(7.89)	(12.06)
$15	(6.55)	(16.05)	(11.96)	(19.05)	(12.19)	(13.10)	(20.04)
$20	(10.11)	(24.76)	(18.45)	(29.39)	(18.80)	(20.22)	(30.92)
$25	(13.33)	(32.66)	(24.33)	(38.74)	(24.79)	(26.66)	(40.77)
$30	(16.86)	(41.32)	(30.79)	(49.02)	(31.36)	(33.73)	(51.59)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.39)	(5.87)	(4.37)	(6.96)	(4.45)	(4.79)	(7.33)
$10	(4.94)	(12.11)	(9.03)	(14.37)	(9.19)	(9.88)	(15.12)
$15	(7.76)	(19.02)	(14.17)	(22.57)	(14.44)	(15.53)	(23.75)
$20	(10.94)	(26.81)	(19.98)	(31.81)	(20.36)	(21.89)	(33.47)
$25	(14.43)	(35.35)	(26.35)	(41.94)	(26.84)	(28.86)	(44.13)
$30	(18.39)	(45.06)	(33.59)	(53.47)	(34.21)	(36.79)	(56.26)
$35	(22.10)	(54.15)	(40.35)	(64.25)	(41.11)	(44.20)	(67.61)
$40	(25.94)	(63.57)	(47.37)	(75.42)	(48.25)	(51.89)	(79.36)
$45	(30.00)	(73.50)	(54.78)	(87.21)	(55.80)	(60.00)	(91.77)
$50	(34.24)	(83.88)	(62.52)	(99.53)	(63.68)	(68.48)	(104.73)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.03)	(4.97)	(3.70)	(5.89)	(3.77)	(4.06)	(6.21)
$10	(4.18)	(10.23)	(7.63)	(12.15)	(7.77)	(8.36)	(12.78)
$15	(6.55)	(16.05)	(11.96)	(19.05)	(12.19)	(13.10)	(20.04)
$20	(9.25)	(22.67)	(16.90)	(26.90)	(17.21)	(18.51)	(28.31)
$25	(12.19)	(29.86)	(22.25)	(35.43)	(22.66)	(24.37)	(37.29)
$30	(15.54)	(38.07)	(28.38)	(45.17)	(28.90)	(31.08)	(47.54)
$35	(18.70)	(45.81)	(34.15)	(54.35)	(34.78)	(37.40)	(57.20)
$40	(21.93)	(53.72)	(40.04)	(63.75)	(40.79)	(43.86)	(67.08)
$45	(25.36)	(62.14)	(46.31)	(73.72)	(47.17)	(50.73)	(77.59)
$50	(28.96)	(70.95)	(52.88)	(84.19)	(53.86)	(57.92)	(88.59)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.19)	(2.92)	(2.18)	(3.46)	(2.22)	(2.38)	(3.65)
$150	(1.98)	(4.84)	(3.61)	(5.75)	(3.68)	(3.95)	(6.04)
$200	(2.80)	(6.87)	(5.12)	(8.14)	(5.21)	(5.60)	(8.57)
$250	(4.04)	(9.88)	(7.37)	(11.73)	(7.51)	(8.07)	(12.34)
$500	(9.66)	(23.67)	(17.64)	(28.08)	(17.96)	(19.32)	(29.55)
$750	(16.57)	(40.60)	(30.25)	(48.17)	(30.81)	(33.14)	(50.69)
$1,000	(24.93)	(61.09)	(45.53)	(72.48)	(46.37)	(49.87)	(76.27)
Copay/Day							
$50 w/3 Day Max	(1.46)	(3.57)	(2.66)	(4.24)	(2.71)	(2.91)	(4.45)
$50 w/5 Day Max	(2.00)	(4.89)	(3.65)	(5.81)	(3.72)	(3.99)	(6.11)
$100 w/3 Day Max	(3.63)	(8.89)	(6.62)	(10.55)	(6.75)	(7.26)	(11.10)
$100 w/5 Day Max	(5.23)	(12.81)	(9.55)	(15.19)	(9.72)	(10.45)	(15.99)
$250 w/3 Day Max	(12.01)	(29.43)	(21.94)	(34.92)	(22.35)	(24.03)	(36.76)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.91)
$75	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$100	(1.46)	(3.57)	(2.66)	(4.24)	(2.71)	(2.91)	(4.45)
$125	(1.91)	(4.67)	(3.47)	(5.54)	(3.55)	(3.81)	(5.83)
$150	(2.37)	(5.82)	(4.33)	(6.90)	(4.41)	(4.75)	(7.27)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
$25	(0.49)	(1.20)	(0.90)	(1.43)	(0.91)	(0.98)	(1.50)
$35	(0.82)	(2.00)	(1.49)	(2.37)	(1.52)	(1.63)	(2.50)
$50	(1.38)	(3.37)	(2.52)	(3.99)	(2.56)	(2.75)	(4.21)
$60	(1.74)	(4.27)	(3.18)	(5.06)	(3.24)	(3.48)	(5.33)
$75	(2.29)	(5.61)	(4.19)	(6.66)	(4.26)	(4.59)	(7.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.54)	(8.67)	(6.46)	(10.29)	(6.58)	(7.08)	(10.83)
$10	(7.46)	(18.28)	(13.62)	(21.69)	(13.88)	(14.92)	(22.82)
$15	(12.42)	(30.43)	(22.68)	(36.10)	(23.10)	(24.84)	(37.99)
$20	(19.15)	(46.92)	(34.97)	(55.67)	(35.62)	(38.30)	(58.58)
$25	(25.23)	(61.81)	(46.07)	(73.34)	(46.93)	(50.46)	(77.18)
$30	(31.90)	(78.16)	(58.25)	(92.73)	(59.33)	(63.80)	(97.58)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
$10	(4.28)	(10.49)	(7.82)	(12.44)	(7.96)	(8.56)	(13.09)
$15	(7.11)	(17.42)	(12.98)	(20.67)	(13.22)	(14.22)	(21.75)
$20	(10.96)	(26.85)	(20.01)	(31.86)	(20.39)	(21.92)	(33.53)
$25	(14.45)	(35.40)	(26.39)	(42.01)	(26.88)	(28.90)	(44.20)
$30	(18.29)	(44.81)	(33.40)	(53.17)	(34.02)	(36.58)	(55.95)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.60)	(6.37)	(4.75)	(7.56)	(4.84)	(5.20)	(7.95)
$10	(5.37)	(13.16)	(9.81)	(15.61)	(9.99)	(10.74)	(16.43)
$15	(8.42)	(20.63)	(15.37)	(24.48)	(15.66)	(16.84)	(25.76)
$20	(11.87)	(29.08)	(21.67)	(34.51)	(22.08)	(23.74)	(36.31)
$25	(15.65)	(38.34)	(28.58)	(45.49)	(29.11)	(31.30)	(47.87)
$30	(19.94)	(48.85)	(36.41)	(57.97)	(37.09)	(39.88)	(61.00)
$35	(23.97)	(58.73)	(43.77)	(69.68)	(44.58)	(47.94)	(73.32)
$40	(28.13)	(68.92)	(51.37)	(81.77)	(52.32)	(56.26)	(86.05)
$45	(32.54)	(79.72)	(59.42)	(94.59)	(60.52)	(65.08)	(99.54)
$50	(37.13)	(90.97)	(67.80)	(107.94)	(69.06)	(74.26)	(113.58)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.39)	(4.02)	(6.40)	(4.09)	(4.40)	(6.73)
$10	(4.52)	(11.07)	(8.25)	(13.14)	(8.41)	(9.04)	(13.83)
$15	(7.11)	(17.42)	(12.98)	(20.67)	(13.22)	(14.22)	(21.75)
$20	(10.03)	(24.57)	(18.31)	(29.16)	(18.66)	(20.06)	(30.68)
$25	(13.22)	(32.39)	(24.14)	(38.43)	(24.59)	(26.44)	(40.44)
$30	(16.85)	(41.28)	(30.77)	(48.98)	(31.34)	(33.70)	(51.54)
$35	(20.28)	(49.69)	(37.03)	(58.95)	(37.72)	(40.56)	(62.04)
$40	(23.79)	(58.29)	(43.44)	(69.16)	(44.25)	(47.58)	(72.77)
$45	(27.50)	(67.38)	(50.22)	(79.94)	(51.15)	(55.00)	(84.12)
$50	(31.40)	(76.93)	(57.34)	(91.28)	(58.40)	(62.80)	(96.05)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
$150	(2.15)	(5.27)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$200	(3.04)	(7.45)	(5.55)	(8.84)	(5.65)	(6.08)	(9.30)
$250	(4.38)	(10.73)	(8.00)	(12.73)	(8.15)	(8.76)	(13.40)
$500	(10.48)	(25.68)	(19.14)	(30.47)	(19.49)	(20.96)	(32.06)
$750	(17.96)	(44.00)	(32.79)	(52.21)	(33.41)	(35.92)	(54.94)
$1,000	(27.04)	(66.25)	(49.38)	(78.61)	(50.29)	(54.08)	(82.72)
Copay/Day							
$50 w/3 Day Max	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
$50 w/5 Day Max	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
$100 w/3 Day Max	(3.93)	(9.63)	(7.18)	(11.42)	(7.31)	(7.86)	(12.02)
$100 w/5 Day Max	(5.67)	(13.89)	(10.35)	(16.48)	(10.55)	(11.34)	(17.34)
$250 w/3 Day Max	(13.02)	(31.90)	(23.77)	(37.85)	(24.22)	(26.04)	(39.83)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$75	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$100	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
$125	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$150	(2.58)	(6.32)	(4.71)	(7.50)	(4.80)	(5.16)	(7.89)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$25	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$35	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$50	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
$60	(1.89)	(4.63)	(3.45)	(5.49)	(3.52)	(3.78)	(5.78)
$75	(2.49)	(6.10)	(4.55)	(7.24)	(4.63)	(4.98)	(7.62)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.82)
$10	(0.58)	(1.43)	(1.06)	(1.70)	(1.09)	(1.16)	(1.78)
$15	(0.97)	(2.37)	(1.77)	(2.81)	(1.79)	(1.93)	(2.96)
$20	(1.49)	(3.65)	(2.73)	(4.33)	(2.78)	(2.98)	(4.56)
$25	(1.97)	(4.82)	(3.59)	(5.71)	(3.66)	(3.93)	(6.01)
$30	(2.47)	(6.07)	(4.52)	(7.18)	(4.60)	(4.94)	(7.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$10	(0.34)	(0.83)	(0.62)	(0.98)	(0.62)	(0.67)	(1.03)
$15	(0.56)	(1.37)	(1.02)	(1.62)	(1.03)	(1.12)	(1.71)
$20	(0.85)	(2.09)	(1.56)	(2.47)	(1.59)	(1.70)	(2.61)
$25	(1.12)	(2.74)	(2.06)	(3.27)	(2.09)	(2.24)	(3.43)
$30	(1.43)	(3.49)	(2.61)	(4.15)	(2.66)	(2.85)	(4.36)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.21)	(0.50)	(0.38)	(0.60)	(0.39)	(0.41)	(0.62)
$10	(0.43)	(1.05)	(0.78)	(1.24)	(0.80)	(0.86)	(1.31)
$15	(0.66)	(1.61)	(1.20)	(1.91)	(1.22)	(1.31)	(2.01)
$20	(0.93)	(2.27)	(1.69)	(2.70)	(1.72)	(1.85)	(2.84)
$25	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.74)
$30	(1.55)	(3.79)	(2.82)	(4.50)	(2.88)	(3.09)	(4.74)
$35	(1.87)	(4.58)	(3.42)	(5.43)	(3.47)	(3.74)	(5.71)
$40	(2.19)	(5.35)	(4.00)	(6.35)	(4.07)	(4.37)	(6.69)
$45	(2.54)	(6.22)	(4.64)	(7.38)	(4.72)	(5.08)	(7.77)
$50	(2.89)	(7.09)	(5.28)	(8.41)	(5.38)	(5.78)	(8.85)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.42)	(0.32)	(0.51)	(0.32)	(0.34)	(0.52)
$10	(0.34)	(0.84)	(0.62)	(0.99)	(0.64)	(0.68)	(1.05)
$15	(0.56)	(1.37)	(1.02)	(1.62)	(1.03)	(1.12)	(1.71)
$20	(0.78)	(1.90)	(1.41)	(2.26)	(1.45)	(1.55)	(2.37)
$25	(1.03)	(2.53)	(1.89)	(3.00)	(1.93)	(2.07)	(3.15)
$30	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.00)
$35	(1.58)	(3.88)	(2.88)	(4.60)	(2.94)	(3.16)	(4.84)
$40	(1.86)	(4.57)	(3.40)	(5.41)	(3.46)	(3.72)	(5.69)
$45	(2.14)	(5.24)	(3.91)	(6.22)	(3.98)	(4.27)	(6.53)
$50	(2.44)	(5.98)	(4.46)	(7.09)	(4.54)	(4.88)	(7.46)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.27)
$150	(0.17)	(0.43)	(0.32)	(0.50)	(0.32)	(0.35)	(0.54)
$200	(0.24)	(0.58)	(0.43)	(0.70)	(0.44)	(0.48)	(0.73)
$250	(0.34)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.06)
$500	(0.82)	(2.01)	(1.50)	(2.39)	(1.53)	(1.64)	(2.51)
$750	(1.39)	(3.40)	(2.54)	(4.04)	(2.60)	(2.78)	(4.25)
$1,000	(2.11)	(5.16)	(3.85)	(6.13)	(3.92)	(4.21)	(6.45)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.30)	(0.23)	(0.35)	(0.23)	(0.25)	(0.38)
$50 w/5 Day Max	(0.17)	(0.43)	(0.31)	(0.50)	(0.32)	(0.35)	(0.53)
$100 w/3 Day Max	(0.30)	(0.74)	(0.56)	(0.87)	(0.56)	(0.60)	(0.92)
$100 w/5 Day Max	(0.44)	(1.08)	(0.80)	(1.29)	(0.83)	(0.89)	(1.35)
$250 w/3 Day Max	(1.01)	(2.47)	(1.83)	(2.93)	(1.87)	(2.01)	(3.07)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.05)	(0.12)	(0.09)	(0.15)	(0.10)	(0.10)	(0.14)
$75	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$100	(0.12)	(0.30)	(0.23)	(0.35)	(0.23)	(0.25)	(0.38)
$125	(0.16)	(0.40)	(0.31)	(0.48)	(0.30)	(0.33)	(0.50)
$150	(0.21)	(0.50)	(0.38)	(0.60)	(0.39)	(0.41)	(0.62)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$35	(0.08)	(0.21)	(0.15)	(0.25)	(0.15)	(0.17)	(0.25)
$50	(0.12)	(0.31)	(0.22)	(0.37)	(0.23)	(0.25)	(0.38)
$60	(0.15)	(0.36)	(0.27)	(0.43)	(0.28)	(0.30)	(0.45)
$75	(0.20)	(0.49)	(0.36)	(0.58)	(0.37)	(0.39)	(0.61)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.2%	8.2%	8.2%	8.2%	8.3%	8.2%
$10	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
$15	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$20	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$25	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.5%	8.7%	8.7%	8.8%	8.5%	8.8%	8.7%
$10	8.6%	8.6%	8.6%	8.6%	8.4%	8.5%	8.5%
$15	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$20	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$25	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$30	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.8%	8.5%	8.7%	8.6%	8.8%	8.6%	8.5%
$10	8.7%	8.7%	8.6%	8.6%	8.7%	8.7%	8.7%
$15	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
$20	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$25	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
$40	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.4%	8.5%	8.6%	8.7%	8.5%	8.4%	8.4%
$10	8.1%	8.2%	8.1%	8.1%	8.2%	8.1%	8.2%
$15	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$20	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
$25	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$50	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	7.6%	7.5%	7.3%	7.5%	7.2%	7.6%	7.4%
$150	8.6%	8.9%	8.9%	8.7%	8.7%	8.9%	8.9%
$200	8.6%	8.4%	8.4%	8.6%	8.4%	8.6%	8.5%
$250	8.4%	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,000	8.5%	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%
Copay/Day							
$50 w/3 Day Max	8.2%	8.4%	8.6%	8.3%	8.5%	8.6%	8.5%
$50 w/5 Day Max	8.5%	8.8%	8.5%	8.6%	8.6%	8.8%	8.7%
$100 w/3 Day Max	8.3%	8.3%	8.5%	8.2%	8.3%	8.3%	8.3%
$100 w/5 Day Max	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
$250 w/3 Day Max	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.1%	7.9%	8.0%	8.3%	8.7%	8.1%	7.3%
$75	7.8%	8.0%	8.1%	7.7%	7.9%	7.8%	7.7%
$100	8.2%	8.4%	8.6%	8.3%	8.5%	8.6%	8.5%
$125	8.4%	8.6%	8.9%	8.7%	8.5%	8.7%	8.6%
$150	8.9%	8.6%	8.8%	8.7%	8.8%	8.6%	8.5%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
$25	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
$35	9.8%	10.5%	10.1%	10.5%	9.9%	10.4%	10.0%
$50	8.7%	9.2%	8.7%	9.3%	9.0%	9.1%	9.0%
$60	8.6%	8.4%	8.5%	8.5%	8.6%	8.6%	8.4%
$75	8.7%	8.7%	8.6%	8.7%	8.7%	8.5%	8.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.26)	(7.99)	(5.95)	(9.48)	(6.06)	(6.52)	(9.98)
$125	(4.04)	(9.88)	(7.37)	(11.73)	(7.51)	(8.07)	(12.34)
$150	(4.80)	(11.76)	(8.76)	(13.95)	(8.93)	(9.60)	(14.68)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.56	1.38	1.02	1.63	1.04	1.12	1.71
60	1.09	2.67	1.99	3.17	2.03	2.18	3.33
90	1.64	4.01	3.00	4.77	3.05	3.28	5.01
120	1.93	4.72	3.52	5.59	3.59	3.85	5.89
Unlimited	2.49	6.09	4.54	7.22	4.63	4.97	7.60
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
40/$10 copay	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
40/$15 copay	(0.45)	(1.10)	(0.82)	(1.30)	(0.84)	(0.90)	(1.38)
40/$20 copay	(0.61)	(1.50)	(1.12)	(1.77)	(1.14)	(1.22)	(1.87)
40/$25 copay	(0.83)	(2.02)	(1.51)	(2.39)	(1.54)	(1.65)	(2.53)
60	0.30	0.72	0.54	0.86	0.55	0.59	0.91
100	0.72	1.77	1.32	2.10	1.35	1.45	2.21
200	1.93	4.72	3.52	5.59	3.59	3.85	5.89
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.14)	(2.79)	(2.09)	(3.32)	(2.12)	(2.28)	(3.50)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.75	1.84	1.38	2.19	1.41	1.51	2.30
90	1.57	3.84	2.86	4.57	2.91	3.14	4.80
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.67	1.65	1.23	1.96	1.25	1.35	2.06
90	1.23	3.02	2.25	3.59	2.29	2.47	3.77
120	2.00	4.89	3.65	5.81	3.72	3.99	6.11
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.96)	(2.34)	(1.75)	(2.78)	(1.78)	(1.92)	(2.93)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.29	0.70	0.52	0.83	0.53	0.57	0.88
30	0.46	1.12	0.84	1.33	0.86	0.92	1.41
Unlimited	0.67	1.65	1.23	1.96	1.25	1.35	2.06
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.38	8.28	6.18	9.83	6.29	6.77	10.35
60	3.96	9.71	7.23	11.52	7.38	7.93	12.13
90	4.73	11.59	8.63	13.75	8.79	9.46	14.46
Unlimited	4.80	11.76	8.76	13.95	8.93	9.60	14.68
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.24)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)
60/$10 copay	(0.28)	(0.67)	(0.50)	(0.79)	(0.51)	(0.55)	(0.85)
60/$15 copay	(0.42)	(1.02)	(0.76)	(1.21)	(0.77)	(0.84)	(1.27)
60/$20 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60/$25 copay	(0.69)	(1.70)	(1.26)	(2.02)	(1.28)	(1.39)	(2.12)
120/$0 copay	0.59	1.45	1.08	1.72	1.10	1.18	1.80
120/$5 copay	0.46	1.12	0.84	1.33	0.86	0.92	1.41
120/$10 copay	0.28	0.67	0.50	0.79	0.51	0.55	0.85
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
120/$25 copay	(0.34)	(0.83)	(0.61)	(0.98)	(0.62)	(0.67)	(1.03)
Unlimited/$0 copay	0.68	1.67	1.24	1.99	1.27	1.37	2.09
Unlimited/$5 copay	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited/$10 copa	0.34	0.83	0.61	0.98	0.62	0.67	1.03
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
Unlimited/$25 copa	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.43	0.32	0.50	0.33	0.35	0.53
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.24)	(0.18)	(0.30)	(0.19)	(0.20)	(0.32)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.53)	(8.65)	(6.45)	(10.26)	(6.57)	(7.06)	(10.80)
$125	(4.38)	(10.73)	(8.00)	(12.73)	(8.15)	(8.76)	(13.40)
$150	(5.21)	(12.76)	(9.51)	(15.15)	(9.69)	(10.42)	(15.94)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.60	1.47	1.10	1.74	1.12	1.20	1.84
60	1.18	2.89	2.15	3.43	2.19	2.36	3.61
90	1.77	4.34	3.23	5.15	3.29	3.54	5.41
120	2.09	5.12	3.82	6.08	3.89	4.18	6.39
Unlimited	2.70	6.62	4.93	7.85	5.02	5.40	8.26
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$15 copay	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
40/$20 copay	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
40/$25 copay	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
60	0.33	0.81	0.60	0.96	0.61	0.66	1.01
100	0.77	1.89	1.41	2.24	1.43	1.54	2.36
200	2.09	5.12	3.82	6.08	3.89	4.18	6.39
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.81	1.98	1.48	2.35	1.51	1.62	2.48
90	1.70	4.17	3.10	4.94	3.16	3.40	5.20
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.72	1.76	1.31	2.09	1.34	1.44	2.20
90	1.32	3.23	2.41	3.84	2.46	2.64	4.04
120	2.17	5.32	3.96	6.31	4.04	4.34	6.64
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.32	0.78	0.58	0.93	0.60	0.64	0.98
30	0.50	1.23	0.91	1.45	0.93	1.00	1.53
Unlimited	0.72	1.76	1.31	2.09	1.34	1.44	2.20
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.68	9.02	6.72	10.70	6.84	7.36	11.26
60	4.30	10.54	7.85	12.50	8.00	8.60	13.15
90	5.13	12.57	9.37	14.91	9.54	10.26	15.69
Unlimited	5.21	12.76	9.51	15.15	9.69	10.42	15.94
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
60/$15 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$20 copay	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
60/$25 copay	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
120/$0 copay	0.64	1.57	1.17	1.86	1.19	1.28	1.96
120/$5 copay	0.50	1.23	0.91	1.45	0.93	1.00	1.53
120/$10 copay	0.31	0.76	0.57	0.90	0.58	0.62	0.95
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
Unlimited/$0 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
Unlimited/$5 copay	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$10 copa	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(0.27)	(0.66)	(0.50)	(0.78)	(0.51)	(0.54)	(0.82)
$125	(0.34)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.06)
$150	(0.41)	(1.00)	(0.75)	(1.20)	(0.76)	(0.82)	(1.26)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.09	0.08	0.11	0.08	0.08	0.13
60	0.09	0.22	0.16	0.26	0.16	0.18	0.28
90	0.13	0.33	0.23	0.38	0.24	0.26	0.40
120	0.16	0.40	0.30	0.49	0.30	0.33	0.50
Unlimited	0.21	0.53	0.39	0.63	0.39	0.43	0.66
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
40/$10 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
40/$15 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
40/$20 copay	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
40/$25 copay	(0.08)	(0.21)	(0.15)	(0.26)	(0.15)	(0.17)	(0.25)
60	0.03	0.09	0.06	0.10	0.06	0.07	0.10
100	0.05	0.12	0.09	0.14	0.08	0.09	0.15
200	0.16	0.40	0.30	0.49	0.30	0.33	0.50
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.26)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.06	0.14	0.10	0.16	0.10	0.11	0.18
90	0.13	0.33	0.24	0.37	0.25	0.26	0.40
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.11	0.08	0.13	0.09	0.09	0.14
90	0.09	0.21	0.16	0.25	0.17	0.17	0.27
120	0.17	0.43	0.31	0.50	0.32	0.35	0.53
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.03	0.08	0.06	0.10	0.07	0.07	0.10
30	0.04	0.11	0.07	0.12	0.07	0.08	0.12
Unlimited	0.05	0.11	0.08	0.13	0.09	0.09	0.14
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.30	0.74	0.54	0.87	0.55	0.59	0.91
60	0.34	0.83	0.62	0.98	0.62	0.67	1.02
90	0.40	0.98	0.74	1.16	0.75	0.80	1.23
Unlimited	0.41	1.00	0.75	1.20	0.76	0.82	1.26
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	(0.01)	0.00	0.01	0.00	0.00	0.01
60/$10 copay	(0.03)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.10)
60/$15 copay	(0.04)	(0.11)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
60/$20 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.13)
60/$25 copay	(0.05)	(0.11)	(0.09)	(0.13)	(0.10)	(0.09)	(0.14)
120/$0 copay	0.05	0.12	0.09	0.14	0.09	0.10	0.16
120/$5 copay	0.04	0.11	0.07	0.12	0.07	0.08	0.12
120/$10 copay	0.03	0.09	0.07	0.11	0.07	0.07	0.10
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
120/$25 copay	(0.03)	(0.08)	(0.07)	(0.10)	(0.07)	(0.07)	(0.10)
Unlimited/$0 copay	0.05	0.12	0.09	0.13	0.09	0.09	0.14
Unlimited/$5 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.12
Unlimited/$10 copa	0.03	0.08	0.07	0.10	0.07	0.07	0.10
Unlimited/$15 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copa	0.00	0.00	0.00	0.00	0.00	0.00	0.01
Unlimited/$25 copa	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.01	0.01	0.01	0.02	0.00	0.01	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	(0.01)	0.00	0.01	0.00	0.00	0.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	8.3%	8.3%	8.4%	8.2%	8.4%	8.3%	8.2%
$125	8.4%	8.6%	8.5%	8.5%	8.5%	8.6%	8.6%
$150	8.5%	8.5%	8.6%	8.6%	8.5%	8.5%	8.6%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.1%	6.5%	7.8%	6.7%	7.7%	7.1%	7.6%
60	8.3%	8.2%	8.0%	8.2%	7.9%	8.3%	8.4%
90	7.9%	8.2%	7.7%	8.0%	7.9%	7.9%	8.0%
120	8.3%	8.5%	8.5%	8.8%	8.4%	8.6%	8.5%
Unlimited	8.4%	8.7%	8.6%	8.7%	8.4%	8.7%	8.7%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
40/$10 copay	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
40/$15 copay	8.9%	9.1%	8.5%	9.2%	8.3%	8.9%	8.7%
40/$20 copay	8.2%	8.0%	8.0%	8.5%	7.9%	8.2%	8.0%
40/$25 copay	9.6%	10.4%	9.9%	10.9%	9.7%	10.3%	9.9%
60	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
100	6.9%	6.8%	6.8%	6.7%	5.9%	6.2%	6.8%
200	8.3%	8.5%	8.5%	8.8%	8.4%	8.6%	8.5%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	7.9%	7.9%	7.7%	7.8%	8.0%	7.9%	7.4%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.0%	7.6%	7.2%	7.3%	7.1%	7.3%	7.8%
90	8.3%	8.6%	8.4%	8.1%	8.6%	8.3%	8.3%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
90	7.3%	7.0%	7.1%	7.0%	7.4%	6.9%	7.2%
120	8.5%	8.8%	8.5%	8.6%	8.6%	8.8%	8.7%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.3%	9.0%	8.6%	8.6%	8.4%	8.3%	8.5%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
30	8.7%	9.8%	8.3%	9.0%	8.1%	8.7%	8.5%
Unlimited	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.9%	8.9%	8.7%	8.9%	8.7%	8.7%	8.8%
60	8.6%	8.5%	8.6%	8.5%	8.4%	8.4%	8.4%
90	8.5%	8.5%	8.6%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.6%	8.6%	8.5%	8.5%	8.6%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	4.2%	0.0%	-3.3%	0.0%	0.0%	-3.1%
60/$10 copay	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
60/$15 copay	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%
60/$20 copay	7.0%	6.4%	6.7%	6.6%	6.6%	7.0%	7.5%
60/$25 copay	7.2%	6.5%	7.1%	6.4%	7.8%	6.5%	6.6%
120/$0 copay	8.5%	8.3%	8.3%	8.1%	8.2%	8.5%	8.9%
120/$5 copay	8.7%	9.8%	8.3%	9.0%	8.1%	8.7%	8.5%
120/$10 copay	10.7%	13.4%	14.0%	13.9%	13.7%	12.7%	11.8%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
120/$25 copay	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
Unlimited/$0 copay	7.4%	7.2%	7.3%	6.5%	7.1%	6.6%	6.7%
Unlimited/$5 copay	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
Unlimited/$10 copa	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
Unlimited/$15 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
Unlimited/$25 copa	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	5.9%	2.3%	3.1%	4.0%	0.0%	2.9%	3.8%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	4.2%	0.0%	-3.3%	0.0%	0.0%	-3.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$25	(0.31)	(0.74)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$10	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$15	(0.46)	(1.12)	(0.84)	(1.33)	(0.86)	(0.92)	(1.41)
$20	(0.65)	(1.60)	(1.19)	(1.90)	(1.21)	(1.30)	(2.00)
$25	(0.85)	(2.07)	(1.55)	(2.46)	(1.57)	(1.69)	(2.59)
$30	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$35	(1.20)	(2.94)	(2.19)	(3.50)	(2.23)	(2.40)	(3.68)
$40	(1.40)	(3.42)	(2.55)	(4.06)	(2.60)	(2.79)	(4.27)
$45	(1.58)	(3.87)	(2.88)	(4.60)	(2.93)	(3.16)	(4.83)
$50	(1.75)	(4.29)	(3.20)	(5.10)	(3.26)	(3.51)	(5.36)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$10	(0.34)	(0.83)	(0.61)	(0.98)	(0.62)	(0.67)	(1.03)
$15	(0.49)	(1.20)	(0.90)	(1.43)	(0.91)	(0.98)	(1.50)
$20	(0.72)	(1.77)	(1.32)	(2.10)	(1.35)	(1.45)	(2.21)
$25	(0.98)	(2.39)	(1.78)	(2.84)	(1.82)	(1.96)	(3.00)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$25	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$35	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
$50	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
$60	(0.42)	(1.02)	(0.76)	(1.21)	(0.77)	(0.84)	(1.27)
$75	(0.54)	(1.32)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
$100	(0.72)	(1.77)	(1.32)	(2.10)	(1.35)	(1.45)	(2.21)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.28)	(0.20)	(0.33)	(0.20)	(0.22)	(0.35)
$35	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$50	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
$60	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)
$75	(0.37)	(0.90)	(0.67)	(1.07)	(0.68)	(0.73)	(1.12)
$100	(0.49)	(1.20)	(0.90)	(1.43)	(0.91)	(0.98)	(1.50)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.05)	(7.47)	(5.56)	(8.86)	(5.67)	(6.09)	(9.32)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.72)	(11.56)	(8.61)	(13.72)	(8.77)	(9.44)	(14.43)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.41)	(1.00)	(0.74)	(1.18)	(0.75)	(0.82)	(1.24)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$20	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$25	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
$30	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$35	(1.29)	(3.16)	(2.36)	(3.75)	(2.40)	(2.58)	(3.95)
$40	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$45	(1.71)	(4.19)	(3.12)	(4.97)	(3.18)	(3.42)	(5.23)
$50	(1.90)	(4.66)	(3.47)	(5.52)	(3.53)	(3.80)	(5.81)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$15	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$20	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
$25	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$60	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$75	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$100	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.30)	(8.09)	(6.03)	(9.59)	(6.14)	(6.60)	(10.09)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(5.12)	(12.54)	(9.35)	(14.88)	(9.52)	(10.24)	(15.66)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$10	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$15	(0.04)	(0.11)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.10)	(0.14)
$25	(0.08)	(0.21)	(0.15)	(0.24)	(0.16)	(0.17)	(0.25)
$30	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$35	(0.09)	(0.22)	(0.17)	(0.25)	(0.17)	(0.18)	(0.27)
$40	(0.12)	(0.30)	(0.23)	(0.36)	(0.23)	(0.25)	(0.38)
$45	(0.13)	(0.32)	(0.24)	(0.37)	(0.25)	(0.26)	(0.40)
$50	(0.15)	(0.37)	(0.27)	(0.42)	(0.27)	(0.29)	(0.45)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$10	(0.03)	(0.08)	(0.07)	(0.10)	(0.07)	(0.07)	(0.10)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$20	(0.05)	(0.12)	(0.09)	(0.14)	(0.08)	(0.09)	(0.15)
$25	(0.08)	(0.21)	(0.16)	(0.24)	(0.15)	(0.16)	(0.24)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$25	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$35	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
$60	(0.04)	(0.11)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
$75	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$100	(0.05)	(0.12)	(0.09)	(0.14)	(0.08)	(0.09)	(0.15)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.01	0.00	0.01	0.00	0.00	0.01
$35	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$50	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.25)	(0.62)	(0.47)	(0.73)	(0.47)	(0.51)	(0.77)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(0.40)	(0.98)	(0.74)	(1.16)	(0.75)	(0.80)	(1.23)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.04)	(0.10)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$25	9.7%	12.2%	10.7%	11.2%	10.5%	11.5%	10.6%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$10	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$15	8.7%	9.8%	8.3%	9.0%	8.1%	8.7%	8.5%
$20	7.7%	7.5%	7.6%	6.8%	7.4%	7.7%	7.0%
$25	9.4%	10.1%	9.7%	9.8%	10.2%	10.1%	9.7%
$30	7.8%	8.0%	8.1%	7.7%	7.9%	7.8%	7.7%
$35	7.5%	7.5%	7.8%	7.1%	7.6%	7.5%	7.3%
$40	8.6%	8.8%	9.0%	8.9%	8.8%	9.0%	8.9%
$45	8.2%	8.3%	8.3%	8.0%	8.5%	8.2%	8.3%
$50	8.6%	8.6%	8.4%	8.2%	8.3%	8.3%	8.4%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$10	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
$15	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
$20	6.9%	6.8%	6.8%	6.7%	5.9%	6.2%	6.8%
$25	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$25	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$35	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
$50	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
$60	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%
$75	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
$100	6.9%	6.8%	6.8%	6.7%	5.9%	6.2%	6.8%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	-3.6%	0.0%	-3.0%	0.0%	0.0%	-2.9%
$35	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$50	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
$60	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%
$75	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
$100	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	8.2%	8.3%	8.5%	8.2%	8.3%	8.4%	8.3%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
19	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
19	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.88	19.30	14.38	22.90	14.65	15.75	24.10
60	8.30	20.35	15.16	24.14	15.45	16.61	25.40
90	8.61	21.09	15.72	25.03	16.02	17.22	26.34
Unlimited	8.70	21.32	15.89	25.30	16.18	17.40	26.62
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.80	21.57	16.08	25.60	16.38	17.61	26.93
30	9.69	23.74	17.69	28.18	18.03	19.38	29.64
40	10.23	25.07	18.68	29.74	19.02	20.46	31.29
60	10.78	26.41	19.69	31.34	20.05	21.56	32.97
Unlimited	10.87	26.64	19.85	31.61	20.23	21.75	33.26
LARGE GROUP				**$5 Copay**			
20	8.28	20.30	15.12	24.08	15.41	16.57	25.34
30	9.11	22.32	16.63	26.48	16.95	18.22	27.87
40	9.68	23.71	17.68	28.14	18.01	19.36	29.61
60	10.14	24.84	18.52	29.47	18.86	20.28	31.02
Unlimited	10.22	25.04	18.66	29.71	19.01	20.44	31.26
LARGE GROUP				**$10 Copay**			
20	7.75	18.99	14.16	22.54	14.42	15.51	23.72
30	8.53	20.90	15.57	24.79	15.87	17.06	26.09
40	9.02	22.09	16.47	26.22	16.77	18.04	27.58
60	9.51	23.29	17.36	27.64	17.68	19.01	29.08
Unlimited	9.58	23.47	17.49	27.85	17.81	19.16	29.30
LARGE GROUP				**$15 Copay**			
20	7.28	17.82	13.29	21.15	13.53	14.55	22.25
30	8.01	19.63	14.62	23.28	14.90	16.02	24.50
40	8.49	20.80	15.50	24.68	15.78	16.98	25.96
60	8.98	21.99	16.40	26.10	16.70	17.95	27.46
Unlimited	9.05	22.17	16.52	26.30	16.83	18.10	27.68
LARGE GROUP				**$20 Copay**			
20	6.85	16.77	12.50	19.90	12.74	13.70	20.95
30	7.50	18.37	13.70	21.81	13.95	15.00	22.94
40	7.92	19.40	14.46	23.02	14.72	15.84	24.22
60	8.42	20.62	15.37	24.47	15.65	16.83	25.75
Unlimited	8.48	20.77	15.48	24.65	15.76	16.96	25.93
LARGE GROUP				**$25 Copay**			
20	6.36	15.58	11.61	18.48	11.83	12.72	19.45
30	6.98	17.10	12.75	20.29	12.98	13.96	21.35
40	7.45	18.25	13.60	21.65	13.86	14.90	22.78
60	7.84	19.20	14.31	22.77	14.57	15.67	23.97
Unlimited	7.91	19.37	14.44	22.99	14.70	15.81	24.19
LARGE GROUP				**$30 Copay**			
20	6.07	14.88	11.09	17.66	11.30	12.15	18.58
30	6.58	16.13	12.02	19.14	12.25	13.17	20.14
40	7.00	17.15	12.78	20.35	13.02	14.00	21.42
60	7.36	18.03	13.43	21.39	13.69	14.71	22.51
Unlimited	7.40	18.13	13.51	21.50	13.76	14.80	22.63
LARGE GROUP				**$35 Copay**			
20	5.77	14.13	10.53	16.76	10.73	11.54	17.64
30	6.16	15.10	11.26	17.92	11.46	12.33	18.86
40	6.55	16.05	11.96	19.05	12.19	13.10	20.04
60	6.88	16.85	12.56	19.99	12.79	13.76	21.04
Unlimited	6.93	16.98	12.66	20.15	12.89	13.86	21.20
LARGE GROUP				**$40 Copay**			
20	5.62	13.78	10.27	16.35	10.47	11.25	17.21
30	5.99	14.68	10.94	17.41	11.15	11.98	18.33
40	6.38	15.63	11.65	18.55	11.86	12.76	19.51
60	6.74	16.50	12.30	19.59	12.52	13.47	20.60
Unlimited	6.78	16.60	12.37	19.70	12.61	13.55	20.73
LARGE GROUP				**$45 Copay**			
20	5.44	13.33	9.94	15.81	10.12	10.88	16.64
30	5.82	14.26	10.63	16.92	10.82	11.64	17.80
40	6.23	15.25	11.37	18.10	11.58	12.45	19.05
60	6.57	16.10	12.00	19.11	12.23	13.15	20.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.54	20.92	15.59	24.83	15.88	17.08	26.12
60	9.00	22.05	16.43	26.16	16.74	18.00	27.53
90	9.34	22.88	17.05	27.15	17.37	18.68	28.57
Unlimited	9.44	23.13	17.24	27.44	17.56	18.88	28.88
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.54	23.37	17.42	27.73	17.74	19.08	29.18
30	10.51	25.75	19.19	30.55	19.55	21.02	32.15
40	11.10	27.20	20.27	32.27	20.65	22.20	33.95
60	11.69	28.64	21.35	33.98	21.74	23.38	35.76
Unlimited	11.79	28.89	21.53	34.27	21.93	23.58	36.07
LARGE GROUP				**$5 Copay**			
20	8.98	22.00	16.40	26.10	16.70	17.96	27.47
30	9.88	24.21	18.04	28.72	18.38	19.76	30.22
40	10.50	25.73	19.17	30.52	19.53	21.00	32.12
60	11.00	26.95	20.09	31.98	20.46	22.00	33.65
Unlimited	11.09	27.17	20.25	32.24	20.63	22.18	33.92
LARGE GROUP				**$10 Copay**			
20	8.41	20.60	15.36	24.45	15.64	16.82	25.73
30	9.25	22.66	16.89	26.89	17.21	18.50	28.30
40	9.78	23.96	17.86	28.43	18.19	19.56	29.92
60	10.31	25.26	18.83	29.97	19.18	20.62	31.54
Unlimited	10.39	25.46	18.97	30.20	19.33	20.78	31.78
LARGE GROUP				**$15 Copay**			
20	7.89	19.33	14.41	22.94	14.68	15.78	24.14
30	8.69	21.29	15.87	25.26	16.16	17.38	26.58
40	9.21	22.56	16.82	26.77	17.13	18.42	28.17
60	9.73	23.84	17.77	28.29	18.10	19.46	29.76
Unlimited	9.81	24.03	17.91	28.52	18.25	19.62	30.01
LARGE GROUP				**$20 Copay**			
20	7.43	18.20	13.57	21.60	13.82	14.86	22.73
30	8.14	19.94	14.86	23.66	15.14	16.28	24.90
40	8.59	21.05	15.69	24.97	15.98	17.18	26.28
60	9.13	22.37	16.67	26.54	16.98	18.26	27.93
Unlimited	9.20	22.54	16.80	26.74	17.11	18.40	28.14
LARGE GROUP				**$25 Copay**			
20	6.90	16.91	12.60	20.06	12.83	13.80	21.11
30	7.57	18.55	13.82	22.01	14.08	15.14	23.16
40	8.09	19.82	14.77	23.52	15.05	16.18	24.75
60	8.50	20.83	15.52	24.71	15.81	17.00	26.00
Unlimited	8.58	21.02	15.67	24.94	15.96	17.16	26.25
LARGE GROUP				**$30 Copay**			
20	6.59	16.15	12.03	19.16	12.26	13.18	20.16
30	7.14	17.49	13.04	20.76	13.28	14.28	21.84
40	7.60	18.62	13.88	22.09	14.14	15.20	23.25
60	7.98	19.55	14.57	23.20	14.84	15.96	24.41
Unlimited	8.02	19.65	14.64	23.31	14.92	16.04	24.53
LARGE GROUP				**$35 Copay**			
20	6.25	15.31	11.41	18.17	11.63	12.50	19.12
30	6.68	16.37	12.20	19.42	12.42	13.36	20.43
40	7.11	17.42	12.98	20.67	13.22	14.22	21.75
60	7.46	18.28	13.62	21.69	13.88	14.92	22.82
Unlimited	7.51	18.40	13.71	21.83	13.97	15.02	22.97
LARGE GROUP				**$40 Copay**			
20	6.10	14.95	11.14	17.73	11.35	12.20	18.66
30	6.50	15.93	11.87	18.90	12.09	13.00	19.88
40	6.92	16.95	12.64	20.12	12.87	13.84	21.17
60	7.30	17.89	13.33	21.22	13.58	14.60	22.33
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP				**$45 Copay**			
20	5.91	14.48	10.79	17.18	10.99	11.82	18.08
30	6.31	15.46	11.52	18.34	11.74	12.62	19.30
40	6.75	16.54	12.33	19.62	12.56	13.50	20.65
60	7.13	17.47	13.02	20.73	13.26	14.26	21.81

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.66	1.62	1.21	1.93	1.23	1.33	2.02
60	0.70	1.70	1.27	2.02	1.29	1.39	2.13
90	0.73	1.79	1.33	2.12	1.35	1.46	2.23
Unlimited	0.74	1.81	1.35	2.14	1.38	1.48	2.26
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.74	1.80	1.34	2.13	1.36	1.47	2.25
30	0.82	2.01	1.50	2.37	1.52	1.64	2.51
40	0.87	2.13	1.59	2.53	1.63	1.74	2.66
60	0.91	2.23	1.66	2.64	1.69	1.82	2.79
Unlimited	0.92	2.25	1.68	2.66	1.70	1.83	2.81
LARGE GROUP				**$5 Copay**			
20	0.70	1.70	1.28	2.02	1.29	1.39	2.13
30	0.77	1.89	1.41	2.24	1.43	1.54	2.35
40	0.82	2.02	1.49	2.38	1.52	1.64	2.51
60	0.86	2.11	1.57	2.51	1.60	1.72	2.63
Unlimited	0.87	2.13	1.59	2.53	1.62	1.74	2.66
LARGE GROUP				**$10 Copay**			
20	0.66	1.61	1.20	1.91	1.22	1.31	2.01
30	0.72	1.76	1.32	2.10	1.34	1.44	2.21
40	0.76	1.87	1.39	2.21	1.42	1.52	2.34
60	0.80	1.97	1.47	2.33	1.50	1.61	2.46
Unlimited	0.81	1.99	1.48	2.35	1.52	1.62	2.48
LARGE GROUP				**$15 Copay**			
20	0.61	1.51	1.12	1.79	1.15	1.23	1.89
30	0.68	1.66	1.25	1.98	1.26	1.36	2.08
40	0.72	1.76	1.32	2.09	1.35	1.44	2.21
60	0.75	1.85	1.37	2.19	1.40	1.51	2.30
Unlimited	0.76	1.86	1.39	2.22	1.42	1.52	2.33
LARGE GROUP				**$20 Copay**			
20	0.58	1.43	1.07	1.70	1.08	1.16	1.78
30	0.64	1.57	1.16	1.85	1.19	1.28	1.96
40	0.67	1.65	1.23	1.95	1.26	1.34	2.06
60	0.71	1.75	1.30	2.07	1.33	1.43	2.18
Unlimited	0.72	1.77	1.32	2.09	1.35	1.44	2.21
LARGE GROUP				**$25 Copay**			
20	0.54	1.33	0.99	1.58	1.00	1.08	1.66
30	0.59	1.45	1.07	1.72	1.10	1.18	1.81
40	0.64	1.57	1.17	1.87	1.19	1.28	1.97
60	0.66	1.63	1.21	1.94	1.24	1.33	2.03
Unlimited	0.67	1.65	1.23	1.95	1.26	1.35	2.06
LARGE GROUP				**$30 Copay**			
20	0.52	1.27	0.94	1.50	0.96	1.03	1.58
30	0.56	1.36	1.02	1.62	1.03	1.11	1.70
40	0.60	1.47	1.10	1.74	1.12	1.20	1.83
60	0.62	1.52	1.14	1.81	1.15	1.25	1.90
Unlimited	0.62	1.52	1.13	1.81	1.16	1.24	1.90
LARGE GROUP				**$35 Copay**			
20	0.48	1.18	0.88	1.41	0.90	0.96	1.48
30	0.52	1.27	0.94	1.50	0.96	1.03	1.57
40	0.56	1.37	1.02	1.62	1.03	1.12	1.71
60	0.58	1.43	1.06	1.70	1.09	1.16	1.78
Unlimited	0.58	1.42	1.05	1.68	1.08	1.16	1.77
LARGE GROUP				**$40 Copay**			
20	0.48	1.17	0.87	1.38	0.88	0.95	1.45
30	0.51	1.25	0.93	1.49	0.94	1.02	1.55
40	0.54	1.32	0.99	1.57	1.01	1.08	1.66
60	0.56	1.39	1.03	1.63	1.06	1.13	1.73
Unlimited	0.57	1.41	1.05	1.67	1.06	1.15	1.75
LARGE GROUP				**$45 Copay**			
20	0.47	1.15	0.85	1.37	0.87	0.94	1.44
30	0.49	1.20	0.89	1.42	0.92	0.98	1.50
40	0.52	1.29	0.96	1.52	0.98	1.05	1.60
60	0.56	1.37	1.02	1.62	1.03	1.11	1.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%
90	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.4%	8.3%	8.3%	8.3%	8.3%	8.3%	8.4%
30	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%
Unlimited	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$5 Copay**			
20	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
40	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$10 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
30	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%
40	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%	8.5%
60	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP				**$15 Copay**			
20	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$20 Copay**			
20	8.5%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
60	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP				**$25 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
LARGE GROUP				**$30 Copay**			
20	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.5%
60	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$35 Copay**			
20	8.3%	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%
30	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.3%
40	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
60	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
Unlimited	8.4%	8.4%	8.3%	8.3%	8.4%	8.4%	8.3%
LARGE GROUP				**$40 Copay**			
20	8.5%	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.5%	8.5%	8.5%	8.6%	8.4%	8.5%	8.5%
40	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.3%	8.4%	8.4%	8.3%	8.5%	8.4%	8.4%
Unlimited	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
LARGE GROUP				**$45 Copay**			
20	8.6%	8.6%	8.6%	8.7%	8.6%	8.6%	8.7%
30	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
40	8.3%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited	6.60	16.18	12.05	19.20	12.28	13.21	20.20
LARGE GROUP			**$50 Copay**				
20	5.30	12.98	9.67	15.41	9.85	10.60	16.21
30	5.68	13.91	10.36	16.50	10.56	11.35	17.36
40	6.07	14.88	11.09	17.66	11.30	12.15	18.58
60	6.40	15.68	11.69	18.61	11.90	12.80	19.57
Unlimited	6.44	15.77	11.76	18.72	11.97	12.88	19.70

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited	7.16	17.54	13.07	20.81	13.32	14.32	21.90
LARGE GROUP			**$50 Copay**				
20	5.75	14.09	10.50	16.72	10.70	11.50	17.59
30	6.15	15.07	11.23	17.88	11.44	12.30	18.81
40	6.59	16.15	12.03	19.16	12.26	13.18	20.16
60	6.94	17.00	12.67	20.17	12.91	13.88	21.23
Unlimited	6.99	17.13	12.76	20.32	13.00	13.98	21.38

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited	0.56	1.36	1.02	1.61	1.04	1.11	1.70
LARGE GROUP			**$50 Copay**				
20	0.45	1.11	0.83	1.31	0.85	0.90	1.38
30	0.47	1.16	0.87	1.38	0.88	0.95	1.45
40	0.52	1.27	0.94	1.50	0.96	1.03	1.58
60	0.54	1.32	0.98	1.56	1.01	1.08	1.66
Unlimited	0.55	1.36	1.00	1.60	1.03	1.10	1.68

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Unlimited	8.5%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
LARGE GROUP			**$50 Copay**				
20	8.5%	8.6%	8.6%	8.5%	8.6%	8.5%	8.5%
30	8.3%	8.3%	8.4%	8.4%	8.3%	8.4%	8.4%
40	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.5%
Unlimited	8.5%	8.6%	8.5%	8.5%	8.6%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.37	10.71	7.98	12.71	8.13	8.74	13.37
$25	4.16	10.19	7.59	12.09	7.73	8.32	12.72
$50	3.88	9.51	7.09	11.29	7.22	7.76	11.87
$100	3.58	8.76	6.53	10.39	6.65	7.15	10.94
$500	1.71	4.20	3.13	4.97	3.18	3.42	5.24
Coinsurance							
80%	3.53	8.64	6.44	10.25	6.56	7.05	10.78
75%	3.29	8.06	6.01	9.57	6.12	6.58	10.07
70%	3.08	7.54	5.61	8.95	5.73	6.15	9.42
Deductible			**Orthotics Riders**				
$0	0.74	1.82	1.36	2.16	1.39	1.49	2.27
$25	0.71	1.74	1.30	2.07	1.32	1.43	2.18
$50	0.67	1.65	1.23	1.96	1.25	1.35	2.06
$100	0.60	1.48	1.10	1.75	1.12	1.20	1.83
$500	0.31	0.74	0.56	0.89	0.57	0.61	0.94
Coinsurance							
80%	0.60	1.48	1.10	1.75	1.12	1.20	1.83
75%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
70%	0.54	1.32	0.99	1.57	1.01	1.08	1.65
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.38	3.37	2.52	3.99	2.56	2.75	4.21
12 Months	2.19	5.37	4.00	6.37	4.08	4.38	6.71
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.14	5.24	3.90	6.22	3.98	4.28	6.54
12 Months	3.41	8.37	6.24	9.93	6.35	6.83	10.44
			Private Duty Nursing Riders				
In Full	0.52	1.27	0.95	1.51	0.97	1.04	1.59
0% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
00% hrs 73-50	0.15	0.38	0.28	0.45	0.29	0.31	0.47
			Dental Network Access				
	0.43	1.05	0.78	1.24	0.79	0.86	1.30
Limit			**Infertility Rider**				
2 IVF	9.26	22.69	16.92	26.92	17.23	18.53	28.34
3 IVF	11.21	27.46	20.47	32.59	20.85	22.42	34.29

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.75	11.64	8.67	13.81	8.84	9.50	14.53
$25	4.50	11.03	8.22	13.08	8.37	9.00	13.77
$50	4.22	10.34	7.71	12.27	7.85	8.44	12.91
$100	3.88	9.51	7.08	11.28	7.22	7.76	11.87
$500	1.84	4.51	3.36	5.35	3.42	3.68	5.63
Coinsurance							
80%	3.82	9.36	6.98	11.10	7.11	7.64	11.69
75%	3.57	8.75	6.52	10.38	6.64	7.14	10.92
70%	3.33	8.16	6.08	9.68	6.19	6.66	10.19
Deductible			**Orthotics Riders**				
$0	0.79	1.94	1.44	2.30	1.47	1.58	2.42
$25	0.76	1.86	1.39	2.21	1.41	1.52	2.32
$50	0.72	1.76	1.31	2.09	1.34	1.44	2.20
$100	0.65	1.59	1.19	1.89	1.21	1.30	1.99
$500	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Coinsurance							
80%	0.65	1.59	1.19	1.89	1.21	1.30	1.99
75%	0.61	1.49	1.11	1.77	1.13	1.22	1.87
70%	0.58	1.42	1.06	1.69	1.08	1.16	1.77
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.56	1.37	1.02	1.63	1.04	1.12	1.71
80% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	10.04	24.60	18.33	29.19	18.67	20.08	30.71
3 IVF	12.16	29.79	22.20	35.35	22.62	24.32	37.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.38	0.93	0.69	1.10	0.71	0.76	1.16
$25	0.34	0.84	0.63	0.99	0.64	0.68	1.05
$50	0.34	0.83	0.62	0.98	0.63	0.68	1.04
$100	0.30	0.75	0.55	0.89	0.57	0.61	0.93
$500	0.13	0.31	0.23	0.38	0.24	0.26	0.39
Coinsurance							
80%	0.29	0.72	0.54	0.85	0.55	0.59	0.91
75%	0.28	0.69	0.51	0.81	0.52	0.56	0.85
70%	0.25	0.62	0.47	0.73	0.46	0.51	0.77
Deductible			**Orthotics Riders**				
$0	0.05	0.12	0.08	0.14	0.08	0.09	0.15
$25	0.05	0.12	0.09	0.14	0.09	0.09	0.14
$50	0.05	0.11	0.08	0.13	0.09	0.09	0.14
$100	0.05	0.11	0.09	0.14	0.09	0.10	0.16
$500	0.03	0.09	0.06	0.10	0.06	0.07	0.10
Coinsurance							
80%	0.05	0.11	0.09	0.14	0.09	0.10	0.16
75%	0.04	0.09	0.07	0.11	0.07	0.08	0.13
70%	0.04	0.10	0.07	0.12	0.07	0.08	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.37	0.23	0.25	0.38
12 Months	0.18	0.44	0.33	0.52	0.33	0.36	0.54
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.32	0.34	0.53
12 Months	0.30	0.72	0.53	0.85	0.55	0.59	0.91
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.12	0.07	0.08	0.12
80% hrs 73-50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
100% hrs 73-50	0.01	0.01	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	0.78	1.91	1.41	2.27	1.44	1.55	2.37
3 IVF	0.95	2.33	1.73	2.76	1.77	1.90	2.91

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.7%	8.7%	8.6%	8.7%	8.7%	8.7%	8.7%
$25	8.2%	8.2%	8.3%	8.2%	8.3%	8.2%	8.3%
$50	8.8%	8.7%	8.7%	8.7%	8.7%	8.8%	8.8%
$100	8.4%	8.6%	8.4%	8.6%	8.6%	8.5%	8.5%
$500	7.6%	7.4%	7.3%	7.6%	7.5%	7.6%	7.4%
Coinsurance							
80%	8.2%	8.3%	8.4%	8.3%	8.4%	8.4%	8.4%
75%	8.5%	8.6%	8.5%	8.5%	8.5%	8.5%	8.4%
70%	8.1%	8.2%	8.4%	8.2%	8.0%	8.3%	8.2%
Deductible			**Orthotics Riders**				
$0	6.8%	6.6%	5.9%	6.5%	5.8%	6.0%	6.6%
$25	7.0%	6.9%	6.9%	6.8%	6.8%	6.3%	6.4%
$50	7.5%	6.7%	6.5%	6.6%	7.2%	6.7%	6.8%
$100	8.3%	7.4%	8.2%	8.0%	8.0%	8.3%	8.7%
$500	9.7%	12.2%	10.7%	11.2%	10.5%	11.5%	10.6%
Coinsurance							
80%	8.3%	7.4%	8.2%	8.0%	8.0%	8.3%	8.7%
75%	7.0%	6.4%	6.7%	6.6%	6.6%	7.0%	7.5%
70%	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.7%	9.2%	8.7%	9.3%	9.0%	9.1%	9.0%
12 Months	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.0%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.9%	8.0%	8.2%	8.0%	8.0%	7.9%	8.1%
12 Months	8.8%	8.6%	8.5%	8.6%	8.7%	8.6%	8.7%
			Private Duty Nursing Riders				
In Full	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	7.5%
80% hrs 73-50	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100% hrs 73-50	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
			Dental Network Access				
	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
Limit			**Infertility Rider**				
2 IVF	8.4%	8.4%	8.3%	8.4%	8.4%	8.4%	8.4%
3 IVF	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
890.37	2,181.38	1,625.75	2,588.29	1,656.03	1,780.68	2,723.61
75% Coinsurance						
846.86	2,074.77	1,546.31	2,461.79	1,575.09	1,693.65	2,590.51
70% Coinsurance						
804.41	1,970.76	1,468.79	2,338.39	1,496.14	1,608.76	2,460.64
50% Coinsurance						
760.91	1,864.18	1,389.36	2,211.92	1,415.23	1,521.74	2,327.57

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
965.65	2,365.84	1,763.28	2,807.14	1,796.11	1,931.30	2,953.92
75% Coinsurance						
918.46	2,250.23	1,677.11	2,669.96	1,708.34	1,836.92	2,809.57
70% Coinsurance						
872.42	2,137.43	1,593.04	2,536.12	1,622.70	1,744.84	2,668.73
50% Coinsurance						
825.24	2,021.84	1,506.89	2,398.97	1,534.95	1,650.48	2,524.41

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
75.28	184.46	137.53	218.85	140.08	150.62	230.31
75% Coinsurance						
71.60	175.46	130.80	208.17	133.25	143.27	219.06
70% Coinsurance						
68.01	166.67	124.25	197.73	126.56	136.08	208.09
50% Coinsurance						
64.33	157.66	117.53	187.05	119.72	128.74	196.84

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
75% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
70% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
50% Coinsurance						
8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(54.54)	(133.61)	(99.58)	(158.54)	(101.43)	(109.07)	(166.83)
$250	(65.06)	(159.40)	(118.81)	(189.14)	(121.02)	(130.12)	(199.02)
$300	(75.62)	(185.26)	(138.07)	(219.83)	(140.64)	(151.23)	(231.31)
$350	(86.17)	(211.11)	(157.33)	(250.48)	(160.27)	(172.32)	(263.58)
$400	(94.45)	(231.40)	(172.47)	(274.57)	(175.68)	(188.89)	(288.92)
$500	(111.02)	(271.99)	(202.72)	(322.73)	(206.49)	(222.03)	(339.60)
$750	(144.18)	(353.23)	(263.26)	(419.12)	(268.16)	(288.35)	(441.03)
$1,000	(169.71)	(415.79)	(309.89)	(493.36)	(315.66)	(339.42)	(519.15)
$1,500	(208.76)	(511.46)	(381.19)	(606.87)	(388.28)	(417.50)	(638.60)
$2,000	(224.73)	(550.58)	(410.34)	(653.28)	(417.98)	(449.44)	(687.44)
$2,500	(240.76)	(589.85)	(439.61)	(699.88)	(447.79)	(481.50)	(736.47)
$5,000	(283.05)	(693.45)	(516.83)	(822.81)	(526.45)	(566.07)	(865.83)
$10,000	(317.95)	(778.95)	(580.55)	(924.26)	(591.36)	(635.87)	(972.58)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(44.69)	(109.50)	(81.61)	(129.92)	(83.13)	(89.39)	(136.72)
$250	(53.31)	(130.62)	(97.35)	(154.98)	(99.16)	(106.63)	(163.08)
$300	(61.97)	(151.81)	(113.14)	(180.13)	(115.25)	(123.93)	(189.54)
$350	(70.58)	(172.90)	(128.86)	(205.17)	(131.27)	(141.14)	(215.89)
$400	(77.52)	(189.91)	(141.54)	(225.33)	(144.17)	(155.02)	(237.11)
$500	(91.42)	(223.99)	(166.93)	(265.77)	(170.04)	(182.84)	(279.66)
$750	(118.92)	(291.34)	(217.14)	(345.69)	(221.17)	(237.82)	(363.76)
$1,000	(140.33)	(343.79)	(256.23)	(407.93)	(261.00)	(280.64)	(429.25)
$1,500	(172.76)	(423.26)	(315.45)	(502.21)	(321.32)	(345.51)	(528.47)
$2,000	(187.48)	(459.30)	(342.31)	(544.98)	(348.69)	(374.93)	(573.48)
$2,500	(202.17)	(495.31)	(369.14)	(587.70)	(376.02)	(404.32)	(618.43)
$5,000	(244.26)	(598.44)	(446.01)	(710.07)	(454.31)	(488.51)	(747.19)
$10,000	(278.99)	(683.51)	(509.42)	(811.02)	(518.91)	(557.96)	(853.42)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(34.84)	(85.35)	(63.62)	(101.28)	(64.80)	(69.68)	(106.58)
$250	(41.57)	(101.83)	(75.90)	(120.83)	(77.31)	(83.13)	(127.14)
$300	(48.29)	(118.31)	(88.17)	(140.38)	(89.81)	(96.58)	(147.71)
$350	(55.01)	(134.76)	(100.43)	(159.90)	(102.31)	(110.01)	(168.26)
$400	(60.63)	(148.54)	(110.70)	(176.25)	(112.77)	(121.26)	(185.47)
$500	(71.77)	(175.83)	(131.04)	(208.63)	(133.48)	(143.53)	(219.53)
$750	(93.64)	(229.41)	(170.97)	(272.20)	(174.16)	(187.26)	(286.43)
$1,000	(110.87)	(271.62)	(202.43)	(322.29)	(206.20)	(221.72)	(339.13)
$1,500	(136.78)	(335.11)	(249.75)	(397.61)	(254.40)	(273.55)	(418.40)
$2,000	(150.20)	(367.98)	(274.25)	(436.63)	(279.36)	(300.39)	(459.46)
$2,500	(163.64)	(400.92)	(298.80)	(475.70)	(304.37)	(327.27)	(500.57)
$5,000	(205.50)	(503.47)	(375.24)	(597.39)	(382.22)	(410.98)	(628.62)
$10,000	(240.08)	(588.18)	(438.36)	(697.89)	(446.53)	(480.13)	(734.38)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(23.95)	(58.66)	(43.73)	(69.61)	(44.54)	(47.89)	(73.26)
$250	(28.70)	(70.30)	(52.40)	(83.42)	(53.38)	(57.39)	(87.78)
$300	(33.47)	(82.01)	(61.12)	(97.30)	(62.26)	(66.95)	(102.40)
$350	(38.22)	(93.65)	(69.79)	(111.11)	(71.10)	(76.45)	(116.92)
$400	(42.36)	(103.77)	(77.34)	(123.14)	(78.79)	(84.72)	(129.58)
$500	(50.59)	(123.95)	(92.38)	(147.07)	(94.10)	(101.19)	(154.77)
$750	(66.39)	(162.64)	(121.22)	(192.99)	(123.47)	(132.77)	(203.08)
$1,000	(79.22)	(194.08)	(144.65)	(230.28)	(147.34)	(158.42)	(242.32)
$1,500	(99.01)	(242.56)	(180.78)	(287.81)	(184.14)	(198.00)	(302.86)
$2,000	(109.54)	(268.37)	(200.02)	(318.44)	(203.74)	(219.07)	(335.09)
$2,500	(120.10)	(294.24)	(219.29)	(349.13)	(223.37)	(240.19)	(367.38)
$5,000	(161.39)	(395.39)	(294.68)	(469.16)	(300.17)	(322.77)	(493.69)
$10,000	(195.45)	(478.86)	(356.88)	(568.18)	(363.53)	(390.89)	(597.89)
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(50.49)	(123.71)	(92.19)	(146.78)	(93.91)	(100.98)	(154.45)
$1,500	(55.08)	(134.94)	(100.57)	(160.11)	(102.44)	(110.15)	(168.48)
$2,000	(57.44)	(140.72)	(104.89)	(166.98)	(106.83)	(114.88)	(175.71)
$3,000	(59.64)	(146.12)	(108.90)	(173.38)	(110.93)	(119.28)	(182.44)
$4,000	(60.55)	(148.35)	(110.56)	(176.01)	(112.62)	(121.10)	(185.21)
$5,000	(61.03)	(149.52)	(111.43)	(177.41)	(113.51)	(122.06)	(186.68)
$7,000	(61.63)	(150.99)	(112.53)	(179.15)	(114.63)	(123.26)	(188.53)
$7,500	(62.13)	(152.21)	(113.45)	(180.61)	(115.55)	(124.25)	(190.04)
$10,000	(63.94)	(156.65)	(116.76)	(185.88)	(118.93)	(127.87)	(195.60)
$20,000	(66.54)	(163.02)	(121.50)	(193.44)	(123.76)	(133.07)	(203.55)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(59.14)	(144.89)	(107.99)	(171.92)	(110.00)	(118.28)	(180.91)
$250	(70.57)	(172.90)	(128.86)	(205.15)	(131.26)	(141.14)	(215.87)
$300	(82.01)	(200.92)	(149.75)	(238.40)	(152.54)	(164.02)	(250.87)
$350	(93.45)	(228.95)	(170.64)	(271.66)	(173.82)	(186.90)	(285.86)
$400	(102.43)	(250.95)	(187.04)	(297.76)	(190.52)	(204.86)	(313.33)
$500	(120.41)	(295.00)	(219.87)	(350.03)	(223.96)	(240.82)	(368.33)
$750	(156.37)	(383.11)	(285.53)	(454.57)	(290.85)	(312.74)	(478.34)
$1,000	(184.07)	(450.97)	(336.11)	(535.09)	(342.37)	(368.14)	(563.07)
$1,500	(226.41)	(554.70)	(413.42)	(658.17)	(421.12)	(452.82)	(692.59)
$2,000	(243.73)	(597.14)	(445.05)	(708.52)	(453.34)	(487.46)	(745.57)
$2,500	(261.12)	(639.74)	(476.81)	(759.08)	(485.68)	(522.24)	(798.77)
$5,000	(306.97)	(752.08)	(560.53)	(892.36)	(570.96)	(613.94)	(939.02)
$10,000	(344.83)	(844.83)	(629.66)	(1,002.42)	(641.38)	(689.66)	(1,054.83)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(48.47)	(118.75)	(88.51)	(140.90)	(90.15)	(96.94)	(148.27)
$250	(57.83)	(141.68)	(105.60)	(168.11)	(107.56)	(115.66)	(176.90)
$300	(67.20)	(164.64)	(122.71)	(195.35)	(124.99)	(134.40)	(205.56)
$350	(76.54)	(187.52)	(139.76)	(222.50)	(142.36)	(153.08)	(234.14)
$400	(84.07)	(205.97)	(153.51)	(244.39)	(156.37)	(168.14)	(257.17)
$500	(99.15)	(242.92)	(181.05)	(288.23)	(184.42)	(198.30)	(303.30)
$750	(128.97)	(315.98)	(235.50)	(374.92)	(239.88)	(257.94)	(394.52)
$1,000	(152.18)	(372.84)	(277.88)	(442.39)	(283.05)	(304.36)	(465.52)
$1,500	(187.36)	(459.03)	(342.12)	(544.66)	(348.49)	(374.72)	(573.13)
$2,000	(203.32)	(498.13)	(371.26)	(591.05)	(378.18)	(406.64)	(621.96)
$2,500	(219.26)	(537.19)	(400.37)	(637.39)	(407.82)	(438.52)	(670.72)
$5,000	(264.92)	(649.05)	(483.74)	(770.12)	(492.75)	(529.84)	(810.39)
$10,000	(302.58)	(741.32)	(552.51)	(879.60)	(562.80)	(605.16)	(925.59)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(37.78)	(92.56)	(68.99)	(109.83)	(70.27)	(75.56)	(115.57)
$250	(45.07)	(110.42)	(82.30)	(131.02)	(83.83)	(90.14)	(137.87)
$300	(52.38)	(128.33)	(95.65)	(152.27)	(97.43)	(104.76)	(160.23)
$350	(59.65)	(146.14)	(108.92)	(173.40)	(110.95)	(119.30)	(182.47)
$400	(65.76)	(161.11)	(120.08)	(191.16)	(122.31)	(131.52)	(201.16)
$500	(77.83)	(190.68)	(142.12)	(226.25)	(144.76)	(155.66)	(238.08)
$750	(101.55)	(248.80)	(185.43)	(295.21)	(188.88)	(203.10)	(310.64)
$1,000	(120.24)	(294.59)	(219.56)	(349.54)	(223.65)	(240.48)	(367.81)
$1,500	(148.34)	(363.43)	(270.87)	(431.22)	(275.91)	(296.68)	(453.77)
$2,000	(162.91)	(399.13)	(297.47)	(473.58)	(303.01)	(325.82)	(498.34)
$2,500	(177.48)	(434.83)	(324.08)	(515.93)	(330.11)	(354.96)	(542.91)
$5,000	(222.88)	(546.06)	(406.98)	(647.91)	(414.56)	(445.76)	(681.79)
$10,000	(260.37)	(637.91)	(475.44)	(756.90)	(484.29)	(520.74)	(796.47)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(25.98)	(63.65)	(47.44)	(75.52)	(48.32)	(51.96)	(79.47)
$250	(31.12)	(76.24)	(56.83)	(90.47)	(57.88)	(62.24)	(95.20)
$300	(36.30)	(88.94)	(66.28)	(105.52)	(67.52)	(72.60)	(111.04)
$350	(41.45)	(101.55)	(75.69)	(120.50)	(77.10)	(82.90)	(126.80)
$400	(45.94)	(112.55)	(83.89)	(133.55)	(85.45)	(91.88)	(140.53)
$500	(54.87)	(134.43)	(100.19)	(159.51)	(102.06)	(109.74)	(167.85)
$750	(72.00)	(176.40)	(131.47)	(209.30)	(133.92)	(144.00)	(220.25)
$1,000	(85.91)	(210.48)	(156.87)	(249.74)	(159.79)	(171.82)	(262.80)
$1,500	(107.37)	(263.06)	(196.06)	(312.12)	(199.71)	(214.74)	(328.44)
$2,000	(118.80)	(291.06)	(216.93)	(345.35)	(220.97)	(237.60)	(363.41)
$2,500	(130.25)	(319.11)	(237.84)	(378.64)	(242.27)	(260.50)	(398.43)
$5,000	(175.02)	(428.80)	(319.59)	(508.78)	(325.54)	(350.04)	(535.39)
$10,000	(211.98)	(519.35)	(387.08)	(616.23)	(394.28)	(423.96)	(648.45)
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(54.75)	(134.14)	(99.97)	(159.16)	(101.84)	(109.50)	(167.48)
$1,500	(59.72)	(146.31)	(109.05)	(173.61)	(111.08)	(119.44)	(182.68)
$2,000	(62.30)	(152.64)	(113.76)	(181.11)	(115.88)	(124.60)	(190.58)
$3,000	(64.68)	(158.47)	(118.11)	(188.02)	(120.30)	(129.36)	(197.86)
$4,000	(65.66)	(160.87)	(119.90)	(190.87)	(122.13)	(131.32)	(200.85)
$5,000	(66.18)	(162.14)	(120.84)	(192.39)	(123.09)	(132.36)	(202.44)
$7,000	(66.84)	(163.76)	(122.05)	(194.30)	(124.32)	(133.68)	(204.46)
$7,500	(67.38)	(165.08)	(123.04)	(195.87)	(125.33)	(134.76)	(206.12)
$10,000	(69.35)	(169.91)	(126.63)	(201.60)	(128.99)	(138.70)	(212.14)
$20,000	(72.17)	(176.82)	(131.78)	(209.80)	(134.24)	(144.34)	(220.77)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(4.60)	(11.28)	(8.41)	(13.38)	(8.57)	(9.21)	(14.08)
$250	(5.51)	(13.50)	(10.05)	(16.01)	(10.24)	(11.02)	(16.85)
$300	(6.39)	(15.66)	(11.68)	(18.57)	(11.90)	(12.79)	(19.56)
$350	(7.28)	(17.84)	(13.31)	(21.18)	(13.55)	(14.58)	(22.28)
$400	(7.98)	(19.55)	(14.57)	(23.19)	(14.84)	(15.97)	(24.41)
$500	(9.39)	(23.01)	(17.15)	(27.30)	(17.47)	(18.79)	(28.73)
$750	(12.19)	(29.88)	(22.27)	(35.45)	(22.69)	(24.39)	(37.31)
$1,000	(14.36)	(35.18)	(26.22)	(41.73)	(26.71)	(28.72)	(43.92)
$1,500	(17.65)	(43.24)	(32.23)	(51.30)	(32.84)	(35.32)	(53.99)
$2,000	(19.00)	(46.56)	(34.71)	(55.24)	(35.36)	(38.02)	(58.13)
$2,500	(20.36)	(49.89)	(37.20)	(59.20)	(37.89)	(40.74)	(62.30)
$5,000	(23.92)	(58.63)	(43.70)	(69.55)	(44.51)	(47.87)	(73.19)
$10,000	(26.88)	(65.88)	(49.11)	(78.16)	(50.02)	(53.79)	(82.25)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(3.78)	(9.25)	(6.90)	(10.98)	(7.02)	(7.55)	(11.55)
$250	(4.52)	(11.06)	(8.25)	(13.13)	(8.40)	(9.03)	(13.82)
$300	(5.23)	(12.83)	(9.57)	(15.22)	(9.74)	(10.47)	(16.02)
$350	(5.96)	(14.62)	(10.90)	(17.33)	(11.09)	(11.94)	(18.25)
$400	(6.55)	(16.06)	(11.97)	(19.06)	(12.20)	(13.12)	(20.06)
$500	(7.73)	(18.93)	(14.12)	(22.46)	(14.38)	(15.46)	(23.64)
$750	(10.05)	(24.64)	(18.36)	(29.23)	(18.71)	(20.12)	(30.76)
$1,000	(11.85)	(29.05)	(21.65)	(34.46)	(22.05)	(23.72)	(36.27)
$1,500	(14.60)	(35.77)	(26.67)	(42.45)	(27.17)	(29.21)	(44.66)
$2,000	(15.84)	(38.83)	(28.95)	(46.07)	(29.49)	(31.71)	(48.48)
$2,500	(17.09)	(41.88)	(31.23)	(49.69)	(31.80)	(34.20)	(52.29)
$5,000	(20.66)	(50.61)	(37.73)	(60.05)	(38.44)	(41.33)	(63.20)
$10,000	(23.59)	(57.81)	(43.09)	(68.58)	(43.89)	(47.20)	(72.17)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(2.94)	(7.21)	(5.37)	(8.55)	(5.47)	(5.88)	(8.99)
$250	(3.50)	(8.59)	(6.40)	(10.19)	(6.52)	(7.01)	(10.73)
$300	(4.09)	(10.02)	(7.48)	(11.89)	(7.62)	(8.18)	(12.52)
$350	(4.64)	(11.38)	(8.49)	(13.50)	(8.64)	(9.29)	(14.21)
$400	(5.13)	(12.57)	(9.38)	(14.91)	(9.54)	(10.26)	(15.69)
$500	(6.06)	(14.85)	(11.08)	(17.62)	(11.28)	(12.13)	(18.55)
$750	(7.91)	(19.39)	(14.46)	(23.01)	(14.72)	(15.84)	(24.21)
$1,000	(9.37)	(22.97)	(17.13)	(27.25)	(17.45)	(18.76)	(28.68)
$1,500	(11.56)	(28.32)	(21.12)	(33.61)	(21.51)	(23.13)	(35.37)
$2,000	(12.71)	(31.15)	(23.22)	(36.95)	(23.65)	(25.43)	(38.88)
$2,500	(13.84)	(33.91)	(25.28)	(40.23)	(25.74)	(27.69)	(42.34)
$5,000	(17.38)	(42.59)	(31.74)	(50.52)	(32.34)	(34.78)	(53.17)
$10,000	(20.29)	(49.73)	(37.08)	(59.01)	(37.76)	(40.61)	(62.09)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(2.03)	(4.99)	(3.71)	(5.91)	(3.78)	(4.07)	(6.21)
$250	(2.42)	(5.94)	(4.43)	(7.05)	(4.50)	(4.85)	(7.42)
$300	(2.83)	(6.93)	(5.16)	(8.22)	(5.26)	(5.65)	(8.64)
$350	(3.23)	(7.90)	(5.90)	(9.39)	(6.00)	(6.45)	(9.88)
$400	(3.58)	(8.78)	(6.55)	(10.41)	(6.66)	(7.16)	(10.95)
$500	(4.28)	(10.48)	(7.81)	(12.44)	(7.96)	(8.55)	(13.08)
$750	(5.61)	(13.76)	(10.25)	(16.31)	(10.45)	(11.23)	(17.17)
$1,000	(6.69)	(16.40)	(12.22)	(19.46)	(12.45)	(13.40)	(20.48)
$1,500	(8.36)	(20.50)	(15.28)	(24.31)	(15.57)	(16.74)	(25.58)
$2,000	(9.26)	(22.69)	(16.91)	(26.91)	(17.23)	(18.53)	(28.32)
$2,500	(10.15)	(24.87)	(18.55)	(29.51)	(18.90)	(20.31)	(31.05)
$5,000	(13.63)	(33.41)	(24.91)	(39.62)	(25.37)	(27.27)	(41.70)
$10,000	(16.53)	(40.49)	(30.20)	(48.05)	(30.75)	(33.07)	(50.56)
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(4.26)	(10.43)	(7.78)	(12.38)	(7.93)	(8.52)	(13.03)
$1,500	(4.64)	(11.37)	(8.48)	(13.50)	(8.64)	(9.29)	(14.20)
$2,000	(4.86)	(11.92)	(8.87)	(14.13)	(9.05)	(9.72)	(14.87)
$3,000	(5.04)	(12.35)	(9.21)	(14.64)	(9.37)	(10.08)	(15.42)
$4,000	(5.11)	(12.52)	(9.34)	(14.86)	(9.51)	(10.22)	(15.64)
$5,000	(5.15)	(12.62)	(9.41)	(14.98)	(9.58)	(10.30)	(15.76)
$7,000	(5.21)	(12.77)	(9.52)	(15.15)	(9.69)	(10.42)	(15.93)
$7,500	(5.25)	(12.87)	(9.59)	(15.26)	(9.78)	(10.51)	(16.08)
$10,000	(5.41)	(13.26)	(9.87)	(15.72)	(10.06)	(10.83)	(16.54)
$20,000	(5.63)	(13.80)	(10.28)	(16.36)	(10.48)	(11.27)	(17.22)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren	FOUR TIER Employee & Spouse	FOUR TIER Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$350	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$400	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
$250	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$300	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%
$350	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$400	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$250	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$300	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$350	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
$750	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$250	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%
$300	8.5%	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%
$350	8.5%	8.4%	8.5%	8.5%	8.4%	8.4%	8.5%
$400	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$500	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%
$750	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,000	8.4%	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%
$1,500	8.4%	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.4%	8.4%	8.5%	8.4%	8.5%	8.4%	8.4%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$1,500	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$4,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$5,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$7,500	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$10,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(48.80)	(119.56)	(89.10)	(141.85)	(90.76)	(97.60)	(149.27)
$1,500	(54.23)	(132.87)	(99.03)	(157.65)	(100.87)	(108.46)	(165.89)
$2,000	(57.25)	(140.26)	(104.53)	(166.41)	(106.48)	(114.49)	(175.12)
$3,000	(60.22)	(147.54)	(109.96)	(175.06)	(112.01)	(120.45)	(184.21)
$4,000	(61.56)	(150.81)	(112.40)	(178.95)	(114.49)	(123.12)	(188.30)
$5,000	(62.31)	(152.66)	(113.78)	(181.14)	(115.89)	(124.61)	(190.61)
$7,000	(63.04)	(154.43)	(115.10)	(183.25)	(117.24)	(126.06)	(192.83)
$7,500	(63.58)	(155.75)	(116.08)	(184.82)	(118.24)	(127.14)	(194.48)
$10,000	(65.82)	(161.25)	(120.18)	(191.33)	(122.41)	(131.62)	(201.33)
$20,000	(69.25)	(169.66)	(126.45)	(201.31)	(128.80)	(138.49)	(211.84)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(47.11)	(115.41)	(86.01)	(136.94)	(87.61)	(94.22)	(144.11)
$1,500	(53.42)	(130.87)	(97.54)	(155.28)	(99.35)	(106.83)	(163.40)
$2,000	(57.06)	(139.81)	(104.19)	(165.88)	(106.14)	(114.13)	(174.55)
$3,000	(60.83)	(149.04)	(111.08)	(176.85)	(113.15)	(121.67)	(186.09)
$4,000	(62.55)	(153.24)	(114.21)	(181.82)	(116.33)	(125.08)	(191.33)
$5,000	(63.56)	(155.70)	(116.04)	(184.75)	(118.20)	(127.10)	(194.42)
$7,000	(64.45)	(157.90)	(117.68)	(187.36)	(119.88)	(128.89)	(197.16)
$7,500	(65.02)	(159.30)	(118.72)	(189.01)	(120.93)	(130.03)	(198.90)
$10,000	(67.48)	(165.32)	(123.21)	(196.16)	(125.50)	(134.95)	(206.41)
$20,000	(71.86)	(176.05)	(131.21)	(208.90)	(133.65)	(143.71)	(219.82)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(53.31)	(130.62)	(97.35)	(154.98)	(99.16)	(106.63)	(163.08)
$1,500	(63.51)	(155.61)	(115.97)	(184.63)	(118.13)	(127.02)	(194.28)
$2,000	(70.11)	(171.76)	(128.01)	(203.80)	(130.39)	(140.20)	(214.46)
$3,000	(78.08)	(191.29)	(142.56)	(226.96)	(145.22)	(156.14)	(238.83)
$4,000	(82.47)	(202.04)	(150.58)	(239.73)	(153.38)	(164.93)	(252.26)
$5,000	(85.16)	(208.63)	(155.49)	(247.56)	(158.38)	(170.31)	(260.50)
$7,000	(87.94)	(215.45)	(160.57)	(255.64)	(163.56)	(175.87)	(269.01)
$7,500	(88.97)	(217.97)	(162.45)	(258.63)	(165.48)	(177.93)	(272.15)
$10,000	(93.11)	(228.10)	(170.01)	(270.66)	(173.17)	(186.20)	(284.81)
$20,000	(101.82)	(249.45)	(185.92)	(295.98)	(189.37)	(203.63)	(311.46)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.40	0.98	0.72	1.15	0.74	0.79	1.21
$1,000,000	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
$50,000	(5.23)	(12.81)	(9.55)	(15.19)	(9.72)	(10.45)	(15.99)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.40)	(0.98)	(0.72)	(1.15)	(0.74)	(0.79)	(1.21)
75%	(0.34)	(0.83)	(0.61)	(0.98)	(0.62)	(0.67)	(1.03)
70%	(0.30)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.91)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(52.93)	(129.68)	(96.65)	(153.87)	(98.45)	(105.86)	(161.91)
$1,500	(58.83)	(144.13)	(107.42)	(171.02)	(109.42)	(117.66)	(179.96)
$2,000	(62.09)	(152.12)	(113.38)	(180.50)	(115.49)	(124.18)	(189.93)
$3,000	(65.32)	(160.03)	(119.27)	(189.89)	(121.50)	(130.64)	(199.81)
$4,000	(66.76)	(163.56)	(121.90)	(194.07)	(124.17)	(133.52)	(204.22)
$5,000	(67.58)	(165.57)	(123.40)	(196.46)	(125.70)	(135.16)	(206.73)
$7,000	(68.36)	(167.48)	(124.83)	(198.72)	(127.15)	(136.72)	(209.11)
$7,500	(68.95)	(168.93)	(125.90)	(200.44)	(128.25)	(137.90)	(210.92)
$10,000	(71.38)	(174.88)	(130.34)	(207.50)	(132.77)	(142.76)	(218.35)
$20,000	(75.10)	(184.00)	(137.13)	(218.32)	(139.69)	(150.20)	(229.73)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(51.09)	(125.17)	(93.29)	(148.52)	(95.03)	(102.18)	(156.28)
$1,500	(57.93)	(141.93)	(105.78)	(168.40)	(107.75)	(115.86)	(177.21)
$2,000	(61.88)	(151.61)	(112.99)	(179.89)	(115.10)	(123.76)	(189.29)
$3,000	(65.98)	(161.65)	(120.48)	(191.80)	(122.72)	(131.96)	(201.83)
$4,000	(67.83)	(166.18)	(123.86)	(197.18)	(126.16)	(135.66)	(207.49)
$5,000	(68.93)	(168.88)	(125.87)	(200.38)	(128.21)	(137.86)	(210.86)
$7,000	(69.90)	(171.26)	(127.64)	(203.20)	(130.01)	(139.80)	(213.82)
$7,500	(70.52)	(172.77)	(128.77)	(205.00)	(131.17)	(141.04)	(215.72)
$10,000	(73.18)	(179.29)	(133.63)	(212.73)	(136.11)	(146.36)	(223.86)
$20,000	(77.94)	(190.95)	(142.32)	(226.57)	(144.97)	(155.88)	(238.42)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(57.83)	(141.68)	(105.60)	(168.11)	(107.56)	(115.66)	(176.90)
$1,500	(68.88)	(168.76)	(125.77)	(200.23)	(128.12)	(137.76)	(210.70)
$2,000	(76.04)	(186.30)	(138.85)	(221.05)	(141.43)	(152.08)	(232.61)
$3,000	(84.68)	(207.47)	(154.63)	(246.16)	(157.50)	(169.36)	(259.04)
$4,000	(89.45)	(219.15)	(163.34)	(260.03)	(166.38)	(178.90)	(273.63)
$5,000	(92.36)	(226.28)	(168.65)	(268.49)	(171.79)	(184.72)	(282.53)
$7,000	(95.38)	(233.68)	(174.16)	(277.27)	(177.41)	(190.76)	(291.77)
$7,500	(96.49)	(236.40)	(176.19)	(280.50)	(179.47)	(192.98)	(295.16)
$10,000	(100.97)	(247.38)	(184.37)	(293.52)	(187.80)	(201.94)	(308.87)
$20,000	(110.42)	(270.53)	(201.63)	(320.99)	(205.38)	(220.84)	(337.77)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.44	1.08	0.80	1.28	0.82	0.88	1.35
$1,000,000	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$50,000	(5.67)	(13.89)	(10.35)	(16.48)	(10.55)	(11.34)	(17.34)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
75%	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
70%	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

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DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(4.13)	(10.12)	(7.55)	(12.02)	(7.69)	(8.26)	(12.64)
$1,500	(4.60)	(11.26)	(8.39)	(13.37)	(8.55)	(9.20)	(14.07)
$2,000	(4.84)	(11.86)	(8.85)	(14.09)	(9.01)	(9.69)	(14.81)
$3,000	(5.10)	(12.49)	(9.31)	(14.83)	(9.49)	(10.19)	(15.60)
$4,000	(5.20)	(12.75)	(9.50)	(15.12)	(9.68)	(10.40)	(15.92)
$5,000	(5.27)	(12.91)	(9.62)	(15.32)	(9.81)	(10.55)	(16.12)
$7,000	(5.32)	(13.05)	(9.73)	(15.47)	(9.91)	(10.66)	(16.28)
$7,500	(5.37)	(13.18)	(9.82)	(15.62)	(10.01)	(10.76)	(16.44)
$10,000	(5.56)	(13.63)	(10.16)	(16.17)	(10.36)	(11.14)	(17.02)
$20,000	(5.85)	(14.34)	(10.68)	(17.01)	(10.89)	(11.71)	(17.89)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(3.98)	(9.76)	(7.28)	(11.58)	(7.42)	(7.96)	(12.17)
$1,500	(4.51)	(11.06)	(8.24)	(13.12)	(8.40)	(9.03)	(13.81)
$2,000	(4.82)	(11.80)	(8.80)	(14.01)	(8.96)	(9.63)	(14.74)
$3,000	(5.15)	(12.61)	(9.40)	(14.95)	(9.57)	(10.29)	(15.74)
$4,000	(5.28)	(12.94)	(9.65)	(15.36)	(9.83)	(10.58)	(16.16)
$5,000	(5.37)	(13.18)	(9.83)	(15.63)	(10.01)	(10.76)	(16.44)
$7,000	(5.45)	(13.36)	(9.96)	(15.84)	(10.13)	(10.91)	(16.66)
$7,500	(5.50)	(13.47)	(10.05)	(15.99)	(10.24)	(11.01)	(16.82)
$10,000	(5.70)	(13.97)	(10.42)	(16.57)	(10.61)	(11.41)	(17.45)
$20,000	(6.08)	(14.90)	(11.11)	(17.67)	(11.32)	(12.17)	(18.60)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(4.52)	(11.06)	(8.25)	(13.13)	(8.40)	(9.03)	(13.82)
$1,500	(5.37)	(13.15)	(9.80)	(15.60)	(9.99)	(10.74)	(16.42)
$2,000	(5.93)	(14.54)	(10.84)	(17.25)	(11.04)	(11.88)	(18.15)
$3,000	(6.60)	(16.18)	(12.07)	(19.20)	(12.28)	(13.22)	(20.21)
$4,000	(6.98)	(17.11)	(12.76)	(20.30)	(13.00)	(13.97)	(21.37)
$5,000	(7.20)	(17.65)	(13.16)	(20.93)	(13.41)	(14.41)	(22.03)
$7,000	(7.44)	(18.23)	(13.59)	(21.63)	(13.85)	(14.89)	(22.76)
$7,500	(7.52)	(18.43)	(13.74)	(21.87)	(13.99)	(15.05)	(23.01)
$10,000	(7.86)	(19.28)	(14.36)	(22.86)	(14.63)	(15.74)	(24.06)
$20,000	(8.60)	(21.08)	(15.71)	(25.01)	(16.01)	(17.21)	(26.31)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.04	0.10	0.08	0.13	0.08	0.09	0.14
$1,000,000	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
$50,000	(0.44)	(1.08)	(0.80)	(1.29)	(0.83)	(0.89)	(1.35)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
75%	(0.03)	(0.08)	(0.07)	(0.10)	(0.07)	(0.07)	(0.10)
70%	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)

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PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%
$7,500	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$20,000	8.4%	8.5%	8.4%	8.4%	8.5%	8.5%	8.4%
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%
$1,500	8.4%	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%
$2,000	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.4%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
$5,000	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.4%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$20,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$1,500	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
$2,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$3,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$4,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$5,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$7,500	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$10,000	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%	8.4%
$20,000	8.4%	8.5%	8.4%	8.4%	8.5%	8.5%	8.4%
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	10.0%	10.2%	11.1%	11.3%	10.8%	11.4%	11.6%
$1,000,000	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
$50,000	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%	8.4%
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	10.0%	10.2%	11.1%	11.3%	10.8%	11.4%	11.6%
75%	8.8%	9.6%	11.5%	10.2%	11.3%	10.4%	9.7%
70%	10.0%	12.5%	11.1%	11.6%	10.9%	11.9%	11.0%

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed]

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

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DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

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HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.20)	(5.39)	(4.01)	(6.40)	(4.10)	(4.40)	(6.74)
$10	(4.62)	(11.31)	(8.43)	(13.42)	(8.59)	(9.23)	(14.12)
$15	(7.67)	(18.80)	(14.01)	(22.31)	(14.28)	(15.35)	(23.47)
$20	(11.84)	(29.01)	(21.62)	(34.42)	(22.02)	(23.68)	(36.23)
$25	(15.59)	(38.19)	(28.47)	(45.33)	(29.00)	(31.18)	(47.69)
$30	(19.72)	(48.31)	(36.00)	(57.32)	(36.67)	(39.44)	(60.31)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.24)	(3.05)	(2.27)	(3.62)	(2.31)	(2.49)	(3.80)
$10	(2.64)	(6.47)	(4.82)	(7.67)	(4.91)	(5.28)	(8.07)
$15	(4.39)	(10.76)	(8.02)	(12.77)	(8.17)	(8.78)	(13.43)
$20	(6.78)	(16.60)	(12.37)	(19.70)	(12.61)	(13.55)	(20.73)
$25	(8.94)	(21.90)	(16.31)	(25.97)	(16.62)	(17.87)	(27.34)
$30	(11.29)	(27.67)	(20.61)	(32.82)	(21.00)	(22.58)	(34.53)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
$10	(3.31)	(8.11)	(6.04)	(9.63)	(6.15)	(6.62)	(10.13)
$15	(5.20)	(12.73)	(9.49)	(15.11)	(9.67)	(10.39)	(15.90)
$20	(7.32)	(17.92)	(13.36)	(21.27)	(13.60)	(14.63)	(22.38)
$25	(9.67)	(23.69)	(17.66)	(28.11)	(17.99)	(19.34)	(29.58)
$30	(12.32)	(30.18)	(22.50)	(35.82)	(22.92)	(24.64)	(37.68)
$35	(14.80)	(36.25)	(27.01)	(43.01)	(27.52)	(29.59)	(45.26)
$40	(17.37)	(42.56)	(31.72)	(50.50)	(32.31)	(34.75)	(53.15)
$45	(20.09)	(49.23)	(36.69)	(58.42)	(37.38)	(40.19)	(61.47)
$50	(22.93)	(56.17)	(41.86)	(66.65)	(42.65)	(45.86)	(70.14)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.37)	(3.34)	(2.50)	(3.97)	(2.54)	(2.73)	(4.18)
$10	(2.80)	(6.87)	(5.12)	(8.14)	(5.21)	(5.60)	(8.57)
$15	(4.39)	(10.76)	(8.02)	(12.77)	(8.17)	(8.78)	(13.43)
$20	(6.20)	(15.18)	(11.31)	(18.01)	(11.52)	(12.39)	(18.95)
$25	(8.17)	(20.02)	(14.92)	(23.75)	(15.20)	(16.34)	(25.00)
$30	(10.42)	(25.54)	(19.03)	(30.31)	(19.39)	(20.85)	(31.88)
$35	(12.53)	(30.70)	(22.89)	(36.44)	(23.31)	(25.07)	(38.34)
$40	(14.69)	(36.00)	(26.83)	(42.72)	(27.33)	(29.39)	(44.95)
$45	(16.99)	(41.62)	(31.02)	(49.38)	(31.59)	(33.97)	(51.96)
$50	(19.39)	(47.51)	(35.41)	(56.37)	(36.06)	(38.78)	(59.32)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.82)	(2.00)	(1.49)	(2.37)	(1.52)	(1.63)	(2.50)
$150	(1.31)	(3.22)	(2.40)	(3.82)	(2.45)	(2.63)	(4.03)
$200	(1.89)	(4.62)	(3.44)	(5.48)	(3.51)	(3.77)	(5.77)
$250	(2.68)	(6.56)	(4.89)	(7.80)	(4.98)	(5.36)	(8.20)
$500	(6.46)	(15.83)	(11.80)	(18.78)	(12.01)	(12.92)	(19.76)
$750	(11.10)	(27.19)	(20.26)	(32.26)	(20.63)	(22.19)	(33.94)
$1,000	(16.70)	(40.91)	(30.50)	(48.56)	(31.06)	(33.40)	(51.09)
Copay/Day							
$50 w/3 Day Max	(0.98)	(2.39)	(1.78)	(2.84)	(1.82)	(1.96)	(3.00)
$50 w/5 Day Max	(1.35)	(3.29)	(2.46)	(3.91)	(2.51)	(2.69)	(4.12)
$100 w/3 Day Max	(2.44)	(5.97)	(4.44)	(7.08)	(4.53)	(4.87)	(7.45)
$100 w/5 Day Max	(3.52)	(8.61)	(6.42)	(10.22)	(6.54)	(7.03)	(10.75)
$250 w/3 Day Max	(8.04)	(19.70)	(14.68)	(23.38)	(14.95)	(16.08)	(24.60)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.44)	(1.07)	(0.81)	(1.27)	(0.82)	(0.88)	(1.35)
$75	(0.68)	(1.67)	(1.24)	(1.99)	(1.27)	(1.37)	(2.09)
$100	(0.98)	(2.39)	(1.78)	(2.84)	(1.82)	(1.96)	(3.00)
$125	(1.26)	(3.10)	(2.30)	(3.67)	(2.35)	(2.53)	(3.86)
$150	(1.59)	(3.89)	(2.90)	(4.62)	(2.96)	(3.18)	(4.86)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.43)	(0.32)	(0.50)	(0.33)	(0.35)	(0.53)
$25	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
$35	(0.54)	(1.32)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
$50	(0.93)	(2.27)	(1.69)	(2.70)	(1.72)	(1.85)	(2.83)
$60	(1.16)	(2.84)	(2.12)	(3.37)	(2.16)	(2.32)	(3.56)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.38)	(5.83)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$10	(5.00)	(12.25)	(9.13)	(14.54)	(9.30)	(10.00)	(15.30)
$15	(8.32)	(20.38)	(15.19)	(24.19)	(15.48)	(16.64)	(25.45)
$20	(12.85)	(31.48)	(23.46)	(37.35)	(23.90)	(25.70)	(39.31)
$25	(16.91)	(41.43)	(30.88)	(49.16)	(31.45)	(33.82)	(51.73)
$30	(21.38)	(52.38)	(39.04)	(62.15)	(39.77)	(42.76)	(65.40)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.33)	(3.26)	(2.43)	(3.87)	(2.47)	(2.66)	(4.07)
$10	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$15	(4.77)	(11.69)	(8.71)	(13.87)	(8.87)	(9.54)	(14.59)
$20	(7.35)	(18.01)	(13.42)	(21.37)	(13.67)	(14.70)	(22.48)
$25	(9.69)	(23.74)	(17.69)	(28.17)	(18.02)	(19.38)	(29.64)
$30	(12.24)	(29.99)	(22.35)	(35.58)	(22.77)	(24.48)	(37.44)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.73)	(4.24)	(3.16)	(5.03)	(3.22)	(3.46)	(5.29)
$10	(3.59)	(8.80)	(6.56)	(10.44)	(6.68)	(7.18)	(10.98)
$15	(5.64)	(13.82)	(10.30)	(16.40)	(10.49)	(11.28)	(17.25)
$20	(7.94)	(19.45)	(14.50)	(23.08)	(14.77)	(15.88)	(24.29)
$25	(10.49)	(25.70)	(19.15)	(30.49)	(19.51)	(20.98)	(32.09)
$30	(13.36)	(32.73)	(24.40)	(38.84)	(24.85)	(26.72)	(40.87)
$35	(16.05)	(39.32)	(29.31)	(46.66)	(29.85)	(32.10)	(49.10)
$40	(18.84)	(46.16)	(34.40)	(54.77)	(35.04)	(37.68)	(57.63)
$45	(21.80)	(53.41)	(39.81)	(63.37)	(40.55)	(43.60)	(66.69)
$50	(24.87)	(60.93)	(45.41)	(72.30)	(46.26)	(49.74)	(76.08)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.56)
$10	(3.04)	(7.45)	(5.55)	(8.84)	(5.65)	(6.08)	(9.30)
$15	(4.77)	(11.69)	(8.71)	(13.87)	(8.87)	(9.54)	(14.59)
$20	(6.72)	(16.46)	(12.27)	(19.54)	(12.50)	(13.44)	(20.56)
$25	(8.87)	(21.73)	(16.20)	(25.79)	(16.50)	(17.74)	(27.13)
$30	(11.30)	(27.69)	(20.63)	(32.85)	(21.02)	(22.60)	(34.57)
$35	(13.59)	(33.30)	(24.82)	(39.51)	(25.28)	(27.18)	(41.57)
$40	(15.94)	(39.05)	(29.11)	(46.34)	(29.65)	(31.88)	(48.76)
$45	(18.42)	(45.13)	(33.63)	(53.55)	(34.26)	(36.84)	(56.35)
$50	(21.03)	(51.52)	(38.40)	(61.13)	(39.12)	(42.06)	(64.33)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$150	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$200	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
$250	(2.90)	(7.11)	(5.30)	(8.43)	(5.39)	(5.80)	(8.87)
$500	(7.01)	(17.17)	(12.80)	(20.38)	(13.04)	(14.02)	(21.44)
$750	(12.03)	(29.47)	(21.97)	(34.97)	(22.38)	(24.06)	(36.80)
$1,000	(18.12)	(44.39)	(33.09)	(52.67)	(33.70)	(36.24)	(55.43)
Copay/Day							
$50 w/3 Day Max	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$50 w/5 Day Max	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$100 w/3 Day Max	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$100 w/5 Day Max	(3.81)	(9.33)	(6.96)	(11.08)	(7.09)	(7.62)	(11.65)
$250 w/3 Day Max	(8.72)	(21.36)	(15.92)	(25.35)	(16.22)	(17.44)	(26.67)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$75	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$100	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$125	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$150	(1.72)	(4.21)	(3.14)	(5.00)	(3.20)	(3.44)	(5.26)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$35	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$50	(1.01)	(2.47)	(1.84)	(2.94)	(1.88)	(2.02)	(3.09)
$60	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)

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HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.18)	(0.44)	(0.34)	(0.52)	(0.33)	(0.36)	(0.54)
$10	(0.38)	(0.94)	(0.70)	(1.12)	(0.71)	(0.77)	(1.18)
$15	(0.65)	(1.58)	(1.18)	(1.88)	(1.20)	(1.29)	(1.98)
$20	(1.01)	(2.47)	(1.84)	(2.93)	(1.88)	(2.02)	(3.08)
$25	(1.32)	(3.24)	(2.41)	(3.83)	(2.45)	(2.64)	(4.04)
$30	(1.66)	(4.07)	(3.04)	(4.83)	(3.10)	(3.32)	(5.09)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.21)	(0.16)	(0.25)	(0.16)	(0.17)	(0.27)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.68)
$15	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.76)	(1.16)
$20	(0.57)	(1.41)	(1.05)	(1.67)	(1.06)	(1.15)	(1.75)
$25	(0.75)	(1.84)	(1.38)	(2.20)	(1.40)	(1.51)	(2.30)
$30	(0.95)	(2.32)	(1.74)	(2.76)	(1.77)	(1.90)	(2.91)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$10	(0.28)	(0.69)	(0.52)	(0.81)	(0.53)	(0.56)	(0.85)
$15	(0.44)	(1.09)	(0.81)	(1.29)	(0.82)	(0.89)	(1.35)
$20	(0.62)	(1.53)	(1.14)	(1.81)	(1.17)	(1.25)	(1.91)
$25	(0.82)	(2.01)	(1.49)	(2.38)	(1.52)	(1.64)	(2.51)
$30	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.19)
$35	(1.25)	(3.07)	(2.30)	(3.65)	(2.33)	(2.51)	(3.84)
$40	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.93)	(4.48)
$45	(1.71)	(4.18)	(3.12)	(4.95)	(3.17)	(3.41)	(5.22)
$50	(1.94)	(4.76)	(3.55)	(5.65)	(3.61)	(3.88)	(5.94)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.31)	(0.22)	(0.36)	(0.23)	(0.25)	(0.38)
$10	(0.24)	(0.58)	(0.43)	(0.70)	(0.44)	(0.48)	(0.73)
$15	(0.38)	(0.93)	(0.69)	(1.10)	(0.70)	(0.76)	(1.16)
$20	(0.52)	(1.28)	(0.96)	(1.53)	(0.98)	(1.05)	(1.61)
$25	(0.70)	(1.71)	(1.28)	(2.04)	(1.30)	(1.40)	(2.13)
$30	(0.88)	(2.15)	(1.60)	(2.54)	(1.63)	(1.75)	(2.69)
$35	(1.06)	(2.60)	(1.93)	(3.07)	(1.97)	(2.11)	(3.23)
$40	(1.25)	(3.05)	(2.28)	(3.62)	(2.32)	(2.49)	(3.81)
$45	(1.43)	(3.51)	(2.61)	(4.17)	(2.67)	(2.87)	(4.39)
$50	(1.64)	(4.01)	(2.99)	(4.76)	(3.06)	(3.28)	(5.01)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.21)	(0.15)	(0.25)	(0.15)	(0.17)	(0.25)
$150	(0.13)	(0.31)	(0.23)	(0.37)	(0.23)	(0.25)	(0.37)
$200	(0.16)	(0.40)	(0.30)	(0.48)	(0.30)	(0.33)	(0.50)
$250	(0.22)	(0.55)	(0.41)	(0.63)	(0.41)	(0.44)	(0.67)
$500	(0.55)	(1.34)	(1.00)	(1.60)	(1.03)	(1.10)	(1.68)
$750	(0.93)	(2.28)	(1.71)	(2.71)	(1.75)	(1.87)	(2.86)
$1,000	(1.42)	(3.48)	(2.59)	(4.11)	(2.64)	(2.84)	(4.34)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.21)	(0.16)	(0.24)	(0.15)	(0.16)	(0.24)
$50 w/5 Day Max	(0.12)	(0.31)	(0.22)	(0.36)	(0.22)	(0.25)	(0.38)
$100 w/3 Day Max	(0.21)	(0.52)	(0.40)	(0.62)	(0.40)	(0.43)	(0.66)
$100 w/5 Day Max	(0.29)	(0.72)	(0.54)	(0.86)	(0.55)	(0.59)	(0.90)
$250 w/3 Day Max	(0.68)	(1.66)	(1.24)	(1.97)	(1.27)	(1.36)	(2.07)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.07)	(0.13)	(0.07)	(0.08)	(0.12)
$75	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.09)	(0.14)
$100	(0.08)	(0.21)	(0.16)	(0.24)	(0.15)	(0.16)	(0.24)
$125	(0.12)	(0.28)	(0.22)	(0.34)	(0.22)	(0.23)	(0.36)
$150	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.01)	(0.01)	(0.02)	0.00	(0.01)	(0.02)
$25	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.17)	(0.26)
$60	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.26)

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PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	8.2%	8.5%	8.1%	8.0%	8.2%	8.0%
$10	8.2%	8.3%	8.3%	8.3%	8.3%	8.3%	8.4%
$15	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.3%	6.9%	7.0%	6.9%	6.9%	6.8%	7.1%
$10	8.3%	8.3%	8.3%	8.3%	8.4%	8.3%	8.4%
$15	8.7%	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%
$20	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
$25	8.4%	8.4%	8.5%	8.5%	8.4%	8.4%	8.4%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.1%	8.2%	8.2%	8.2%	8.1%	8.1%	8.2%
$10	8.5%	8.5%	8.6%	8.4%	8.6%	8.5%	8.4%
$15	8.5%	8.6%	8.5%	8.5%	8.5%	8.6%	8.5%
$20	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
$25	8.5%	8.5%	8.4%	8.5%	8.4%	8.5%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.5%
$35	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$40	8.5%	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%
$45	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$50	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.8%	9.3%	8.8%	9.1%	9.1%	9.2%	9.1%
$10	8.6%	8.4%	8.4%	8.6%	8.4%	8.6%	8.5%
$15	8.7%	8.6%	8.6%	8.6%	8.6%	8.7%	8.6%
$20	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
$25	8.6%	8.5%	8.6%	8.6%	8.6%	8.6%	8.5%
$30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$35	8.5%	8.5%	8.4%	8.4%	8.5%	8.4%	8.4%
$40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
$45	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$50	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	9.8%	10.5%	10.1%	10.5%	9.9%	10.4%	10.0%
$150	9.9%	9.6%	9.6%	9.7%	9.4%	9.5%	9.2%
$200	8.5%	8.7%	8.7%	8.8%	8.5%	8.8%	8.7%
$250	8.2%	8.4%	8.4%	8.1%	8.2%	8.2%	8.2%
$500	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
$750	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
$1,000	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Copay/Day							
$50 w/3 Day Max	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$50 w/5 Day Max	8.9%	9.4%	8.9%	9.2%	8.8%	9.3%	9.2%
$100 w/3 Day Max	8.6%	8.7%	9.0%	8.8%	8.8%	8.8%	8.9%
$100 w/5 Day Max	8.2%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
$250 w/3 Day Max	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
$75	7.4%	7.2%	7.3%	6.5%	7.1%	6.6%	6.7%
$100	8.2%	8.8%	9.0%	8.5%	8.2%	8.2%	8.0%
$125	9.5%	9.0%	9.6%	9.3%	9.4%	9.1%	9.3%
$150	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.2%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	5.9%	2.3%	3.1%	4.0%	0.0%	2.9%	3.8%
$25	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
$35	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
$50	8.6%	8.8%	8.9%	8.9%	9.3%	9.2%	9.2%
$60	7.8%	7.7%	7.5%	7.7%	7.9%	7.8%	7.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.54)	(3.77)	(2.81)	(4.47)	(2.86)	(3.08)	(4.71)
$100	(2.19)	(5.37)	(4.00)	(6.37)	(4.08)	(4.38)	(6.71)
$125	(2.68)	(6.56)	(4.89)	(7.80)	(4.98)	(5.36)	(8.20)
$150	(3.22)	(7.89)	(5.88)	(9.36)	(5.99)	(6.44)	(9.85)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.44	1.07	0.81	1.27	0.82	0.88	1.35
60	0.85	2.07	1.55	2.46	1.57	1.69	2.59
90	1.25	3.07	2.29	3.65	2.33	2.51	3.83
120	1.48	3.62	2.70	4.30	2.75	2.96	4.52
Unlimited	1.91	4.67	3.47	5.54	3.55	3.81	5.83
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
40/$15 copay	(0.31)	(0.74)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
40/$20 copay	(0.42)	(1.02)	(0.76)	(1.21)	(0.77)	(0.84)	(1.27)
40/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
60	0.19	0.48	0.36	0.56	0.36	0.39	0.59
100	0.49	1.20	0.90	1.43	0.91	0.98	1.50
200	1.28	3.15	2.34	3.73	2.38	2.57	3.92
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.89)	(2.17)	(1.62)	(2.58)	(1.65)	(1.77)	(2.71)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.58	1.43	1.06	1.69	1.08	1.16	1.77
90	1.19	2.92	2.18	3.46	2.22	2.38	3.65
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.51	1.24	0.93	1.48	0.95	1.02	1.56
90	0.95	2.32	1.73	2.75	1.76	1.90	2.89
120	1.53	3.74	2.79	4.44	2.84	3.06	4.68
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.72)	(1.77)	(1.32)	(2.10)	(1.35)	(1.45)	(2.21)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.50	0.38	0.59	0.38	0.41	0.62
30	0.35	0.85	0.63	1.01	0.64	0.69	1.06
Unlimited	0.51	1.24	0.93	1.48	0.95	1.02	1.56
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.26	5.54	4.13	6.57	4.21	4.52	6.92
60	2.66	6.51	4.86	7.73	4.94	5.32	8.13
90	3.17	7.76	5.79	9.21	5.89	6.34	9.69
Unlimited	3.22	7.89	5.88	9.36	5.99	6.44	9.85
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
60/$15 copay	(0.32)	(0.77)	(0.58)	(0.92)	(0.59)	(0.63)	(0.97)
60/$20 copay	(0.45)	(1.10)	(0.82)	(1.30)	(0.84)	(0.90)	(1.38)
60/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.01)	(1.08)	(1.65)
120/$0 copay	0.46	1.12	0.84	1.33	0.86	0.92	1.41
120/$5 copay	0.35	0.85	0.63	1.01	0.64	0.69	1.06
120/$10 copay	0.19	0.48	0.36	0.56	0.36	0.39	0.59
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.33)	(0.24)	(0.39)	(0.24)	(0.26)	(0.41)
120/$25 copay	(0.24)	(0.60)	(0.45)	(0.71)	(0.46)	(0.49)	(0.74)
Unlimited/$0 copay	0.53	1.29	0.97	1.54	0.99	1.06	1.62
Unlimited/$5 copay	0.41	1.00	0.74	1.18	0.75	0.82	1.24
Unlimited/$10 copay	0.24	0.60	0.45	0.71	0.46	0.49	0.74
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.20)	(0.50)	(0.38)	(0.59)	(0.38)	(0.41)	(0.62)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.13	0.33	0.24	0.39	0.24	0.26	0.41
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.67)	(4.09)	(3.05)	(4.85)	(3.11)	(3.34)	(5.11)
$100	(2.37)	(5.81)	(4.33)	(6.89)	(4.41)	(4.74)	(7.25)
$125	(2.90)	(7.11)	(5.30)	(8.43)	(5.39)	(5.80)	(8.87)
$150	(3.48)	(8.53)	(6.35)	(10.12)	(6.47)	(6.96)	(10.65)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.48	1.18	0.88	1.40	0.89	0.96	1.47
60	0.93	2.28	1.70	2.70	1.73	1.86	2.84
90	1.35	3.31	2.47	3.92	2.51	2.70	4.13
120	1.60	3.92	2.92	4.65	2.98	3.20	4.89
Unlimited	2.07	5.07	3.78	6.02	3.85	4.14	6.33
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$25 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.53	1.30	0.97	1.54	0.99	1.06	1.62
200	1.41	3.45	2.57	4.10	2.62	2.82	4.31
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.63	1.54	1.15	1.83	1.17	1.26	1.93
90	1.28	3.14	2.34	3.72	2.38	2.56	3.92
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.55	1.35	1.00	1.60	1.02	1.10	1.68
90	1.03	2.52	1.88	2.99	1.92	2.06	3.15
120	1.66	4.07	3.03	4.83	3.09	3.32	5.08
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.39	0.96	0.71	1.13	0.73	0.78	1.19
Unlimited	0.55	1.35	1.00	1.60	1.02	1.10	1.68
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.45	6.00	4.47	7.12	4.56	4.90	7.49
60	2.88	7.06	5.26	8.37	5.36	5.76	8.81
90	3.43	8.40	6.26	9.97	6.38	6.86	10.49
Unlimited	3.48	8.53	6.35	10.12	6.47	6.96	10.65
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
60/$20 copay	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
60/$25 copay	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
120/$0 copay	0.50	1.23	0.91	1.45	0.93	1.00	1.53
120/$5 copay	0.39	0.96	0.71	1.13	0.73	0.78	1.19
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
Unlimited/$0 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
Unlimited/$5 copay	0.45	1.10	0.82	1.31	0.84	0.90	1.38
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(0.13)	(0.32)	(0.24)	(0.38)	(0.25)	(0.26)	(0.40)
$100	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.54)
$125	(0.22)	(0.55)	(0.41)	(0.63)	(0.41)	(0.44)	(0.67)
$150	(0.26)	(0.64)	(0.47)	(0.76)	(0.48)	(0.52)	(0.80)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.11	0.07	0.13	0.07	0.08	0.12
60	0.08	0.21	0.15	0.24	0.16	0.17	0.25
90	0.10	0.24	0.18	0.27	0.18	0.19	0.30
120	0.12	0.30	0.22	0.35	0.23	0.24	0.37
Unlimited	0.16	0.40	0.31	0.48	0.30	0.33	0.50
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
40/$15 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
40/$20 copay	(0.04)	(0.11)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)
40/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60	0.01	0.01	0.01	0.02	0.01	0.01	0.02
100	0.04	0.10	0.07	0.11	0.08	0.08	0.12
200	0.13	0.30	0.23	0.37	0.24	0.25	0.39
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.17)	(0.26)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.05	0.11	0.09	0.14	0.09	0.10	0.16
90	0.09	0.22	0.16	0.26	0.16	0.18	0.27
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.11	0.07	0.12	0.07	0.08	0.12
90	0.08	0.20	0.15	0.24	0.16	0.16	0.26
120	0.13	0.33	0.24	0.39	0.25	0.26	0.40
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	(0.05)	(0.12)	(0.09)	(0.14)	(0.08)	(0.09)	(0.15)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.01	0.01	0.00	0.02	0.01	0.01	0.02
30	0.04	0.11	0.08	0.12	0.09	0.09	0.13
Unlimited	0.04	0.11	0.07	0.12	0.07	0.08	0.12
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.19	0.46	0.34	0.55	0.35	0.38	0.57
60	0.22	0.55	0.40	0.64	0.42	0.44	0.68
90	0.26	0.64	0.47	0.76	0.49	0.52	0.80
Unlimited	0.26	0.64	0.47	0.76	0.48	0.52	0.80
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$10 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
60/$15 copay	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
120/$0 copay	0.04	0.11	0.07	0.12	0.07	0.08	0.12
120/$5 copay	0.04	0.11	0.08	0.12	0.09	0.09	0.13
120/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	(0.01)	(0.01)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
120/$25 copay	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Unlimited/$0 copay	0.04	0.11	0.07	0.12	0.07	0.08	0.12
Unlimited/$5 copay	0.04	0.10	0.08	0.13	0.09	0.08	0.14
Unlimited/$10 copay	0.01	0.01	0.01	0.02	0.01	0.01	0.02
Unlimited/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$20 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unlimited/$25 copay	(0.01)	(0.01)	0.00	(0.02)	(0.01)	(0.01)	(0.02)
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	0.01	0.01	0.02	0.02	0.02	0.02	0.02
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	8.4%	8.5%	8.5%	8.5%	8.7%	8.4%	8.5%
$100	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.0%
$125	8.2%	8.4%	8.4%	8.1%	8.2%	8.2%	8.2%
$150	8.1%	8.1%	8.0%	8.1%	8.0%	8.1%	8.1%
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	9.1%	10.3%	8.6%	10.2%	8.5%	9.1%	8.9%
60	9.4%	10.1%	9.7%	9.8%	10.2%	10.1%	9.7%
90	8.0%	7.8%	7.9%	7.4%	7.7%	7.6%	7.8%
120	8.1%	8.3%	8.1%	8.1%	8.4%	8.1%	8.2%
Unlimited	8.4%	8.6%	8.9%	8.7%	8.5%	8.7%	8.6%
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
40/$15 copay	9.7%	12.2%	10.7%	11.2%	10.5%	11.5%	10.6%
40/$20 copay	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%
40/$25 copay	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
60	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
100	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
200	10.2%	9.5%	9.8%	9.9%	10.1%	9.7%	9.9%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	9.0%	9.7%	9.3%	9.3%	9.1%	9.6%	9.6%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.6%	7.7%	8.5%	8.3%	8.3%	8.6%	9.0%
90	7.6%	7.5%	7.3%	7.5%	7.2%	7.6%	7.4%
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.8%	8.9%	7.5%	8.1%	7.4%	7.8%	7.7%
90	8.4%	8.6%	8.7%	8.7%	9.1%	8.4%	9.0%
120	8.5%	8.8%	8.6%	8.8%	8.8%	8.5%	8.5%
# Days			**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**				
0	6.9%	6.8%	6.8%	6.7%	5.9%	6.2%	6.8%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
30	11.4%	12.9%	12.7%	11.9%	14.1%	13.0%	12.3%
Unlimited	7.8%	8.9%	7.5%	8.1%	7.4%	7.8%	7.7%
# Days			**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**				
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.4%	8.3%	8.2%	8.4%	8.3%	8.4%	8.2%
60	8.3%	8.4%	8.2%	8.3%	8.5%	8.3%	8.4%
90	8.2%	8.2%	8.1%	8.3%	8.3%	8.2%	8.3%
Unlimited	8.1%	8.1%	8.0%	8.1%	8.0%	8.1%	8.1%
# Visits			**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
60/$15 copay	9.4%	11.7%	10.3%	10.9%	10.2%	11.1%	10.3%
60/$20 copay	8.9%	9.1%	8.5%	9.2%	8.3%	8.9%	8.7%
60/$25 copay	7.4%	7.6%	7.1%	7.6%	6.9%	7.4%	7.3%
120/$0 copay	8.7%	9.8%	8.3%	9.0%	8.1%	8.7%	8.5%
120/$5 copay	11.4%	12.9%	12.7%	11.9%	14.1%	13.0%	12.3%
120/$10 copay	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
120/$25 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
Unlimited/$0 copay	7.5%	8.5%	7.2%	7.8%	7.1%	7.5%	7.4%
Unlimited/$5 copay	9.8%	10.0%	10.8%	11.0%	12.0%	9.8%	11.3%
Unlimited/$10 copay	4.2%	1.7%	2.2%	2.8%	2.2%	2.0%	2.7%
Unlimited/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$25 copay	5.0%	2.0%	0.0%	3.4%	2.6%	2.4%	3.2%
Copay			**Dialysis Treatment Copay [std: $10]**				
$0	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.40)	(0.30)	(0.48)	(0.31)	(0.33)	(0.50)
$25	(0.22)	(0.55)	(0.41)	(0.65)	(0.42)	(0.45)	(0.68)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$15	(0.31)	(0.74)	(0.56)	(0.89)	(0.57)	(0.61)	(0.94)
$20	(0.45)	(1.10)	(0.82)	(1.30)	(0.84)	(0.90)	(1.38)
$25	(0.56)	(1.38)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$30	(0.68)	(1.67)	(1.24)	(1.99)	(1.27)	(1.37)	(2.09)
$35	(0.82)	(2.00)	(1.49)	(2.37)	(1.52)	(1.63)	(2.50)
$40	(0.94)	(2.29)	(1.71)	(2.72)	(1.74)	(1.87)	(2.86)
$45	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$50	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.59)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$10	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$15	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
$20	(0.49)	(1.20)	(0.90)	(1.43)	(0.91)	(0.98)	(1.50)
$25	(0.65)	(1.60)	(1.19)	(1.90)	(1.21)	(1.30)	(2.00)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$35	(0.14)	(0.35)	(0.26)	(0.42)	(0.26)	(0.29)	(0.44)
$50	(0.21)	(0.52)	(0.39)	(0.62)	(0.40)	(0.43)	(0.65)
$60	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)
$75	(0.37)	(0.90)	(0.67)	(1.07)	(0.68)	(0.73)	(1.12)
$100	(0.49)	(1.20)	(0.90)	(1.43)	(0.91)	(0.98)	(1.50)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.29)
$50	(0.15)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.47)
$60	(0.19)	(0.48)	(0.36)	(0.56)	(0.36)	(0.39)	(0.59)
$75	(0.23)	(0.57)	(0.43)	(0.68)	(0.44)	(0.47)	(0.71)
$100	(0.33)	(0.79)	(0.59)	(0.95)	(0.61)	(0.65)	(1.00)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.04)	(4.99)	(3.72)	(5.92)	(3.79)	(4.08)	(6.24)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(3.17)	(7.76)	(5.79)	(9.21)	(5.89)	(6.34)	(9.69)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.29)	(0.70)	(0.52)	(0.83)	(0.53)	(0.57)	(0.88)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$25	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
$30	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$35	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
$40	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$45	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
$50	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$20	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$25	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.21)	(5.41)	(4.04)	(6.42)	(4.11)	(4.42)	(6.76)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(3.43)	(8.40)	(6.26)	(9.97)	(6.38)	(6.86)	(10.49)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
$25	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.04)	(0.09)	(0.08)	(0.11)	(0.08)	(0.08)	(0.13)
$30	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.09)	(0.14)
$35	(0.08)	(0.21)	(0.15)	(0.25)	(0.15)	(0.17)	(0.25)
$40	(0.08)	(0.21)	(0.15)	(0.25)	(0.16)	(0.17)	(0.26)
$45	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.16)	(0.18)	(0.26)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$10	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$15	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$25	(0.05)	(0.12)	(0.09)	(0.13)	(0.09)	(0.10)	(0.14)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$20	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$35	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)	(0.01)	(0.02)
$50	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$35	0.00	0.00	0.00	0.00	0.00	0.00	0.01
$50	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$60	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$75	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.01)	(0.02)
$100	(0.03)	(0.09)	(0.07)	(0.10)	(0.06)	(0.07)	(0.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.17)	(0.42)	(0.32)	(0.50)	(0.32)	(0.34)	(0.52)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(0.26)	(0.64)	(0.47)	(0.76)	(0.49)	(0.52)	(0.80)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.03)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	6.3%	5.0%	3.3%	2.1%	3.2%	3.0%	4.0%
$25	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$15	9.7%	12.2%	10.7%	11.2%	10.5%	11.5%	10.6%
$20	8.9%	9.1%	8.5%	9.2%	8.3%	8.9%	8.7%
$25	7.1%	6.5%	7.8%	6.7%	7.7%	7.1%	7.6%
$30	7.4%	7.2%	7.3%	6.5%	7.1%	6.6%	6.7%
$35	9.8%	10.5%	10.1%	10.5%	9.9%	10.4%	10.0%
$40	8.5%	9.2%	8.8%	9.2%	9.2%	9.1%	9.1%
$45	8.5%	8.5%	8.2%	8.4%	8.6%	8.5%	8.6%
$50	7.7%	7.7%	7.5%	7.6%	7.3%	7.7%	7.2%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$10	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$15	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
$20	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
$25	7.7%	7.5%	7.6%	6.8%	7.4%	7.7%	7.0%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$35	7.1%	5.7%	3.8%	4.8%	7.7%	3.4%	4.5%
$50	4.8%	3.8%	2.6%	3.2%	2.5%	2.3%	3.1%
$60	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%
$75	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
$100	8.2%	8.3%	7.8%	7.7%	8.8%	8.2%	8.0%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$35	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-3.4%
$50	6.7%	2.6%	3.6%	4.4%	3.4%	3.2%	4.3%
$60	5.3%	2.1%	2.8%	3.6%	2.8%	2.6%	3.4%
$75	4.3%	3.5%	2.3%	2.9%	2.3%	2.1%	2.8%
$100	9.1%	11.4%	11.9%	10.5%	9.8%	10.8%	10.0%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.3%	8.4%	8.6%	8.4%	8.4%	8.3%	8.3%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	8.2%	8.2%	8.1%	8.3%	8.3%	8.2%	8.3%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.3%	11.4%	11.5%	12.0%	13.2%	12.3%	11.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.27	20.27	15.11	24.05	15.39	16.55	25.31
60	8.72	21.37	15.93	25.35	16.22	17.45	26.68
90	9.04	22.14	16.51	26.27	16.81	18.08	27.65
Unlimited	9.14	22.40	16.69	26.58	17.00	18.28	27.96
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.24	22.64	16.87	26.87	17.19	18.48	28.27
30	10.18	24.95	18.59	29.59	18.93	20.36	31.14
40	10.74	26.31	19.62	31.22	19.97	21.48	32.85
60	11.32	27.74	20.68	32.91	21.05	22.64	34.63
Unlimited	11.41	27.96	20.84	33.18	21.23	22.83	34.91
LARGE GROUP				**$5 Copay**			
20	8.69	21.30	15.88	25.27	16.17	17.38	26.59
30	9.56	23.42	17.46	27.79	17.78	19.12	29.24
40	10.17	24.91	18.57	29.56	18.91	20.34	31.11
60	10.64	26.07	19.42	30.93	19.79	21.28	32.55
Unlimited	10.73	26.29	19.60	31.19	19.95	21.46	32.82
LARGE GROUP				**$10 Copay**			
20	8.14	19.95	14.87	23.67	15.14	16.28	24.90
30	8.97	21.97	16.38	26.07	16.68	17.93	27.43
40	9.48	23.21	17.30	27.54	17.63	18.95	28.99
60	9.99	24.47	18.23	29.03	18.58	19.97	30.55
Unlimited	10.06	24.64	18.36	29.24	18.71	20.12	30.76
LARGE GROUP				**$15 Copay**			
20	7.64	18.72	13.95	22.21	14.22	15.29	23.38
30	8.42	20.62	15.37	24.47	15.65	16.83	25.75
40	8.92	21.85	16.28	25.92	16.58	17.83	27.28
60	9.44	23.12	17.23	27.43	17.55	18.87	28.87
Unlimited	9.51	23.29	17.36	27.64	17.68	19.01	29.08
LARGE GROUP				**$20 Copay**			
20	7.19	17.63	13.13	20.91	13.38	14.39	22.01
30	7.89	19.32	14.40	22.93	14.67	15.77	24.13
40	8.32	20.37	15.18	24.17	15.47	16.63	25.43
60	8.83	21.64	16.13	25.68	16.44	17.67	27.02
Unlimited	8.91	21.82	16.26	25.89	16.57	17.81	27.25
LARGE GROUP				**$25 Copay**			
20	6.68	16.38	12.21	19.43	12.43	13.37	20.45
30	7.35	18.00	13.41	21.36	13.66	14.69	22.48
40	7.83	19.18	14.29	22.75	14.55	15.65	23.94
60	8.23	20.18	15.03	23.94	15.32	16.47	25.19
Unlimited	8.30	20.35	15.16	24.14	15.45	16.61	25.40
LARGE GROUP				**$30 Copay**			
20	6.37	15.60	11.63	18.52	11.84	12.74	19.48
30	6.91	16.93	12.62	20.08	12.85	13.82	21.13
40	7.37	18.05	13.45	21.42	13.71	14.73	22.54
60	7.72	18.92	14.10	22.45	14.37	15.45	23.63
Unlimited	7.76	19.02	14.17	22.57	14.44	15.53	23.75
LARGE GROUP				**$35 Copay**			
20	6.06	14.86	11.07	17.63	11.28	12.13	18.55
30	6.46	15.83	11.80	18.78	12.01	12.92	19.76
40	6.89	16.87	12.57	20.02	12.81	13.78	21.07
60	7.22	17.70	13.20	21.00	13.44	14.45	22.10
Unlimited	7.28	17.82	13.29	21.15	13.53	14.55	22.25
LARGE GROUP				**$40 Copay**			
20	5.89	14.43	10.75	17.12	10.95	11.78	18.02
30	6.29	15.41	11.48	18.28	11.70	12.57	19.23
40	6.71	16.43	12.24	19.49	12.47	13.41	20.51
60	7.06	17.30	12.89	20.53	13.13	14.12	21.60
Unlimited	7.12	17.46	13.00	20.71	13.25	14.25	21.79
LARGE GROUP				**$45 Copay**			
20	5.73	14.03	10.45	16.65	10.65	11.45	17.52

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.97	21.98	16.38	26.08	16.68	17.94	27.44
60	9.46	23.18	17.27	27.50	17.60	18.92	28.94
90	9.80	24.01	17.89	28.49	18.23	19.60	29.98
Unlimited	9.91	24.28	18.10	28.81	18.43	19.82	30.31
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	10.02	24.55	18.30	29.13	18.64	20.04	30.65
30	11.04	27.05	20.16	32.09	20.53	22.08	33.77
40	11.65	28.54	21.27	33.87	21.67	23.30	35.64
60	12.27	30.06	22.41	35.67	22.82	24.54	37.53
Unlimited	12.38	30.33	22.61	35.99	23.03	24.76	37.87
LARGE GROUP				**$5 Copay**			
20	9.43	23.10	17.22	27.41	17.54	18.86	28.85
30	10.37	25.41	18.94	30.15	19.29	20.74	31.72
40	11.03	27.02	20.14	32.06	20.52	22.06	33.74
60	11.54	28.27	21.07	33.55	21.46	23.08	35.30
Unlimited	11.64	28.52	21.25	33.84	21.65	23.28	35.61
LARGE GROUP				**$10 Copay**			
20	8.83	21.63	16.12	25.67	16.42	17.66	27.01
30	9.72	23.81	17.75	28.26	18.08	19.44	29.73
40	10.27	25.16	18.75	29.85	19.10	20.54	31.42
60	10.83	26.53	19.78	31.48	20.14	21.66	33.13
Unlimited	10.91	26.73	19.92	31.72	20.29	21.82	33.37
LARGE GROUP				**$15 Copay**			
20	8.28	20.29	15.12	24.07	15.40	16.56	25.33
30	9.13	22.37	16.67	26.54	16.98	18.26	27.93
40	9.67	23.69	17.66	28.11	17.99	19.34	29.58
60	10.23	25.06	18.68	29.74	19.03	20.46	31.29
Unlimited	10.31	25.26	18.83	29.97	19.18	20.62	31.54
LARGE GROUP				**$20 Copay**			
20	7.80	19.11	14.24	22.67	14.51	15.60	23.86
30	8.55	20.95	15.61	24.85	15.90	17.10	26.15
40	9.01	22.07	16.45	26.19	16.76	18.02	27.56
60	9.59	23.50	17.51	27.88	17.84	19.18	29.34
Unlimited	9.66	23.67	17.64	28.08	17.97	19.32	29.55
LARGE GROUP				**$25 Copay**			
20	7.25	17.76	13.24	21.08	13.49	14.50	22.18
30	7.97	19.53	14.55	23.17	14.82	15.94	24.38
40	8.49	20.80	15.50	24.68	15.79	16.98	25.97
60	8.93	21.88	16.31	25.96	16.61	17.86	27.32
Unlimited	9.00	22.05	16.43	26.16	16.74	18.00	27.53
LARGE GROUP				**$30 Copay**			
20	6.91	16.93	12.62	20.09	12.85	13.82	21.14
30	7.49	18.35	13.68	21.77	13.93	14.98	22.91
40	7.99	19.58	14.59	23.23	14.86	15.98	24.44
60	8.38	20.53	15.30	24.36	15.59	16.76	25.63
Unlimited	8.42	20.63	15.37	24.48	15.66	16.84	25.76
LARGE GROUP				**$35 Copay**			
20	6.57	16.10	12.00	19.10	12.22	13.14	20.10
30	7.01	17.17	12.80	20.38	13.04	14.02	21.44
40	7.47	18.30	13.64	21.72	13.89	14.94	22.85
60	7.84	19.21	14.32	22.79	14.58	15.68	23.98
Unlimited	7.89	19.33	14.41	22.94	14.68	15.78	24.14
LARGE GROUP				**$40 Copay**			
20	6.39	15.66	11.67	18.58	11.89	12.78	19.55
30	6.81	16.68	12.44	19.80	12.67	13.62	20.83
40	7.27	17.81	13.28	21.13	13.52	14.54	22.24
60	7.66	18.77	13.99	22.27	14.25	15.32	23.43
Unlimited	7.72	18.91	14.10	22.44	14.36	15.44	23.62
LARGE GROUP				**$45 Copay**			
20	6.21	15.21	11.34	18.05	11.55	12.42	19.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.70	1.71	1.27	2.03	1.29	1.39	2.13
60	0.74	1.81	1.34	2.15	1.38	1.47	2.26
90	0.76	1.87	1.38	2.22	1.42	1.52	2.33
Unlimited	0.77	1.88	1.41	2.23	1.43	1.54	2.35
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.78	1.91	1.43	2.26	1.45	1.56	2.38
30	0.86	2.10	1.57	2.50	1.60	1.72	2.63
40	0.91	2.23	1.65	2.65	1.70	1.82	2.79
60	0.95	2.32	1.73	2.76	1.77	1.90	2.90
Unlimited	0.97	2.37	1.77	2.81	1.80	1.93	2.96
LARGE GROUP				**$5 Copay**			
20	0.74	1.80	1.34	2.14	1.37	1.48	2.26
30	0.81	1.99	1.48	2.36	1.51	1.62	2.48
40	0.86	2.11	1.57	2.50	1.61	1.72	2.63
60	0.90	2.20	1.65	2.62	1.67	1.80	2.75
Unlimited	0.91	2.23	1.65	2.65	1.70	1.82	2.79
LARGE GROUP				**$10 Copay**			
20	0.69	1.68	1.25	2.00	1.28	1.38	2.11
30	0.75	1.84	1.37	2.19	1.40	1.51	2.30
40	0.79	1.95	1.45	2.31	1.47	1.59	2.43
60	0.84	2.06	1.55	2.45	1.56	1.69	2.58
Unlimited	0.85	2.09	1.56	2.48	1.58	1.70	2.61
LARGE GROUP				**$15 Copay**			
20	0.64	1.57	1.17	1.86	1.18	1.27	1.95
30	0.71	1.75	1.30	2.07	1.33	1.43	2.18
40	0.75	1.84	1.38	2.19	1.41	1.51	2.30
60	0.79	1.94	1.45	2.31	1.48	1.59	2.42
Unlimited	0.80	1.97	1.47	2.33	1.50	1.61	2.46
LARGE GROUP				**$20 Copay**			
20	0.61	1.48	1.11	1.76	1.13	1.21	1.85
30	0.66	1.63	1.21	1.92	1.23	1.33	2.02
40	0.69	1.70	1.27	2.02	1.29	1.39	2.13
60	0.76	1.86	1.38	2.20	1.40	1.51	2.32
Unlimited	0.75	1.85	1.38	2.19	1.40	1.51	2.30
LARGE GROUP				**$25 Copay**			
20	0.57	1.38	1.03	1.65	1.06	1.13	1.73
30	0.62	1.53	1.14	1.81	1.16	1.25	1.90
40	0.66	1.62	1.21	1.93	1.24	1.33	2.03
60	0.70	1.70	1.28	2.02	1.29	1.39	2.13
Unlimited	0.70	1.70	1.27	2.02	1.29	1.39	2.13
LARGE GROUP				**$30 Copay**			
20	0.54	1.33	0.99	1.57	1.01	1.08	1.66
30	0.58	1.42	1.06	1.69	1.08	1.16	1.78
40	0.62	1.53	1.14	1.81	1.15	1.25	1.90
60	0.66	1.61	1.20	1.91	1.22	1.31	2.00
Unlimited	0.66	1.61	1.20	1.91	1.22	1.31	2.01
LARGE GROUP				**$35 Copay**			
20	0.51	1.24	0.93	1.47	0.94	1.01	1.55
30	0.55	1.34	1.00	1.60	1.03	1.10	1.68
40	0.58	1.43	1.07	1.70	1.08	1.16	1.78
60	0.62	1.51	1.12	1.79	1.14	1.23	1.88
Unlimited	0.61	1.51	1.12	1.79	1.15	1.23	1.89
LARGE GROUP				**$40 Copay**			
20	0.50	1.23	0.92	1.46	0.94	1.00	1.53
30	0.52	1.27	0.96	1.52	0.97	1.05	1.60
40	0.56	1.38	1.04	1.64	1.05	1.13	1.73
60	0.60	1.47	1.10	1.74	1.12	1.20	1.83
Unlimited	0.60	1.45	1.10	1.73	1.11	1.19	1.83
LARGE GROUP				**$45 Copay**			
20	0.48	1.18	0.89	1.40	0.90	0.97	1.48

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%
90	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
40	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$5 Copay**			
20	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
30	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.4%	8.5%	8.5%	8.4%	8.5%	8.4%
Unlimited	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$10 Copay**			
20	8.5%	8.4%	8.4%	8.4%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.3%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.5%	8.4%
Unlimited	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
LARGE GROUP				**$15 Copay**			
20	8.4%	8.4%	8.4%	8.4%	8.3%	8.3%	8.3%
30	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%
60	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.5%	8.5%	8.4%	8.5%	8.5%	8.5%
LARGE GROUP				**$20 Copay**			
20	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.3%	8.3%	8.4%	8.4%	8.3%	8.4%	8.4%
60	8.6%	8.6%	8.6%	8.6%	8.5%	8.5%	8.6%
Unlimited	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
LARGE GROUP				**$25 Copay**			
20	8.5%	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
40	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.5%	8.4%	8.5%	8.4%	8.4%	8.4%	8.5%
Unlimited	8.4%	8.4%	8.4%	8.4%	8.3%	8.4%	8.4%
LARGE GROUP				**$30 Copay**			
20	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
30	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.5%	8.5%	8.5%	8.5%	8.4%	8.4%	8.5%
LARGE GROUP				**$35 Copay**			
20	8.4%	8.3%	8.4%	8.3%	8.3%	8.3%	8.4%
30	8.5%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
40	8.4%	8.5%	8.5%	8.5%	8.4%	8.4%	8.4%
60	8.6%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.5%	8.4%	8.5%	8.5%	8.5%	8.5%
LARGE GROUP				**$40 Copay**			
20	8.5%	8.5%	8.6%	8.5%	8.6%	8.5%	8.5%
30	8.3%	8.2%	8.4%	8.3%	8.3%	8.4%	8.3%
40	8.3%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
60	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Unlimited	8.4%	8.3%	8.5%	8.4%	8.4%	8.4%	8.4%
LARGE GROUP				**$45 Copay**			
20	8.4%	8.4%	8.5%	8.4%	8.5%	8.5%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.11	14.98	11.17	17.77	11.37	12.23	18.70
40	6.53	16.00	11.92	18.98	12.15	13.06	19.98
60	6.90	16.91	12.59	20.05	12.83	13.80	21.10
Unlimited	6.93	16.98	12.66	20.15	12.89	13.86	21.20
LARGE GROUP			**$50 Copay**				
20	5.57	13.65	10.18	16.20	10.36	11.15	17.05
30	5.95	14.58	10.86	17.30	11.07	11.90	18.20
40	6.37	15.60	11.63	18.52	11.84	12.74	19.48
60	6.73	16.48	12.28	19.55	12.51	13.45	20.57
Unlimited	6.77	16.58	12.35	19.67	12.58	13.53	20.70

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.63	16.24	12.11	19.27	12.33	13.26	20.28
40	7.09	17.37	12.95	20.61	13.19	14.18	21.69
60	7.48	18.33	13.66	21.74	13.91	14.96	22.88
Unlimited	7.51	18.40	13.71	21.83	13.97	15.02	22.97
LARGE GROUP			**$50 Copay**				
20	6.04	14.80	11.03	17.56	11.23	12.08	18.48
30	6.46	15.83	11.80	18.78	12.02	12.92	19.76
40	6.91	16.93	12.62	20.09	12.85	13.82	21.14
60	7.29	17.86	13.31	21.19	13.56	14.58	22.30
Unlimited	7.34	17.98	13.40	21.34	13.65	14.68	22.45

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	0.52	1.26	0.94	1.50	0.96	1.03	1.58
40	0.56	1.37	1.03	1.63	1.04	1.12	1.71
60	0.58	1.42	1.07	1.69	1.08	1.16	1.78
Unlimited	0.58	1.42	1.05	1.68	1.08	1.16	1.77
LARGE GROUP			**$50 Copay**				
20	0.47	1.15	0.85	1.36	0.87	0.93	1.43
30	0.51	1.25	0.94	1.48	0.95	1.02	1.56
40	0.54	1.33	0.99	1.57	1.01	1.08	1.66
60	0.56	1.38	1.03	1.64	1.05	1.13	1.73
Unlimited	0.57	1.40	1.05	1.67	1.07	1.15	1.75

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	8.5%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
40	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
60	8.4%	8.4%	8.5%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.3%	8.3%	8.4%	8.4%	8.3%
LARGE GROUP			**$50 Copay**				
20	8.4%	8.4%	8.3%	8.4%	8.4%	8.3%	8.4%
30	8.6%	8.6%	8.7%	8.6%	8.6%	8.6%	8.6%
40	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
60	8.3%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
Unlimited	8.4%	8.4%	8.5%	8.5%	8.5%	8.5%	8.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individua	Family	Two Persons	Family	Employee & Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.55	16.05	11.96	19.05	12.19	13.10	20.04
$25	6.15	15.08	11.24	17.89	11.44	12.31	18.83
$50	5.80	14.20	10.59	16.85	10.78	11.60	17.74
$100	5.20	12.73	9.49	15.11	9.67	10.39	15.90
$500	2.56	6.27	4.67	7.44	4.76	5.12	7.83
Coinsurance							
80%	5.21	12.76	9.51	15.13	9.68	10.41	15.93
75%	4.90	12.00	8.95	14.25	9.12	9.80	14.99
70%	4.58	11.21	8.36	13.30	8.51	9.15	13.99
Deductible			**Orthotics Riders**				
$0	1.11	2.72	2.03	3.23	2.07	2.22	3.39
$25	1.07	2.62	1.96	3.11	1.99	2.14	3.27
$50	1.02	2.50	1.86	2.97	1.90	2.04	3.12
$100	0.93	2.27	1.69	2.70	1.72	1.85	2.83
$500	0.45	1.10	0.82	1.30	0.84	0.90	1.38
Coinsurance							
80%	0.93	2.27	1.69	2.70	1.72	1.85	2.83
75%	0.86	2.10	1.56	2.49	1.59	1.71	2.62
70%	0.81	1.98	1.47	2.34	1.50	1.61	2.47
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.38	3.37	2.52	3.99	2.56	2.75	4.21
12 Months	2.19	5.37	4.00	6.37	4.08	4.38	6.71
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.14	5.24	3.90	6.22	3.98	4.28	6.54
12 Months	3.41	8.37	6.24	9.93	6.35	6.83	10.44
			Private Duty Nursing Riders				
In Full	0.76	1.87	1.40	2.22	1.42	1.53	2.33
80% hrs 73-504	0.13	0.33	0.24	0.39	0.24	0.26	0.41
100% hrs 73-504	0.22	0.55	0.41	0.65	0.42	0.45	0.68
			Dental Network Access				
	0.43	1.05	0.78	1.24	0.79	0.86	1.30
Limit			**Infertility Rider**				
2 IVF	14.33	35.10	26.16	41.65	26.65	28.65	43.83
3 IVF	17.20	42.15	31.41	50.00	32.00	34.40	52.62

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	7.11	17.42	12.98	20.67	13.22	14.22	21.75
$25	6.67	16.34	12.18	19.39	12.41	13.34	20.40
$50	6.28	15.39	11.47	18.26	11.68	12.56	19.21
$100	5.64	13.82	10.30	16.40	10.49	11.28	17.25
$500	2.77	6.79	5.06	8.05	5.15	5.54	8.47
Coinsurance							
80%	5.65	13.84	10.32	16.42	10.51	11.30	17.28
75%	5.32	13.03	9.71	15.47	9.90	10.64	16.27
70%	4.96	12.15	9.06	14.42	9.23	9.92	15.17
Deductible			**Orthotics Riders**				
$0	1.20	2.94	2.19	3.49	2.23	2.40	3.67
$25	1.16	2.84	2.12	3.37	2.16	2.32	3.55
$50	1.10	2.70	2.01	3.20	2.05	2.20	3.36
$100	1.01	2.47	1.84	2.94	1.88	2.02	3.09
$500	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Coinsurance							
80%	1.01	2.47	1.84	2.94	1.88	2.02	3.09
75%	0.94	2.30	1.72	2.73	1.75	1.88	2.88
70%	0.89	2.18	1.63	2.59	1.66	1.78	2.72
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.50	3.68	2.74	4.36	2.79	3.00	4.59
12 Months	2.37	5.81	4.33	6.89	4.41	4.74	7.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.31	5.66	4.22	6.72	4.30	4.62	7.07
12 Months	3.71	9.09	6.77	10.78	6.90	7.42	11.35
			Private Duty Nursing Riders				
In Full	0.83	2.03	1.52	2.41	1.54	1.66	2.54
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.47	1.15	0.86	1.37	0.87	0.94	1.44
Limit			**Infertility Rider**				
2 IVF	15.54	38.07	28.38	45.17	28.90	31.08	47.54
3 IVF	18.65	45.69	34.05	54.22	34.69	37.30	57.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.56	1.37	1.02	1.62	1.03	1.12	1.71
$25	0.52	1.26	0.94	1.50	0.97	1.03	1.57
$50	0.48	1.19	0.88	1.41	0.90	0.96	1.47
$100	0.44	1.09	0.81	1.29	0.82	0.89	1.35
$500	0.21	0.52	0.39	0.61	0.39	0.42	0.64
Coinsurance							
80%	0.44	1.08	0.81	1.29	0.83	0.89	1.35
75%	0.42	1.03	0.76	1.22	0.78	0.84	1.28
70%	0.38	0.94	0.70	1.12	0.72	0.77	1.18
Deductible			**Orthotics Riders**				
$0	0.09	0.22	0.16	0.26	0.16	0.18	0.28
$25	0.09	0.22	0.16	0.26	0.17	0.18	0.28
$50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$100	0.08	0.20	0.15	0.24	0.16	0.17	0.26
$500	0.04	0.10	0.07	0.12	0.07	0.08	0.12
Coinsurance							
80%	0.08	0.20	0.15	0.24	0.16	0.17	0.26
75%	0.08	0.20	0.16	0.24	0.16	0.17	0.26
70%	0.08	0.20	0.16	0.25	0.16	0.17	0.25
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.31	0.22	0.37	0.23	0.25	0.38
12 Months	0.18	0.44	0.33	0.52	0.33	0.36	0.54
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.17	0.42	0.32	0.50	0.32	0.34	0.53
12 Months	0.30	0.72	0.53	0.85	0.55	0.59	0.91
			Private Duty Nursing Riders				
In Full	0.07	0.16	0.12	0.19	0.12	0.13	0.21
80% hrs 73-504	0.01	0.01	0.02	0.02	0.02	0.02	0.02
100% hrs 73-504	0.01	0.01	0.01	0.02	0.01	0.01	0.02
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.14
Limit			**Infertility Rider**				
2 IVF	1.21	2.97	2.22	3.52	2.25	2.43	3.71
3 IVF	1.45	3.54	2.64	4.22	2.69	2.90	4.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.5%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
$25	8.5%	8.4%	8.4%	8.4%	8.5%	8.4%	8.3%
$50	8.3%	8.4%	8.3%	8.4%	8.3%	8.3%	8.3%
$100	8.5%	8.6%	8.5%	8.5%	8.5%	8.6%	8.5%
$500	8.2%	8.3%	8.4%	8.2%	8.2%	8.2%	8.2%
Coinsurance							
80%	8.4%	8.5%	8.5%	8.5%	8.6%	8.5%	8.5%
75%	8.6%	8.6%	8.5%	8.6%	8.6%	8.6%	8.5%
70%	8.3%	8.4%	8.4%	8.4%	8.5%	8.4%	8.4%
Deductible			**Orthotics Riders**				
$0	8.1%	8.1%	7.9%	8.0%	7.7%	8.1%	8.3%
$25	8.4%	8.4%	8.2%	8.4%	8.5%	8.4%	8.6%
$50	7.8%	8.0%	8.1%	7.7%	7.9%	7.8%	7.7%
$100	8.6%	8.8%	8.9%	8.9%	9.3%	9.2%	9.2%
$500	8.9%	9.1%	8.5%	9.2%	8.3%	8.9%	8.7%
Coinsurance							
80%	8.6%	8.8%	8.9%	8.9%	9.3%	9.2%	9.2%
75%	9.3%	9.5%	10.3%	9.6%	10.1%	9.9%	9.9%
70%	9.9%	10.1%	10.9%	10.7%	10.7%	10.6%	10.1%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.7%	9.2%	8.7%	9.3%	9.0%	9.1%	9.0%
12 Months	8.2%	8.2%	8.3%	8.2%	8.1%	8.2%	8.0%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.9%	8.0%	8.2%	8.0%	8.0%	7.9%	8.1%
12 Months	8.8%	8.6%	8.5%	8.6%	8.7%	8.6%	8.7%
			Private Duty Nursing Riders				
In Full	9.2%	8.6%	8.6%	8.6%	8.5%	8.5%	9.0%
80% hrs 73-504	7.7%	3.0%	8.3%	5.1%	8.3%	7.7%	4.9%
100% hrs 73-504	4.5%	1.8%	2.4%	3.1%	2.4%	2.2%	2.9%
			Dental Network Access				
	9.3%	9.5%	10.3%	10.5%	10.1%	9.3%	10.8%
Limit			**Infertility Rider**				
2 IVF	8.4%	8.5%	8.5%	8.5%	8.4%	8.5%	8.5%
3 IVF	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
LARGE GROUP HMO
VHLI - LGRP - 01
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	550.71	1,433.05
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.07	5.07
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.29	3.15
Outpatient Mental Health: 20 Visits	5.72	14.03
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.05	2.56
Other Riders		
Durable Medical Equipment	1.52	3.59
Chiropractic: $5 Copay	4.04	10.62
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	134.90	350.74
Infertility Drug Coverage: $7 Brand Copay	3.15	8.24
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.08
Inpatient Substance Abuse Rehab: Unlimited days	4.34	10.63
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.61	1.49
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.47	1.15

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	582.69	1,516.30
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.19	5.37
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.36	3.33
Outpatient Mental Health: 20 Visits	5.72	14.03
	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.11	2.71
Other Riders		
Durable Medical Equipment	1.61	3.80
Chiropractic: $5 Copay	4.28	11.24
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	142.73	371.11
Infertility Drug Coverage: $7 Brand Copay	3.33	8.72
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	22.31
Inpatient Substance Abuse Rehab: Unlimited days	4.59	11.25
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.64	1.58
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.50	1.21

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	31.98	83.25
Mental Health Coverage		
Inpatient Mental Health: 30 Days	0.12	0.30
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.07	0.18
Outpatient Mental Health: 20 Visits	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.06	0.15
Other Riders		
Durable Medical Equipment	0.09	0.21
Chiropractic: $5 Copay	0.24	0.62
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	7.83	20.37
Infertility Drug Coverage: $7 Brand Copay	0.18	0.48
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	1.23
Inpatient Substance Abuse Rehab: Unlimited days	0.25	0.62
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.03	0.09
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.03	0.06

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	5.8%	5.8%
Mental Health Coverage		
Inpatient Mental Health: 30 Days	5.8%	5.9%
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	5.4%	5.7%
Outpatient Mental Health: 20 Visits	0.0%	0.0%
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	5.7%	5.9%
Other Riders		
Durable Medical Equipment	5.9%	5.8%
Chiropractic: $5 Copay	5.9%	5.8%
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	5.8%	5.8%
Infertility Drug Coverage: $7 Brand Copay	5.7%	5.8%
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	N/A
Inpatient Substance Abuse Rehab: Unlimited days	5.8%	5.8%
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	4.9%	6.0%
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	6.4%	5.2%

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	#DIV/0!	0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
July 1, 2012 - September 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
JULY - SEPTEMBER 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2010 1st QUARTER

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
3rd QUARTER 2012 LARGE GROUP RATE MANUAL

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.00	0.00	0.00
$750 *	0.00	0.00	0.00
$1,000	0.00	0.00	0.00
$2,000	0.00	0.00	0.00
$2,500	0.00	0.00	0.00
$3,000	0.00	0.00	0.00
$4,000	0.00	0.00	0.00
$5,000	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	#DIV/0!	0.0%
$1,000	0.0%	0.0%	#DIV/0!	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.0%	#DIV/0!	0.0%	#DIV/0!
$750 *	0.0%	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter 2Q2010-2Q2011	2.5%

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	0.0000
Family	1.2179
Three Tier	
Individual EE	0.0000
Two Persons	1.2179
Family	2.2238
Four Tier	
Individual EE	0.0000
EE + Child(ren)	1.2179
EE + Spouse	2.2652
Family	2.4357

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	**2.5%**
3Q2011	**1.9%**
4Q2011	**1.9%**
1Q2012-3Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.00
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.00
$2,000 (Brand & Generic)	0.00
$2,500 (Brand & Generic)	0.00
$3,000 (Brand & Generic)	0.00
$4,000 (Brand & Generic)	0.00
$5,000 (Brand & Generic)	0.00
[c] Non Formulary Coverage, Generic Only Plans	0.00
[d] PICA Adjustm Applies only to New York City account	0.00
[e] IC Adjustme Applies only to New York City account	0.00
[f] Product Fact HMO, Access I, and EPO	0.00
POS, Access II, and PPO	0.00
[g] Trend per Quarter	(0.03)
2Q2010-2Q2011	0.03
3Q2011	0.02
4Q2011	0.02
1Q2012-3Q2012	0.02

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.22
Family	1.77
Three Tier	
Individual EE	1.22
Two Persons	1.01
Family	1.32
Four Tier	
Individual EE	1.22
EE + Child(ren)	1.05
EE + Spouse	0.17
Family	1.29

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.0%
$2,000 (Brand & Generic)	0.0%
$2,500 (Brand & Generic)	0.0%
$3,000 (Brand & Generic)	0.0%
$4,000 (Brand & Generic)	0.0%
$5,000 (Brand & Generic)	0.0%
[c] Non Formulary Coverage, Generic Only Plans	0.0%
[d] PICA Adjustm Applies only to New York City account	0.0%
[e] IC Adjustme Applies only to New York City account	0.0%
[f] Product Fact HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
2Q2010-2Q2011	#DIV/0!
3Q2011	#DIV/0!
4Q2011	#DIV/0!
1Q2012-3Q2012	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	#DIV/0!
Family	145.0%
Three Tier	
Individual EE	#DIV/0!
Two Persons	82.6%
Family	59.2%
Four Tier	
Individual EE	#DIV/0!
EE + Child(ren)	86.0%
EE + Spouse	7.5%
Family	53.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - BASE BENEFITS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	480.86	1,178.07	878.01	1,397.83	894.36	961.67	1,470.91

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	518.47	1,270.25	946.73	1,507.19	964.35	1,036.94	1,586.00

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	37.61	92.18	68.72	109.36	69.99	75.27	115.09

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Large Group*	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.22)	(7.89)	(5.87)	(9.35)	(5.98)	(6.43)	(9.84)
$10	(6.76)	(16.55)	(12.34)	(19.65)	(12.57)	(13.52)	(20.67)
$15	(11.25)	(27.56)	(20.54)	(32.70)	(20.92)	(22.50)	(34.41)
$20	(17.36)	(42.53)	(31.70)	(50.46)	(32.28)	(34.72)	(53.10)
$25	(22.86)	(56.02)	(41.75)	(66.46)	(42.52)	(45.73)	(69.94)
$30	(28.91)	(70.83)	(52.79)	(84.04)	(53.77)	(57.82)	(88.44)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.84)	(4.50)	(3.35)	(5.35)	(3.42)	(3.68)	(5.62)
$10	(3.88)	(9.49)	(7.07)	(11.26)	(7.21)	(7.75)	(11.85)
$15	(6.44)	(15.79)	(11.77)	(18.74)	(11.99)	(12.89)	(19.71)
$20	(9.94)	(24.36)	(18.15)	(28.90)	(18.50)	(19.89)	(30.42)
$25	(13.10)	(32.09)	(23.92)	(38.07)	(24.36)	(26.20)	(40.07)
$30	(16.58)	(40.61)	(30.27)	(48.18)	(30.83)	(33.15)	(50.71)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.34)	(5.73)	(4.27)	(6.80)	(4.36)	(4.68)	(7.15)
$10	(4.86)	(11.90)	(8.87)	(14.12)	(9.03)	(9.71)	(14.85)
$15	(7.62)	(18.68)	(13.92)	(22.16)	(14.18)	(15.25)	(23.32)
$20	(10.75)	(26.33)	(19.63)	(31.24)	(19.99)	(21.50)	(32.88)
$25	(14.18)	(34.75)	(25.90)	(41.24)	(26.38)	(28.37)	(43.39)
$30	(18.07)	(44.26)	(32.99)	(52.53)	(33.61)	(36.14)	(55.27)
$35	(21.71)	(53.20)	(39.65)	(63.13)	(40.39)	(43.43)	(66.43)
$40	(25.50)	(62.46)	(46.55)	(74.12)	(47.42)	(50.99)	(77.99)
$45	(29.46)	(72.18)	(53.80)	(85.66)	(54.80)	(58.93)	(90.13)
$50	(33.64)	(82.42)	(61.43)	(97.79)	(62.57)	(67.29)	(102.91)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.99)	(4.89)	(3.65)	(5.80)	(3.71)	(3.99)	(6.10)
$10	(4.12)	(10.08)	(7.51)	(11.96)	(7.66)	(8.23)	(12.59)
$15	(6.44)	(15.79)	(11.77)	(18.74)	(11.99)	(12.89)	(19.71)
$20	(9.10)	(22.29)	(16.61)	(26.45)	(16.92)	(18.19)	(27.82)
$25	(11.99)	(29.38)	(21.89)	(34.85)	(22.30)	(23.98)	(36.68)
$30	(15.28)	(37.43)	(27.90)	(44.42)	(28.42)	(30.56)	(46.74)
$35	(18.38)	(45.04)	(33.57)	(53.44)	(34.19)	(36.77)	(56.23)
$40	(21.56)	(52.82)	(39.37)	(62.67)	(40.10)	(43.12)	(65.95)
$45	(24.92)	(61.06)	(45.51)	(72.44)	(46.35)	(49.84)	(76.24)
$50	(28.44)	(69.68)	(51.93)	(82.68)	(52.90)	(56.88)	(87.00)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.17)	(2.86)	(2.14)	(3.40)	(2.17)	(2.34)	(3.58)
$150	(1.94)	(4.76)	(3.55)	(5.65)	(3.61)	(3.89)	(5.94)
$200	(2.76)	(6.76)	(5.03)	(8.01)	(5.13)	(5.51)	(8.44)
$250	(3.95)	(9.67)	(7.21)	(11.48)	(7.34)	(7.90)	(12.07)
$500	(9.48)	(23.24)	(17.32)	(27.57)	(17.64)	(18.97)	(29.02)
$750	(16.29)	(39.92)	(29.75)	(47.37)	(30.30)	(32.59)	(49.84)
$1,000	(24.50)	(60.04)	(44.75)	(71.23)	(45.57)	(49.01)	(74.95)
Copay/Day							
$50 w/3 Day Max	(1.43)	(3.51)	(2.61)	(4.16)	(2.66)	(2.86)	(4.38)
$50 w/5 Day Max	(1.96)	(4.82)	(3.58)	(5.71)	(3.66)	(3.93)	(6.01)
$100 w/3 Day Max	(3.57)	(8.75)	(6.52)	(10.38)	(6.64)	(7.14)	(10.93)
$100 w/5 Day Max	(5.14)	(12.59)	(9.38)	(14.94)	(9.56)	(10.28)	(15.72)
$250 w/3 Day Max	(11.80)	(28.91)	(21.55)	(34.31)	(21.95)	(23.61)	(36.11)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.62)	(1.51)	(1.13)	(1.80)	(1.15)	(1.23)	(1.88)
$75	(1.00)	(2.45)	(1.83)	(2.91)	(1.87)	(2.01)	(3.07)
$100	(1.43)	(3.51)	(2.61)	(4.16)	(2.66)	(2.86)	(4.38)
$125	(1.87)	(4.59)	(3.42)	(5.43)	(3.48)	(3.74)	(5.72)
$150	(2.33)	(5.70)	(4.25)	(6.77)	(4.33)	(4.66)	(7.12)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.87)
$25	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.47)
$35	(0.78)	(1.92)	(1.43)	(2.28)	(1.45)	(1.57)	(2.39)
$50	(1.35)	(3.30)	(2.46)	(3.92)	(2.51)	(2.69)	(4.13)
$60	(1.71)	(4.20)	(3.12)	(4.98)	(3.19)	(3.43)	(5.24)
$75	(2.26)	(5.53)	(4.12)	(6.56)	(4.20)	(4.51)	(6.90)
$100	(3.21)	(7.85)	(5.86)	(9.32)	(5.96)	(6.41)	(9.81)
$125	(3.95)	(9.67)	(7.21)	(11.48)	(7.34)	(7.90)	(12.07)
$150	(4.72)	(11.56)	(8.62)	(13.72)	(8.78)	(9.44)	(14.45)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.55	1.36	1.01	1.61	1.03	1.11	1.69
60	1.08	2.63	1.96	3.12	2.01	2.15	3.29

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.46)	(8.48)	(6.32)	(10.06)	(6.44)	(6.92)	(10.58)
$10	(7.29)	(17.86)	(13.31)	(21.19)	(13.56)	(14.58)	(22.30)
$15	(12.13)	(29.72)	(22.15)	(35.26)	(22.56)	(24.26)	(37.11)
$20	(18.72)	(45.86)	(34.18)	(54.42)	(34.82)	(37.44)	(57.26)
$25	(24.64)	(60.37)	(44.99)	(71.63)	(45.83)	(49.28)	(75.37)
$30	(31.17)	(76.37)	(56.92)	(90.61)	(57.98)	(62.34)	(95.35)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$10	(4.19)	(10.27)	(7.65)	(12.18)	(7.79)	(8.38)	(12.82)
$15	(6.94)	(17.00)	(12.67)	(20.17)	(12.91)	(13.88)	(21.23)
$20	(10.72)	(26.26)	(19.57)	(31.16)	(19.94)	(21.44)	(32.79)
$25	(14.12)	(34.59)	(25.78)	(41.05)	(26.26)	(28.24)	(43.19)
$30	(17.88)	(43.81)	(32.65)	(51.98)	(33.26)	(35.76)	(54.69)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.53)	(6.20)	(4.62)	(7.35)	(4.71)	(5.06)	(7.74)
$10	(5.24)	(12.84)	(9.57)	(15.23)	(9.75)	(10.48)	(16.03)
$15	(8.21)	(20.11)	(14.99)	(23.87)	(15.27)	(16.42)	(25.11)
$20	(11.59)	(28.40)	(21.16)	(33.69)	(21.56)	(23.18)	(35.45)
$25	(15.29)	(37.46)	(27.92)	(44.45)	(28.44)	(30.58)	(46.77)
$30	(19.48)	(47.73)	(35.57)	(56.63)	(36.23)	(38.96)	(59.59)
$35	(23.41)	(57.35)	(42.75)	(68.05)	(43.54)	(46.82)	(71.61)
$40	(27.48)	(67.33)	(50.18)	(79.88)	(51.11)	(54.96)	(84.06)
$45	(31.76)	(77.81)	(57.99)	(92.33)	(59.07)	(63.52)	(97.15)
$50	(36.27)	(88.86)	(66.23)	(105.44)	(67.46)	(72.54)	(110.95)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.15)	(5.27)	(3.93)	(6.25)	(4.00)	(4.30)	(6.58)
$10	(4.44)	(10.88)	(8.11)	(12.91)	(8.26)	(8.88)	(13.58)
$15	(6.94)	(17.00)	(12.67)	(20.17)	(12.91)	(13.88)	(21.23)
$20	(9.81)	(24.03)	(17.91)	(28.52)	(18.25)	(19.62)	(30.01)
$25	(12.93)	(31.68)	(23.61)	(37.59)	(24.05)	(25.86)	(39.55)
$30	(16.48)	(40.38)	(30.09)	(47.91)	(30.65)	(32.96)	(50.41)
$35	(19.82)	(48.56)	(36.19)	(57.62)	(36.87)	(39.64)	(60.63)
$40	(23.25)	(56.96)	(42.45)	(67.59)	(43.25)	(46.50)	(71.12)
$45	(26.86)	(65.81)	(49.05)	(78.08)	(49.96)	(53.72)	(82.16)
$50	(30.66)	(75.12)	(55.99)	(89.13)	(57.03)	(61.32)	(93.79)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
$150	(2.10)	(5.15)	(3.83)	(6.10)	(3.91)	(4.20)	(6.42)
$200	(2.97)	(7.28)	(5.42)	(8.63)	(5.52)	(5.94)	(9.09)
$250	(4.27)	(10.46)	(7.80)	(12.41)	(7.94)	(8.54)	(13.06)
$500	(10.22)	(25.04)	(18.66)	(29.71)	(19.01)	(20.44)	(31.26)
$750	(17.57)	(43.05)	(32.08)	(51.08)	(32.68)	(35.14)	(53.75)
$1,000	(26.41)	(64.70)	(48.22)	(76.77)	(49.12)	(52.82)	(80.79)
Copay/Day							
$50 w/3 Day Max	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$50 w/5 Day Max	(2.12)	(5.19)	(3.87)	(6.16)	(3.94)	(4.24)	(6.49)
$100 w/3 Day Max	(3.85)	(9.43)	(7.03)	(11.19)	(7.16)	(7.70)	(11.78)
$100 w/5 Day Max	(5.54)	(13.57)	(10.12)	(16.10)	(10.30)	(11.08)	(16.95)
$250 w/3 Day Max	(12.72)	(31.16)	(23.23)	(36.98)	(23.66)	(25.44)	(38.91)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$75	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$100	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$125	(2.03)	(4.97)	(3.71)	(5.90)	(3.78)	(4.06)	(6.21)
$150	(2.52)	(6.17)	(4.60)	(7.33)	(4.69)	(5.04)	(7.71)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$25	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$35	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$50	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$60	(1.83)	(4.48)	(3.34)	(5.32)	(3.40)	(3.66)	(5.60)
$75	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$100	(3.45)	(8.45)	(6.30)	(10.03)	(6.42)	(6.90)	(10.55)
$125	(4.27)	(10.46)	(7.80)	(12.41)	(7.94)	(8.54)	(13.06)
$150	(5.08)	(12.45)	(9.28)	(14.77)	(9.45)	(10.16)	(15.54)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.59	1.45	1.08	1.72	1.10	1.18	1.80
60	1.16	2.84	2.12	3.37	2.16	2.32	3.55

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.24)	(0.59)	(0.45)	(0.71)	(0.46)	(0.49)	(0.74)
$10	(0.53)	(1.31)	(0.97)	(1.54)	(0.99)	(1.06)	(1.63)
$15	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.70)
$20	(1.36)	(3.33)	(2.48)	(3.96)	(2.54)	(2.72)	(4.16)
$25	(1.78)	(4.35)	(3.24)	(5.17)	(3.31)	(3.55)	(5.43)
$30	(2.26)	(5.54)	(4.13)	(6.57)	(4.21)	(4.52)	(6.91)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.38)	(0.28)	(0.43)	(0.28)	(0.30)	(0.47)
$10	(0.31)	(0.78)	(0.58)	(0.92)	(0.58)	(0.63)	(0.97)
$15	(0.50)	(1.21)	(0.90)	(1.43)	(0.92)	(0.99)	(1.52)
$20	(0.78)	(1.90)	(1.42)	(2.26)	(1.44)	(1.55)	(2.37)
$25	(1.02)	(2.50)	(1.86)	(2.98)	(1.90)	(2.04)	(3.12)
$30	(1.30)	(3.20)	(2.38)	(3.80)	(2.43)	(2.61)	(3.98)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.59)
$10	(0.38)	(0.94)	(0.70)	(1.11)	(0.72)	(0.77)	(1.18)
$15	(0.59)	(1.43)	(1.07)	(1.71)	(1.09)	(1.17)	(1.79)
$20	(0.84)	(2.07)	(1.53)	(2.45)	(1.57)	(1.68)	(2.57)
$25	(1.11)	(2.71)	(2.02)	(3.21)	(2.06)	(2.21)	(3.38)
$30	(1.41)	(3.47)	(2.58)	(4.10)	(2.62)	(2.82)	(4.32)
$35	(1.70)	(4.15)	(3.10)	(4.92)	(3.15)	(3.39)	(5.18)
$40	(1.98)	(4.87)	(3.63)	(5.76)	(3.69)	(3.97)	(6.07)
$45	(2.30)	(5.63)	(4.19)	(6.67)	(4.27)	(4.59)	(7.02)
$50	(2.63)	(6.44)	(4.80)	(7.65)	(4.89)	(5.25)	(8.04)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.38)	(0.28)	(0.45)	(0.29)	(0.31)	(0.48)
$10	(0.32)	(0.80)	(0.60)	(0.95)	(0.60)	(0.65)	(0.99)
$15	(0.50)	(1.21)	(0.90)	(1.43)	(0.92)	(0.99)	(1.52)
$20	(0.71)	(1.74)	(1.30)	(2.07)	(1.33)	(1.43)	(2.19)
$25	(0.94)	(2.30)	(1.72)	(2.74)	(1.75)	(1.88)	(2.87)
$30	(1.20)	(2.95)	(2.19)	(3.49)	(2.23)	(2.40)	(3.67)
$35	(1.44)	(3.52)	(2.62)	(4.18)	(2.68)	(2.87)	(4.40)
$40	(1.69)	(4.14)	(3.08)	(4.92)	(3.15)	(3.38)	(5.17)
$45	(1.94)	(4.75)	(3.54)	(5.64)	(3.61)	(3.88)	(5.92)
$50	(2.22)	(5.44)	(4.06)	(6.45)	(4.13)	(4.44)	(6.79)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.20)	(0.14)	(0.23)	(0.16)	(0.16)	(0.24)
$150	(0.16)	(0.39)	(0.28)	(0.45)	(0.30)	(0.31)	(0.48)
$200	(0.21)	(0.52)	(0.39)	(0.62)	(0.39)	(0.43)	(0.65)
$250	(0.32)	(0.79)	(0.59)	(0.93)	(0.60)	(0.64)	(0.99)
$500	(0.74)	(1.80)	(1.34)	(2.14)	(1.37)	(1.47)	(2.24)
$750	(1.28)	(3.13)	(2.33)	(3.71)	(2.38)	(2.55)	(3.91)
$1,000	(1.91)	(4.66)	(3.47)	(5.54)	(3.55)	(3.81)	(5.84)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)
$50 w/5 Day Max	(0.16)	(0.37)	(0.29)	(0.45)	(0.28)	(0.31)	(0.48)
$100 w/3 Day Max	(0.28)	(0.68)	(0.51)	(0.81)	(0.52)	(0.56)	(0.85)
$100 w/5 Day Max	(0.40)	(0.98)	(0.74)	(1.16)	(0.74)	(0.80)	(1.23)
$250 w/3 Day Max	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.83)	(2.80)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.08)	(0.12)	(0.08)	(0.09)	(0.14)
$75	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.15)	(0.23)
$100	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)
$125	(0.16)	(0.38)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$150	(0.19)	(0.47)	(0.35)	(0.56)	(0.36)	(0.38)	(0.59)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.09)	(0.07)	(0.12)	(0.08)	(0.08)	(0.11)
$25	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.07)	(0.16)	(0.12)	(0.19)	(0.13)	(0.13)	(0.21)
$50	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.25)	(0.37)
$60	(0.12)	(0.28)	(0.22)	(0.34)	(0.21)	(0.23)	(0.36)
$75	(0.17)	(0.42)	(0.32)	(0.50)	(0.32)	(0.35)	(0.53)
$100	(0.24)	(0.60)	(0.44)	(0.71)	(0.46)	(0.49)	(0.74)
$125	(0.32)	(0.79)	(0.59)	(0.93)	(0.60)	(0.64)	(0.99)
$150	(0.36)	(0.89)	(0.66)	(1.05)	(0.67)	(0.72)	(1.09)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.09	0.07	0.11	0.07	0.07	0.11
60	0.08	0.21	0.16	0.25	0.15	0.17	0.26

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.5%	7.5%	7.7%	7.6%	7.7%	7.6%	7.5%
$10	7.8%	7.9%	7.9%	7.8%	7.9%	7.8%	7.9%
$15	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	8.4%	8.4%	8.0%	8.2%	8.2%	8.4%
$10	8.0%	8.2%	8.2%	8.2%	8.0%	8.1%	8.2%
$15	7.8%	7.7%	7.6%	7.6%	7.7%	7.7%	7.7%
$20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.8%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.1%	8.2%	8.2%	8.1%	8.0%	8.1%	8.3%
$10	7.8%	7.9%	7.9%	7.9%	8.0%	7.9%	7.9%
$15	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
$20	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$35	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.0%	7.8%	7.7%	7.8%	7.8%	7.8%	7.9%
$10	7.8%	7.9%	8.0%	7.9%	7.8%	7.9%	7.9%
$15	7.8%	7.7%	7.6%	7.6%	7.7%	7.7%	7.7%
$20	7.8%	7.8%	7.8%	7.8%	7.9%	7.9%	7.9%
$25	7.8%	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%
$30	7.9%	7.9%	7.8%	7.9%	7.8%	7.9%	7.9%
$35	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$40	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	6.8%	7.0%	6.5%	6.8%	7.4%	6.8%	6.7%
$150	8.2%	8.2%	7.9%	8.0%	8.3%	8.0%	8.1%
$200	7.6%	7.7%	7.8%	7.7%	7.6%	7.8%	7.7%
$250	8.1%	8.2%	8.2%	8.1%	8.2%	8.1%	8.2%
$500	7.8%	7.7%	7.7%	7.8%	7.8%	7.7%	7.7%
$750	7.9%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Day							
$50 w/3 Day Max	8.4%	8.3%	8.4%	8.4%	8.3%	8.4%	8.2%
$50 w/5 Day Max	8.2%	7.7%	8.1%	7.9%	7.7%	7.9%	8.0%
$100 w/3 Day Max	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$100 w/5 Day Max	7.8%	7.8%	7.9%	7.8%	7.7%	7.8%	7.8%
$250 w/3 Day Max	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	6.5%	7.3%	7.1%	6.7%	7.0%	7.3%	7.4%
$75	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$100	8.4%	8.3%	8.4%	8.4%	8.3%	8.4%	8.2%
$125	8.6%	8.3%	8.5%	8.7%	8.6%	8.6%	8.6%
$150	8.2%	8.2%	8.2%	8.3%	8.3%	8.2%	8.3%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
$25	8.3%	7.6%	8.0%	7.9%	7.8%	8.3%	8.2%
$35	9.0%	8.3%	8.4%	8.3%	9.0%	8.3%	8.8%
$50	8.9%	9.1%	8.9%	8.9%	8.8%	9.3%	9.0%
$60	7.0%	6.7%	7.1%	6.8%	6.6%	6.7%	6.9%
$75	7.5%	7.6%	7.8%	7.6%	7.6%	7.8%	7.7%
$100	7.5%	7.6%	7.5%	7.6%	7.7%	7.6%	7.5%
$125	8.1%	8.2%	8.2%	8.1%	8.2%	8.1%	8.2%
$150	7.6%	7.7%	7.7%	7.7%	7.6%	7.6%	7.5%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
60	7.4%	8.0%	8.2%	8.0%	7.5%	7.9%	7.9%

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HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.62	3.97	2.96	4.71	3.01	3.24	4.95
120	1.89	4.63	3.45	5.49	3.52	3.78	5.79
Unlimited	2.43	5.96	4.44	7.07	4.52	4.87	7.45
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.33)	(0.25)	(0.40)	(0.25)	(0.27)	(0.42)
40/$10 copay	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
40/$15 copay	(0.44)	(1.08)	(0.80)	(1.27)	(0.81)	(0.88)	(1.34)
40/$20 copay	(0.61)	(1.48)	(1.11)	(1.77)	(1.13)	(1.21)	(1.85)
40/$25 copay	(0.80)	(1.97)	(1.47)	(2.34)	(1.49)	(1.61)	(2.46)
60	0.29	0.72	0.53	0.85	0.54	0.58	0.90
100	0.71	1.74	1.30	2.07	1.32	1.42	2.17
200	1.89	4.63	3.45	5.49	3.52	3.78	5.79
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.13)	(2.77)	(2.06)	(3.28)	(2.10)	(2.26)	(3.45)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.74	1.82	1.36	2.15	1.38	1.48	2.27
90	1.55	3.79	2.82	4.49	2.87	3.09	4.73
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.66	1.61	1.20	1.91	1.22	1.32	2.02
90	1.21	2.97	2.21	3.52	2.26	2.42	3.71
120	1.96	4.82	3.58	5.71	3.66	3.93	6.01
visits for all other	(Verizon Benefit)						
	1.52	3.74	2.79	4.43	2.84	3.05	4.67
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.94)	(2.30)	(1.71)	(2.74)	(1.74)	(1.88)	(2.87)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.28	0.69	0.51	0.81	0.52	0.56	0.87
30	0.45	1.10	0.83	1.31	0.84	0.90	1.38
Unlimited	0.66	1.61	1.20	1.91	1.22	1.32	2.02
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.32	8.14	6.07	9.65	6.17	6.64	10.16
60	3.90	9.55	7.11	11.32	7.25	7.79	11.92
90	4.66	11.42	8.50	13.55	8.67	9.32	14.25
Unlimited	4.72	11.56	8.62	13.72	8.78	9.44	14.45
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.19)	(0.30)	(0.20)	(0.21)	(0.32)
60/$10 copay	(0.25)	(0.62)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.41)	(1.00)	(0.74)	(1.18)	(0.76)	(0.81)	(1.24)
60/$20 copay	(0.56)	(1.38)	(1.03)	(1.64)	(1.04)	(1.13)	(1.72)
60/$25 copay	(0.68)	(1.66)	(1.24)	(1.97)	(1.26)	(1.36)	(2.08)
120/$0 copay	0.58	1.43	1.07	1.70	1.09	1.17	1.79
120/$5 copay	0.45	1.10	0.83	1.31	0.84	0.90	1.38
120/$10 copay	0.25	0.62	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
120/$25 copay	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
Unlimited/$0 copay	0.67	1.64	1.22	1.94	1.24	1.34	2.05
Unlimited/$5 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.57
Unlimited/$10 copay	0.33	0.81	0.61	0.97	0.63	0.67	1.02
Unlimited/$15 copay	0.08	0.21	0.16	0.24	0.16	0.17	0.25
Unlimited/$20 copay	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
Unlimited/$25 copay	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.87)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.41	0.30	0.49	0.31	0.33	0.51
$5	0.08	0.21	0.16	0.24	0.16	0.17	0.25
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.19)	(0.30)	(0.20)	(0.21)	(0.32)
$20	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.33)	(0.25)	(0.40)	(0.25)	(0.27)	(0.42)
$10	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
$15	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
$20	(0.64)	(1.56)	(1.16)	(1.85)	(1.18)	(1.27)	(1.95)
$25	(0.84)	(2.05)	(1.52)	(2.43)	(1.56)	(1.67)	(2.56)
$30	(1.00)	(2.45)	(1.83)	(2.91)	(1.87)	(2.01)	(3.07)
$35	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$40	(1.38)	(3.37)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	1.74	4.26	3.18	5.06	3.24	3.48	5.32
120	2.05	5.02	3.74	5.96	3.81	4.10	6.27
Unlimited	2.63	6.44	4.80	7.65	4.89	5.26	8.05
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
40/$10 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$15 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
40/$20 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
40/$25 copay	(0.88)	(2.16)	(1.61)	(2.56)	(1.64)	(1.76)	(2.69)
60	0.33	0.81	0.60	0.96	0.61	0.66	1.01
100	0.75	1.84	1.37	2.18	1.40	1.50	2.29
200	2.05	5.02	3.74	5.96	3.81	4.10	6.27
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.78	1.91	1.42	2.27	1.45	1.56	2.39
90	1.67	4.09	3.05	4.85	3.11	3.34	5.11
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.70	1.72	1.28	2.03	1.30	1.40	2.14
90	1.29	3.16	2.36	3.75	2.40	2.58	3.95
120	2.12	5.19	3.87	6.16	3.94	4.24	6.49
visits for all other	(Verizon Benefit)						
	1.64	4.02	2.99	4.77	3.05	3.28	5.02
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.32	0.78	0.58	0.93	0.60	0.64	0.98
30	0.49	1.20	0.89	1.42	0.91	0.98	1.50
Unlimited	0.70	1.72	1.28	2.03	1.30	1.40	2.14
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.58	8.77	6.54	10.41	6.66	7.16	10.95
60	4.21	10.31	7.69	12.24	7.83	8.42	12.88
90	5.02	12.30	9.17	14.59	9.34	10.04	15.36
Unlimited	5.08	12.45	9.28	14.77	9.45	10.16	15.54
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
60/$15 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
60/$20 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
60/$25 copay	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
120/$0 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
120/$5 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
120/$25 copay	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
Unlimited/$0 copay	0.71	1.74	1.30	2.06	1.32	1.42	2.17
Unlimited/$5 copay	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Unlimited/$10 copay	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Unlimited/$15 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copay	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.42	0.31	0.49	0.32	0.34	0.52
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$10	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$15	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$20	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$25	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$30	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$35	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
$40	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	0.12	0.29	0.22	0.35	0.23	0.24	0.37
120	0.16	0.39	0.29	0.47	0.29	0.32	0.48
Unlimited	0.20	0.48	0.36	0.58	0.37	0.39	0.60
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
40/$10 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
40/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
40/$20 copay	(0.04)	(0.11)	(0.08)	(0.12)	(0.08)	(0.09)	(0.14)
40/$25 copay	(0.08)	(0.19)	(0.14)	(0.22)	(0.15)	(0.15)	(0.23)
60	0.04	0.09	0.07	0.11	0.07	0.08	0.11
100	0.04	0.10	0.07	0.11	0.08	0.08	0.12
200	0.16	0.39	0.29	0.47	0.29	0.32	0.48
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.08)	(0.19)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.09	0.06	0.12	0.07	0.08	0.12
90	0.12	0.30	0.23	0.36	0.24	0.25	0.38
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.11	0.08	0.12	0.08	0.08	0.12
90	0.08	0.19	0.15	0.23	0.14	0.16	0.24
120	0.16	0.37	0.29	0.45	0.28	0.31	0.48
visits for all other	(Verizon Benefit)						
	0.12	0.28	0.20	0.34	0.21	0.23	0.35
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.08)	(0.20)	(0.15)	(0.23)	(0.16)	(0.16)	(0.25)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.04	0.09	0.07	0.12	0.08	0.08	0.11
30	0.04	0.10	0.06	0.11	0.07	0.08	0.12
Unlimited	0.04	0.11	0.08	0.12	0.08	0.08	0.12
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.26	0.63	0.47	0.76	0.49	0.52	0.79
60	0.31	0.76	0.58	0.92	0.58	0.63	0.96
90	0.36	0.88	0.67	1.04	0.67	0.72	1.11
Unlimited	0.36	0.89	0.66	1.05	0.67	0.72	1.09
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.01	0.01	0.01	0.01	0.01
60/$10 copay	0.00	0.01	0.00	0.00	0.00	0.00	0.00
60/$15 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
60/$20 copay	(0.04)	(0.09)	(0.07)	(0.10)	(0.08)	(0.07)	(0.12)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.12)	(0.08)	(0.08)	(0.12)
120/$0 copay	0.04	0.09	0.06	0.10	0.06	0.07	0.11
120/$5 copay	0.04	0.10	0.06	0.11	0.07	0.08	0.12
120/$10 copay	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
120/$25 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
Unlimited/$0 copay	0.04	0.10	0.08	0.12	0.08	0.08	0.12
Unlimited/$5 copay	0.04	0.10	0.07	0.12	0.07	0.08	0.11
Unlimited/$10 copay	0.04	0.10	0.07	0.11	0.06	0.07	0.11
Unlimited/$15 copay	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Unlimited/$20 copay	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Unlimited/$25 copay	(0.04)	(0.09)	(0.07)	(0.12)	(0.08)	(0.08)	(0.11)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.00	0.01	0.01	0.00	0.01	0.01	0.01
$5	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.01	0.01	0.01	0.01	0.01
$20	0.00	0.00	0.01	0.00	0.00	0.00	0.00
$25	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$10	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$15	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.09)	(0.13)
$25	(0.08)	(0.20)	(0.16)	(0.24)	(0.15)	(0.17)	(0.25)
$30	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.15)	(0.23)
$35	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$40	(0.12)	(0.31)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
90	7.4%	7.3%	7.4%	7.4%	7.6%	7.4%	7.5%
120	8.5%	8.4%	8.4%	8.6%	8.2%	8.5%	8.3%
Unlimited	8.2%	8.1%	8.1%	8.2%	8.2%	8.0%	8.1%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
40/$10 copay	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
40/$15 copay	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
40/$20 copay	6.6%	7.4%	7.2%	6.8%	7.1%	7.4%	7.6%
40/$25 copay	10.0%	9.6%	9.5%	9.4%	10.1%	9.3%	9.3%
60	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
100	5.6%	5.7%	5.4%	5.3%	6.1%	5.6%	5.5%
200	8.5%	8.4%	8.4%	8.6%	8.2%	8.5%	8.3%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	7.1%	6.9%	7.3%	7.3%	7.1%	7.1%	7.2%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	5.4%	4.9%	4.4%	5.6%	5.1%	5.4%	5.3%
90	7.7%	7.9%	8.2%	8.0%	8.4%	8.1%	8.0%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	6.1%	6.8%	6.7%	6.3%	6.6%	6.1%	5.9%
90	6.6%	6.4%	6.8%	6.5%	6.2%	6.6%	6.5%
120	8.2%	7.7%	8.1%	7.9%	7.7%	7.9%	8.0%
visits for all other	(Verizon Benefit)						
	7.9%	7.5%	7.2%	7.7%	7.4%	7.5%	7.5%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.5%	8.7%	8.8%	8.4%	9.2%	8.5%	8.7%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
30	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
Unlimited	6.1%	6.8%	6.7%	6.3%	6.6%	6.1%	5.9%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	7.8%	7.7%	7.7%	7.9%	7.9%	7.8%	7.8%
60	7.9%	8.0%	8.2%	8.1%	8.0%	8.1%	8.1%
90	7.7%	7.7%	7.9%	7.7%	7.7%	7.7%	7.8%
Unlimited	7.6%	7.7%	7.7%	7.7%	7.6%	7.6%	7.5%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	-5.3%	-3.3%	-5.0%	-4.8%	-3.1%
60/$10 copay	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$15 copay	9.8%	10.0%	10.8%	11.0%	10.5%	11.1%	11.3%
60/$20 copay	7.1%	6.5%	6.8%	6.1%	7.7%	6.2%	7.0%
60/$25 copay	5.9%	6.0%	5.6%	6.1%	6.3%	5.9%	5.8%
120/$0 copay	6.9%	6.3%	5.6%	5.9%	5.5%	6.0%	6.1%
120/$5 copay	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
120/$10 copay	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
120/$25 copay	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
Unlimited/$0 copay	6.0%	6.1%	6.6%	6.2%	6.5%	6.0%	5.9%
Unlimited/$5 copay	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.0%
Unlimited/$10 copay	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
Unlimited/$15 copay	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
Unlimited/$20 copay	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
Unlimited/$25 copay	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.0%	2.4%	3.3%	0.0%	3.2%	3.0%	2.0%
$5	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$10	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	-5.3%	-3.3%	-5.0%	-4.8%	-3.1%
$20	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
$25	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
$10	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
$15	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
$20	6.3%	7.1%	6.9%	7.0%	6.8%	7.1%	6.7%
$25	9.5%	9.8%	10.5%	9.9%	9.6%	10.2%	9.8%
$30	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$35	6.8%	6.9%	7.0%	6.7%	6.8%	6.8%	6.6%
$40	8.7%	9.2%	8.7%	8.7%	8.6%	8.7%	8.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.56)	(3.81)	(2.84)	(4.52)	(2.89)	(3.11)	(4.76)
$50	(1.72)	(4.22)	(3.14)	(5.01)	(3.21)	(3.45)	(5.27)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$10	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
$15	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.47)
$20	(0.71)	(1.74)	(1.30)	(2.07)	(1.32)	(1.42)	(2.17)
$25	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.93)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$20	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$25	(0.11)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$25	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$35	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
$50	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
$60	(0.41)	(1.00)	(0.74)	(1.18)	(0.76)	(0.81)	(1.24)
$75	(0.53)	(1.31)	(0.97)	(1.55)	(0.99)	(1.07)	(1.63)
$100	(0.71)	(1.74)	(1.30)	(2.07)	(1.32)	(1.42)	(2.17)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.11)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
$35	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$50	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
$75	(0.37)	(0.90)	(0.67)	(1.07)	(0.68)	(0.73)	(1.12)
$100	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.47)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.00)	(7.34)	(5.47)	(8.71)	(5.58)	(6.00)	(9.17)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(4.65)	(11.38)	(8.49)	(13.52)	(8.65)	(9.30)	(14.22)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.40)	(0.97)	(0.72)	(1.15)	(0.74)	(0.79)	(1.21)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(1.68)	(4.12)	(3.07)	(4.88)	(3.12)	(3.36)	(5.14)
$50	(1.84)	(4.51)	(3.36)	(5.35)	(3.42)	(3.68)	(5.63)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$15	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$20	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
$25	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$35	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$50	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$60	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$100	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.24)	(7.94)	(5.92)	(9.42)	(6.03)	(6.48)	(9.91)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(5.01)	(12.27)	(9.15)	(14.56)	(9.32)	(10.02)	(15.33)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	(0.12)	(0.31)	(0.23)	(0.36)	(0.23)	(0.25)	(0.38)
$50	(0.12)	(0.29)	(0.22)	(0.34)	(0.21)	(0.23)	(0.36)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$10	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
$15	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
$25	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.25)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$20	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.02
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$25	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$35	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
$50	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
$60	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
$75	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.02
$35	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$50	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$60	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.24)	(0.60)	(0.45)	(0.71)	(0.45)	(0.48)	(0.74)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	(0.36)	(0.89)	(0.66)	(1.04)	(0.67)	(0.72)	(1.11)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$45	7.7%	8.1%	8.1%	8.0%	8.0%	8.0%	8.0%
$50	7.0%	6.9%	7.0%	6.8%	6.5%	6.7%	6.8%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$10	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
$15	8.3%	7.6%	8.0%	7.9%	7.8%	8.3%	8.2%
$20	5.6%	5.7%	5.4%	5.3%	6.1%	5.6%	5.5%
$25	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.5%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$20	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$25	0.0%	-3.6%	-4.8%	-3.0%	-4.8%	-4.3%	-5.6%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$25	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$35	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
$50	12.5%	11.4%	10.0%	11.7%	9.8%	10.8%	11.1%
$60	9.8%	10.0%	10.8%	11.0%	10.5%	11.1%	11.3%
$75	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
$100	5.6%	5.7%	5.4%	5.3%	6.1%	5.6%	5.5%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-3.6%	-4.8%	-3.0%	-4.8%	-4.3%	-5.6%
$35	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$50	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
$60	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
$75	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
$100	8.3%	7.6%	8.0%	7.9%	7.8%	8.3%	8.2%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.0%	8.2%	8.2%	8.2%	8.1%	8.0%	8.1%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum [20%, $100]; $500 annual maximum				
	7.7%	7.8%	7.8%	7.7%	7.7%	7.7%	7.8%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	10.0%	11.3%	11.1%	11.3%	10.8%	11.4%	11.6%
Copay			**Mammogram Copay [std: $0] (HealthPass)**				
$10/15/20	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
NYSHIP "Other Children" Dependents							
	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Grandchildren							
	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Class II Dependents							
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
NYSHIP: Three Month Extension							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NYSHIP "Other Children" Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grandchildren							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Class II Dependents							
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copy same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.74	18.96	14.13	22.50	14.39	15.48	23.68
60	8.16	19.98	14.89	23.71	15.18	16.31	24.95
90	8.47	20.75	15.47	24.63	15.75	16.94	25.91
Unlimited	8.55	20.96	15.61	24.87	15.91	17.11	26.16
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copy same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	8.65	21.19	15.79	25.14	16.08	17.30	26.46
30	9.53	23.33	17.39	27.69	17.71	19.05	29.14
40	10.06	24.64	18.36	29.23	18.71	20.12	30.77
60	10.60	25.98	19.35	30.82	19.72	21.20	32.43
Unlimited	10.68	26.17	19.51	31.06	19.88	21.37	32.68
LARGE GROUP			**$5 Copay**				
20	8.14	19.94	14.85	23.66	15.13	16.27	24.89
30	8.95	21.93	16.35	26.02	16.65	17.90	27.39
40	9.52	23.31	17.37	27.66	17.69	19.03	29.11
60	9.96	24.41	18.19	28.96	18.53	19.93	30.48
Unlimited	10.04	24.59	18.33	29.18	18.66	20.07	30.71
LARGE GROUP			**$10 Copay**				
20	7.61	18.65	13.90	22.13	14.16	15.23	23.29
30	8.39	20.54	15.31	24.38	15.60	16.77	25.65
40	8.87	21.73	16.19	25.78	16.49	17.74	27.13
60	9.35	22.91	17.07	27.18	17.39	18.70	28.60
Unlimited	9.42	23.08	17.20	27.39	17.53	18.84	28.82
LARGE GROUP			**$15 Copay**				
20	7.14	17.51	13.05	20.76	13.29	14.29	21.85
30	7.89	19.32	14.40	22.93	14.66	15.77	24.13
40	8.35	20.45	15.24	24.26	15.52	16.69	25.53
60	8.83	21.62	16.12	25.65	16.42	17.65	27.00
Unlimited	8.90	21.80	16.25	25.87	16.55	17.80	27.22
LARGE GROUP			**$20 Copay**				
20	6.73	16.48	12.28	19.55	12.51	13.45	20.58
30	7.38	18.09	13.48	21.46	13.73	14.77	22.59
40	7.78	19.06	14.20	22.62	14.48	15.56	23.80
60	8.27	20.26	15.10	24.04	15.39	16.54	25.31
Unlimited	8.33	20.42	15.22	24.23	15.50	16.67	25.50
LARGE GROUP			**$25 Copay**				
20	6.26	15.33	11.43	18.18	11.64	12.51	19.13
30	6.87	16.84	12.54	19.98	12.78	13.75	21.03
40	7.32	17.93	13.37	21.29	13.62	14.64	22.39
60	7.70	18.86	14.06	22.37	14.32	15.40	23.54
Unlimited	7.77	19.04	14.18	22.59	14.46	15.54	23.77
LARGE GROUP			**$30 Copay**				
20	5.96	14.61	10.89	17.34	11.09	11.93	18.25
30	6.47	15.84	11.80	18.79	12.02	12.93	19.77
40	6.89	16.89	12.59	20.04	12.83	13.79	21.09
60	7.23	17.70	13.20	21.01	13.44	14.46	22.11
Unlimited	7.27	17.81	13.28	21.13	13.53	14.54	22.24
LARGE GROUP			**$35 Copay**				
20	5.67	13.89	10.35	16.48	10.55	11.34	17.35
30	6.05	14.82	11.04	17.58	11.25	12.10	18.50
40	6.44	15.79	11.77	18.74	11.99	12.89	19.71
60	6.76	16.55	12.34	19.65	12.57	13.52	20.67
Unlimited	6.82	16.71	12.45	19.82	12.69	13.64	20.86
LARGE GROUP			**$40 Copay**				
20	5.51	13.52	10.07	16.03	10.26	11.03	16.87
30	5.89	14.43	10.76	17.13	10.96	11.78	18.02
40	6.28	15.37	11.46	18.25	11.68	12.55	19.20
60	6.61	16.20	12.07	19.22	12.29	13.22	20.22
Unlimited	6.66	16.33	12.17	19.38	12.40	13.33	20.39
LARGE GROUP			**$45 Copay**				
20	5.36	13.13	9.79	15.57	9.96	10.72	16.39
30	5.72	14.03	10.46	16.64	10.64	11.45	17.51
40	6.11	14.97	11.15	17.77	11.36	12.22	18.69
60	6.45	15.81	11.78	18.77	12.00	12.91	19.74

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.35	20.46	15.25	24.27	15.53	16.70	25.54
60	8.80	21.56	16.07	25.58	16.37	17.60	26.92
90	9.13	22.37	16.67	26.54	16.98	18.26	27.93
Unlimited	9.22	22.59	16.84	26.80	17.15	18.44	28.20
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	9.32	22.83	17.02	27.09	17.34	18.64	28.51
30	10.27	25.16	18.75	29.85	19.10	20.54	31.42
40	10.84	26.56	19.79	31.51	20.16	21.68	33.16
60	11.43	28.00	20.87	33.23	21.26	22.86	34.96
Unlimited	11.51	28.20	21.02	33.46	21.41	23.02	35.21
LARGE GROUP			**$5 Copay**				
20	8.77	21.49	16.01	25.49	16.31	17.54	26.83
30	9.65	23.64	17.62	28.05	17.95	19.30	29.52
40	10.26	25.14	18.73	29.83	19.08	20.52	31.39
60	10.74	26.31	19.61	31.22	19.98	21.48	32.85
Unlimited	10.82	26.51	19.76	31.45	20.13	21.64	33.10
LARGE GROUP			**$10 Copay**				
20	8.20	20.09	14.97	23.84	15.25	16.40	25.08
30	9.05	22.17	16.53	26.31	16.83	18.10	27.68
40	9.56	23.42	17.46	27.79	17.78	19.12	29.24
60	10.08	24.70	18.41	29.30	18.75	20.16	30.83
Unlimited	10.16	24.89	18.55	29.54	18.90	20.32	31.08
LARGE GROUP			**$15 Copay**				
20	7.70	18.87	14.06	22.38	14.32	15.40	23.55
30	8.51	20.85	15.54	24.74	15.83	17.02	26.03
40	9.00	22.05	16.43	26.16	16.74	18.00	27.53
60	9.52	23.32	17.38	27.67	17.71	19.04	29.12
Unlimited	9.60	23.52	17.53	27.91	17.86	19.20	29.37
LARGE GROUP			**$20 Copay**				
20	7.26	17.79	13.26	21.10	13.50	14.52	22.21
30	7.96	19.50	14.53	23.14	14.81	15.92	24.35
40	8.39	20.56	15.32	24.39	15.61	16.78	25.67
60	8.92	21.85	16.29	25.93	16.59	17.84	27.29
Unlimited	8.98	22.00	16.40	26.10	16.70	17.96	27.47
LARGE GROUP			**$25 Copay**				
20	6.75	16.54	12.33	19.62	12.56	13.50	20.65
30	7.41	18.15	13.53	21.54	13.78	14.82	22.67
40	7.89	19.33	14.41	22.94	14.68	15.78	24.14
60	8.30	20.34	15.16	24.13	15.44	16.60	25.39
Unlimited	8.38	20.53	15.30	24.36	15.59	16.76	25.63
LARGE GROUP			**$30 Copay**				
20	6.43	15.75	11.74	18.69	11.96	12.86	19.67
30	6.98	17.10	12.75	20.29	12.98	13.96	21.35
40	7.43	18.20	13.57	21.60	13.82	14.86	22.73
60	7.80	19.11	14.24	22.67	14.51	15.60	23.86
Unlimited	7.84	19.21	14.32	22.79	14.58	15.68	23.98
LARGE GROUP			**$35 Copay**				
20	6.11	14.97	11.16	17.76	11.36	12.22	18.69
30	6.52	15.97	11.91	18.95	12.13	13.04	19.94
40	6.94	17.00	12.67	20.17	12.91	13.88	21.23
60	7.29	17.86	13.31	21.19	13.56	14.58	22.30
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP			**$40 Copay**				
20	5.94	14.55	10.85	17.27	11.05	11.88	18.17
30	6.35	15.56	11.60	18.46	11.81	12.70	19.42
40	6.77	16.59	12.36	19.68	12.59	13.54	20.71
60	7.13	17.47	13.02	20.73	13.26	14.26	21.81
Unlimited	7.18	17.59	13.11	20.87	13.35	14.36	21.96
LARGE GROUP			**$45 Copay**				
20	5.78	14.16	10.55	16.80	10.75	11.56	17.68
30	6.16	15.09	11.25	17.91	11.46	12.32	18.84
40	6.59	16.15	12.03	19.16	12.26	13.18	20.16
60	6.95	17.03	12.69	20.20	12.93	13.90	21.26

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.61	1.50	1.12	1.77	1.14	1.22	1.86
60	0.64	1.58	1.18	1.87	1.19	1.29	1.97
90	0.66	1.62	1.20	1.91	1.23	1.32	2.02
Unlimited	0.67	1.63	1.23	1.93	1.24	1.33	2.04
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	0.67	1.64	1.23	1.95	1.26	1.34	2.05
30	0.74	1.83	1.36	2.16	1.39	1.49	2.28
40	0.78	1.92	1.43	2.28	1.45	1.56	2.39
60	0.83	2.02	1.52	2.41	1.54	1.66	2.53
Unlimited	0.83	2.03	1.51	2.40	1.53	1.65	2.53
LARGE GROUP			**$5 Copay**				
20	0.63	1.55	1.16	1.83	1.18	1.27	1.94
30	0.70	1.71	1.27	2.03	1.30	1.40	2.13
40	0.74	1.83	1.36	2.17	1.39	1.49	2.28
60	0.78	1.90	1.42	2.26	1.45	1.55	2.37
Unlimited	0.78	1.92	1.43	2.27	1.47	1.57	2.39
LARGE GROUP			**$10 Copay**				
20	0.59	1.44	1.07	1.71	1.09	1.17	1.79
30	0.66	1.63	1.22	1.93	1.23	1.33	2.03
40	0.69	1.69	1.27	2.01	1.29	1.38	2.11
60	0.73	1.79	1.34	2.12	1.36	1.46	2.23
Unlimited	0.74	1.81	1.35	2.15	1.37	1.48	2.26
LARGE GROUP			**$15 Copay**				
20	0.56	1.36	1.01	1.62	1.03	1.11	1.70
30	0.62	1.53	1.14	1.81	1.17	1.25	1.90
40	0.65	1.60	1.19	1.90	1.22	1.31	2.00
60	0.69	1.70	1.26	2.02	1.29	1.39	2.12
Unlimited	0.70	1.72	1.28	2.04	1.31	1.40	2.15
LARGE GROUP			**$20 Copay**				
20	0.53	1.31	0.98	1.55	0.99	1.07	1.63
30	0.58	1.41	1.05	1.68	1.08	1.15	1.76
40	0.61	1.50	1.12	1.77	1.13	1.22	1.87
60	0.65	1.59	1.19	1.89	1.20	1.30	1.98
Unlimited	0.65	1.58	1.18	1.87	1.20	1.29	1.97
LARGE GROUP			**$25 Copay**				
20	0.49	1.21	0.90	1.44	0.92	0.99	1.52
30	0.54	1.31	0.99	1.56	1.00	1.07	1.64
40	0.57	1.40	1.04	1.65	1.06	1.14	1.75
60	0.60	1.48	1.10	1.76	1.12	1.20	1.85
Unlimited	0.61	1.49	1.12	1.77	1.13	1.22	1.86
LARGE GROUP			**$30 Copay**				
20	0.47	1.14	0.85	1.35	0.87	0.93	1.42
30	0.51	1.26	0.95	1.50	0.96	1.03	1.58
40	0.54	1.31	0.98	1.56	0.99	1.07	1.64
60	0.57	1.41	1.04	1.66	1.07	1.14	1.75
Unlimited	0.57	1.40	1.04	1.66	1.05	1.14	1.74
LARGE GROUP			**$35 Copay**				
20	0.44	1.08	0.81	1.28	0.81	0.88	1.34
30	0.47	1.15	0.87	1.37	0.88	0.94	1.44
40	0.50	1.21	0.90	1.43	0.92	0.99	1.52
60	0.53	1.31	0.97	1.54	0.99	1.06	1.63
Unlimited	0.53	1.30	0.97	1.55	0.98	1.06	1.62
LARGE GROUP			**$40 Copay**				
20	0.43	1.03	0.78	1.24	0.79	0.85	1.30
30	0.46	1.13	0.84	1.33	0.85	0.92	1.40
40	0.49	1.22	0.90	1.43	0.91	0.99	1.51
60	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited	0.52	1.26	0.94	1.49	0.95	1.03	1.57
LARGE GROUP			**$45 Copay**				
20	0.42	1.03	0.76	1.23	0.79	0.84	1.29
30	0.44	1.06	0.79	1.27	0.82	0.87	1.33
40	0.48	1.18	0.88	1.39	0.90	0.96	1.47
60	0.50	1.22	0.91	1.43	0.93	0.99	1.52

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
60	7.8%	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%
90	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			**$0 Copay**				
20	7.7%	7.7%	7.8%	7.8%	7.8%	7.7%	7.7%
30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
60	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP			**$5 Copay**				
20	7.7%	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%
30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
LARGE GROUP			**$10 Copay**				
20	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
30	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.9%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.9%	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%
LARGE GROUP			**$15 Copay**				
20	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.9%	7.9%	7.9%	8.0%	7.9%	7.9%
40	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
60	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
LARGE GROUP			**$20 Copay**				
20	7.9%	7.9%	8.0%	7.9%	7.9%	8.0%	7.9%
30	7.9%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
40	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%	7.9%
60	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%	7.8%
Unlimited	7.8%	7.7%	7.8%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP			**$25 Copay**				
20	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
30	7.9%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%	7.9%
Unlimited	7.9%	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%
LARGE GROUP			**$30 Copay**				
20	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	8.0%	8.1%	8.0%	8.0%	8.0%	8.0%
40	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
60	7.9%	8.0%	7.9%	7.9%	8.0%	7.9%	7.9%
Unlimited	7.8%	7.9%	7.8%	7.9%	7.8%	7.8%	7.8%
LARGE GROUP			**$35 Copay**				
20	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.7%
30	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.7%	7.6%	7.6%	7.7%	7.7%	7.7%
60	7.8%	7.9%	7.9%	7.8%	7.9%	7.8%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
LARGE GROUP			**$40 Copay**				
20	7.8%	7.6%	7.7%	7.7%	7.7%	7.7%	7.7%
30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%
60	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP			**$45 Copay**				
20	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.9%
30	7.7%	7.6%	7.6%	7.6%	7.7%	7.6%	7.6%
40	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%	7.9%
60	7.8%	7.7%	7.7%	7.6%	7.8%	7.7%	7.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO GROUP CONTRACT - MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.49	15.89	11.84	18.85	12.06	12.97	19.85
LARGE GROUP			**$50 Copay**				
20	5.21	12.77	9.52	15.16	9.69	10.42	15.94
30	5.57	13.64	10.16	16.18	10.35	11.13	17.02
40	5.96	14.61	10.89	17.34	11.09	11.93	18.25
60	6.30	15.43	11.50	18.31	11.72	12.60	19.27
Unlimited	6.34	15.53	11.57	18.43	11.79	12.68	19.40

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	7.00	17.15	12.78	20.35	13.02	14.00	21.41
LARGE GROUP			**$50 Copay**				
20	5.61	13.74	10.24	16.31	10.43	11.22	17.16
30	6.01	14.72	10.97	17.47	11.18	12.02	18.38
40	6.43	15.75	11.74	18.69	11.96	12.86	19.67
60	6.79	16.64	12.40	19.74	12.63	13.58	20.77
Unlimited	6.84	16.76	12.49	19.88	12.72	13.68	20.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.51	1.26	0.94	1.50	0.96	1.03	1.56
LARGE GROUP			**$50 Copay**				
20	0.40	0.97	0.72	1.15	0.74	0.80	1.22
30	0.44	1.08	0.81	1.29	0.83	0.89	1.36
40	0.47	1.14	0.85	1.35	0.87	0.93	1.42
60	0.49	1.21	0.90	1.43	0.91	0.98	1.50
Unlimited	0.50	1.23	0.92	1.45	0.93	1.00	1.52

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	7.9%	7.9%	7.9%	8.0%	8.0%	7.9%	7.9%
LARGE GROUP			**$50 Copay**				
20	7.7%	7.6%	7.6%	7.6%	7.6%	7.7%	7.7%
30	7.9%	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%
40	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP HMO LARGE GROUP CONTRACT - RIDERS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.30	10.54	7.85	12.51	8.00	8.61	13.16
$0/Max $5000	4.09	10.03	7.48	11.91	7.61	8.19	12.52
$0/Max $2500	3.82	9.37	6.98	11.11	7.11	7.65	11.70
$25	4.09	10.03	7.48	11.91	7.61	8.19	12.52
$50	3.82	9.37	6.98	11.11	7.11	7.65	11.70
$100	3.51	8.60	6.41	10.20	6.53	7.02	10.74
$500	1.68	4.12	3.07	4.89	3.12	3.36	5.14
$5,000	0.28	0.69	0.51	0.81	0.52	0.56	0.87
Coinsurance							
80%	3.45	8.44	6.30	10.02	6.41	6.89	10.54
75%	3.24	7.93	5.91	9.41	6.03	6.48	9.90
70%	3.03	7.42	5.54	8.80	5.63	6.06	9.26
Deductible			**Orthotics Riders**				
$0	0.73	1.79	1.34	2.12	1.36	1.46	2.24
$0/Max $5000	0.70	1.71	1.27	2.04	1.31	1.40	2.14
$0/Max $2500	0.66	1.61	1.20	1.91	1.22	1.32	2.02
$25	0.70	1.71	1.27	2.04	1.31	1.40	2.14
$50	0.66	1.61	1.20	1.91	1.22	1.32	2.02
$100	0.60	1.46	1.09	1.73	1.11	1.19	1.82
$500	0.30	0.74	0.55	0.88	0.56	0.61	0.93
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.60	1.46	1.09	1.73	1.11	1.19	1.82
75%	0.56	1.38	1.03	1.64	1.04	1.13	1.72
70%	0.53	1.31	0.97	1.55	0.99	1.07	1.63
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.41	3.46	2.58	4.09	2.62	2.82	4.31
12 Months	2.25	5.50	4.10	6.53	4.18	4.49	6.87
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.19	5.37	4.00	6.37	4.08	4.39	6.71
12 Months	3.50	8.58	6.39	10.17	6.51	7.00	10.71
			Private Duty Nursing Riders				
In Full	0.51	1.25	0.93	1.48	0.95	1.02	1.57
80% hrs 73-504	0.08	0.21	0.16	0.24	0.16	0.17	0.25
100% hrs 73-504	0.15	0.36	0.27	0.43	0.27	0.29	0.45
			Dental Network Access				
	0.44	1.08	0.80	1.27	0.81	0.88	1.34
			Infertility Rider				
Limit							
2 IVF	9.11	22.31	16.63	26.48	16.94	18.22	27.86
3 IVF	11.01	26.97	20.11	32.00	20.47	22.02	33.67
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.71	6.63	4.94	7.86	5.03	5.41	8.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.63	11.34	8.45	13.46	8.61	9.26	14.16
$0/Max $5000	4.41	10.80	8.05	12.82	8.20	8.82	13.49
$0/Max $2500	4.12	10.09	7.52	11.98	7.66	8.24	12.60
$25	4.41	10.80	8.05	12.82	8.20	8.82	13.49
$50	4.12	10.09	7.52	11.98	7.66	8.24	12.60
$100	3.79	9.29	6.92	11.02	7.05	7.58	11.59
$500	1.80	4.41	3.29	5.23	3.35	3.60	5.51
$5,000	0.32	0.78	0.58	0.93	0.60	0.64	0.98
Coinsurance							
80%	3.73	9.14	6.81	10.84	6.94	7.46	11.41
75%	3.48	8.53	6.35	10.12	6.47	6.96	10.65
70%	3.27	8.01	5.97	9.51	6.08	6.54	10.00
Deductible			**Orthotics Riders**				
$0	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$0/Max $5000	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$0/Max $2500	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$25	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$50	0.70	1.72	1.28	2.03	1.30	1.40	2.14
$100	0.64	1.57	1.17	1.86	1.19	1.28	1.96
$500	0.34	0.83	0.62	0.99	0.63	0.68	1.04
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.64	1.57	1.17	1.86	1.19	1.28	1.96
75%	0.60	1.47	1.10	1.74	1.12	1.20	1.84
70%	0.57	1.40	1.04	1.66	1.06	1.14	1.74
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.55	1.35	1.00	1.60	1.02	1.10	1.68
80% hrs 73-504	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-504	0.15	0.37	0.27	0.44	0.28	0.30	0.46
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
			Infertility Rider				
Limit							
2 IVF	9.82	24.06	17.93	28.55	18.27	19.64	30.04
3 IVF	11.87	29.08	21.67	34.51	22.08	23.74	36.31
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	2.91	7.13	5.31	8.46	5.41	5.82	8.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.33	0.80	0.60	0.95	0.61	0.65	1.00
$0/Max $5000	0.32	0.77	0.57	0.91	0.59	0.63	0.97
$0/Max $2500	0.30	0.72	0.54	0.87	0.55	0.59	0.90
$25	0.32	0.77	0.57	0.91	0.59	0.63	0.97
$50	0.30	0.72	0.54	0.87	0.55	0.59	0.90
$100	0.28	0.69	0.51	0.82	0.52	0.56	0.85
$500	0.12	0.29	0.22	0.34	0.23	0.24	0.37
$5,000	0.04	0.09	0.07	0.12	0.08	0.08	0.11
Coinsurance							
80%	0.28	0.70	0.51	0.82	0.53	0.57	0.87
75%	0.24	0.60	0.44	0.71	0.44	0.48	0.75
70%	0.24	0.59	0.43	0.71	0.45	0.48	0.74
Deductible			**Orthotics Riders**				
$0	0.04	0.10	0.07	0.12	0.07	0.08	0.12
$0/Max $5000	0.04	0.10	0.08	0.11	0.07	0.08	0.12
$0/Max $2500	0.04	0.11	0.08	0.12	0.08	0.08	0.12
$25	0.04	0.10	0.08	0.11	0.07	0.08	0.12
$50	0.04	0.11	0.08	0.12	0.08	0.08	0.12
$100	0.04	0.11	0.08	0.13	0.08	0.09	0.14
$500	0.04	0.09	0.07	0.11	0.07	0.07	0.11
$5,000	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Coinsurance							
80%	0.04	0.11	0.08	0.13	0.08	0.09	0.14
75%	0.04	0.09	0.07	0.10	0.08	0.07	0.12
70%	0.04	0.09	0.07	0.11	0.07	0.07	0.11
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.36	0.23	0.24	0.37
12 Months	0.17	0.43	0.32	0.50	0.32	0.35	0.53
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.16	0.39	0.29	0.46	0.29	0.31	0.48
12 Months	0.28	0.68	0.51	0.82	0.52	0.56	0.85
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.12	0.07	0.08	0.11
80% hrs 73-504	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
100% hrs 73-504	0.00	0.01	0.00	0.01	0.01	0.01	0.01
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.13
			Infertility Rider				
Limit							
2 IVF	0.71	1.75	1.30	2.07	1.33	1.42	2.18
3 IVF	0.86	2.11	1.56	2.51	1.61	1.72	2.64
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	0.20	0.50	0.37	0.60	0.38	0.41	0.63

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	7.7%	7.6%	7.6%	7.6%	7.6%	7.5%	7.6%
$0/Max $5000	7.8%	7.7%	7.6%	7.6%	7.8%	7.7%	7.7%
$0/Max $2500	7.9%	7.7%	7.7%	7.8%	7.7%	7.7%	7.7%
$25	7.8%	7.7%	7.6%	7.6%	7.8%	7.7%	7.7%
$50	7.9%	7.7%	7.7%	7.8%	7.7%	7.7%	7.7%
$100	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	7.9%
$500	7.1%	7.0%	7.2%	7.0%	7.4%	7.1%	7.2%
$5,000	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
Coinsurance							
80%	8.1%	8.3%	8.1%	8.2%	8.3%	8.3%	8.3%
75%	7.4%	7.6%	7.4%	7.5%	7.3%	7.4%	7.6%
70%	7.9%	8.0%	7.8%	8.1%	8.0%	7.9%	8.0%
Deductible			**Orthotics Riders**				
$0	5.5%	5.6%	5.2%	5.7%	5.1%	5.5%	5.4%
$0/Max $5000	5.7%	5.8%	6.3%	5.4%	5.3%	5.7%	5.6%
$0/Max $2500	6.1%	6.8%	6.7%	6.3%	6.6%	6.1%	5.9%
$25	5.7%	5.8%	6.3%	5.4%	5.3%	5.7%	5.6%
$50	6.1%	6.8%	6.7%	6.3%	6.6%	6.1%	5.9%
$100	6.7%	7.5%	7.3%	7.5%	7.2%	7.6%	7.7%
$500	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance							
80%	6.7%	7.5%	7.3%	7.5%	7.2%	7.6%	7.7%
75%	7.1%	6.5%	6.8%	6.1%	7.7%	6.2%	7.0%
70%	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.5%	8.4%	8.1%	8.8%	8.8%	8.5%	8.6%
12 Months	7.6%	7.8%	7.8%	7.7%	7.7%	7.8%	7.7%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.3%	7.3%	7.3%	7.2%	7.1%	7.1%	7.2%
12 Months	8.0%	7.9%	8.0%	8.1%	8.0%	8.0%	7.9%
			Private Duty Nursing Riders				
In Full	7.8%	8.0%	7.5%	8.1%	7.4%	7.8%	7.0%
80% hrs 73-504	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
100% hrs 73-504	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
			Dental Network Access				
	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
			Infertility Rider				
Limit							
2 IVF	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
3 IVF	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
			Hearing Aid (Verizon Benefit)				
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	7.4%	7.5%	7.5%	7.6%	7.6%	7.6%	7.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
887.94	2,175.41	1,621.32	2,581.21	1,651.50	1,775.81	2,716.17
80% Coinsurance						
874.61	2,142.75	1,596.98	2,542.46	1,626.71	1,749.14	2,675.39
75% Coinsurance						
832.44	2,039.42	1,519.96	2,419.85	1,548.26	1,664.79	2,546.38
70% Coinsurance						
790.26	1,936.09	1,442.95	2,297.25	1,469.82	1,580.45	2,417.35
50% Coinsurance						
748.09	1,832.78	1,365.96	2,174.68	1,391.39	1,496.12	2,288.37

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
957.37	2,345.56	1,748.16	2,783.07	1,780.71	1,914.74	2,928.59
80% Coinsurance						
943.00	2,310.35	1,721.92	2,741.30	1,753.98	1,886.00	2,884.64
75% Coinsurance						
897.54	2,198.97	1,638.91	2,609.15	1,669.42	1,795.08	2,745.57
70% Coinsurance						
852.05	2,087.52	1,555.84	2,476.91	1,584.81	1,704.10	2,606.42
50% Coinsurance						
806.58	1,976.12	1,472.82	2,344.73	1,500.24	1,613.16	2,467.33

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
69.43	170.15	126.84	201.86	129.21	138.93	212.42
80% Coinsurance						
68.39	167.60	124.94	198.84	127.27	136.86	209.25
75% Coinsurance						
65.10	159.55	118.95	189.30	121.16	130.29	199.19
70% Coinsurance						
61.79	151.43	112.89	179.66	114.99	123.65	189.07
50% Coinsurance						
58.49	143.34	106.86	170.05	108.85	117.04	178.96

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group **						
100% Hos/80% Med Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
80% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
75% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
70% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
50% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(40.11)	(98.26)	(73.24)	(116.59)	(74.60)	(80.22)	(122.68)
$350	(53.09)	(130.07)	(96.94)	(154.33)	(98.74)	(106.18)	(162.41)
$500	(68.31)	(167.36)	(124.73)	(198.58)	(127.05)	(136.61)	(208.96)
$750	(88.75)	(217.43)	(162.05)	(258.00)	(165.07)	(177.49)	(271.48)
$1,000	(104.41)	(255.79)	(190.64)	(303.50)	(194.19)	(208.80)	(319.37)
$1,500	(128.40)	(314.56)	(234.44)	(373.24)	(238.81)	(256.78)	(392.76)
$2,500	(143.54)	(351.67)	(262.10)	(417.28)	(266.98)	(287.07)	(439.09)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(53.60)	(131.32)	(97.88)	(155.83)	(99.70)	(107.20)	(163.97)
$250	(63.94)	(156.66)	(116.75)	(185.87)	(118.92)	(127.88)	(195.60)
$300	(74.31)	(182.06)	(135.69)	(216.03)	(138.22)	(148.62)	(227.32)
$350	(84.68)	(207.45)	(154.61)	(246.15)	(157.49)	(169.34)	(259.02)
$400	(92.82)	(227.41)	(169.49)	(269.83)	(172.64)	(185.63)	(283.94)
$500	(109.11)	(267.30)	(199.22)	(317.17)	(202.93)	(218.20)	(333.75)
$750	(141.69)	(347.14)	(258.73)	(411.90)	(263.54)	(283.38)	(433.44)
$1,000	(166.78)	(408.61)	(304.53)	(484.83)	(310.20)	(333.55)	(510.17)
$1,500	(205.16)	(502.62)	(374.60)	(596.38)	(381.58)	(410.29)	(627.56)
$2,000	(220.85)	(541.08)	(403.26)	(642.02)	(410.77)	(441.69)	(675.59)
$2,500	(236.60)	(579.67)	(432.03)	(687.81)	(440.07)	(473.19)	(723.76)
$5,000	(278.15)	(681.47)	(507.89)	(808.59)	(517.35)	(556.29)	(850.86)
$10,000	(312.47)	(765.53)	(570.54)	(908.33)	(581.16)	(624.91)	(955.82)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(43.92)	(107.60)	(80.19)	(127.68)	(81.69)	(87.84)	(134.35)
$250	(52.38)	(128.33)	(95.64)	(152.26)	(97.43)	(104.76)	(160.23)
$300	(60.89)	(149.18)	(111.18)	(177.02)	(113.25)	(121.79)	(186.27)
$350	(69.36)	(169.94)	(126.65)	(201.64)	(129.01)	(138.72)	(212.19)
$400	(76.18)	(186.65)	(139.10)	(221.46)	(141.69)	(152.36)	(233.04)
$500	(89.85)	(220.12)	(164.06)	(261.18)	(167.11)	(179.68)	(274.83)
$750	(116.87)	(286.32)	(213.39)	(339.73)	(217.37)	(233.72)	(357.49)
$1,000	(137.90)	(337.86)	(251.80)	(400.88)	(256.49)	(275.79)	(421.83)
$1,500	(169.78)	(415.95)	(310.00)	(493.55)	(315.78)	(339.55)	(519.34)
$2,000	(184.23)	(451.37)	(336.40)	(535.57)	(342.66)	(368.46)	(563.57)
$2,500	(198.69)	(486.78)	(362.80)	(577.58)	(369.55)	(397.36)	(607.78)
$5,000	(240.05)	(588.11)	(438.31)	(697.82)	(446.48)	(480.08)	(734.31)
$10,000	(274.19)	(671.74)	(500.64)	(797.05)	(509.96)	(548.35)	(838.72)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(34.24)	(83.88)	(62.51)	(99.53)	(63.68)	(68.48)	(104.73)
$250	(40.85)	(100.08)	(74.59)	(118.75)	(75.98)	(81.70)	(124.96)
$300	(47.45)	(116.25)	(86.64)	(137.93)	(88.26)	(94.90)	(145.15)
$350	(54.04)	(132.40)	(98.67)	(157.10)	(100.51)	(108.08)	(165.31)
$400	(59.59)	(145.99)	(108.80)	(173.22)	(110.83)	(119.17)	(182.27)
$500	(70.53)	(172.81)	(128.79)	(205.04)	(131.19)	(141.06)	(215.76)
$750	(92.02)	(225.44)	(168.01)	(267.49)	(171.15)	(184.03)	(281.48)
$1,000	(108.97)	(266.97)	(198.97)	(316.77)	(202.68)	(217.93)	(333.33)
$1,500	(134.41)	(329.30)	(245.43)	(390.74)	(250.00)	(268.82)	(411.17)
$2,000	(147.62)	(361.65)	(269.54)	(429.11)	(274.55)	(295.22)	(451.55)
$2,500	(160.82)	(394.00)	(293.64)	(467.50)	(299.11)	(321.63)	(491.94)
$5,000	(201.96)	(494.79)	(368.76)	(587.09)	(375.62)	(403.90)	(617.79)
$10,000	(235.93)	(578.01)	(430.78)	(685.83)	(438.80)	(471.83)	(721.69)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(23.53)	(57.66)	(42.97)	(68.40)	(43.76)	(47.06)	(71.99)
$250	(28.20)	(69.09)	(51.49)	(81.98)	(52.45)	(56.40)	(86.26)
$300	(32.91)	(80.63)	(60.10)	(95.67)	(61.22)	(65.82)	(100.68)
$350	(37.56)	(92.02)	(68.58)	(109.18)	(69.85)	(75.12)	(114.89)
$400	(41.62)	(101.97)	(76.00)	(120.99)	(77.42)	(83.24)	(127.32)
$500	(49.73)	(121.83)	(90.80)	(144.56)	(92.49)	(99.45)	(152.12)
$750	(65.24)	(159.83)	(119.12)	(189.65)	(121.34)	(130.47)	(199.56)
$1,000	(77.86)	(190.74)	(142.15)	(226.33)	(144.81)	(155.70)	(238.15)
$1,500	(97.29)	(238.36)	(177.65)	(282.82)	(180.96)	(194.58)	(297.61)
$2,000	(107.64)	(263.72)	(196.55)	(312.91)	(200.20)	(215.28)	(329.28)
$2,500	(118.03)	(289.15)	(215.51)	(343.10)	(219.52)	(236.04)	(361.03)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(43.25)	(105.96)	(78.97)	(125.73)	(80.45)	(86.50)	(132.30)
$350	(57.25)	(140.26)	(104.54)	(166.43)	(106.49)	(114.50)	(175.13)
$500	(73.65)	(180.44)	(134.48)	(214.10)	(136.99)	(147.30)	(225.30)
$750	(95.69)	(234.44)	(174.73)	(278.17)	(177.98)	(191.38)	(292.72)
$1,000	(112.57)	(275.80)	(205.55)	(327.24)	(209.38)	(225.14)	(344.35)
$1,500	(138.44)	(339.18)	(252.79)	(402.45)	(257.50)	(276.88)	(423.49)
$2,500	(154.77)	(379.19)	(282.61)	(449.92)	(287.87)	(309.54)	(473.44)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(57.80)	(141.61)	(105.54)	(168.02)	(107.51)	(115.60)	(176.81)
$250	(68.94)	(168.90)	(125.88)	(200.41)	(128.23)	(137.88)	(210.89)
$300	(80.12)	(196.29)	(146.30)	(232.91)	(149.02)	(160.24)	(245.09)
$350	(91.30)	(223.69)	(166.71)	(265.41)	(169.82)	(182.60)	(279.29)
$400	(100.08)	(245.20)	(182.75)	(290.93)	(186.15)	(200.16)	(306.14)
$500	(117.63)	(288.19)	(214.79)	(341.95)	(218.79)	(235.26)	(359.83)
$750	(152.77)	(374.29)	(278.96)	(444.10)	(284.15)	(305.54)	(467.32)
$1,000	(179.82)	(440.56)	(328.35)	(522.74)	(334.47)	(359.64)	(550.07)
$1,500	(221.20)	(541.94)	(403.91)	(643.03)	(411.43)	(442.40)	(676.65)
$2,000	(238.13)	(583.42)	(434.83)	(692.24)	(442.92)	(476.26)	(728.44)
$2,500	(255.11)	(625.02)	(465.83)	(741.60)	(474.50)	(510.22)	(780.38)
$5,000	(299.90)	(734.76)	(547.62)	(871.81)	(557.81)	(599.80)	(917.39)
$10,000	(336.90)	(825.41)	(615.18)	(979.37)	(626.63)	(673.80)	(1,030.58)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(47.35)	(116.01)	(86.46)	(137.65)	(88.07)	(94.70)	(144.84)
$250	(56.47)	(138.35)	(103.11)	(164.16)	(105.03)	(112.94)	(172.74)
$300	(65.65)	(160.84)	(119.88)	(190.84)	(122.11)	(131.30)	(200.82)
$350	(74.78)	(183.21)	(136.55)	(217.39)	(139.09)	(149.56)	(228.75)
$400	(82.13)	(201.22)	(149.97)	(238.75)	(152.76)	(164.26)	(251.24)
$500	(96.88)	(237.36)	(176.90)	(281.63)	(180.20)	(193.76)	(296.36)
$750	(126.01)	(308.72)	(230.09)	(366.31)	(234.38)	(252.02)	(385.46)
$1,000	(148.68)	(364.27)	(271.49)	(432.21)	(276.54)	(297.36)	(454.81)
$1,500	(183.06)	(448.50)	(334.27)	(532.16)	(340.49)	(366.12)	(559.98)
$2,000	(198.63)	(486.64)	(362.70)	(577.42)	(369.45)	(397.26)	(607.61)
$2,500	(214.23)	(524.86)	(391.18)	(622.77)	(398.47)	(428.46)	(655.33)
$5,000	(258.83)	(634.13)	(472.62)	(752.42)	(481.42)	(517.66)	(791.76)
$10,000	(295.63)	(724.29)	(539.82)	(859.40)	(549.87)	(591.26)	(904.33)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(36.92)	(90.45)	(67.42)	(107.33)	(68.67)	(73.84)	(112.94)
$250	(44.05)	(107.92)	(80.44)	(128.05)	(81.93)	(88.10)	(134.75)
$300	(51.16)	(125.34)	(93.42)	(148.72)	(95.16)	(102.32)	(156.50)
$350	(58.28)	(142.79)	(106.42)	(169.42)	(108.40)	(116.56)	(178.28)
$400	(64.25)	(157.41)	(117.32)	(186.77)	(119.51)	(128.50)	(196.54)
$500	(76.05)	(186.32)	(138.87)	(221.08)	(141.45)	(152.10)	(232.64)
$750	(99.22)	(243.09)	(181.18)	(288.43)	(184.55)	(198.44)	(303.51)
$1,000	(117.49)	(287.85)	(214.54)	(341.54)	(218.53)	(234.98)	(359.40)
$1,500	(144.91)	(355.03)	(264.61)	(421.25)	(269.53)	(289.82)	(443.28)
$2,000	(159.16)	(389.94)	(290.63)	(462.68)	(296.04)	(318.32)	(486.87)
$2,500	(173.39)	(424.81)	(316.61)	(504.04)	(322.51)	(346.78)	(530.40)
$5,000	(217.75)	(533.49)	(397.61)	(633.00)	(405.02)	(435.50)	(666.10)
$10,000	(254.37)	(623.21)	(464.48)	(739.45)	(473.13)	(508.74)	(778.12)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(25.37)	(62.16)	(46.33)	(73.75)	(47.19)	(50.74)	(77.61)
$250	(30.42)	(74.53)	(55.55)	(88.43)	(56.58)	(60.84)	(93.05)
$300	(35.49)	(86.95)	(64.80)	(103.17)	(66.01)	(70.98)	(108.56)
$350	(40.50)	(99.23)	(73.95)	(117.73)	(75.33)	(81.00)	(123.89)
$400	(44.88)	(109.96)	(81.95)	(130.47)	(83.48)	(89.76)	(137.29)
$500	(53.61)	(131.34)	(97.89)	(155.84)	(99.71)	(107.22)	(163.99)
$750	(70.34)	(172.33)	(128.44)	(204.48)	(130.83)	(140.68)	(215.17)
$1,000	(83.96)	(205.70)	(153.31)	(244.07)	(156.17)	(167.92)	(256.83)
$1,500	(104.90)	(257.01)	(191.55)	(304.94)	(195.11)	(209.80)	(320.89)
$2,000	(116.05)	(284.32)	(211.91)	(337.36)	(215.85)	(232.10)	(355.00)
$2,500	(127.26)	(311.79)	(232.38)	(369.94)	(236.70)	(254.52)	(389.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	(3.14)	(7.70)	(5.73)	(9.14)	(5.85)	(6.28)	(9.62)
$350	(4.16)	(10.19)	(7.60)	(12.10)	(7.75)	(8.32)	(12.72)
$500	(5.34)	(13.08)	(9.75)	(15.52)	(9.94)	(10.69)	(16.34)
$750	(6.94)	(17.01)	(12.68)	(20.17)	(12.91)	(13.89)	(21.24)
$1,000	(8.16)	(20.01)	(14.91)	(23.74)	(15.19)	(16.34)	(24.98)
$1,500	(10.04)	(24.62)	(18.35)	(29.21)	(18.69)	(20.10)	(30.73)
$2,500	(11.23)	(27.52)	(20.51)	(32.64)	(20.89)	(22.47)	(34.35)
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	(4.20)	(10.29)	(7.66)	(12.19)	(7.81)	(8.40)	(12.84)
$250	(5.00)	(12.24)	(9.13)	(14.54)	(9.31)	(10.00)	(15.29)
$300	(5.81)	(14.23)	(10.61)	(16.88)	(10.80)	(11.62)	(17.77)
$350	(6.62)	(16.24)	(12.10)	(19.26)	(12.33)	(13.26)	(20.27)
$400	(7.26)	(17.79)	(13.26)	(21.10)	(13.51)	(14.53)	(22.20)
$500	(8.52)	(20.89)	(15.57)	(24.78)	(15.86)	(17.06)	(26.08)
$750	(11.08)	(27.15)	(20.23)	(32.20)	(20.61)	(22.16)	(33.88)
$1,000	(13.04)	(31.95)	(23.82)	(37.91)	(24.27)	(26.09)	(39.90)
$1,500	(16.04)	(39.32)	(29.31)	(46.65)	(29.85)	(32.11)	(49.09)
$2,000	(17.28)	(42.34)	(31.57)	(50.22)	(32.15)	(34.57)	(52.85)
$2,500	(18.51)	(45.35)	(33.80)	(53.79)	(34.43)	(37.03)	(56.62)
$5,000	(21.75)	(53.29)	(39.73)	(63.22)	(40.46)	(43.51)	(66.53)
$10,000	(24.43)	(59.88)	(44.64)	(71.04)	(45.47)	(48.89)	(74.76)
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	(3.43)	(8.41)	(6.27)	(9.97)	(6.38)	(6.86)	(10.49)
$250	(4.09)	(10.02)	(7.47)	(11.90)	(7.60)	(8.18)	(12.51)
$300	(4.76)	(11.66)	(8.70)	(13.82)	(8.86)	(9.51)	(14.55)
$350	(5.42)	(13.27)	(9.90)	(15.75)	(10.08)	(10.84)	(16.56)
$400	(5.95)	(14.57)	(10.87)	(17.29)	(11.07)	(11.90)	(18.20)
$500	(7.03)	(17.24)	(12.84)	(20.45)	(13.09)	(14.08)	(21.53)
$750	(9.14)	(22.40)	(16.70)	(26.58)	(17.01)	(18.30)	(27.97)
$1,000	(10.78)	(26.41)	(19.69)	(31.33)	(20.05)	(21.57)	(32.98)
$1,500	(13.28)	(32.55)	(24.27)	(38.61)	(24.71)	(26.57)	(40.64)
$2,000	(14.40)	(35.27)	(26.30)	(41.85)	(26.79)	(28.80)	(44.04)
$2,500	(15.54)	(38.08)	(28.38)	(45.19)	(28.92)	(31.10)	(47.55)
$5,000	(18.78)	(46.02)	(34.31)	(54.60)	(34.94)	(37.58)	(57.45)
$10,000	(21.44)	(52.55)	(39.18)	(62.35)	(39.91)	(42.91)	(65.61)
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	(2.68)	(6.57)	(4.91)	(7.80)	(4.99)	(5.36)	(8.21)
$250	(3.20)	(7.84)	(5.85)	(9.30)	(5.95)	(6.40)	(9.79)
$300	(3.71)	(9.09)	(6.78)	(10.79)	(6.90)	(7.42)	(11.35)
$350	(4.24)	(10.39)	(7.75)	(12.32)	(7.89)	(8.48)	(12.97)
$400	(4.66)	(11.42)	(8.52)	(13.55)	(8.68)	(9.33)	(14.27)
$500	(5.52)	(13.51)	(10.08)	(16.04)	(10.26)	(11.04)	(16.88)
$750	(7.20)	(17.65)	(13.17)	(20.94)	(13.40)	(14.41)	(22.03)
$1,000	(8.52)	(20.88)	(15.57)	(24.77)	(15.85)	(17.05)	(26.07)
$1,500	(10.50)	(25.73)	(19.18)	(30.51)	(19.53)	(21.00)	(32.11)
$2,000	(11.54)	(28.29)	(21.09)	(33.57)	(21.49)	(23.10)	(35.32)
$2,500	(12.57)	(30.81)	(22.97)	(36.54)	(23.40)	(25.15)	(38.46)
$5,000	(15.79)	(38.70)	(28.85)	(45.91)	(29.40)	(31.60)	(48.31)
$10,000	(18.44)	(45.20)	(33.70)	(53.62)	(34.33)	(36.91)	(56.43)
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	(1.84)	(4.50)	(3.36)	(5.35)	(3.43)	(3.68)	(5.62)
$250	(2.22)	(5.44)	(4.06)	(6.45)	(4.13)	(4.44)	(6.79)
$300	(2.58)	(6.32)	(4.70)	(7.50)	(4.79)	(5.16)	(7.88)
$350	(2.94)	(7.21)	(5.37)	(8.55)	(5.48)	(5.88)	(9.00)
$400	(3.26)	(7.99)	(5.95)	(9.48)	(6.06)	(6.52)	(9.97)
$500	(3.88)	(9.51)	(7.09)	(11.28)	(7.22)	(7.77)	(11.87)
$750	(5.10)	(12.50)	(9.32)	(14.83)	(9.49)	(10.21)	(15.61)
$1,000	(6.10)	(14.96)	(11.16)	(17.74)	(11.36)	(12.22)	(18.68)
$1,500	(7.61)	(18.65)	(13.90)	(22.12)	(14.15)	(15.22)	(23.28)
$2,000	(8.41)	(20.60)	(15.36)	(24.45)	(15.65)	(16.82)	(25.72)
$2,500	(9.23)	(22.64)	(16.87)	(26.84)	(17.18)	(18.48)	(28.26)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

LARGE GROUP

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible	**Deductible Credits - 100% Hospital / 80% Medical Coinsurance**						
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible	**Deductible Credits - 80% Coinsurance**						
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible	**Deductible Credits - 75% Coinsurance**						
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible	**Deductible Credits - 70% Coinsurance**						
$200	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible	**Deductible Credits - 50% Coinsurance**						
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(158.60)	(388.58)	(289.60)	(461.05)	(294.99)	(317.20)	(485.16)
$10,000	(192.09)	(470.61)	(350.75)	(558.40)	(357.27)	(384.16)	(587.59)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(31.18)	(76.38)	(56.92)	(90.63)	(57.99)	(62.36)	(95.37)
$1,500	(34.00)	(83.30)	(62.07)	(98.83)	(63.23)	(68.00)	(104.00)
$2,000	(35.49)	(86.95)	(64.81)	(103.17)	(66.01)	(70.98)	(108.56)
$3,000	(36.78)	(90.10)	(67.15)	(106.90)	(68.40)	(73.55)	(112.50)
$4,000	(37.36)	(91.53)	(68.21)	(108.60)	(69.49)	(74.72)	(114.29)
$5,000	(37.66)	(92.28)	(68.77)	(109.49)	(70.05)	(75.33)	(115.22)
$7,000	(38.01)	(93.11)	(69.41)	(110.48)	(70.69)	(76.02)	(116.27)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(49.62)	(121.58)	(90.61)	(144.25)	(92.29)	(99.25)	(151.79)
$1,500	(54.14)	(132.63)	(98.85)	(157.37)	(100.69)	(108.27)	(165.60)
$2,000	(56.45)	(138.31)	(103.08)	(164.11)	(105.00)	(112.91)	(172.69)
$3,000	(58.61)	(143.58)	(107.01)	(170.36)	(109.00)	(117.21)	(179.27)
$4,000	(59.51)	(145.81)	(108.67)	(173.01)	(110.69)	(119.03)	(182.05)
$5,000	(59.98)	(146.96)	(109.52)	(174.38)	(111.57)	(119.97)	(183.49)
$7,000	(60.56)	(148.37)	(110.58)	(176.05)	(112.64)	(121.12)	(185.25)
$7,500	(61.05)	(149.57)	(111.48)	(177.47)	(113.54)	(122.10)	(186.75)
$10,000	(62.84)	(153.95)	(114.74)	(182.66)	(116.87)	(125.67)	(192.21)
$20,000	(65.38)	(160.19)	(119.38)	(190.07)	(121.61)	(130.76)	(200.01)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(47.95)	(117.48)	(87.56)	(139.40)	(89.19)	(95.90)	(146.69)
$1,500	(53.30)	(130.58)	(97.32)	(154.94)	(99.13)	(106.60)	(163.04)
$2,000	(56.27)	(137.85)	(102.73)	(163.56)	(104.65)	(112.53)	(172.12)
$3,000	(59.18)	(144.98)	(108.06)	(172.04)	(110.07)	(118.36)	(181.03)
$4,000	(60.51)	(148.24)	(110.48)	(175.89)	(112.54)	(121.01)	(185.09)
$5,000	(61.24)	(150.03)	(111.81)	(178.02)	(113.90)	(122.48)	(187.33)
$7,000	(61.95)	(151.77)	(113.12)	(180.08)	(115.22)	(123.90)	(189.50)
$7,500	(62.48)	(153.08)	(114.09)	(181.63)	(116.21)	(124.96)	(191.13)
$10,000	(64.67)	(158.45)	(118.09)	(188.01)	(120.29)	(129.34)	(197.83)
$20,000	(68.06)	(166.74)	(124.27)	(197.84)	(126.58)	(136.11)	(208.18)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(46.29)	(113.41)	(84.53)	(134.57)	(86.10)	(92.58)	(141.60)
$1,500	(52.50)	(128.61)	(95.85)	(152.60)	(97.64)	(104.99)	(160.58)
$2,000	(56.07)	(137.36)	(102.38)	(162.99)	(104.28)	(112.13)	(171.50)
$3,000	(59.78)	(146.45)	(109.15)	(173.77)	(111.17)	(119.55)	(182.85)
$4,000	(61.47)	(150.59)	(112.24)	(178.69)	(114.33)	(122.93)	(188.03)
$5,000	(62.46)	(153.03)	(114.05)	(181.57)	(116.17)	(124.92)	(191.07)
$7,000	(63.34)	(155.18)	(115.64)	(184.12)	(117.81)	(126.67)	(193.74)
$7,500	(63.90)	(156.56)	(116.68)	(185.76)	(118.85)	(127.79)	(195.47)
$10,000	(66.32)	(162.49)	(121.11)	(192.80)	(123.36)	(132.64)	(202.88)
$20,000	(70.63)	(173.04)	(128.96)	(205.31)	(131.36)	(141.24)	(216.05)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(52.38)	(128.33)	(95.64)	(152.26)	(97.43)	(104.76)	(160.23)
$1,500	(62.42)	(152.92)	(113.97)	(181.45)	(116.09)	(124.84)	(190.93)
$2,000	(68.89)	(168.79)	(125.80)	(200.27)	(128.14)	(137.78)	(210.74)
$3,000	(76.73)	(187.97)	(140.10)	(223.05)	(142.71)	(153.44)	(234.70)
$4,000	(81.03)	(198.52)	(147.96)	(235.55)	(150.71)	(162.05)	(247.86)
$5,000	(83.68)	(205.02)	(152.80)	(243.27)	(155.65)	(167.36)	(255.98)
$7,000	(86.42)	(211.73)	(157.80)	(251.22)	(160.73)	(172.83)	(264.36)
$7,500	(87.43)	(214.21)	(159.65)	(254.16)	(162.61)	(174.86)	(267.46)
$10,000	(91.50)	(224.17)	(167.06)	(265.98)	(170.18)	(182.98)	(279.88)
$20,000	(100.06)	(245.15)	(182.70)	(290.88)	(186.10)	(200.11)	(306.08)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.39	0.95	0.71	1.13	0.72	0.77	1.18
$1,000,000	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
$50,000	(5.14)	(12.59)	(9.38)	(14.94)	(9.56)	(10.28)	(15.72)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(171.00)	(418.95)	(312.25)	(497.10)	(318.06)	(342.00)	(523.09)
$10,000	(207.11)	(507.42)	(378.18)	(602.07)	(385.22)	(414.22)	(633.55)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(33.62)	(82.37)	(61.39)	(97.73)	(62.53)	(67.24)	(102.84)
$1,500	(36.66)	(89.82)	(66.94)	(106.57)	(68.19)	(73.32)	(112.14)
$2,000	(38.26)	(93.74)	(69.86)	(111.22)	(71.16)	(76.52)	(117.04)
$3,000	(39.66)	(97.17)	(72.42)	(115.29)	(73.77)	(79.32)	(121.32)
$4,000	(40.28)	(98.69)	(73.55)	(117.09)	(74.92)	(80.56)	(123.22)
$5,000	(40.61)	(99.49)	(74.15)	(118.05)	(75.53)	(81.22)	(124.23)
$7,000	(40.98)	(100.40)	(74.83)	(119.13)	(76.22)	(81.96)	(125.36)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(53.50)	(131.08)	(97.69)	(155.52)	(99.51)	(107.00)	(163.66)
$1,500	(58.38)	(143.03)	(106.60)	(169.71)	(108.59)	(116.76)	(178.58)
$2,000	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$3,000	(63.19)	(154.82)	(115.38)	(183.69)	(117.53)	(126.38)	(193.30)
$4,000	(64.16)	(157.19)	(117.16)	(186.51)	(119.34)	(128.32)	(196.27)
$5,000	(64.67)	(158.44)	(118.09)	(188.00)	(120.29)	(129.34)	(197.83)
$7,000	(65.29)	(159.96)	(119.22)	(189.80)	(121.44)	(130.58)	(199.72)
$7,500	(65.82)	(161.26)	(120.19)	(191.34)	(122.43)	(131.64)	(201.34)
$10,000	(67.75)	(165.99)	(123.71)	(196.95)	(126.02)	(135.50)	(207.25)
$20,000	(70.49)	(172.70)	(128.71)	(204.91)	(131.11)	(140.98)	(215.63)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(51.70)	(126.67)	(94.40)	(150.29)	(96.16)	(103.40)	(158.15)
$1,500	(57.46)	(140.78)	(104.92)	(167.04)	(106.88)	(114.92)	(175.77)
$2,000	(60.67)	(148.64)	(110.78)	(176.37)	(112.85)	(121.34)	(185.59)
$3,000	(63.81)	(156.33)	(116.52)	(185.50)	(118.69)	(127.62)	(195.19)
$4,000	(65.24)	(159.84)	(119.13)	(189.65)	(121.35)	(130.48)	(199.57)
$5,000	(66.03)	(161.77)	(120.57)	(191.95)	(122.82)	(132.06)	(201.99)
$7,000	(66.80)	(163.66)	(121.98)	(194.19)	(124.25)	(133.60)	(204.34)
$7,500	(67.37)	(165.06)	(123.02)	(195.84)	(125.31)	(134.74)	(206.08)
$10,000	(69.73)	(170.84)	(127.33)	(202.71)	(129.70)	(139.46)	(213.30)
$20,000	(73.38)	(179.78)	(133.99)	(213.32)	(136.49)	(146.76)	(224.47)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(49.91)	(122.28)	(91.14)	(145.09)	(92.83)	(99.82)	(152.67)
$1,500	(56.62)	(138.72)	(103.39)	(164.59)	(105.31)	(113.24)	(173.20)
$2,000	(60.47)	(148.15)	(110.42)	(175.79)	(112.47)	(120.94)	(184.98)
$3,000	(64.46)	(157.93)	(117.70)	(187.39)	(119.90)	(128.92)	(197.18)
$4,000	(66.28)	(162.39)	(121.03)	(192.68)	(123.28)	(132.56)	(202.75)
$5,000	(67.35)	(165.01)	(122.98)	(195.79)	(125.27)	(134.70)	(206.02)
$7,000	(68.29)	(167.31)	(124.70)	(198.52)	(127.02)	(136.58)	(208.90)
$7,500	(68.89)	(168.78)	(125.79)	(200.26)	(128.14)	(137.78)	(210.73)
$10,000	(71.50)	(175.18)	(130.56)	(207.85)	(132.99)	(143.00)	(218.72)
$20,000	(76.15)	(186.57)	(139.05)	(221.37)	(141.64)	(152.30)	(232.94)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(56.47)	(138.35)	(103.11)	(164.16)	(105.03)	(112.94)	(172.74)
$1,500	(67.30)	(164.89)	(122.89)	(195.64)	(125.18)	(134.60)	(205.87)
$2,000	(74.27)	(181.96)	(135.62)	(215.90)	(138.14)	(148.54)	(227.19)
$3,000	(82.73)	(202.69)	(151.06)	(240.50)	(153.88)	(165.46)	(253.07)
$4,000	(87.37)	(214.06)	(159.54)	(253.98)	(162.51)	(174.74)	(267.26)
$5,000	(90.22)	(221.04)	(164.74)	(262.27)	(167.81)	(180.44)	(275.98)
$7,000	(93.17)	(228.27)	(170.13)	(270.85)	(173.30)	(186.34)	(285.01)
$7,500	(94.26)	(230.94)	(172.12)	(274.01)	(175.32)	(188.52)	(288.34)
$10,000	(98.66)	(241.72)	(180.15)	(286.80)	(183.51)	(197.32)	(301.80)
$20,000	(107.88)	(264.31)	(196.99)	(313.61)	(200.66)	(215.76)	(330.00)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.43	1.05	0.79	1.25	0.80	0.86	1.32
$1,000,000	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$50,000	(5.54)	(13.57)	(10.12)	(16.10)	(10.30)	(11.08)	(16.95)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	(12.40)	(30.37)	(22.65)	(36.05)	(23.07)	(24.80)	(37.93)
$10,000	(15.02)	(36.81)	(27.43)	(43.67)	(27.95)	(30.06)	(45.96)

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	(2.44)	(5.99)	(4.47)	(7.10)	(4.54)	(4.88)	(7.47)
$1,500	(2.66)	(6.52)	(4.87)	(7.74)	(4.96)	(5.32)	(8.14)
$2,000	(2.77)	(6.79)	(5.05)	(8.05)	(5.15)	(5.54)	(8.48)
$3,000	(2.88)	(7.07)	(5.27)	(8.39)	(5.37)	(5.77)	(8.82)
$4,000	(2.92)	(7.16)	(5.34)	(8.49)	(5.43)	(5.84)	(8.93)
$5,000	(2.95)	(7.21)	(5.38)	(8.56)	(5.48)	(5.89)	(9.01)
$7,000	(2.97)	(7.29)	(5.42)	(8.65)	(5.53)	(5.94)	(9.09)
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	(3.88)	(9.50)	(7.08)	(11.27)	(7.22)	(7.75)	(11.87)
$1,500	(4.24)	(10.40)	(7.75)	(12.34)	(7.90)	(8.49)	(12.98)
$2,000	(4.40)	(10.77)	(8.03)	(12.78)	(8.18)	(8.79)	(13.45)
$3,000	(4.58)	(11.24)	(8.37)	(13.33)	(8.53)	(9.17)	(14.03)
$4,000	(4.65)	(11.38)	(8.49)	(13.50)	(8.65)	(9.29)	(14.22)
$5,000	(4.69)	(11.48)	(8.57)	(13.62)	(8.72)	(9.37)	(14.34)
$7,000	(4.73)	(11.59)	(8.64)	(13.75)	(8.80)	(9.46)	(14.47)
$7,500	(4.77)	(11.69)	(8.71)	(13.87)	(8.89)	(9.54)	(14.59)
$10,000	(4.91)	(12.04)	(8.97)	(14.29)	(9.15)	(9.83)	(15.04)
$20,000	(5.11)	(12.51)	(9.33)	(14.84)	(9.50)	(10.22)	(15.62)
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	(3.75)	(9.19)	(6.84)	(10.89)	(6.97)	(7.50)	(11.46)
$1,500	(4.16)	(10.20)	(7.60)	(12.10)	(7.75)	(8.32)	(12.73)
$2,000	(4.40)	(10.79)	(8.05)	(12.81)	(8.20)	(8.81)	(13.47)
$3,000	(4.63)	(11.35)	(8.46)	(13.46)	(8.62)	(9.26)	(14.16)
$4,000	(4.73)	(11.60)	(8.65)	(13.76)	(8.81)	(9.47)	(14.48)
$5,000	(4.79)	(11.74)	(8.76)	(13.93)	(8.92)	(9.58)	(14.66)
$7,000	(4.85)	(11.89)	(8.86)	(14.11)	(9.03)	(9.70)	(14.84)
$7,500	(4.89)	(11.98)	(8.93)	(14.21)	(9.10)	(9.78)	(14.95)
$10,000	(5.06)	(12.39)	(9.24)	(14.70)	(9.41)	(10.12)	(15.47)
$20,000	(5.32)	(13.04)	(9.72)	(15.48)	(9.91)	(10.65)	(16.29)
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	(3.62)	(8.87)	(6.61)	(10.52)	(6.73)	(7.24)	(11.07)
$1,500	(4.12)	(10.11)	(7.54)	(11.99)	(7.67)	(8.25)	(12.62)
$2,000	(4.40)	(10.79)	(8.04)	(12.80)	(8.19)	(8.81)	(13.48)
$3,000	(4.68)	(11.48)	(8.55)	(13.62)	(8.73)	(9.37)	(14.33)
$4,000	(4.81)	(11.80)	(8.79)	(13.99)	(8.95)	(9.63)	(14.72)
$5,000	(4.89)	(11.98)	(8.93)	(14.22)	(9.10)	(9.78)	(14.95)
$7,000	(4.95)	(12.13)	(9.06)	(14.40)	(9.21)	(9.91)	(15.16)
$7,500	(4.99)	(12.22)	(9.11)	(14.50)	(9.29)	(9.99)	(15.26)
$10,000	(5.18)	(12.69)	(9.45)	(15.05)	(9.63)	(10.36)	(15.84)
$20,000	(5.52)	(13.53)	(10.09)	(16.06)	(10.28)	(11.06)	(16.89)
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	(4.09)	(10.02)	(7.47)	(11.90)	(7.60)	(8.18)	(12.51)
$1,500	(4.88)	(11.97)	(8.92)	(14.19)	(9.09)	(9.76)	(14.94)
$2,000	(5.38)	(13.17)	(9.82)	(15.63)	(10.00)	(10.76)	(16.45)
$3,000	(6.00)	(14.72)	(10.96)	(17.45)	(11.17)	(12.02)	(18.37)
$4,000	(6.34)	(15.54)	(11.58)	(18.43)	(11.80)	(12.69)	(19.40)
$5,000	(6.54)	(16.02)	(11.94)	(19.00)	(12.16)	(13.08)	(20.00)
$7,000	(6.75)	(16.54)	(12.33)	(19.63)	(12.57)	(13.51)	(20.65)
$7,500	(6.83)	(16.73)	(12.47)	(19.85)	(12.71)	(13.66)	(20.88)
$10,000	(7.16)	(17.55)	(13.09)	(20.82)	(13.33)	(14.34)	(21.92)
$20,000	(7.82)	(19.16)	(14.29)	(22.73)	(14.56)	(15.65)	(23.92)
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	0.04	0.10	0.08	0.12	0.08	0.09	0.14
$1,000,000	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
$50,000	(0.40)	(0.98)	(0.74)	(1.16)	(0.74)	(0.80)	(1.23)
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

LARGE GROUP

Maximum	Coinsurance Maximum Credits - 100% Hospital / 80% Medical Coinsurance						
$1,000	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum	**Coinsurance Maximum Credits - 80% Coinsurance**						
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum	**Coinsurance Maximum Credits - 75% Coinsurance**						
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum	**Coinsurance Maximum Credits - 70% Coinsurance**						
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
$2,000	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
$3,000	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum	**Coinsurance Maximum Credits - 50% Coinsurance**						
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum	**Annual Benefit Maximum [$5,000,000 standard]**						
Unlimited	10.3%	10.5%	11.3%	10.6%	11.1%	11.7%	11.9%
$1,000,000	12.5%	11.4%	10.0%	11.7%	9.8%	10.8%	11.1%
$50,000	7.8%	7.8%	7.9%	7.8%	7.7%	7.8%	7.8%
OON Coins	**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**						

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.39)	(0.95)	(0.71)	(1.13)	(0.72)	(0.77)	(1.18)
75%	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
70%	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
80%	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
75%	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
70%	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
80%	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.14)
75%	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
70%	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
80%	10.3%	10.5%	11.3%	10.6%	11.1%	11.7%	11.9%
75%	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
70%	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.16)	(5.30)	(3.95)	(6.29)	(4.02)	(4.32)	(6.61)
$10	(4.53)	(11.10)	(8.27)	(13.18)	(8.43)	(9.07)	(13.87)
$15	(7.54)	(18.48)	(13.77)	(21.92)	(14.03)	(15.08)	(23.07)
$20	(11.64)	(28.50)	(21.24)	(33.82)	(21.64)	(23.27)	(35.60)
$25	(15.32)	(37.54)	(27.98)	(44.55)	(28.50)	(30.64)	(46.87)
$30	(19.38)	(47.47)	(35.38)	(56.32)	(36.03)	(38.75)	(59.26)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.22)	(3.00)	(2.24)	(3.55)	(2.28)	(2.44)	(3.74)
$10	(2.60)	(6.37)	(4.75)	(7.56)	(4.84)	(5.20)	(7.96)
$15	(4.32)	(10.59)	(7.90)	(12.57)	(8.04)	(8.65)	(13.22)
$20	(6.66)	(16.33)	(12.17)	(19.38)	(12.40)	(13.33)	(20.39)
$25	(8.77)	(21.50)	(16.02)	(25.51)	(16.31)	(17.55)	(26.84)
$30	(11.09)	(27.18)	(20.25)	(32.24)	(20.63)	(22.18)	(33.93)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.58)	(3.86)	(2.88)	(4.59)	(2.93)	(3.15)	(4.83)
$10	(3.26)	(7.98)	(5.95)	(9.47)	(6.06)	(6.52)	(9.96)
$15	(5.11)	(12.51)	(9.33)	(14.85)	(9.50)	(10.21)	(15.63)
$20	(7.20)	(17.63)	(13.14)	(20.92)	(13.38)	(14.39)	(22.02)
$25	(9.49)	(23.26)	(17.34)	(27.60)	(17.66)	(18.99)	(29.05)
$30	(12.11)	(29.65)	(22.10)	(35.19)	(22.52)	(24.21)	(37.03)
$35	(14.54)	(35.62)	(26.55)	(42.27)	(27.04)	(29.08)	(44.47)
$40	(17.07)	(41.81)	(31.17)	(49.61)	(31.74)	(34.13)	(52.20)
$45	(19.74)	(48.36)	(36.04)	(57.38)	(36.71)	(39.48)	(60.38)
$50	(22.53)	(55.20)	(41.14)	(65.49)	(41.90)	(45.06)	(68.91)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.34)	(3.28)	(2.44)	(3.89)	(2.49)	(2.67)	(4.09)
$10	(2.76)	(6.76)	(5.03)	(8.01)	(5.13)	(5.51)	(8.44)
$15	(4.32)	(10.59)	(7.90)	(12.57)	(8.04)	(8.65)	(13.22)
$20	(6.08)	(14.89)	(11.10)	(17.67)	(11.30)	(12.16)	(18.59)
$25	(8.03)	(19.68)	(14.66)	(23.34)	(14.94)	(16.06)	(24.57)
$30	(10.24)	(25.08)	(18.69)	(29.76)	(19.04)	(20.47)	(31.31)
$35	(12.31)	(30.16)	(22.49)	(35.79)	(22.91)	(24.63)	(37.67)
$40	(14.45)	(35.39)	(26.37)	(41.99)	(26.86)	(28.89)	(44.19)
$45	(16.69)	(40.89)	(30.48)	(48.52)	(31.04)	(33.38)	(51.05)
$50	(19.06)	(46.70)	(34.80)	(55.41)	(35.45)	(38.12)	(58.31)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.78)	(1.92)	(1.43)	(2.28)	(1.45)	(1.57)	(2.39)
$150	(1.28)	(3.14)	(2.35)	(3.74)	(2.39)	(2.57)	(3.93)
$200	(1.84)	(4.50)	(3.35)	(5.35)	(3.42)	(3.68)	(5.62)
$250	(2.64)	(6.48)	(4.83)	(7.68)	(4.92)	(5.29)	(8.08)
$500	(6.36)	(15.58)	(11.61)	(18.49)	(11.83)	(12.72)	(19.46)
$750	(10.90)	(26.72)	(19.91)	(31.70)	(20.28)	(21.81)	(33.36)
$1,000	(16.41)	(40.20)	(29.97)	(47.70)	(30.52)	(32.82)	(50.20)
Copay/Day							
$50 w/3 Day Max	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.93)
$50 w/5 Day Max	(1.31)	(3.20)	(2.38)	(3.79)	(2.42)	(2.61)	(3.99)
$100 w/3 Day Max	(2.38)	(5.84)	(4.35)	(6.92)	(4.43)	(4.76)	(7.28)
$100 w/5 Day Max	(3.44)	(8.42)	(6.28)	(9.99)	(6.39)	(6.87)	(10.51)
$250 w/3 Day Max	(7.92)	(19.40)	(14.46)	(23.01)	(14.73)	(15.83)	(24.22)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.43)	(1.04)	(0.78)	(1.24)	(0.79)	(0.86)	(1.31)
$75	(0.67)	(1.64)	(1.22)	(1.94)	(1.24)	(1.34)	(2.05)
$100	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.93)
$125	(1.24)	(3.05)	(2.27)	(3.61)	(2.31)	(2.49)	(3.80)
$150	(1.57)	(3.83)	(2.86)	(4.55)	(2.91)	(3.13)	(4.79)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.41)	(0.30)	(0.49)	(0.31)	(0.33)	(0.51)
$25	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
$35	(0.53)	(1.31)	(0.97)	(1.55)	(0.99)	(1.07)	(1.63)
$50	(0.91)	(2.22)	(1.66)	(2.64)	(1.69)	(1.82)	(2.78)
$60	(1.14)	(2.79)	(2.08)	(3.31)	(2.12)	(2.28)	(3.48)
$75	(1.51)	(3.71)	(2.77)	(4.41)	(2.82)	(3.03)	(4.64)
$100	(2.15)	(5.27)	(3.93)	(6.26)	(4.00)	(4.30)	(6.58)
$125	(2.64)	(6.48)	(4.83)	(7.68)	(4.92)	(5.29)	(8.08)
$150	(3.16)	(7.75)	(5.78)	(9.20)	(5.89)	(6.33)	(9.68)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.43	1.04	0.78	1.24	0.79	0.86	1.31
60	0.84	2.05	1.52	2.43	1.56	1.67	2.56
90	1.23	3.02	2.25	3.58	2.29	2.46	3.77
120	1.45	3.56	2.65	4.22	2.71	2.90	4.44
Unlimited	1.87	4.59	3.42	5.43	3.48	3.74	5.72
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.32)	(5.68)	(4.24)	(6.74)	(4.32)	(4.64)	(7.10)
$10	(4.89)	(11.98)	(8.93)	(14.22)	(9.10)	(9.78)	(14.96)
$15	(8.13)	(19.92)	(14.85)	(23.63)	(15.12)	(16.26)	(24.87)
$20	(12.55)	(30.75)	(22.92)	(36.48)	(23.34)	(25.10)	(38.39)
$25	(16.52)	(40.47)	(30.17)	(48.02)	(30.73)	(33.04)	(50.53)
$30	(20.90)	(51.21)	(38.16)	(60.76)	(38.87)	(41.80)	(63.93)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$10	(2.80)	(6.86)	(5.11)	(8.14)	(5.21)	(5.60)	(8.57)
$15	(4.66)	(11.42)	(8.51)	(13.55)	(8.67)	(9.32)	(14.25)
$20	(7.18)	(17.59)	(13.11)	(20.87)	(13.35)	(14.36)	(21.96)
$25	(9.46)	(23.18)	(17.27)	(27.50)	(17.60)	(18.92)	(28.94)
$30	(11.95)	(29.28)	(21.82)	(34.74)	(22.23)	(23.90)	(36.56)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$10	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$15	(5.51)	(13.50)	(10.06)	(16.02)	(10.25)	(11.02)	(16.86)
$20	(7.76)	(19.01)	(14.17)	(22.56)	(14.43)	(15.52)	(23.74)
$25	(10.23)	(25.06)	(18.68)	(29.74)	(19.03)	(20.46)	(31.29)
$30	(13.05)	(31.97)	(23.83)	(37.94)	(24.27)	(26.10)	(39.92)
$35	(15.68)	(38.42)	(28.63)	(45.58)	(29.16)	(31.36)	(47.97)
$40	(18.40)	(45.08)	(33.60)	(53.49)	(34.22)	(36.80)	(56.29)
$45	(21.29)	(52.16)	(38.88)	(61.89)	(39.60)	(42.58)	(65.13)
$50	(24.29)	(59.51)	(44.35)	(70.61)	(45.18)	(48.58)	(74.30)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$10	(2.97)	(7.28)	(5.42)	(8.63)	(5.52)	(5.94)	(9.09)
$15	(4.66)	(11.42)	(8.51)	(13.55)	(8.67)	(9.32)	(14.25)
$20	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$25	(8.66)	(21.22)	(15.81)	(25.17)	(16.11)	(17.32)	(26.49)
$30	(11.04)	(27.05)	(20.16)	(32.09)	(20.53)	(22.08)	(33.77)
$35	(13.27)	(32.51)	(24.23)	(38.58)	(24.68)	(26.54)	(40.59)
$40	(15.58)	(38.17)	(28.45)	(45.29)	(28.98)	(31.16)	(47.66)
$45	(18.00)	(44.10)	(32.87)	(52.33)	(33.48)	(36.00)	(55.06)
$50	(20.55)	(50.35)	(37.52)	(59.74)	(38.22)	(41.10)	(62.86)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$150	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$200	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$250	(2.84)	(6.96)	(5.19)	(8.26)	(5.28)	(5.68)	(8.69)
$500	(6.86)	(16.81)	(12.53)	(19.94)	(12.76)	(13.72)	(20.98)
$750	(11.76)	(28.81)	(21.47)	(34.19)	(21.87)	(23.52)	(35.97)
$1,000	(17.69)	(43.34)	(32.30)	(51.42)	(32.90)	(35.38)	(54.11)
Copay/Day							
$50 w/3 Day Max	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$50 w/5 Day Max	(1.42)	(3.48)	(2.59)	(4.13)	(2.64)	(2.84)	(4.34)
$100 w/3 Day Max	(2.58)	(6.32)	(4.71)	(7.50)	(4.80)	(5.16)	(7.89)
$100 w/5 Day Max	(3.72)	(9.11)	(6.79)	(10.81)	(6.92)	(7.44)	(11.38)
$250 w/3 Day Max	(8.54)	(20.92)	(15.59)	(24.83)	(15.88)	(17.08)	(26.12)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$100	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$125	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
$150	(1.69)	(4.14)	(3.09)	(4.91)	(3.14)	(3.38)	(5.17)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$35	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$50	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$60	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$75	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
$100	(2.31)	(5.66)	(4.22)	(6.72)	(4.30)	(4.62)	(7.07)
$125	(2.84)	(6.96)	(5.19)	(8.26)	(5.28)	(5.68)	(8.69)
$150	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.47	1.15	0.86	1.37	0.87	0.94	1.44
60	0.92	2.25	1.68	2.67	1.71	1.84	2.81
90	1.31	3.21	2.39	3.81	2.44	2.62	4.01
120	1.57	3.85	2.87	4.56	2.92	3.14	4.80
Unlimited	2.03	4.97	3.71	5.90	3.78	4.06	6.21
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.38)	(0.29)	(0.45)	(0.30)	(0.32)	(0.49)
$10	(0.36)	(0.88)	(0.66)	(1.04)	(0.67)	(0.71)	(1.09)
$15	(0.59)	(1.44)	(1.08)	(1.71)	(1.09)	(1.18)	(1.80)
$20	(0.91)	(2.25)	(1.68)	(2.66)	(1.70)	(1.83)	(2.79)
$25	(1.20)	(2.93)	(2.19)	(3.47)	(2.23)	(2.40)	(3.66)
$30	(1.52)	(3.74)	(2.78)	(4.44)	(2.84)	(3.05)	(4.67)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.19)	(0.13)	(0.23)	(0.14)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.36)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.34)	(0.83)	(0.61)	(0.98)	(0.63)	(0.67)	(1.03)
$20	(0.52)	(1.26)	(0.94)	(1.49)	(0.95)	(1.03)	(1.57)
$25	(0.69)	(1.68)	(1.25)	(1.99)	(1.29)	(1.37)	(2.10)
$30	(0.86)	(2.10)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.31)	(0.22)	(0.35)	(0.23)	(0.25)	(0.37)
$10	(0.25)	(0.62)	(0.46)	(0.73)	(0.47)	(0.50)	(0.78)
$15	(0.40)	(0.99)	(0.73)	(1.17)	(0.75)	(0.81)	(1.23)
$20	(0.56)	(1.38)	(1.03)	(1.64)	(1.05)	(1.13)	(1.72)
$25	(0.74)	(1.80)	(1.34)	(2.14)	(1.37)	(1.47)	(2.24)
$30	(0.94)	(2.32)	(1.73)	(2.75)	(1.75)	(1.89)	(2.89)
$35	(1.14)	(2.80)	(2.08)	(3.31)	(2.12)	(2.28)	(3.50)
$40	(1.33)	(3.27)	(2.43)	(3.88)	(2.48)	(2.67)	(4.09)
$45	(1.55)	(3.80)	(2.84)	(4.51)	(2.89)	(3.10)	(4.75)
$50	(1.76)	(4.31)	(3.21)	(5.12)	(3.28)	(3.52)	(5.39)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.30)	(0.23)	(0.35)	(0.23)	(0.25)	(0.38)
$10	(0.21)	(0.52)	(0.39)	(0.62)	(0.39)	(0.43)	(0.65)
$15	(0.34)	(0.83)	(0.61)	(0.98)	(0.63)	(0.67)	(1.03)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.48)
$25	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.92)
$30	(0.80)	(1.97)	(1.47)	(2.33)	(1.49)	(1.61)	(2.46)
$35	(0.96)	(2.35)	(1.74)	(2.79)	(1.77)	(1.91)	(2.92)
$40	(1.13)	(2.78)	(2.08)	(3.30)	(2.12)	(2.27)	(3.47)
$45	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.01)
$50	(1.49)	(3.65)	(2.72)	(4.33)	(2.77)	(2.98)	(4.55)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.07)	(0.16)	(0.12)	(0.19)	(0.13)	(0.13)	(0.21)
$150	(0.10)	(0.24)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$200	(0.15)	(0.38)	(0.28)	(0.43)	(0.28)	(0.30)	(0.47)
$250	(0.20)	(0.48)	(0.36)	(0.58)	(0.36)	(0.39)	(0.61)
$500	(0.50)	(1.23)	(0.92)	(1.45)	(0.93)	(1.00)	(1.52)
$750	(0.86)	(2.09)	(1.56)	(2.49)	(1.59)	(1.71)	(2.61)
$1,000	(1.28)	(3.14)	(2.33)	(3.72)	(2.38)	(2.56)	(3.91)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.25)
$50 w/5 Day Max	(0.11)	(0.28)	(0.21)	(0.34)	(0.22)	(0.23)	(0.35)
$100 w/3 Day Max	(0.20)	(0.48)	(0.36)	(0.58)	(0.37)	(0.40)	(0.61)
$100 w/5 Day Max	(0.28)	(0.69)	(0.51)	(0.82)	(0.53)	(0.57)	(0.87)
$250 w/3 Day Max	(0.62)	(1.52)	(1.13)	(1.82)	(1.15)	(1.25)	(1.90)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.12)
$100	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.25)
$125	(0.08)	(0.18)	(0.14)	(0.23)	(0.15)	(0.15)	(0.24)
$150	(0.12)	(0.31)	(0.23)	(0.36)	(0.23)	(0.25)	(0.38)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.00)	(0.01)	(0.01)	0.00	(0.01)	(0.01)	(0.01)
$25	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
$35	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$50	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$60	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$75	(0.12)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.35)
$100	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.49)
$125	(0.20)	(0.48)	(0.36)	(0.58)	(0.36)	(0.39)	(0.61)
$150	(0.24)	(0.58)	(0.43)	(0.68)	(0.43)	(0.47)	(0.72)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.11	0.08	0.13	0.08	0.08	0.13
60	0.08	0.20	0.16	0.24	0.15	0.17	0.25
90	0.08	0.19	0.14	0.23	0.15	0.16	0.24
120	0.12	0.29	0.22	0.34	0.21	0.24	0.36
Unlimited	0.16	0.38	0.29	0.47	0.30	0.32	0.49
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.4%	7.2%	7.3%	7.2%	7.5%	7.4%	7.4%
$10	7.9%	7.9%	8.0%	7.9%	7.9%	7.8%	7.9%
$15	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	6.6%	6.3%	5.8%	6.5%	6.1%	6.6%	6.4%
$10	7.7%	7.7%	7.6%	7.7%	7.6%	7.7%	7.7%
$15	7.9%	7.8%	7.7%	7.8%	7.8%	7.7%	7.8%
$20	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
$25	7.9%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$30	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.6%	8.0%	7.6%	7.6%	7.8%	7.9%	7.7%
$10	7.7%	7.8%	7.7%	7.7%	7.8%	7.7%	7.8%
$15	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
$20	7.8%	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%
$25	7.8%	7.7%	7.7%	7.8%	7.8%	7.7%	7.7%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$35	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%	7.9%
$40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$45	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	9.0%	9.1%	9.4%	9.0%	9.2%	9.4%	9.3%
$10	7.6%	7.7%	7.8%	7.7%	7.6%	7.8%	7.7%
$15	7.9%	7.8%	7.7%	7.8%	7.8%	7.7%	7.8%
$20	7.9%	7.9%	7.9%	7.9%	8.0%	7.9%	8.0%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%
$35	7.8%	7.8%	7.7%	7.8%	7.7%	7.8%	7.8%
$40	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
$45	7.8%	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	9.0%	8.3%	8.4%	8.3%	9.0%	8.3%	8.8%
$150	7.8%	7.6%	7.2%	7.2%	7.5%	7.4%	7.4%
$200	8.2%	8.4%	8.4%	8.0%	8.2%	8.2%	8.4%
$250	7.6%	7.4%	7.5%	7.6%	7.3%	7.4%	7.5%
$500	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%	7.8%
$750	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Day							
$50 w/3 Day Max	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.5%
$50 w/5 Day Max	8.4%	8.7%	8.8%	9.0%	9.1%	8.8%	8.8%
$100 w/3 Day Max	8.4%	8.2%	8.3%	8.4%	8.4%	8.4%	8.4%
$100 w/5 Day Max	8.1%	8.2%	8.1%	8.2%	8.3%	8.3%	8.3%
$250 w/3 Day Max	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%	7.8%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	9.3%	10.6%	10.3%	10.5%	10.1%	9.3%	9.9%
$75	6.0%	6.1%	6.6%	6.2%	6.5%	6.0%	5.9%
$100	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
40/$10 copay	(0.19)	(0.46)	(0.34)	(0.54)	(0.34)	(0.38)	(0.57)
40/$15 copay	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
40/$20 copay	(0.41)	(1.00)	(0.74)	(1.18)	(0.76)	(0.81)	(1.24)
40/$25 copay	(0.53)	(1.31)	(0.97)	(1.55)	(0.99)	(1.07)	(1.63)
60	0.19	0.46	0.34	0.54	0.34	0.38	0.57
100	0.48	1.18	0.88	1.40	0.90	0.96	1.47
200	1.26	3.09	2.31	3.68	2.35	2.53	3.86
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
Inpatient Therapies Limit [std: 30 days]							
# Days							
0	(0.88)	(2.15)	(1.60)	(2.55)	(1.63)	(1.75)	(2.68)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.57	1.41	1.04	1.67	1.07	1.15	1.75
90	1.17	2.86	2.14	3.40	2.17	2.34	3.58
Outpatient Therapies Limit [std: 30 visits]							
[Copay same as Specialist Physician Office Visit]							
# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.50	1.23	0.92	1.46	0.93	1.00	1.54
90	0.93	2.28	1.70	2.71	1.73	1.86	2.84
120	1.50	3.69	2.75	4.38	2.80	3.01	4.60
Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]							
[Copay same as Inpatient Facility]							
# Days							
0	(0.71)	(1.74)	(1.30)	(2.07)	(1.32)	(1.42)	(2.17)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.57	0.37	0.40	0.61
30	0.34	0.85	0.63	1.00	0.64	0.69	1.05
Unlimited	0.50	1.23	0.92	1.46	0.93	1.00	1.54
Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]							
[Copay same as Inpatient Facility]							
# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.22	5.45	4.06	6.47	4.14	4.45	6.81
60	2.62	6.42	4.78	7.62	4.88	5.24	8.02
90	3.12	7.66	5.70	9.08	5.81	6.25	9.56
Unlimited	3.16	7.75	5.78	9.20	5.89	6.33	9.68
Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
60/$10 copay	(0.19)	(0.46)	(0.34)	(0.54)	(0.34)	(0.38)	(0.57)
60/$15 copay	(0.31)	(0.76)	(0.57)	(0.91)	(0.58)	(0.63)	(0.96)
60/$20 copay	(0.44)	(1.08)	(0.80)	(1.27)	(0.81)	(0.88)	(1.34)
60/$25 copay	(0.53)	(1.31)	(0.97)	(1.55)	(0.99)	(1.07)	(1.63)
120/$0 copay	0.45	1.10	0.83	1.31	0.84	0.90	1.38
120/$5 copay	0.34	0.85	0.63	1.00	0.64	0.69	1.05
120/$10 copay	0.19	0.46	0.34	0.54	0.34	0.38	0.57
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.30)	(0.23)	(0.37)	(0.23)	(0.25)	(0.39)
120/$25 copay	(0.24)	(0.58)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
)nlimited/$0 copa	0.52	1.27	0.95	1.51	0.97	1.04	1.60
)nlimited/$5 copa	0.40	0.97	0.72	1.15	0.74	0.79	1.21
nlimited/$10 copa	0.24	0.58	0.44	0.70	0.45	0.48	0.73
nlimited/$15 copa	0.06	0.16	0.11	0.18	0.11	0.13	0.19
nlimited/$20 copa	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
nlimited/$25 copa	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
Dialysis Treatment Copay [std: $10]							
Copay							
$0	0.13	0.30	0.23	0.37	0.23	0.25	0.39
$5	0.06	0.16	0.11	0.18	0.11	0.13	0.19
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$20	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
$25	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Refractive Eye Exam Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$10	(0.19)	(0.46)	(0.34)	(0.54)	(0.34)	(0.38)	(0.57)
$15	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
$20	(0.44)	(1.08)	(0.80)	(1.27)	(0.81)	(0.88)	(1.34)
$25	(0.55)	(1.36)	(1.01)	(1.61)	(1.03)	(1.11)	(1.69)
$30	(0.67)	(1.64)	(1.22)	(1.94)	(1.24)	(1.34)	(2.05)
$35	(0.78)	(1.92)	(1.43)	(2.28)	(1.45)	(1.57)	(2.39)
$40	(0.92)	(2.26)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$45	(1.04)	(2.56)	(1.91)	(3.04)	(1.94)	(2.09)	(3.20)
$50	(1.15)	(2.81)	(2.10)	(3.34)	(2.14)	(2.30)	(3.51)
Diabetic Supplies Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$10	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.47)
$25	(0.64)	(1.56)	(1.16)	(1.85)	(1.18)	(1.27)	(1.95)
Chemotherapy [std: $0]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
40/$15 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$20 copay	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
40/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60	0.19	0.47	0.35	0.55	0.35	0.38	0.58
100	0.52	1.27	0.95	1.51	0.97	1.04	1.59
200	1.35	3.31	2.47	3.92	2.51	2.70	4.13
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
Inpatient Therapies Limit [std: 30 days]							
# Days							
0	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.61	1.49	1.11	1.77	1.13	1.22	1.87
90	1.25	3.06	2.28	3.63	2.33	2.50	3.82
Outpatient Therapies Limit [std: 30 visits]							
[Copay same as Specialist Physician Office Visit]							
# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.54	1.32	0.99	1.57	1.00	1.08	1.65
90	1.01	2.47	1.84	2.94	1.88	2.02	3.09
120	1.62	3.97	2.96	4.71	3.01	3.24	4.96
Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]							
[Copay same as Inpatient Facility]							
# Days							
0	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.20	0.49	0.37	0.58	0.37	0.40	0.61
30	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited	0.54	1.32	0.99	1.57	1.00	1.08	1.65
Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]							
[Copay same as Inpatient Facility]							
# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.38	5.83	4.35	6.92	4.43	4.76	7.28
60	2.82	6.91	5.15	8.20	5.25	5.64	8.63
90	3.36	8.23	6.14	9.77	6.25	6.72	10.28
Unlimited	3.40	8.33	6.21	9.88	6.32	6.80	10.40
Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
60/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
60/$20 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
60/$25 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
120/$0 copay	0.49	1.20	0.89	1.42	0.91	0.98	1.50
120/$5 copay	0.38	0.93	0.69	1.10	0.71	0.76	1.16
120/$10 copay	0.19	0.47	0.35	0.55	0.35	0.38	0.58
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
120/$25 copay	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
Unlimited/$0 copa	0.56	1.37	1.02	1.63	1.04	1.12	1.71
Unlimited/$5 copa	0.44	1.08	0.80	1.28	0.82	0.88	1.35
Unlimited/$10 copa	0.24	0.59	0.44	0.70	0.45	0.48	0.73
Unlimited/$15 copa	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copa	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copa	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
Dialysis Treatment Copay [std: $10]							
Copay							
$0	0.13	0.32	0.24	0.38	0.24	0.26	0.40
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
Refractive Eye Exam Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$15	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$30	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$35	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$40	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$45	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$50	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
Diabetic Supplies Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$20	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
$25	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
Chemotherapy [std: $0]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.00	0.01	0.01	0.01	0.01	0.01	0.01
40/$10 copay	0.00	(0.01)	(0.01)	(0.01)	(0.01)	0.00	(0.01)
40/$15 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
40/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
40/$25 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
60	0.00	0.01	0.01	0.01	0.01	0.00	0.01
100	0.04	0.09	0.07	0.11	0.07	0.08	0.12
200	0.09	0.22	0.16	0.24	0.16	0.17	0.27
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
Inpatient Therapies Limit [std: 30 days]							
# Days							
0	(0.08)	(0.20)	(0.15)	(0.24)	(0.16)	(0.17)	(0.26)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.08	0.07	0.10	0.06	0.07	0.12
90	0.08	0.20	0.14	0.23	0.16	0.16	0.24
Outpatient Therapies Limit [std: 30 visits]							
[Copay same as Specialist Physician Office Visit]							
# Visits							
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.09	0.07	0.11	0.07	0.08	0.11
90	0.08	0.19	0.14	0.23	0.15	0.16	0.25
120	0.12	0.28	0.21	0.33	0.21	0.23	0.36
Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]							
[Copay same as Inpatient Facility]							
# Days							
0	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.00	0.00	0.00	0.01	0.00	0.00	0.00
30	0.04	0.08	0.06	0.10	0.07	0.07	0.11
Unlimited	0.04	0.09	0.07	0.11	0.07	0.08	0.11
Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]							
[Copay same as Inpatient Facility]							
# Days							
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.16	0.38	0.29	0.45	0.29	0.31	0.47
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
90	0.24	0.57	0.44	0.69	0.44	0.47	0.72
Unlimited	0.24	0.58	0.43	0.68	0.43	0.47	0.72
Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
# Visits							
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.01	0.01	0.01	0.01	0.01	0.01
60/$10 copay	0.00	(0.01)	(0.01)	(0.01)	(0.01)	0.00	(0.01)
60/$15 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
60/$20 copay	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
60/$25 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
120/$0 copay	0.04	0.10	0.06	0.11	0.07	0.08	0.12
120/$5 copay	0.04	0.08	0.06	0.10	0.07	0.07	0.11
120/$10 copay	0.00	0.01	0.01	0.01	0.01	0.00	0.01
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	0.00	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
120/$25 copay	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
Unlimited/$0 copa	0.04	0.10	0.07	0.12	0.07	0.08	0.11
Unlimited/$5 copa	0.04	0.11	0.08	0.13	0.08	0.09	0.14
Unlimited/$10 copa	0.00	0.01	0.00	0.00	0.00	0.00	0.00
Unlimited/$15 copa	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	(0.01)
Unlimited/$20 copa	0.00	0.01	0.00	0.01	0.00	0.01	0.01
Unlimited/$25 copa	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
Dialysis Treatment Copay [std: $10]							
Copay							
$0	0.00	0.02	0.01	0.01	0.01	0.01	0.01
$5	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	(0.01)
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$20	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$25	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
Refractive Eye Exam Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$10	0.00	(0.01)	(0.01)	(0.01)	(0.01)	0.00	(0.01)
$15	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$20	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
$25	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$30	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.12)
$35	(0.07)	(0.16)	(0.12)	(0.19)	(0.13)	(0.13)	(0.21)
$40	(0.08)	(0.19)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
$45	(0.08)	(0.18)	(0.14)	(0.22)	(0.14)	(0.15)	(0.23)
$50	(0.08)	(0.20)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
Diabetic Supplies Copay [std: $0]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$10	0.00	0.00	0.01	0.00	0.00	0.00	0.00
$15	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
$20	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.09)	(0.13)
Chemotherapy [std: $0]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40/$5 copay	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
40/$10 copay	0.0%	2.2%	2.9%	1.9%	2.9%	0.0%	1.8%
40/$15 copay	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
40/$20 copay	9.8%	10.0%	10.8%	11.0%	10.5%	11.1%	11.3%
40/$25 copay	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
60	0.0%	2.2%	2.9%	1.9%	2.9%	0.0%	1.8%
100	8.3%	7.6%	8.0%	7.9%	7.8%	8.3%	8.2%
200	7.1%	7.1%	6.9%	6.5%	6.8%	6.7%	7.0%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
Inpatient Therapies Limit [std: 30 days]							
# Days							
0	9.1%	9.3%	9.4%	9.4%	9.8%	9.7%	9.7%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.0%	5.7%	6.7%	6.0%	5.6%	6.1%	6.9%
90	6.8%	7.0%	6.5%	6.8%	7.4%	6.8%	6.7%
Outpatient Therapies Limit [std: 30 visits]							
[Copay same as Specialist Physician Office Visit]							
# Visits							
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
90	8.6%	8.3%	8.2%	8.5%	8.7%	8.6%	8.8%
120	8.0%	7.6%	7.6%	7.5%	7.5%	7.6%	7.8%
Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]							
[Copay same as Inpatient Facility]							
# Days							
0	5.6%	5.7%	5.4%	5.3%	6.1%	5.6%	5.5%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
30	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
Unlimited	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]							
[Copay same as Inpatient Facility]							
# Days							
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	7.2%	7.0%	7.1%	7.0%	7.0%	7.0%	6.9%
60	7.6%	7.6%	7.7%	7.6%	7.6%	7.6%	7.6%
90	7.7%	7.4%	7.7%	7.6%	7.6%	7.5%	7.5%
Unlimited	7.6%	7.5%	7.4%	7.4%	7.3%	7.4%	7.4%
Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]							
[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]							
# Visits							
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
60/$10 copay	0.0%	2.2%	2.9%	1.9%	2.9%	0.0%	1.8%
60/$15 copay	12.9%	13.2%	12.3%	12.1%	12.1%	11.1%	11.5%
60/$20 copay	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
60/$25 copay	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
120/$0 copay	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
120/$5 copay	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
120/$10 copay	0.0%	2.2%	2.9%	1.9%	2.9%	0.0%	1.8%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	0.0%	6.7%	4.3%	2.7%	4.3%	4.0%	2.6%
120/$25 copay	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$0 copa	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	6.9%
Unlimited/$5 copa	10.0%	11.3%	11.1%	11.3%	10.8%	11.4%	11.6%
Unlimited/$10 copa	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$15 copa	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
Unlimited/$20 copa	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
Unlimited/$25 copa	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Dialysis Treatment Copay [std: $10]							
Copay							
$0	0.0%	6.7%	4.3%	2.7%	4.3%	4.0

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.13)
$20	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.07)	(0.18)	(0.14)	(0.21)	(0.14)	(0.15)	(0.22)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$35	(0.14)	(0.33)	(0.25)	(0.40)	(0.25)	(0.27)	(0.42)
$50	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.87)
$75	(0.37)	(0.90)	(0.67)	(1.07)	(0.68)	(0.73)	(1.12)
$100	(0.48)	(1.18)	(0.88)	(1.40)	(0.90)	(0.96)	(1.47)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.13)
$25	(0.07)	(0.18)	(0.14)	(0.21)	(0.14)	(0.15)	(0.22)
$35	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$50	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$60	(0.19)	(0.46)	(0.34)	(0.54)	(0.34)	(0.38)	(0.57)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.01)	(4.91)	(3.67)	(5.83)	(3.73)	(4.01)	(6.13)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.12)	(7.66)	(5.70)	(9.08)	(5.81)	(6.25)	(9.56)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.87)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$50	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$60	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$75	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$100	(0.52)	(1.27)	(0.95)	(1.51)	(0.97)	(1.04)	(1.59)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$75	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$100	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(2.17)	(5.32)	(3.96)	(6.31)	(4.04)	(4.34)	(6.64)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$20	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$35	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$50	0.00	0.00	0.01	0.00	0.00	0.00	0.00
$60	(0.04)	(0.09)	(0.07)	(0.12)	(0.08)	(0.08)	(0.11)
$75	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$35	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$50	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$60	0.00	(0.01)	(0.01)	(0.01)	(0.01)	0.00	(0.01)
$75	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.16)	(0.41)	(0.29)	(0.48)	(0.31)	(0.33)	(0.51)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(0.24)	(0.57)	(0.44)	(0.69)	(0.44)	(0.47)	(0.72)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.04)	(0.09)	(0.07)	(0.12)	(0.08)	(0.08)	(0.11)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-7.7%	0.0%	0.0%	-7.7%
$20	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-5.6%	-7.1%	-4.8%	-7.1%	-6.7%	-4.5%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$35	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
$50	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
$60	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
$75	10.8%	11.1%	11.9%	11.2%	11.8%	12.3%	11.6%
$100	8.3%	7.6%	8.0%	7.9%	7.8%	8.3%	8.2%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-7.7%	0.0%	0.0%	-7.7%
$25	0.0%	-5.6%	-7.1%	-4.8%	-7.1%	-6.7%	-4.5%
$35	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$50	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$60	0.0%	2.2%	2.9%	1.9%	2.9%	0.0%	1.8%
$75	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	12.5%	11.4%	10.0%	11.7%	9.8%	10.8%	11.1%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	8.0%	8.4%	7.9%	8.2%	8.3%	8.2%	8.3%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	7.7%	7.4%	7.7%	7.6%	7.6%	7.5%	7.5%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.13	19.91	14.84	23.63	15.11	16.25	24.86
60	8.58	21.00	15.66	24.93	15.95	17.15	26.23
90	8.89	21.78	16.23	25.84	16.53	17.78	27.19
Unlimited	8.98	22.01	16.40	26.11	16.71	17.96	27.48
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP $0 Copay							
20	9.09	22.26	16.60	26.41	16.90	18.17	27.79
30	10.00	24.49	18.25	29.06	18.59	19.99	30.57
40	10.55	25.84	19.26	30.67	19.63	21.10	32.27
60	11.12	27.25	20.32	32.34	20.69	22.25	34.03
Unlimited	11.22	27.48	20.48	32.61	20.87	22.44	34.31
LARGE GROUP $5 Copay							
20	8.54	20.93	15.60	24.84	15.89	17.09	26.13
30	9.40	23.03	17.16	27.32	17.48	18.80	28.75
40	9.99	24.46	18.24	29.03	18.57	19.97	30.54
60	10.47	25.64	19.11	30.43	19.47	20.93	32.01
Unlimited	10.54	25.82	19.24	30.63	19.60	21.08	32.23
LARGE GROUP $10 Copay							
20	8.00	19.60	14.61	23.26	14.88	16.00	24.47
30	8.82	21.60	16.10	25.62	16.40	17.63	26.97
40	9.31	22.80	16.99	27.05	17.31	18.61	28.47
60	9.81	24.03	17.91	28.51	18.24	19.62	30.00
Unlimited	9.89	24.23	18.06	28.75	18.39	19.78	30.26
LARGE GROUP $15 Copay							
20	7.51	18.40	13.71	21.83	13.96	15.02	22.97
30	8.27	20.26	15.10	24.04	15.39	16.54	25.31
40	8.75	21.44	15.98	25.44	16.28	17.51	26.77
60	9.26	22.70	16.92	26.93	17.23	18.53	28.34
Unlimited	9.35	22.91	17.07	27.18	17.39	18.70	28.60
LARGE GROUP $20 Copay							
20	7.06	17.30	12.89	20.52	13.13	14.12	21.60
30	7.75	18.99	14.15	22.53	14.41	15.50	23.71
40	8.17	20.01	14.92	23.74	15.19	16.34	24.98
60	8.68	21.27	15.84	25.23	16.15	17.36	26.55
Unlimited	8.74	21.42	15.96	25.41	16.26	17.48	26.74
LARGE GROUP $25 Copay							
20	6.56	16.07	11.98	19.07	12.20	13.12	20.06
30	7.22	17.68	13.18	20.98	13.42	14.43	22.08
40	7.69	18.83	14.04	22.35	14.30	15.37	23.51
60	8.08	19.80	14.76	23.50	15.04	16.17	24.73
Unlimited	8.16	19.98	14.89	23.71	15.18	16.31	24.95
LARGE GROUP $30 Copay							
20	6.27	15.35	11.45	18.22	11.66	12.53	19.17
30	6.80	16.66	12.42	19.76	12.65	13.60	20.80
40	7.24	17.74	13.21	21.05	13.46	14.48	22.14
60	7.58	18.58	13.85	22.04	14.10	15.17	23.20
Unlimited	7.62	18.68	13.92	22.16	14.18	15.25	23.32
LARGE GROUP $35 Copay							
20	5.95	14.58	10.87	17.31	11.07	11.91	18.22
30	6.36	15.58	11.61	18.49	11.83	12.72	19.46
40	6.77	16.59	12.36	19.68	12.59	13.54	20.70
60	7.09	17.38	12.95	20.62	13.19	14.18	21.69
Unlimited	7.14	17.51	13.05	20.76	13.29	14.29	21.85
LARGE GROUP $40 Copay							

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.76	21.46	16.00	25.47	16.29	17.52	26.80
60	9.25	22.66	16.89	26.89	17.21	18.50	28.30
90	9.59	23.50	17.51	27.88	17.84	19.18	29.34
Unlimited	9.68	23.72	17.68	28.14	18.00	19.36	29.61
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP $0 Copay							
20	9.80	24.01	17.89	28.49	18.23	19.60	29.98
30	10.78	26.41	19.68	31.34	20.05	21.56	32.98
40	11.37	27.86	20.76	33.05	21.15	22.74	34.78
60	11.99	29.38	21.89	34.85	22.30	23.98	36.68
Unlimited	12.10	29.65	22.09	35.17	22.51	24.20	37.01
LARGE GROUP $5 Copay							
20	9.21	22.56	16.82	26.77	17.13	18.42	28.17
30	10.14	24.84	18.52	29.48	18.86	20.28	31.02
40	10.77	26.39	19.67	31.31	20.03	21.54	32.95
60	11.29	27.66	20.62	32.82	21.00	22.58	34.54
Unlimited	11.36	27.83	20.74	33.02	21.13	22.72	34.75
LARGE GROUP $10 Copay							
20	8.62	21.12	15.74	25.06	16.03	17.24	26.37
30	9.51	23.30	17.37	27.65	17.69	19.02	29.09
40	10.04	24.60	18.33	29.19	18.67	20.08	30.71
60	10.58	25.92	19.32	30.76	19.68	21.16	32.36
Unlimited	10.67	26.14	19.48	31.02	19.85	21.34	32.64
LARGE GROUP $15 Copay							
20	8.10	19.85	14.79	23.55	15.07	16.20	24.78
30	8.92	21.85	16.29	25.93	16.59	17.84	27.29
40	9.44	23.13	17.24	27.44	17.56	18.88	28.88
60	9.99	24.48	18.24	29.04	18.58	19.98	30.56
Unlimited	10.08	24.70	18.41	29.30	18.75	20.16	30.83
LARGE GROUP $20 Copay							
20	7.61	18.64	13.90	22.12	14.15	15.22	23.28
30	8.36	20.48	15.27	24.30	15.55	16.72	25.57
40	8.81	21.58	16.09	25.61	16.39	17.62	26.95
60	9.35	22.91	17.07	27.18	17.39	18.70	28.60
Unlimited	9.43	23.10	17.22	27.41	17.54	18.86	28.85
LARGE GROUP $25 Copay							
20	7.07	17.32	12.91	20.55	13.15	14.14	21.63
30	7.79	19.09	14.22	22.65	14.49	15.58	23.83
40	8.29	20.31	15.14	24.10	15.42	16.58	25.36
60	8.71	21.34	15.90	25.32	16.20	17.42	26.64
Unlimited	8.80	21.56	16.07	25.58	16.37	17.60	26.92
LARGE GROUP $30 Copay							
20	6.76	16.56	12.34	19.65	12.57	13.52	20.68
30	7.33	17.96	13.38	21.31	13.63	14.66	22.42
40	7.81	19.13	14.26	22.70	14.53	15.62	23.89
60	8.17	20.02	14.92	23.75	15.20	16.34	24.99
Unlimited	8.21	20.11	14.99	23.87	15.27	16.42	25.11
LARGE GROUP $35 Copay							
20	6.42	15.73	11.72	18.66	11.94	12.84	19.64
30	6.86	16.81	12.53	19.94	12.76	13.72	20.98
40	7.30	17.89	13.33	21.22	13.58	14.60	22.33
60	7.64	18.72	13.95	22.21	14.21	15.28	23.37
Unlimited	7.70	18.87	14.06	22.38	14.32	15.40	23.55
LARGE GROUP $40 Copay							

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.63	1.55	1.16	1.84	1.18	1.27	1.94
60	0.67	1.66	1.23	1.96	1.26	1.35	2.07
90	0.70	1.72	1.28	2.04	1.31	1.40	2.15
Unlimited	0.70	1.71	1.28	2.03	1.29	1.40	2.13
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP $0 Copay							
20	0.71	1.75	1.29	2.08	1.33	1.43	2.19
30	0.78	1.92	1.43	2.28	1.46	1.57	2.41
40	0.82	2.02	1.50	2.38	1.52	1.64	2.51
60	0.87	2.13	1.57	2.51	1.61	1.73	2.65
Unlimited	0.88	2.17	1.61	2.56	1.64	1.76	2.70
LARGE GROUP $5 Copay							
20	0.67	1.63	1.22	1.93	1.24	1.33	2.04
30	0.74	1.81	1.36	2.16	1.38	1.48	2.27
40	0.78	1.93	1.43	2.28	1.46	1.57	2.41
60	0.82	2.02	1.51	2.39	1.53	1.65	2.53
Unlimited	0.82	2.01	1.50	2.39	1.53	1.64	2.52
LARGE GROUP $10 Copay							
20	0.62	1.52	1.13	1.80	1.15	1.24	1.90
30	0.69	1.70	1.27	2.03	1.29	1.39	2.12
40	0.73	1.80	1.34	2.14	1.36	1.47	2.24
60	0.77	1.89	1.41	2.25	1.44	1.54	2.36
Unlimited	0.78	1.91	1.42	2.27	1.46	1.56	2.38
LARGE GROUP $15 Copay							
20	0.59	1.45	1.08	1.72	1.11	1.18	1.81
30	0.65	1.59	1.19	1.89	1.20	1.30	1.98
40	0.69	1.69	1.26	2.00	1.28	1.37	2.11
60	0.73	1.78	1.32	2.11	1.35	1.45	2.22
Unlimited	0.73	1.79	1.34	2.12	1.36	1.46	2.23
LARGE GROUP $20 Copay							
20	0.55	1.34	1.01	1.60	1.02	1.10	1.68
30	0.61	1.49	1.12	1.77	1.14	1.22	1.86
40	0.64	1.57	1.17	1.87	1.20	1.28	1.97
60	0.67	1.64	1.23	1.95	1.24	1.34	2.05
Unlimited	0.69	1.68	1.26	2.00	1.28	1.38	2.11
LARGE GROUP $25 Copay							
20	0.51	1.25	0.93	1.48	0.95	1.02	1.57
30	0.57	1.41	1.04	1.67	1.07	1.15	1.75
40	0.60	1.48	1.10	1.75	1.12	1.21	1.85
60	0.63	1.54	1.14	1.82	1.16	1.25	1.91
Unlimited	0.64	1.58	1.18	1.87	1.19	1.29	1.97
LARGE GROUP $30 Copay							
20	0.49	1.21	0.89	1.43	0.91	0.99	1.51
30	0.53	1.30	0.96	1.55	0.98	1.06	1.62
40	0.57	1.39	1.05	1.65	1.07	1.14	1.75
60	0.59	1.44	1.07	1.71	1.10	1.17	1.79
Unlimited	0.59	1.43	1.07	1.71	1.09	1.17	1.79
LARGE GROUP $35 Copay							
20	0.47	1.15	0.85	1.35	0.87	0.93	1.42
30	0.50	1.23	0.92	1.45	0.93	1.00	1.52
40	0.53	1.30	0.97	1.54	0.99	1.06	1.63
60	0.55	1.34	1.00	1.59	1.02	1.10	1.68
Unlimited	0.56	1.36	1.01	1.62	1.03	1.11	1.70
LARGE GROUP $40 Copay							

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.7%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
90	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP $0 Copay							
20	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
30	7.8%	7.8%	7.8%	7.8%	7.9%	7.9%	7.9%
40	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
60	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
LARGE GROUP $5 Copay							
20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
40	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
60	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP $10 Copay							
20	7.7%	7.8%	7.7%	7.7%	7.7%	7.7%	7.8%
30	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
40	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
60	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
Unlimited	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
LARGE GROUP $15 Copay							
20	7.9%	7.9%	7.9%	7.9%	8.0%	7.9%	7.9%
30	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%	7.8%
40	7.9%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
60	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP $20 Copay							
20	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%
40	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.9%
60	7.7%	7.7%	7.8%	7.7%	7.7%	7.7%	7.7%
Unlimited	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%
LARGE GROUP $25 Copay							
20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	8.0%	7.9%	8.0%	8.0%	8.0%	7.9%
40	7.8%	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%
60	7.8%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
Unlimited	7.8%	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%
LARGE GROUP $30 Copay							
20	7.8%	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%
30	7.8%	7.8%	7.7%	7.8%	7.7%	7.8%	7.8%
40	7.9%	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%
60	7.8%	7.8%	7.7%	7.8%	7.8%	7.7%	7.7%
Unlimited	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP $35 Copay							
20	7.9%	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%
30	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%
60	7.8%	7.7%	7.7%	7.7%	7.7%	7.8%	7.7%
Unlimited	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP $40 Copay							

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS GROUP CONTRACT
MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	5.80	14.20	10.58	16.85	10.78	11.59	17.74
30	6.18	15.14	11.29	17.98	11.50	12.37	18.92
40	6.58	16.12	12.01	19.12	12.24	13.16	20.13
60	6.95	17.01	12.68	20.19	12.92	13.89	21.24
Unlimited	7.00	17.14	12.77	20.35	13.01	14.00	21.40
LARGE GROUP				**$45 Copay**			
20	5.63	13.80	10.28	16.37	10.47	11.26	17.22
30	6.00	14.69	10.95	17.43	11.15	11.99	18.34
40	6.42	15.74	11.73	18.68	11.95	12.85	19.65
60	6.78	16.61	12.38	19.71	12.61	13.56	20.73
Unlimited	6.82	16.71	12.45	19.82	12.69	13.64	20.86
LARGE GROUP				**$50 Copay**			
20	5.46	13.38	9.97	15.88	10.16	10.93	16.71
30	5.86	14.35	10.70	17.04	10.89	11.72	17.92
40	6.27	15.35	11.45	18.22	11.66	12.53	19.17
60	6.60	16.17	12.05	19.19	12.27	13.20	20.19
Unlimited	6.64	16.27	12.13	19.31	12.36	13.29	20.32

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	6.25	15.31	11.41	18.17	11.63	12.50	19.12
30	6.66	16.32	12.16	19.36	12.39	13.32	20.37
40	7.10	17.40	12.96	20.64	13.21	14.20	21.72
60	7.49	18.35	13.68	21.77	13.93	14.98	22.91
Unlimited	7.55	18.50	13.79	21.95	14.04	15.10	23.10
LARGE GROUP				**$45 Copay**			
20	6.07	14.87	11.08	17.65	11.29	12.14	18.57
30	6.47	15.85	11.81	18.81	12.03	12.94	19.79
40	6.92	16.95	12.64	20.12	12.87	13.84	21.17
60	7.31	17.91	13.35	21.25	13.60	14.62	22.36
Unlimited	7.35	18.01	13.42	21.37	13.67	14.70	22.48
LARGE GROUP				**$50 Copay**			
20	5.89	14.43	10.76	17.12	10.96	11.78	18.02
30	6.32	15.48	11.54	18.37	11.76	12.64	19.33
40	6.76	16.56	12.34	19.65	12.57	13.52	20.68
60	7.12	17.44	13.00	20.70	13.24	14.24	21.78
Unlimited	7.16	17.54	13.07	20.81	13.32	14.32	21.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	0.45	1.11	0.83	1.32	0.85	0.91	1.38
30	0.48	1.18	0.87	1.38	0.89	0.95	1.45
40	0.52	1.28	0.95	1.52	0.97	1.04	1.59
60	0.54	1.34	1.00	1.58	1.01	1.09	1.67
Unlimited	0.55	1.36	1.02	1.60	1.03	1.10	1.70
LARGE GROUP				**$45 Copay**			
20	0.44	1.07	0.80	1.28	0.82	0.88	1.35
30	0.47	1.16	0.86	1.38	0.88	0.95	1.45
40	0.50	1.21	0.91	1.44	0.92	0.99	1.52
60	0.53	1.30	0.97	1.54	0.99	1.06	1.63
Unlimited	0.53	1.30	0.97	1.55	0.98	1.06	1.62
LARGE GROUP				**$50 Copay**			
20	0.43	1.05	0.79	1.24	0.80	0.85	1.31
30	0.46	1.13	0.84	1.33	0.87	0.92	1.41
40	0.49	1.21	0.89	1.43	0.91	0.99	1.51
60	0.52	1.27	0.95	1.51	0.97	1.04	1.59
Unlimited	0.52	1.27	0.94	1.50	0.96	1.03	1.58

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
20	7.8%	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%
30	7.8%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
40	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
60	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%	7.9%
Unlimited	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.9%
LARGE GROUP				**$45 Copay**			
20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
40	7.8%	7.7%	7.8%	7.7%	7.7%	7.7%	7.7%
60	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
LARGE GROUP				**$50 Copay**			
20	7.9%	7.8%	7.9%	7.8%	7.9%	7.8%	7.8%
30	7.8%	7.9%	7.9%	7.8%	8.0%	7.8%	7.9%
40	7.8%	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%
60	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP POS LARGE GROUP CONTRACT - RIDERS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.44	15.79	11.77	18.74	11.99	12.89	19.71
$0/Max $5000	6.04	14.79	11.02	17.55	11.23	12.07	18.47
$0/Max $2500	5.69	13.94	10.39	16.54	10.59	11.38	17.41
$25	6.04	14.79	11.02	17.55	11.23	12.07	18.47
$50	5.69	13.94	10.39	16.54	10.59	11.38	17.41
$100	5.11	12.51	9.33	14.85	9.50	10.21	15.63
$500	2.52	6.16	4.60	7.32	4.68	5.03	7.70
$5,000	0.34	0.85	0.63	1.00	0.64	0.69	1.05
Coinsurance							
80%	5.12	12.53	9.35	14.87	9.52	10.24	15.66
75%	4.83	11.82	8.82	14.03	8.97	9.65	14.76
70%	4.48	10.98	8.18	13.02	8.33	8.96	13.70
			Orthotics Riders				
$0/Max $5000	6.68	16.38	12.21	19.43	12.43	13.37	20.45
$0/Max $2500	6.19	15.18	11.31	18.01	11.52	12.39	18.95
Deductible							
$0	1.10	2.68	2.01	3.19	2.04	2.19	3.35
$0/Max $5000	1.05	2.58	1.92	3.07	1.96	2.11	3.23
$0/Max $2500	1.00	2.45	1.83	2.91	1.87	2.01	3.07
$25	1.05	2.58	1.92	3.07	1.96	2.11	3.23
$50	1.00	2.45	1.83	2.91	1.87	2.01	3.07
$100	0.91	2.22	1.66	2.64	1.69	1.82	2.78
$500	0.44	1.08	0.80	1.27	0.81	0.88	1.34
$5,000	0.05	0.13	0.09	0.16	0.09	0.10	0.16
Coinsurance							
80%	0.91	2.22	1.66	2.64	1.69	1.82	2.78
75%	0.85	2.07	1.55	2.45	1.58	1.69	2.59
70%	0.77	1.89	1.41	2.25	1.44	1.55	2.36
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.41	3.46	2.58	4.09	2.62	2.82	4.31
12 Months	2.25	5.50	4.10	6.53	4.18	4.49	6.87
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.19	5.37	4.00	6.37	4.08	4.39	6.71
12 Months	3.50	8.58	6.39	10.17	6.51	7.00	10.71
			Private Duty Nursing Riders				
In Full	0.75	1.84	1.37	2.18	1.40	1.50	2.30
80% hrs 73-504	0.13	0.30	0.23	0.37	0.23	0.25	0.39
100% hrs 73-504	0.22	0.53	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.44	1.08	0.80	1.27	0.81	0.88	1.34
Limit			**Infertility Rider**				
2 IVF	14.07	34.47	25.69	40.90	26.16	28.14	43.03
3 IVF	16.91	41.42	30.87	49.15	31.45	33.82	51.72

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.94	17.00	12.67	20.17	12.91	13.88	21.23
$0/Max $5000	6.51	15.95	11.89	18.92	12.11	13.02	19.91
$0/Max $2500	6.13	15.02	11.19	17.82	11.40	12.26	18.75
$25	6.51	15.95	11.89	18.92	12.11	13.02	19.91
$50	6.13	15.02	11.19	17.82	11.40	12.26	18.75
$100	5.51	13.50	10.06	16.02	10.25	11.02	16.86
$500	2.72	6.66	4.97	7.91	5.06	5.44	8.32
$5,000	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Coinsurance							
80%	5.52	13.52	10.08	16.05	10.27	11.04	16.89
75%	5.21	12.76	9.51	15.15	9.69	10.42	15.94
70%	4.84	11.86	8.84	14.07	9.00	9.68	14.81
			Orthotics Riders				
$0/Max $5000	7.20	17.64	13.15	20.93	13.39	14.40	22.02
$0/Max $2500	6.67	16.34	12.18	19.39	12.41	13.34	20.40
Deductible							
$0	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$0/Max $5000	1.13	2.77	2.06	3.28	2.10	2.26	3.46
$0/Max $2500	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$25	1.13	2.77	2.06	3.28	2.10	2.26	3.46
$50	1.08	2.65	1.97	3.14	2.01	2.16	3.30
$100	0.99	2.43	1.81	2.88	1.84	1.98	3.03
$500	0.48	1.18	0.88	1.40	0.89	0.96	1.47
$5,000	0.05	0.12	0.09	0.15	0.09	0.10	0.15
Coinsurance							
80%	0.99	2.43	1.81	2.88	1.84	1.98	3.03
75%	0.93	2.28	1.70	2.70	1.73	1.86	2.84
70%	0.83	2.03	1.52	2.41	1.54	1.66	2.54
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.79	1.94	1.44	2.30	1.47	1.58	2.42
80% hrs 73-504	0.13	0.32	0.24	0.38	0.24	0.26	0.40
100% hrs 73-504	0.22	0.54	0.40	0.64	0.41	0.44	0.67
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	15.17	37.17	27.70	44.10	28.22	30.34	46.41
3 IVF	18.23	44.66	33.29	52.99	33.91	36.46	55.77

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.50	1.21	0.90	1.43	0.92	0.99	1.52
$0/Max $5000	0.47	1.16	0.87	1.37	0.88	0.95	1.44
$0/Max $2500	0.44	1.08	0.80	1.28	0.81	0.88	1.34
$25	0.47	1.16	0.87	1.37	0.88	0.95	1.44
$50	0.44	1.08	0.80	1.28	0.81	0.88	1.34
$100	0.40	0.99	0.73	1.17	0.75	0.81	1.23
$500	0.20	0.50	0.37	0.59	0.38	0.41	0.62
$5,000	0.04	0.08	0.06	0.10	0.07	0.07	0.11
Coinsurance							
80%	0.40	0.99	0.73	1.18	0.75	0.80	1.23
75%	0.38	0.94	0.69	1.12	0.72	0.77	1.18
70%	0.36	0.88	0.66	1.05	0.67	0.72	1.11
			Orthotics Riders				
$0/Max $5000	0.52	1.26	0.94	1.50	0.96	1.03	1.57
$0/Max $2500	0.48	1.16	0.87	1.38	0.89	0.95	1.45
Deductible							
$0	0.08	0.21	0.14	0.24	0.15	0.17	0.26
$0/Max $5000	0.08	0.19	0.14	0.21	0.14	0.15	0.23
$0/Max $2500	0.08	0.20	0.14	0.23	0.14	0.15	0.23
$25	0.08	0.19	0.14	0.21	0.14	0.15	0.23
$50	0.08	0.20	0.14	0.23	0.14	0.15	0.23
$100	0.08	0.21	0.15	0.24	0.15	0.16	0.25
$500	0.04	0.10	0.08	0.13	0.08	0.08	0.13
$5,000	0.00	(0.01)	0.00	(0.01)	0.00	0.00	(0.01)
Coinsurance							
80%	0.08	0.21	0.15	0.24	0.15	0.16	0.25
75%	0.08	0.21	0.15	0.25	0.15	0.17	0.25
70%	0.06	0.14	0.11	0.16	0.10	0.11	0.18
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.36	0.23	0.24	0.37
12 Months	0.17	0.43	0.32	0.50	0.32	0.35	0.53
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.16	0.39	0.29	0.46	0.29	0.31	0.48
12 Months	0.28	0.68	0.51	0.82	0.52	0.56	0.85
			Private Duty Nursing Riders				
In Full	0.04	0.10	0.07	0.12	0.07	0.08	0.12
80% hrs 73-504	0.00	0.02	0.01	0.01	0.01	0.01	0.01
100% hrs 73-504	0.00	0.01	0.00	0.00	0.00	0.00	0.00
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	1.10	2.70	2.01	3.20	2.06	2.20	3.38
3 IVF	1.32	3.24	2.42	3.84	2.46	2.64	4.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	7.8%	7.7%	7.6%	7.6%	7.7%	7.7%	7.7%
$0/Max $5000	7.8%	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%
$0/Max $2500	7.7%	7.7%	7.7%	7.7%	7.6%	7.7%	7.7%
$25	7.8%	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%
$50	7.7%	7.7%	7.7%	7.7%	7.6%	7.7%	7.7%
$100	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
$500	7.9%	8.1%	8.0%	8.1%	8.1%	8.2%	8.1%
$5,000	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
Coinsurance							
80%	7.8%	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%
75%	7.9%	8.0%	7.8%	8.0%	8.0%	8.0%	8.0%
70%	8.0%	8.0%	8.1%	8.1%	8.0%	8.0%	8.1%
			Orthotics Riders				
$0/Max $5000	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
$0/Max $2500	7.8%	7.6%	7.7%	7.7%	7.7%	7.7%	7.7%
Deductible							
$0	7.3%	7.8%	7.0%	7.5%	7.4%	7.8%	7.8%
$0/Max $5000	7.6%	7.4%	7.3%	6.8%	7.1%	7.1%	7.1%
$0/Max $2500	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$25	7.6%	7.4%	7.3%	6.8%	7.1%	7.1%	7.1%
$50	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$100	8.8%	9.5%	9.0%	9.1%	8.9%	8.8%	9.0%
$500	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
$5,000	0.0%	-7.7%	0.0%	-6.3%	0.0%	0.0%	-6.3%
Coinsurance							
80%	8.8%	9.5%	9.0%	9.1%	8.9%	8.8%	9.0%
75%	9.4%	10.1%	9.7%	10.2%	9.5%	10.1%	9.7%
70%	7.8%	7.4%	7.8%	7.1%	6.9%	7.1%	7.6%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.5%	8.4%	8.1%	8.8%	8.8%	8.5%	8.6%
12 Months	7.6%	7.8%	7.8%	7.7%	7.7%	7.8%	7.7%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.3%	7.3%	7.3%	7.2%	7.1%	7.1%	7.2%
12 Months	8.0%	7.9%	8.0%	8.1%	8.0%	8.0%	7.9%
			Private Duty Nursing Riders				
In Full	5.3%	5.4%	5.1%	5.5%	5.0%	5.3%	5.2%
80% hrs 73-504	0.0%	6.7%	4.3%	2.7%	4.3%	4.0%	2.6%
100% hrs 73-504	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dental Network Access				
	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
Limit			**Infertility Rider**				
2 IVF	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%
3 IVF	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	501.52	1,228.69	915.73	1,457.89	932.78	1,002.99	1,534.11

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	540.73	1,324.79	987.37	1,571.90	1,005.76	1,081.46	1,654.09

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	39.21	96.10	71.64	114.01	72.98	78.47	119.98

**** Base rates exclude premium component for mandatory mental health coverage***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Large Group*	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

**** Base rates exclude premium component for mandatory mental health cove***

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child[ren]	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.35)	(8.21)	(6.12)	(9.74)	(6.24)	(6.71)	(10.26)
$10	(7.05)	(17.28)	(12.88)	(20.49)	(13.11)	(14.10)	(21.57)
$15	(11.74)	(28.76)	(21.43)	(34.12)	(21.84)	(23.48)	(35.91)
$20	(18.10)	(44.35)	(33.05)	(52.62)	(33.66)	(36.20)	(55.37)
$25	(23.85)	(58.42)	(43.54)	(69.32)	(44.35)	(47.69)	(72.95)
$30	(30.16)	(73.90)	(55.08)	(87.68)	(56.10)	(60.33)	(92.27)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.93)	(4.73)	(3.53)	(5.62)	(3.59)	(3.86)	(5.91)
$10	(4.04)	(9.90)	(7.38)	(11.75)	(7.52)	(8.08)	(12.37)
$15	(6.72)	(16.45)	(12.26)	(19.52)	(12.49)	(13.43)	(20.54)
$20	(10.36)	(25.38)	(18.92)	(30.12)	(19.27)	(20.72)	(31.69)
$25	(13.66)	(33.48)	(24.94)	(39.71)	(25.41)	(27.32)	(41.79)
$30	(17.29)	(42.35)	(31.56)	(50.25)	(32.15)	(34.57)	(52.88)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.45)	(6.02)	(4.48)	(7.13)	(4.56)	(4.91)	(7.51)
$10	(5.07)	(12.41)	(9.25)	(14.73)	(9.42)	(10.13)	(15.50)
$15	(7.96)	(19.50)	(14.53)	(23.14)	(14.80)	(15.92)	(24.35)
$20	(11.22)	(27.48)	(20.48)	(32.61)	(20.87)	(22.44)	(34.31)
$25	(14.79)	(36.23)	(27.01)	(42.99)	(27.51)	(29.58)	(45.24)
$30	(18.85)	(46.19)	(34.43)	(54.80)	(35.06)	(37.71)	(57.67)
$35	(22.65)	(55.50)	(41.36)	(65.85)	(42.13)	(45.31)	(69.30)
$40	(26.59)	(65.15)	(48.56)	(77.30)	(49.46)	(53.18)	(81.34)
$45	(30.75)	(75.34)	(56.15)	(89.39)	(57.20)	(61.50)	(94.07)
$50	(35.09)	(85.98)	(64.08)	(102.01)	(65.27)	(70.19)	(107.35)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.08)	(5.10)	(3.79)	(6.04)	(3.86)	(4.16)	(6.36)
$10	(4.28)	(10.49)	(7.82)	(12.45)	(7.97)	(8.56)	(13.10)
$15	(6.72)	(16.45)	(12.26)	(19.52)	(12.49)	(13.43)	(20.54)
$20	(9.48)	(23.24)	(17.32)	(27.57)	(17.64)	(18.97)	(29.02)
$25	(12.49)	(30.60)	(22.81)	(36.32)	(23.23)	(24.98)	(38.22)
$30	(15.93)	(39.02)	(29.09)	(46.30)	(29.62)	(31.86)	(48.72)
$35	(19.17)	(46.96)	(35.00)	(55.71)	(35.65)	(38.33)	(58.63)
$40	(22.48)	(55.06)	(41.04)	(65.34)	(41.81)	(44.95)	(68.76)
$45	(26.00)	(63.69)	(47.47)	(75.57)	(48.35)	(51.99)	(79.53)
$50	(29.68)	(72.73)	(54.20)	(86.29)	(55.21)	(59.37)	(90.81)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.22)	(3.00)	(2.24)	(3.55)	(2.28)	(2.44)	(3.74)
$150	(2.03)	(4.96)	(3.70)	(5.89)	(3.77)	(4.05)	(6.19)
$200	(2.87)	(7.04)	(5.24)	(8.35)	(5.34)	(5.74)	(8.78)
$250	(4.14)	(10.13)	(7.55)	(12.02)	(7.70)	(8.27)	(12.65)
$500	(9.90)	(24.26)	(18.08)	(28.79)	(18.41)	(19.80)	(30.29)
$750	(16.98)	(41.61)	(31.01)	(49.37)	(31.58)	(33.97)	(51.95)
$1,000	(25.56)	(62.62)	(46.67)	(74.29)	(47.53)	(51.12)	(78.18)
Copay/Day							
$50 w/3 Day Max	(1.49)	(3.66)	(2.73)	(4.35)	(2.78)	(2.99)	(4.56)
$50 w/5 Day Max	(2.05)	(5.01)	(3.74)	(5.95)	(3.81)	(4.09)	(6.27)
$100 w/3 Day Max	(3.72)	(9.11)	(6.79)	(10.81)	(6.91)	(7.44)	(11.37)
$100 w/5 Day Max	(5.36)	(13.13)	(9.79)	(15.57)	(9.96)	(10.72)	(16.39)
$250 w/3 Day Max	(12.31)	(30.16)	(22.49)	(35.79)	(22.91)	(24.63)	(37.67)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.64)	(1.56)	(1.16)	(1.85)	(1.18)	(1.27)	(1.95)
$75	(1.04)	(2.56)	(1.91)	(3.04)	(1.94)	(2.09)	(3.20)
$100	(1.49)	(3.66)	(2.73)	(4.35)	(2.78)	(2.99)	(4.56)
$125	(1.95)	(4.78)	(3.56)	(5.68)	(3.63)	(3.91)	(5.97)
$150	(2.43)	(5.96)	(4.44)	(7.07)	(4.52)	(4.87)	(7.45)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
$25	(0.50)	(1.23)	(0.92)	(1.46)	(0.93)	(1.00)	(1.54)
$35	(0.84)	(2.05)	(1.52)	(2.43)	(1.56)	(1.67)	(2.56)
$50	(1.41)	(3.46)	(2.58)	(4.09)	(2.62)	(2.82)	(4.31)
$60	(1.79)	(4.38)	(3.26)	(5.19)	(3.32)	(3.57)	(5.46)
$75	(2.35)	(5.76)	(4.29)	(6.83)	(4.37)	(4.70)	(7.19)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child[ren]	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.61)	(8.84)	(6.59)	(10.49)	(6.71)	(7.22)	(11.04)
$10	(7.60)	(18.62)	(13.88)	(22.09)	(14.14)	(15.20)	(23.25)
$15	(12.66)	(31.02)	(23.12)	(36.80)	(23.55)	(25.32)	(38.73)
$20	(19.51)	(47.80)	(35.63)	(56.72)	(36.29)	(39.02)	(59.68)
$25	(25.71)	(62.99)	(46.95)	(74.74)	(47.82)	(51.42)	(78.65)
$30	(32.51)	(79.65)	(59.36)	(94.51)	(60.47)	(65.02)	(99.45)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$10	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$15	(7.25)	(17.76)	(13.24)	(21.08)	(13.49)	(14.50)	(22.18)
$20	(11.17)	(27.37)	(20.40)	(32.47)	(20.78)	(22.34)	(34.17)
$25	(14.72)	(36.06)	(26.88)	(42.79)	(27.38)	(29.44)	(45.03)
$30	(18.64)	(45.67)	(34.04)	(54.19)	(34.67)	(37.28)	(57.02)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$10	(5.47)	(13.40)	(9.99)	(15.90)	(10.17)	(10.94)	(16.73)
$15	(8.58)	(21.02)	(15.67)	(24.94)	(15.96)	(17.16)	(26.25)
$20	(12.10)	(29.65)	(22.09)	(35.17)	(22.51)	(24.20)	(37.01)
$25	(15.95)	(39.08)	(29.12)	(46.37)	(29.67)	(31.90)	(48.79)
$30	(20.32)	(49.78)	(37.10)	(59.07)	(37.80)	(40.64)	(62.16)
$35	(24.43)	(59.85)	(44.61)	(71.02)	(45.44)	(48.86)	(74.73)
$40	(28.66)	(70.22)	(52.33)	(83.31)	(53.31)	(57.32)	(87.67)
$45	(33.16)	(81.24)	(60.55)	(96.40)	(61.68)	(66.32)	(101.44)
$50	(37.84)	(92.71)	(69.10)	(110.00)	(70.38)	(75.68)	(115.75)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.24)	(5.49)	(4.09)	(6.51)	(4.17)	(4.48)	(6.85)
$10	(4.61)	(11.29)	(8.42)	(13.40)	(8.57)	(9.22)	(14.10)
$15	(7.25)	(17.76)	(13.24)	(21.08)	(13.49)	(14.50)	(22.18)
$20	(10.22)	(25.04)	(18.66)	(29.71)	(19.01)	(20.44)	(31.26)
$25	(13.47)	(33.00)	(24.60)	(39.16)	(25.05)	(26.94)	(41.20)
$30	(17.17)	(42.07)	(31.35)	(49.91)	(31.94)	(34.34)	(52.52)
$35	(20.67)	(50.64)	(37.74)	(60.09)	(38.45)	(41.34)	(63.23)
$40	(24.24)	(59.39)	(44.26)	(70.47)	(45.09)	(48.48)	(74.15)
$45	(28.02)	(68.65)	(51.16)	(81.45)	(52.12)	(56.04)	(85.71)
$50	(32.00)	(78.40)	(58.43)	(93.02)	(59.52)	(64.00)	(97.89)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$150	(2.19)	(5.37)	(4.00)	(6.37)	(4.07)	(4.38)	(6.70)
$200	(3.10)	(7.60)	(5.66)	(9.01)	(5.77)	(6.20)	(9.48)
$250	(4.46)	(10.93)	(8.14)	(12.97)	(8.30)	(8.92)	(13.64)
$500	(10.68)	(26.17)	(19.50)	(31.05)	(19.86)	(21.36)	(32.67)
$750	(18.30)	(44.84)	(33.42)	(53.20)	(34.04)	(36.60)	(55.98)
$1,000	(27.55)	(67.50)	(50.31)	(80.09)	(51.24)	(55.10)	(84.28)
Copay/Day							
$50 w/3 Day Max	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$50 w/5 Day Max	(2.21)	(5.41)	(4.04)	(6.42)	(4.11)	(4.42)	(6.76)
$100 w/3 Day Max	(4.00)	(9.80)	(7.30)	(11.63)	(7.44)	(8.00)	(12.24)
$100 w/5 Day Max	(5.78)	(14.16)	(10.55)	(16.80)	(10.75)	(11.56)	(17.68)
$250 w/3 Day Max	(13.27)	(32.51)	(24.23)	(38.58)	(24.68)	(26.54)	(40.59)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$75	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$100	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$125	(2.11)	(5.17)	(3.85)	(6.13)	(3.92)	(4.22)	(6.45)
$150	(2.63)	(6.44)	(4.80)	(7.65)	(4.89)	(5.26)	(8.05)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$25	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$35	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$50	(1.53)	(3.75)	(2.79)	(4.45)	(2.85)	(3.06)	(4.68)
$60	(1.93)	(4.73)	(3.52)	(5.61)	(3.59)	(3.86)	(5.90)
$75	(2.54)	(6.22)	(4.64)	(7.38)	(4.72)	(5.08)	(7.77)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child[ren]	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.26)	(0.63)	(0.47)	(0.75)	(0.47)	(0.51)	(0.78)
$10	(0.55)	(1.34)	(1.00)	(1.60)	(1.03)	(1.10)	(1.68)
$15	(0.92)	(2.26)	(1.69)	(2.68)	(1.71)	(1.84)	(2.82)
$20	(1.41)	(3.45)	(2.58)	(4.10)	(2.63)	(2.82)	(4.31)
$25	(1.86)	(4.57)	(3.41)	(5.42)	(3.47)	(3.73)	(5.70)
$30	(2.35)	(5.75)	(4.28)	(6.83)	(4.37)	(4.69)	(7.18)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.48)
$10	(0.32)	(0.78)	(0.58)	(0.92)	(0.59)	(0.64)	(0.97)
$15	(0.53)	(1.31)	(0.98)	(1.56)	(1.00)	(1.07)	(1.64)
$20	(0.81)	(1.99)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$25	(1.06)	(2.58)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$30	(1.35)	(3.32)	(2.48)	(3.94)	(2.52)	(2.71)	(4.14)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.20)	(0.47)	(0.36)	(0.57)	(0.37)	(0.39)	(0.60)
$10	(0.40)	(0.99)	(0.74)	(1.17)	(0.75)	(0.81)	(1.23)
$15	(0.62)	(1.52)	(1.14)	(1.80)	(1.16)	(1.24)	(1.90)
$20	(0.88)	(2.17)	(1.61)	(2.56)	(1.64)	(1.76)	(2.70)
$25	(1.16)	(2.85)	(2.11)	(3.38)	(2.16)	(2.32)	(3.55)
$30	(1.47)	(3.59)	(2.67)	(4.27)	(2.74)	(2.93)	(4.49)
$35	(1.78)	(4.35)	(3.25)	(5.17)	(3.31)	(3.55)	(5.43)
$40	(2.07)	(5.07)	(3.77)	(6.01)	(3.85)	(4.14)	(6.33)
$45	(2.41)	(5.90)	(4.40)	(7.01)	(4.48)	(4.82)	(7.37)
$50	(2.75)	(6.73)	(5.02)	(7.99)	(5.11)	(5.49)	(8.40)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.30)	(0.47)	(0.31)	(0.32)	(0.49)
$10	(0.33)	(0.80)	(0.60)	(0.95)	(0.60)	(0.66)	(1.00)
$15	(0.53)	(1.31)	(0.98)	(1.56)	(1.00)	(1.07)	(1.64)
$20	(0.74)	(1.80)	(1.34)	(2.14)	(1.37)	(1.47)	(2.24)
$25	(0.98)	(2.40)	(1.79)	(2.84)	(1.82)	(1.96)	(2.98)
$30	(1.24)	(3.05)	(2.26)	(3.61)	(2.32)	(2.48)	(3.80)
$35	(1.50)	(3.68)	(2.74)	(4.38)	(2.80)	(3.01)	(4.60)
$40	(1.76)	(4.33)	(3.22)	(5.13)	(3.28)	(3.53)	(5.39)
$45	(2.02)	(4.96)	(3.69)	(5.88)	(3.77)	(4.05)	(6.18)
$50	(2.32)	(5.67)	(4.23)	(6.73)	(4.31)	(4.63)	(7.08)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.19)	(0.13)	(0.23)	(0.14)	(0.16)	(0.24)
$150	(0.16)	(0.41)	(0.30)	(0.48)	(0.30)	(0.33)	(0.51)
$200	(0.23)	(0.56)	(0.42)	(0.66)	(0.43)	(0.46)	(0.70)
$250	(0.32)	(0.80)	(0.59)	(0.95)	(0.60)	(0.65)	(0.99)
$500	(0.78)	(1.91)	(1.42)	(2.26)	(1.45)	(1.56)	(2.38)
$750	(1.32)	(3.23)	(2.41)	(3.83)	(2.46)	(2.63)	(4.03)
$1,000	(1.99)	(4.88)	(3.64)	(5.80)	(3.71)	(3.98)	(6.10)
Copay/Day							
$50 w/3 Day Max	(0.12)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
$50 w/5 Day Max	(0.16)	(0.40)	(0.30)	(0.47)	(0.30)	(0.33)	(0.49)
$100 w/3 Day Max	(0.28)	(0.69)	(0.51)	(0.82)	(0.53)	(0.56)	(0.87)
$100 w/5 Day Max	(0.42)	(1.03)	(0.76)	(1.23)	(0.79)	(0.84)	(1.29)
$250 w/3 Day Max	(0.96)	(2.35)	(1.74)	(2.79)	(1.77)	(1.91)	(2.92)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.09)	(0.13)
$75	(0.08)	(0.18)	(0.14)	(0.22)	(0.14)	(0.15)	(0.23)
$100	(0.12)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
$125	(0.16)	(0.39)	(0.29)	(0.45)	(0.29)	(0.31)	(0.48)
$150	(0.20)	(0.48)	(0.36)	(0.58)	(0.37)	(0.39)	(0.60)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$25	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$35	(0.08)	(0.20)	(0.16)	(0.24)	(0.15)	(0.17)	(0.25)
$50	(0.12)	(0.29)	(0.21)	(0.36)	(0.23)	(0.24)	(0.37)
$60	(0.14)	(0.35)	(0.26)	(0.42)	(0.27)	(0.29)	(0.44)
$75	(0.19)	(0.46)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child[ren]	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.8%	7.7%	7.7%	7.7%	7.5%	7.6%	7.6%
$10	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$15	7.8%	7.9%	7.9%	7.9%	7.8%	7.8%	7.9%
$20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.3%	8.2%	8.2%	8.2%	8.4%	8.3%	8.1%
$10	7.9%	7.9%	7.9%	7.8%	7.8%	7.9%	7.8%
$15	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
$20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$25	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.2%	7.8%	8.0%	8.0%	8.1%	7.9%	8.0%
$10	7.9%	8.0%	8.0%	7.9%	8.0%	8.0%	7.9%
$15	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
$25	7.8%	7.9%	7.8%	7.9%	7.9%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$35	7.9%	7.8%	7.9%	7.9%	7.9%	7.8%	7.8%
$40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.7%	7.6%	7.9%	7.8%	8.0%	7.7%	7.7%
$10	7.7%	7.6%	7.7%	7.6%	7.5%	7.7%	7.6%
$15	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
$20	7.8%	7.7%	7.7%	7.8%	7.8%	7.7%	7.7%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$35	7.8%	7.8%	7.8%	7.9%	7.9%	7.9%	7.8%
$40	7.8%	7.9%	7.8%	7.9%	7.8%	7.9%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	6.6%	6.3%	5.8%	6.5%	6.1%	6.6%	6.4%
$150	7.9%	8.3%	8.1%	8.1%	8.0%	8.1%	8.2%
$200	8.0%	8.0%	8.0%	7.9%	8.1%	8.0%	8.0%
$250	7.7%	7.9%	7.8%	7.9%	7.8%	7.9%	7.8%
$500	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%	7.9%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Day							
$50 w/3 Day Max	8.1%	7.7%	7.7%	7.6%	7.6%	7.7%	7.9%
$50 w/5 Day Max	7.8%	8.0%	8.0%	7.9%	7.9%	8.1%	7.8%
$100 w/3 Day Max	7.5%	7.6%	7.5%	7.6%	7.7%	7.5%	7.7%
$100 w/5 Day Max	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.9%
$250 w/3 Day Max	7.8%	7.8%	7.7%	7.8%	7.7%	7.8%	7.8%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	6.3%	7.1%	6.9%	7.0%	6.8%	7.1%	6.7%
$75	7.7%	7.0%	7.3%	7.2%	7.2%	7.2%	7.2%
$100	8.1%	7.7%	7.7%	7.6%	7.6%	7.7%	7.9%
$125	8.2%	8.2%	8.1%	7.9%	8.0%	7.9%	8.0%
$150	8.2%	8.1%	8.1%	8.2%	8.2%	8.0%	8.1%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
$25	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
$35	9.5%	9.8%	10.5%	9.9%	9.6%	10.2%	9.8%
$50	8.5%	8.4%	8.1%	8.8%	8.8%	8.5%	8.6%
$60	7.8%	8.0%	8.0%	8.1%	8.1%	8.1%	8.1%
$75	8.1%	8.0%	8.2%	8.1%	8.0%	8.1%	8.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.34)	(8.19)	(6.10)	(9.71)	(6.21)	(6.68)	(10.23)
$125	(4.14)	(10.13)	(7.55)	(12.02)	(7.70)	(8.27)	(12.65)
$150	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.57	1.41	1.04	1.67	1.07	1.15	1.75
60	1.12	2.74	2.04	3.25	2.08	2.24	3.42
90	1.68	4.12	3.07	4.89	3.12	3.36	5.14
120	1.97	4.84	3.60	5.73	3.68	3.95	6.04
Unlimited	2.55	6.25	4.66	7.41	4.74	5.10	7.79
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
40/$10 copay	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
40/$15 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$20 copay	(0.63)	(1.54)	(1.15)	(1.82)	(1.17)	(1.25)	(1.92)
40/$25 copay	(0.85)	(2.07)	(1.55)	(2.45)	(1.58)	(1.69)	(2.59)
60	0.30	0.74	0.55	0.88	0.56	0.61	0.93
100	0.74	1.82	1.36	2.15	1.38	1.48	2.27
200	1.97	4.84	3.60	5.73	3.68	3.95	6.04
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.17)	(2.86)	(2.14)	(3.40)	(2.17)	(2.34)	(3.58)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.77	1.89	1.41	2.25	1.44	1.55	2.36
90	1.61	3.94	2.93	4.68	2.99	3.22	4.92
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.69	1.69	1.26	2.01	1.28	1.38	2.11
90	1.26	3.09	2.31	3.68	2.35	2.53	3.86
120	2.05	5.01	3.74	5.95	3.81	4.09	6.27
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.98)	(2.40)	(1.80)	(2.85)	(1.83)	(1.96)	(3.01)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.29	0.72	0.53	0.85	0.54	0.58	0.90
30	0.47	1.15	0.86	1.37	0.88	0.94	1.44
Unlimited	0.69	1.69	1.26	2.01	1.28	1.38	2.11
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.47	8.49	6.33	10.08	6.44	6.94	10.61
60	4.06	9.95	7.42	11.81	7.56	8.13	12.43
90	4.85	11.88	8.85	14.09	9.01	9.69	14.82
Unlimited	4.92	12.05	8.98	14.30	9.15	9.84	15.05
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.19)	(0.30)	(0.20)	(0.21)	(0.32)
60/$10 copay	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.87)
60/$15 copay	(0.43)	(1.04)	(0.78)	(1.24)	(0.79)	(0.86)	(1.31)
60/$20 copay	(0.58)	(1.43)	(1.07)	(1.70)	(1.09)	(1.17)	(1.79)
60/$25 copay	(0.71)	(1.74)	(1.30)	(2.07)	(1.32)	(1.42)	(2.17)
120/$0 copay	0.61	1.48	1.11	1.77	1.13	1.21	1.85
120/$5 copay	0.47	1.15	0.86	1.37	0.88	0.94	1.44
120/$10 copay	0.28	0.69	0.51	0.81	0.52	0.56	0.87
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.41)	(0.30)	(0.49)	(0.31)	(0.33)	(0.51)
120/$25 copay	(0.34)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.05)
Unlimited/$0 copay	0.70	1.71	1.27	2.04	1.31	1.40	2.14
Unlimited/$5 copay	0.53	1.31	0.97	1.55	0.99	1.07	1.63
Unlimited/$10 copa	0.34	0.85	0.63	1.00	0.64	0.69	1.05
Unlimited/$15 copa	0.08	0.21	0.16	0.24	0.16	0.17	0.25
Unlimited/$20 copa	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
Unlimited/$25 copa	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.18	0.44	0.32	0.51	0.33	0.36	0.54
$5	0.08	0.21	0.16	0.24	0.16	0.17	0.25
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.19)	(0.30)	(0.20)	(0.21)	(0.32)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(3.60)	(8.82)	(6.57)	(10.47)	(6.70)	(7.20)	(11.01)
$125	(4.46)	(10.93)	(8.14)	(12.97)	(8.30)	(8.92)	(13.64)
$150	(5.31)	(13.01)	(9.70)	(15.44)	(9.88)	(10.62)	(16.24)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.61	1.49	1.11	1.77	1.13	1.22	1.87
60	1.20	2.94	2.19	3.49	2.23	2.40	3.67
90	1.80	4.41	3.29	5.23	3.35	3.60	5.51
120	2.13	5.22	3.89	6.19	3.96	4.26	6.52
Unlimited	2.75	6.74	5.02	7.99	5.12	5.50	8.41
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
40/$10 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
40/$15 copay	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
40/$20 copay	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
40/$25 copay	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
60	0.34	0.83	0.62	0.99	0.63	0.68	1.04
100	0.78	1.91	1.42	2.27	1.45	1.56	2.39
200	2.13	5.22	3.89	6.19	3.96	4.26	6.52
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.25)	(3.06)	(2.28)	(3.63)	(2.33)	(2.50)	(3.82)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.83	2.03	1.52	2.41	1.54	1.66	2.54
90	1.73	4.24	3.16	5.03	3.22	3.46	5.29
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.73	1.79	1.33	2.12	1.36	1.46	2.23
90	1.35	3.31	2.47	3.92	2.51	2.70	4.13
120	2.21	5.41	4.04	6.42	4.11	4.42	6.76
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.33	0.81	0.60	0.96	0.61	0.66	1.01
30	0.51	1.25	0.93	1.48	0.95	1.02	1.56
Unlimited	0.73	1.79	1.33	2.12	1.36	1.46	2.23
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	3.75	9.19	6.85	10.90	6.98	7.50	11.47
60	4.38	10.73	8.00	12.73	8.15	8.76	13.40
90	5.23	12.81	9.55	15.20	9.73	10.46	16.00
Unlimited	5.31	13.01	9.70	15.44	9.88	10.62	16.24
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
60/$10 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
60/$15 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
60/$20 copay	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
60/$25 copay	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
120/$0 copay	0.65	1.59	1.19	1.89	1.21	1.30	1.99
120/$5 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.56
120/$10 copay	0.32	0.78	0.58	0.93	0.60	0.64	0.98
120/$15 copay	0.02	0.05	0.04	0.06	0.04	0.04	0.06
120/$20 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
120/$25 copay	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
Unlimited/$0 copay	0.74	1.81	1.35	2.15	1.38	1.48	2.26
Unlimited/$5 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
Unlimited/$10 copa	0.38	0.93	0.69	1.10	0.71	0.76	1.16
Unlimited/$15 copa	0.08	0.20	0.15	0.23	0.15	0.16	0.24
Unlimited/$20 copa	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
Unlimited/$25 copa	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.18	0.44	0.33	0.52	0.33	0.36	0.55
$5	0.08	0.20	0.15	0.23	0.15	0.16	0.24
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(0.26)	(0.63)	(0.47)	(0.76)	(0.49)	(0.52)	(0.78)
$125	(0.32)	(0.80)	(0.59)	(0.95)	(0.60)	(0.65)	(0.99)
$150	(0.39)	(0.96)	(0.72)	(1.14)	(0.73)	(0.78)	(1.19)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.08	0.07	0.10	0.06	0.07	0.12
60	0.08	0.20	0.15	0.24	0.15	0.16	0.25
90	0.12	0.29	0.22	0.34	0.23	0.24	0.37
120	0.16	0.38	0.29	0.46	0.28	0.31	0.48
Unlimited	0.20	0.49	0.36	0.58	0.38	0.40	0.62
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
40/$10 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
40/$15 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
40/$20 copay	(0.04)	(0.10)	(0.07)	(0.13)	(0.08)	(0.09)	(0.13)
40/$25 copay	(0.08)	(0.21)	(0.15)	(0.25)	(0.15)	(0.17)	(0.25)
60	0.04	0.09	0.07	0.11	0.07	0.07	0.11
100	0.04	0.09	0.06	0.12	0.07	0.08	0.12
200	0.16	0.38	0.29	0.46	0.28	0.31	0.48
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.08)	(0.20)	(0.14)	(0.23)	(0.16)	(0.16)	(0.24)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.06	0.14	0.11	0.16	0.10	0.11	0.18
90	0.12	0.30	0.23	0.35	0.23	0.24	0.37
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.07	0.11	0.08	0.08	0.12
90	0.09	0.22	0.16	0.24	0.16	0.17	0.27
120	0.16	0.40	0.30	0.47	0.30	0.33	0.49
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.16)	(0.23)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.04	0.09	0.07	0.11	0.07	0.08	0.11
30	0.04	0.10	0.07	0.11	0.07	0.08	0.12
Unlimited	0.04	0.10	0.07	0.11	0.08	0.08	0.12
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.28	0.70	0.52	0.82	0.54	0.56	0.86
60	0.32	0.78	0.58	0.92	0.59	0.63	0.97
90	0.38	0.93	0.70	1.11	0.72	0.77	1.18
Unlimited	0.39	0.96	0.72	1.14	0.73	0.78	1.19
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.00	0.01	0.01	0.01	0.01	0.01
60/$10 copay	(0.04)	(0.09)	(0.07)	(0.12)	(0.08)	(0.08)	(0.11)
60/$15 copay	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
60/$20 copay	(0.04)	(0.09)	(0.06)	(0.10)	(0.06)	(0.07)	(0.11)
60/$25 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.08)	(0.08)	(0.12)
120/$0 copay	0.04	0.11	0.08	0.12	0.08	0.09	0.14
120/$5 copay	0.04	0.10	0.07	0.11	0.07	0.08	0.12
120/$10 copay	0.04	0.09	0.07	0.12	0.08	0.08	0.11
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	0.00	(0.01)	(0.01)	0.00	(0.01)	(0.01)	(0.01)
120/$25 copay	(0.04)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.11)
Unlimited/$0 copay	0.04	0.10	0.08	0.11	0.07	0.08	0.12
Unlimited/$5 copay	0.04	0.09	0.07	0.11	0.07	0.07	0.11
Unlimited/$10 copa	0.04	0.08	0.06	0.10	0.07	0.07	0.11
Unlimited/$15 copa	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Unlimited/$20 copa	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Unlimited/$25 copa	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.00	0.00	0.01	0.01	0.00	0.00	0.01
$5	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.01	0.01	0.01	0.01	0.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	7.8%	7.7%	7.7%	7.8%	7.9%	7.8%	7.6%
$125	7.7%	7.9%	7.8%	7.9%	7.8%	7.9%	7.8%
$150	7.9%	8.0%	8.0%	8.0%	8.0%	7.9%	7.9%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	7.0%	5.7%	6.7%	6.0%	5.6%	6.1%	6.9%
60	7.1%	7.3%	7.4%	7.4%	7.2%	7.1%	7.3%
90	7.1%	7.0%	7.2%	7.0%	7.4%	7.1%	7.2%
120	8.1%	7.9%	8.1%	8.0%	7.6%	7.8%	7.9%
Unlimited	7.8%	7.8%	7.7%	7.8%	8.0%	7.8%	8.0%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
40/$10 copay	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
40/$15 copay	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
40/$20 copay	6.3%	6.5%	6.1%	7.1%	6.8%	7.2%	6.8%
40/$25 copay	9.4%	10.1%	9.7%	10.2%	9.5%	10.1%	9.7%
60	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
100	5.4%	4.9%	4.4%	5.6%	5.1%	5.4%	5.3%
200	8.1%	7.9%	8.1%	8.0%	7.6%	7.8%	7.9%
** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*							
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	6.8%	7.0%	6.5%	6.8%	7.4%	6.8%	6.7%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.8%	7.4%	7.8%	7.1%	6.9%	7.1%	7.6%
90	7.5%	7.6%	7.8%	7.5%	7.7%	7.5%	7.5%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	5.8%	5.9%	5.6%	5.5%	6.3%	5.8%	5.7%
90	7.1%	7.1%	6.9%	6.5%	6.8%	6.7%	7.0%
120	7.8%	8.0%	8.0%	7.9%	7.9%	8.1%	7.8%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.2%	8.3%	7.8%	8.1%	7.7%	8.2%	7.6%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
30	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
Unlimited	5.8%	5.9%	5.6%	5.5%	6.3%	5.8%	5.7%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	8.1%	8.2%	8.2%	8.1%	8.4%	8.1%	8.1%
60	7.9%	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%
90	7.8%	7.8%	7.9%	7.9%	8.0%	7.9%	8.0%
Unlimited	7.9%	8.0%	8.0%	8.0%	8.0%	7.9%	7.9%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	0.0%	-5.3%	-3.3%	-5.0%	-4.8%	-3.1%
60/$10 copay	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
60/$15 copay	9.3%	10.6%	10.3%	10.5%	10.1%	9.3%	9.9%
60/$20 copay	6.9%	6.3%	5.6%	5.9%	5.5%	6.0%	6.1%
60/$25 copay	5.6%	5.7%	5.4%	5.3%	6.1%	5.6%	5.5%
120/$0 copay	6.6%	7.4%	7.2%	6.8%	7.1%	7.4%	7.6%
120/$5 copay	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
120/$10 copay	14.3%	13.0%	13.7%	14.8%	15.4%	14.3%	12.6%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	0.0%	2.4%	3.3%	0.0%	3.2%	3.0%	2.0%
120/$25 copay	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
Unlimited/$0 copay	5.7%	5.8%	6.3%	5.4%	5.3%	5.7%	5.6%
Unlimited/$5 copay	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
Unlimited/$10 copa	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
Unlimited/$15 copa	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
Unlimited/$20 copa	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
Unlimited/$25 copa	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.0%	0.0%	3.1%	2.0%	0.0%	0.0%	1.9%
$5	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	-5.3%	-3.3%	-5.0%	-4.8%	-3.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.31)	(0.76)	(0.57)	(0.91)	(0.58)	(0.63)	(0.96)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$10	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
$15	(0.47)	(1.15)	(0.86)	(1.37)	(0.88)	(0.94)	(1.44)
$20	(0.67)	(1.64)	(1.22)	(1.94)	(1.24)	(1.34)	(2.05)
$25	(0.87)	(2.12)	(1.59)	(2.52)	(1.61)	(1.73)	(2.65)
$30	(1.04)	(2.56)	(1.91)	(3.04)	(1.94)	(2.09)	(3.20)
$35	(1.23)	(3.02)	(2.25)	(3.58)	(2.29)	(2.46)	(3.77)
$40	(1.43)	(3.51)	(2.61)	(4.16)	(2.66)	(2.86)	(4.38)
$45	(1.62)	(3.97)	(2.96)	(4.71)	(3.01)	(3.24)	(4.95)
$50	(1.80)	(4.40)	(3.28)	(5.22)	(3.34)	(3.59)	(5.49)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
$10	(0.34)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.05)
$15	(0.50)	(1.23)	(0.92)	(1.46)	(0.93)	(1.00)	(1.54)
$20	(0.74)	(1.82)	(1.36)	(2.15)	(1.38)	(1.48)	(2.27)
$25	(1.00)	(2.45)	(1.83)	(2.91)	(1.87)	(2.01)	(3.07)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$20	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$25	(0.11)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$25	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
$35	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
$60	(0.43)	(1.04)	(0.78)	(1.24)	(0.79)	(0.86)	(1.31)
$75	(0.55)	(1.36)	(1.01)	(1.61)	(1.03)	(1.11)	(1.69)
$100	(0.74)	(1.82)	(1.36)	(2.15)	(1.38)	(1.48)	(2.27)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.11)	(0.28)	(0.21)	(0.33)	(0.21)	(0.23)	(0.36)
$35	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)
$75	(0.38)	(0.92)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
$100	(0.50)	(1.23)	(0.92)	(1.46)	(0.93)	(1.00)	(1.54)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.12)	(7.66)	(5.70)	(9.08)	(5.81)	(6.25)	(9.56)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.84)	(11.84)	(8.83)	(14.06)	(8.99)	(9.67)	(14.79)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.42)	(1.02)	(0.76)	(1.21)	(0.77)	(0.84)	(1.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$10	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$15	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$20	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$25	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$30	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$35	(1.31)	(3.21)	(2.39)	(3.81)	(2.44)	(2.62)	(4.01)
$40	(1.55)	(3.80)	(2.83)	(4.51)	(2.88)	(3.10)	(4.74)
$45	(1.74)	(4.26)	(3.18)	(5.06)	(3.24)	(3.48)	(5.32)
$50	(1.94)	(4.75)	(3.54)	(5.64)	(3.61)	(3.88)	(5.93)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$10	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$15	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$20	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
$25	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$20	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$25	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$35	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$50	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$60	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$75	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$100	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$35	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$60	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
$75	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$100	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.36)	(8.23)	(6.14)	(9.77)	(6.25)	(6.72)	(10.28)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(5.22)	(12.79)	(9.53)	(15.17)	(9.71)	(10.44)	(15.97)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$10	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$20	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.12)
$25	(0.08)	(0.21)	(0.14)	(0.24)	(0.16)	(0.17)	(0.26)
$30	(0.08)	(0.18)	(0.14)	(0.22)	(0.14)	(0.15)	(0.23)
$35	(0.08)	(0.19)	(0.14)	(0.23)	(0.15)	(0.16)	(0.24)
$40	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.36)
$45	(0.12)	(0.29)	(0.22)	(0.35)	(0.23)	(0.24)	(0.37)
$50	(0.14)	(0.35)	(0.26)	(0.42)	(0.27)	(0.29)	(0.44)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$10	(0.04)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.11)
$15	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$20	(0.04)	(0.09)	(0.06)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.15)	(0.23)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$20	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.02
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$25	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$35	0.00	0.00	0.01	0.00	0.00	0.00	0.00
$50	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
$60	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
$75	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$100	(0.04)	(0.09)	(0.06)	(0.12)	(0.07)	(0.08)	(0.12)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.02
$35	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$60	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$75	(0.04)	(0.11)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.24)	(0.57)	(0.44)	(0.69)	(0.44)	(0.47)	(0.72)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(0.38)	(0.95)	(0.70)	(1.11)	(0.72)	(0.77)	(1.18)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.04)	(0.11)	(0.08)	(0.13)	(0.09)	(0.08)	(0.14)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP CONTRACT - BASE BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
$25	12.9%	13.2%	12.3%	12.1%	12.1%	11.1%	11.5%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$10	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
$15	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
$20	6.0%	6.1%	6.6%	6.2%	6.5%	6.0%	5.9%
$25	9.2%	9.9%	8.8%	9.5%	9.9%	9.8%	9.8%
$30	7.7%	7.0%	7.3%	7.2%	7.2%	7.2%	7.2%
$35	6.5%	6.3%	6.2%	6.4%	6.6%	6.5%	6.4%
$40	8.4%	8.3%	8.4%	8.4%	8.3%	8.4%	8.2%
$45	7.4%	7.3%	7.4%	7.4%	7.6%	7.4%	7.5%
$50	7.8%	8.0%	7.9%	8.0%	8.1%	8.1%	8.0%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
$10	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
$15	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
$20	5.4%	4.9%	4.4%	5.6%	5.1%	5.4%	5.3%
$25	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$20	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$25	0.0%	-3.6%	-4.8%	-3.0%	-4.8%	-4.3%	-5.6%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$25	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
$35	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
$50	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
$60	9.3%	10.6%	10.3%	10.5%	10.1%	9.3%	9.9%
$75	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
$100	5.4%	4.9%	4.4%	5.6%	5.1%	5.4%	5.3%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-3.6%	-4.8%	-3.0%	-4.8%	-4.3%	-5.6%
$35	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
$50	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$60	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%
$75	10.5%	12.0%	11.6%	10.9%	11.4%	12.0%	11.3%
$100	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	7.7%	7.4%	7.7%	7.6%	7.6%	7.5%	7.5%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	7.9%	8.0%	7.9%	7.9%	8.0%	8.0%	8.0%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
19	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
19	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
19	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
19	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP HMO Access 1 LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
	Dependent Coverage						
	Expressed as % add-on to each premium rate otherwise computed						
	Dependent Children [std: covered to 19 end of month]						
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Full-time Students [std: covered to 23 end of year]						
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.07	19.78	14.74	23.47	15.02	16.15	24.70
60	8.51	20.86	15.54	24.74	15.83	17.02	26.04
90	8.83	21.62	16.12	25.65	16.42	17.65	27.00
Unlimited	8.92	21.85	16.28	25.93	16.59	17.84	27.28
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.02	22.11	16.48	26.24	16.78	18.05	27.61
30	9.93	24.34	18.13	28.88	18.48	19.87	30.38
40	10.49	25.69	19.15	30.49	19.50	20.97	32.08
60	11.05	27.07	20.18	32.13	20.56	22.10	33.80
Unlimited	11.14	27.30	20.35	32.40	20.73	22.29	34.09
LARGE GROUP				**$5 Copay**			
20	8.49	20.81	15.50	24.68	15.79	16.98	25.98
30	9.34	22.87	17.05	27.15	17.37	18.68	28.57
40	9.92	24.30	18.12	28.85	18.46	19.85	30.35
60	10.39	25.46	18.98	30.21	19.33	20.79	31.79
Unlimited	10.48	25.66	19.12	30.46	19.49	20.95	32.04
LARGE GROUP				**$10 Copay**			
20	7.95	19.47	14.52	23.10	14.78	15.90	24.32
30	8.74	21.42	15.96	25.41	16.26	17.48	26.74
40	9.24	22.64	16.88	26.87	17.19	18.49	28.27
60	9.74	23.88	17.80	28.33	18.12	19.49	29.81
Unlimited	9.82	24.05	17.92	28.55	18.26	19.64	30.03
LARGE GROUP				**$15 Copay**			
20	7.46	18.27	13.62	21.68	13.87	14.92	22.81
30	8.21	20.12	14.99	23.87	15.27	16.42	25.11
40	8.70	21.32	15.89	25.30	16.18	17.40	26.61
60	9.20	22.54	16.81	26.75	17.12	18.40	28.15
Unlimited	9.27	22.73	16.93	26.96	17.25	18.55	28.37
LARGE GROUP				**$20 Copay**			
20	7.02	17.19	12.82	20.40	13.06	14.04	21.47
30	7.69	18.83	14.04	22.35	14.30	15.37	23.51
40	8.12	19.89	14.82	23.59	15.09	16.23	24.83
60	8.63	21.14	15.75	25.08	16.04	17.25	26.39
Unlimited	8.69	21.29	15.87	25.27	16.16	17.38	26.58
LARGE GROUP				**$25 Copay**			
20	6.52	15.97	11.90	18.95	12.13	13.04	19.94
30	7.15	17.53	13.07	20.80	13.31	14.31	21.88
40	7.64	18.71	13.94	22.20	14.20	15.27	23.35
60	8.03	19.68	14.66	23.34	14.94	16.06	24.57
Unlimited	8.11	19.86	14.80	23.56	15.07	16.21	24.80
LARGE GROUP				**$30 Copay**			
20	6.23	15.25	11.36	18.10	11.58	12.45	19.04
30	6.75	16.53	12.32	19.62	12.55	13.49	20.64
40	7.18	17.58	13.10	20.86	13.35	14.35	21.95
60	7.54	18.48	13.77	21.92	14.03	15.08	23.07
Unlimited	7.58	18.58	13.85	22.04	14.10	15.17	23.20
LARGE GROUP				**$35 Copay**			
20	5.91	14.49	10.79	17.18	11.00	11.82	18.08
30	6.32	15.48	11.54	18.37	11.75	12.64	19.33
40	6.72	16.45	12.26	19.52	12.49	13.43	20.54
60	7.05	17.28	12.88	20.49	13.11	14.10	21.57
Unlimited	7.10	17.40	12.97	20.65	13.21	14.20	21.73
LARGE GROUP				**$40 Copay**			
20	5.77	14.12	10.53	16.76	10.73	11.53	17.64
30	6.14	15.05	11.22	17.85	11.43	12.28	18.79
40	6.54	16.02	11.94	19.01	12.16	13.08	20.00
60	6.90	16.91	12.61	20.07	12.84	13.81	21.12
Unlimited	6.95	17.01	12.68	20.19	12.92	13.89	21.24
LARGE GROUP				**$45 Copay**			
20	5.58	13.66	10.18	16.21	10.37	11.15	17.06
30	5.96	14.61	10.89	17.34	11.09	11.93	18.25
40	6.38	15.64	11.66	18.55	11.87	12.76	19.52
60	6.74	16.50	12.30	19.58	12.53	13.47	20.61

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.70	21.32	15.89	25.29	16.18	17.40	26.61
60	9.17	22.47	16.74	26.66	17.06	18.34	28.05
90	9.52	23.32	17.38	27.67	17.71	19.04	29.12
Unlimited	9.62	23.57	17.57	27.97	17.89	19.24	29.43
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	9.72	23.81	17.75	28.26	18.08	19.44	29.73
30	10.71	26.24	19.56	31.13	19.92	21.42	32.76
40	11.31	27.71	20.65	32.88	21.04	22.62	34.60
60	11.91	29.18	21.75	34.62	22.15	23.82	36.43
Unlimited	12.01	29.42	21.93	34.91	22.34	24.02	36.74
LARGE GROUP				**$5 Copay**			
20	9.15	22.42	16.71	26.60	17.02	18.30	27.99
30	10.07	24.67	18.39	29.27	18.73	20.14	30.80
40	10.70	26.22	19.54	31.10	19.90	21.40	32.73
60	11.21	27.46	20.47	32.59	20.85	22.42	34.29
Unlimited	11.30	27.69	20.63	32.85	21.02	22.60	34.57
LARGE GROUP				**$10 Copay**			
20	8.57	21.00	15.65	24.91	15.94	17.14	26.22
30	9.43	23.10	17.22	27.41	17.54	18.86	28.85
40	9.97	24.43	18.21	28.98	18.54	19.94	30.50
60	10.51	25.75	19.19	30.55	19.55	21.02	32.15
Unlimited	10.59	25.95	19.34	30.79	19.70	21.18	32.39
LARGE GROUP				**$15 Copay**			
20	8.04	19.70	14.68	23.37	14.95	16.08	24.59
30	8.86	21.71	16.18	25.76	16.48	17.72	27.10
40	9.38	22.98	17.13	27.27	17.45	18.76	28.69
60	9.91	24.28	18.10	28.81	18.43	19.82	30.31
Unlimited	10.00	24.50	18.26	29.07	18.60	20.00	30.59
LARGE GROUP				**$20 Copay**			
20	7.57	18.55	13.82	22.01	14.08	15.14	23.16
30	8.29	20.31	15.14	24.10	15.42	16.58	25.36
40	8.75	21.44	15.98	25.44	16.28	17.50	26.77
60	9.30	22.79	16.98	27.04	17.30	18.60	28.45
Unlimited	9.37	22.96	17.11	27.24	17.43	18.74	28.66
LARGE GROUP				**$25 Copay**			
20	7.03	17.22	12.84	20.44	13.08	14.06	21.50
30	7.71	18.89	14.08	22.41	14.34	15.42	23.58
40	8.24	20.19	15.05	23.95	15.33	16.48	25.21
60	8.66	21.22	15.81	25.17	16.11	17.32	26.49
Unlimited	8.74	21.41	15.96	25.41	16.26	17.48	26.74
LARGE GROUP				**$30 Copay**			
20	6.72	16.46	12.27	19.54	12.50	13.44	20.56
30	7.28	17.84	13.29	21.16	13.54	14.56	22.27
40	7.74	18.96	14.13	22.50	14.40	15.48	23.68
60	8.13	19.92	14.85	23.63	15.12	16.26	24.87
Unlimited	8.17	20.02	14.92	23.75	15.20	16.34	24.99
LARGE GROUP				**$35 Copay**			
20	6.37	15.61	11.63	18.52	11.85	12.74	19.49
30	6.81	16.68	12.44	19.80	12.67	13.62	20.83
40	7.25	17.76	13.24	21.08	13.49	14.50	22.18
60	7.60	18.62	13.88	22.09	14.14	15.20	23.25
Unlimited	7.65	18.74	13.97	22.24	14.23	15.30	23.40
LARGE GROUP				**$40 Copay**			
20	6.22	15.24	11.36	18.08	11.57	12.44	19.03
30	6.62	16.22	12.09	19.24	12.31	13.24	20.25
40	7.05	17.27	12.87	20.49	13.11	14.10	21.57
60	7.44	18.23	13.59	21.63	13.84	14.88	22.76
Unlimited	7.49	18.35	13.68	21.77	13.93	14.98	22.91
LARGE GROUP				**$45 Copay**			
20	6.02	14.75	10.99	17.50	11.20	12.04	18.42
30	6.43	15.75	11.74	18.69	11.96	12.86	19.67
40	6.88	16.86	12.56	20.00	12.80	13.76	21.05
60	7.27	17.81	13.28	21.13	13.52	14.54	22.24

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.63	1.54	1.15	1.82	1.16	1.25	1.91
60	0.66	1.61	1.20	1.92	1.23	1.32	2.01
90	0.69	1.70	1.26	2.02	1.29	1.39	2.12
Unlimited	0.70	1.72	1.29	2.04	1.30	1.40	2.15
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	0.70	1.70	1.27	2.02	1.30	1.39	2.12
30	0.78	1.90	1.43	2.25	1.44	1.55	2.38
40	0.82	2.02	1.50	2.39	1.54	1.65	2.52
60	0.86	2.11	1.57	2.49	1.59	1.72	2.63
Unlimited	0.87	2.12	1.58	2.51	1.61	1.73	2.65
LARGE GROUP				**$5 Copay**			
20	0.66	1.61	1.21	1.92	1.23	1.32	2.01
30	0.73	1.80	1.34	2.12	1.36	1.46	2.23
40	0.78	1.92	1.42	2.25	1.44	1.55	2.38
60	0.82	2.00	1.49	2.38	1.52	1.63	2.50
Unlimited	0.82	2.03	1.51	2.39	1.53	1.65	2.53
LARGE GROUP				**$10 Copay**			
20	0.62	1.53	1.13	1.81	1.16	1.24	1.90
30	0.69	1.68	1.26	2.00	1.28	1.38	2.11
40	0.73	1.79	1.33	2.11	1.35	1.45	2.23
60	0.77	1.87	1.39	2.22	1.43	1.53	2.34
Unlimited	0.77	1.90	1.42	2.24	1.44	1.54	2.36
LARGE GROUP				**$15 Copay**			
20	0.58	1.43	1.06	1.69	1.08	1.16	1.78
30	0.65	1.59	1.19	1.89	1.21	1.30	1.99
40	0.68	1.66	1.24	1.97	1.27	1.36	2.08
60	0.71	1.74	1.29	2.06	1.31	1.42	2.16
Unlimited	0.73	1.77	1.33	2.11	1.35	1.45	2.22
LARGE GROUP				**$20 Copay**			
20	0.55	1.36	1.00	1.61	1.02	1.10	1.69
30	0.60	1.48	1.10	1.75	1.12	1.21	1.85
40	0.63	1.55	1.16	1.85	1.19	1.27	1.94
60	0.67	1.65	1.23	1.96	1.26	1.35	2.06
Unlimited	0.68	1.67	1.24	1.97	1.27	1.36	2.08
LARGE GROUP				**$25 Copay**			
20	0.51	1.25	0.94	1.49	0.95	1.02	1.56
30	0.56	1.36	1.01	1.61	1.03	1.11	1.70
40	0.60	1.48	1.11	1.75	1.13	1.21	1.86
60	0.63	1.54	1.15	1.83	1.17	1.26	1.92
Unlimited	0.63	1.55	1.16	1.85	1.19	1.27	1.94
LARGE GROUP				**$30 Copay**			
20	0.49	1.21	0.91	1.44	0.92	0.99	1.52
30	0.53	1.31	0.97	1.54	0.99	1.07	1.63
40	0.56	1.38	1.03	1.64	1.05	1.13	1.73
60	0.59	1.44	1.08	1.71	1.09	1.18	1.80
Unlimited	0.59	1.44	1.07	1.71	1.10	1.17	1.79
LARGE GROUP				**$35 Copay**			
20	0.46	1.12	0.84	1.34	0.85	0.92	1.41
30	0.49	1.20	0.90	1.43	0.92	0.98	1.50
40	0.53	1.31	0.98	1.56	1.00	1.07	1.64
60	0.55	1.34	1.00	1.60	1.03	1.10	1.68
Unlimited	0.55	1.34	1.00	1.59	1.02	1.10	1.67
LARGE GROUP				**$40 Copay**			
20	0.45	1.12	0.83	1.32	0.84	0.91	1.39
30	0.48	1.17	0.87	1.39	0.88	0.96	1.46
40	0.51	1.25	0.93	1.48	0.95	1.02	1.57
60	0.54	1.32	0.98	1.56	1.00	1.07	1.64
Unlimited	0.54	1.34	1.00	1.58	1.01	1.09	1.67
LARGE GROUP				**$45 Copay**			
20	0.44	1.09	0.81	1.29	0.83	0.89	1.36
30	0.47	1.14	0.85	1.35	0.87	0.93	1.42
40	0.50	1.22	0.90	1.45	0.93	1.00	1.53
60	0.53	1.31	0.98	1.55	0.99	1.07	1.63

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.8%	7.8%	7.8%	7.8%	7.7%	7.7%	7.7%
60	7.8%	7.7%	7.7%	7.8%	7.8%	7.8%	7.7%
90	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.9%	7.9%	7.9%	7.8%	7.8%	7.9%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
LARGE GROUP # Visits				**$0 Copay**			
20	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
30	7.9%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.9%	7.8%	7.8%	7.9%	7.9%	7.9%
60	7.8%	7.8%	7.8%	7.7%	7.7%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%
LARGE GROUP				**$5 Copay**			
20	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%	7.7%
30	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%	7.8%
40	7.9%	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.9%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
Unlimited	7.8%	7.9%	7.9%	7.8%	7.9%	7.9%	7.9%
LARGE GROUP				**$10 Copay**			
20	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%
40	7.9%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
60	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%
Unlimited	7.8%	7.9%	7.9%	7.8%	7.9%	7.8%	7.9%
LARGE GROUP				**$15 Copay**			
20	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
Unlimited	7.9%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP				**$20 Copay**			
20	7.8%	7.9%	7.8%	7.9%	7.8%	7.8%	7.9%
30	7.8%	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%
40	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
60	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
LARGE GROUP				**$25 Copay**			
20	7.8%	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%
30	7.8%	7.8%	7.7%	7.7%	7.7%	7.8%	7.8%
40	7.9%	7.9%	8.0%	7.9%	8.0%	7.9%	8.0%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.8%
LARGE GROUP				**$30 Copay**			
20	7.9%	7.9%	8.0%	8.0%	7.9%	8.0%	8.0%
30	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%	7.9%
40	7.8%	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.7%	7.8%	7.8%	7.7%	7.7%
LARGE GROUP				**$35 Copay**			
20	7.8%	7.7%	7.8%	7.8%	7.7%	7.8%	7.8%
30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
60	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
Unlimited	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP				**$40 Copay**			
20	7.8%	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%
30	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.9%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%
Unlimited	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%	7.9%
LARGE GROUP				**$45 Copay**			
20	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
30	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
60	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	6.77	16.59	12.36	19.68	12.59	13.54	20.70
LARGE GROUP			**$50 Copay**				
20	5.43	13.31	9.91	15.79	10.10	10.86	16.62
30	5.82	14.26	10.62	16.91	10.82	11.64	17.80
40	6.23	15.25	11.36	18.10	11.58	12.45	19.04
60	6.56	16.07	11.98	19.07	12.20	13.12	20.06
Unlimited	6.60	16.17	12.05	19.19	12.27	13.20	20.19

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	7.30	17.89	13.33	21.22	13.58	14.60	22.33
LARGE GROUP			**$50 Copay**				
20	5.86	14.36	10.70	17.04	10.90	11.72	17.93
30	6.27	15.36	11.45	18.23	11.66	12.54	19.18
40	6.72	16.46	12.27	19.54	12.50	13.44	20.56
60	7.07	17.32	12.91	20.55	13.15	14.14	21.63
Unlimited	7.12	17.44	13.00	20.70	13.24	14.24	21.78

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	0.53	1.30	0.97	1.54	0.99	1.06	1.63
LARGE GROUP			**$50 Copay**				
20	0.43	1.05	0.79	1.25	0.80	0.86	1.31
30	0.45	1.10	0.83	1.32	0.84	0.90	1.38
40	0.49	1.21	0.91	1.44	0.92	0.99	1.52
60	0.51	1.25	0.93	1.48	0.95	1.02	1.57
Unlimited	0.52	1.27	0.95	1.51	0.97	1.04	1.59

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess I HMO LARGE GROUP CONTRACT - MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Unlimited	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%
LARGE GROUP			**$50 Copay**				
20	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.9%
30	7.7%	7.7%	7.8%	7.8%	7.8%	7.7%	7.8%
40	7.9%	7.9%	8.0%	8.0%	7.9%	8.0%	8.0%
60	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.48	10.98	8.18	13.02	8.33	8.96	13.70
$25	4.26	10.44	7.78	12.39	7.93	8.52	13.04
$50	3.98	9.74	7.27	11.57	7.41	7.96	12.17
$100	3.67	8.98	6.70	10.65	6.82	7.33	11.22
$500	1.75	4.30	3.21	5.10	3.26	3.51	5.37
Coinsurance							
80%	3.61	8.86	6.60	10.51	6.73	7.23	11.05
75%	3.37	8.26	6.16	9.81	6.28	6.75	10.32
70%	3.15	7.73	5.76	9.17	5.87	6.31	9.65
Deductible			**Orthotics Riders**				
$0	0.76	1.87	1.39	2.21	1.42	1.52	2.33
$25	0.73	1.79	1.34	2.12	1.36	1.46	2.24
$50	0.69	1.69	1.26	2.01	1.28	1.38	2.11
$100	0.62	1.51	1.13	1.80	1.15	1.23	1.88
$500	0.31	0.76	0.57	0.91	0.58	0.63	0.96
Coinsurance							
80%	0.62	1.51	1.13	1.80	1.15	1.23	1.88
75%	0.58	1.43	1.07	1.70	1.09	1.17	1.79
70%	0.55	1.36	1.01	1.61	1.03	1.11	1.69
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.41	3.46	2.58	4.09	2.62	2.82	4.31
12 Months	2.25	5.50	4.10	6.53	4.18	4.49	6.87
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.19	5.37	4.00	6.37	4.08	4.39	6.71
12 Months	3.50	8.58	6.39	10.17	6.51	7.00	10.71
			Private Duty Nursing Riders				
In Full	0.53	1.31	0.97	1.55	0.99	1.07	1.63
0% hrs 73-50	0.08	0.21	0.16	0.24	0.16	0.17	0.25
00% hrs 73-50	0.16	0.39	0.28	0.46	0.29	0.31	0.48
			Dental Network Access				
	0.44	1.08	0.80	1.27	0.81	0.88	1.34
Limit			**Infertility Rider**				
2 IVF	9.49	23.26	17.34	27.60	17.66	18.99	29.05
3 IVF	11.49	28.15	20.98	33.40	21.37	22.98	35.15

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	4.84	11.86	8.84	14.07	9.00	9.68	14.81
$25	4.59	11.25	8.38	13.34	8.54	9.18	14.04
$50	4.30	10.54	7.85	12.50	8.00	8.60	13.15
$100	3.95	9.68	7.21	11.48	7.35	7.90	12.08
$500	1.87	4.58	3.41	5.44	3.48	3.74	5.72
Coinsurance							
80%	3.89	9.53	7.10	11.31	7.24	7.78	11.90
75%	3.64	8.92	6.65	10.58	6.77	7.28	11.13
70%	3.39	8.31	6.19	9.85	6.31	6.78	10.37
Deductible			**Orthotics Riders**				
$0	0.81	1.98	1.48	2.35	1.51	1.62	2.48
$25	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$50	0.73	1.79	1.33	2.12	1.36	1.46	2.23
$100	0.66	1.62	1.21	1.92	1.23	1.32	2.02
$500	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Coinsurance							
80%	0.66	1.62	1.21	1.92	1.23	1.32	2.02
75%	0.62	1.52	1.13	1.80	1.15	1.24	1.90
70%	0.59	1.45	1.08	1.72	1.10	1.18	1.80
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.57	1.40	1.04	1.66	1.06	1.14	1.74
80% hrs 73-50	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100% hrs 73-50	0.16	0.39	0.29	0.47	0.30	0.32	0.49
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	10.23	25.06	18.68	29.74	19.03	20.46	31.29
3 IVF	12.39	30.36	22.62	36.02	23.05	24.78	37.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.36	0.88	0.66	1.05	0.67	0.72	1.11
$25	0.33	0.81	0.60	0.95	0.61	0.66	1.00
$50	0.32	0.80	0.58	0.93	0.59	0.64	0.98
$100	0.28	0.70	0.51	0.83	0.53	0.57	0.86
$500	0.12	0.28	0.20	0.34	0.22	0.23	0.35
Coinsurance							
80%	0.28	0.67	0.50	0.80	0.51	0.55	0.85
75%	0.27	0.66	0.49	0.77	0.49	0.53	0.81
70%	0.24	0.58	0.43	0.68	0.44	0.47	0.72
Deductible			**Orthotics Riders**				
$0	0.05	0.11	0.09	0.14	0.09	0.10	0.15
$25	0.04	0.10	0.07	0.12	0.07	0.08	0.12
$50	0.04	0.10	0.07	0.11	0.08	0.08	0.12
$100	0.04	0.11	0.08	0.12	0.08	0.09	0.14
$500	0.04	0.10	0.07	0.11	0.07	0.07	0.11
Coinsurance							
80%	0.04	0.11	0.08	0.12	0.08	0.09	0.14
75%	0.04	0.09	0.06	0.10	0.06	0.07	0.11
70%	0.04	0.09	0.07	0.11	0.07	0.07	0.11
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.36	0.23	0.24	0.37
12 Months	0.17	0.43	0.32	0.50	0.32	0.35	0.53
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.16	0.39	0.29	0.46	0.29	0.31	0.48
12 Months	0.28	0.68	0.51	0.82	0.52	0.56	0.85
			Private Duty Nursing Riders				
In Full	0.04	0.09	0.07	0.11	0.07	0.07	0.11
80% hrs 73-50	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
100% hrs 73-50	0.00	0.00	0.01	0.01	0.01	0.01	0.01
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	0.74	1.80	1.34	2.14	1.37	1.47	2.24
3 IVF	0.90	2.21	1.64	2.62	1.68	1.80	2.75

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* 1 HMO LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Deductible			**Durable Medical Equipment Riders**				
$0	8.0%	8.0%	8.1%	8.1%	8.0%	8.0%	8.1%
$25	7.7%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
$50	8.0%	8.2%	8.0%	8.0%	8.0%	8.0%	8.1%
$100	7.6%	7.8%	7.6%	7.8%	7.8%	7.8%	7.7%
$500	6.9%	6.5%	6.2%	6.7%	6.7%	6.6%	6.5%
Coinsurance							
80%	7.8%	7.6%	7.6%	7.6%	7.6%	7.6%	7.7%
75%	8.0%	8.0%	8.0%	7.8%	7.8%	7.9%	7.8%
70%	7.6%	7.5%	7.5%	7.4%	7.5%	7.4%	7.5%
Deductible			**Orthotics Riders**				
$0	6.6%	5.9%	6.5%	6.3%	6.3%	6.6%	6.4%
$25	5.5%	5.6%	5.2%	5.7%	5.1%	5.5%	5.4%
$50	5.8%	5.9%	5.6%	5.5%	6.3%	5.8%	5.7%
$100	6.5%	7.3%	7.1%	6.7%	7.0%	7.3%	7.4%
$500	12.9%	13.2%	12.3%	12.1%	12.1%	11.1%	11.5%
Coinsurance							
80%	6.5%	7.3%	7.1%	6.7%	7.0%	7.3%	7.4%
75%	6.9%	6.3%	5.6%	5.9%	5.5%	6.0%	6.1%
70%	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.5%	8.4%	8.1%	8.8%	8.8%	8.5%	8.6%
12 Months	7.6%	7.8%	7.8%	7.7%	7.7%	7.8%	7.7%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.3%	7.3%	7.3%	7.2%	7.1%	7.1%	7.2%
12 Months	8.0%	7.9%	8.0%	8.1%	8.0%	8.0%	7.9%
			Private Duty Nursing Riders				
In Full	7.5%	6.9%	7.2%	7.1%	7.1%	6.5%	6.7%
80% hrs 73-50	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
100% hrs 73-50	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
			Dental Network Access				
	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
Limit			**Infertility Rider**				
2 IVF	7.8%	7.7%	7.7%	7.8%	7.8%	7.7%	7.7%
3 IVF	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
912.63	2,235.92	1,666.40	2,653.00	1,697.43	1,825.20	2,791.70
75% Coinsurance						
868.03	2,126.63	1,584.97	2,523.34	1,614.47	1,735.99	2,655.27
70% Coinsurance						
824.52	2,020.03	1,505.51	2,396.85	1,533.54	1,648.98	2,522.16
50% Coinsurance						
779.93	1,910.78	1,424.09	2,267.22	1,450.61	1,559.79	2,385.76

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
984.00	2,410.80	1,796.78	2,860.49	1,830.24	1,968.00	3,010.06
75% Coinsurance						
935.91	2,292.98	1,708.97	2,720.69	1,740.79	1,871.82	2,862.95
70% Coinsurance						
889.00	2,178.05	1,623.31	2,584.32	1,653.54	1,778.00	2,719.45
50% Coinsurance						
840.92	2,060.25	1,535.52	2,444.55	1,564.11	1,681.84	2,572.37

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
DOLLAR CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
71.37	174.88	130.38	207.49	132.81	142.80	218.36
75% Coinsurance						
67.88	166.35	124.00	197.35	126.32	135.83	207.68
70% Coinsurance						
64.48	158.02	117.80	187.47	120.00	129.02	197.29
50% Coinsurance						
60.99	149.47	111.43	177.33	113.50	122.05	186.61

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL

HIPaccess II POS LARGE GROUP CONTRACT - BASE BENEFITS *
PERCENTAGE CHANGE IN RATES

ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Large Group**						
80% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
75% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
70% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
50% Coinsurance						
7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

*Base Benefits = In-network: HMO base benefits, Standard Out-of-network coverage = $250 ded and $1,000 coins max
** Base rates excludes ded. and coins. max premium credit and mandatory mental health coverage premium component

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(55.90)	(136.95)	(102.07)	(162.50)	(103.97)	(111.80)	(171.00)
$250	(66.69)	(163.39)	(121.78)	(193.87)	(124.04)	(133.37)	(204.00)
$300	(77.51)	(189.90)	(141.53)	(225.32)	(144.16)	(155.01)	(237.10)
$350	(88.32)	(216.38)	(161.27)	(256.74)	(164.28)	(176.63)	(270.17)
$400	(96.81)	(237.19)	(176.78)	(281.43)	(180.07)	(193.61)	(296.14)
$500	(113.80)	(278.79)	(207.79)	(330.80)	(211.65)	(227.58)	(348.09)
$750	(147.78)	(362.06)	(269.84)	(429.60)	(274.86)	(295.56)	(452.06)
$1,000	(173.96)	(426.19)	(317.64)	(505.69)	(323.55)	(347.90)	(532.13)
$1,500	(213.98)	(524.24)	(390.72)	(622.04)	(397.99)	(427.94)	(654.56)
$2,000	(230.35)	(564.34)	(420.60)	(669.61)	(428.43)	(460.68)	(704.62)
$2,500	(246.78)	(604.59)	(450.60)	(717.38)	(458.98)	(493.54)	(754.88)
$5,000	(290.12)	(710.79)	(529.75)	(843.38)	(539.61)	(580.23)	(887.48)
$10,000	(325.90)	(798.43)	(595.07)	(947.37)	(606.14)	(651.76)	(996.90)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(45.81)	(112.24)	(83.65)	(133.17)	(85.21)	(91.62)	(140.14)
$250	(54.65)	(133.88)	(99.78)	(158.85)	(101.64)	(109.29)	(167.16)
$300	(63.51)	(155.61)	(115.97)	(184.63)	(118.13)	(127.03)	(194.28)
$350	(72.34)	(177.23)	(132.08)	(210.29)	(134.55)	(144.67)	(221.28)
$400	(79.45)	(194.66)	(145.08)	(230.96)	(147.77)	(158.90)	(243.04)
$500	(93.71)	(229.59)	(171.11)	(272.41)	(174.29)	(187.41)	(286.66)
$750	(121.89)	(298.63)	(222.57)	(354.33)	(226.70)	(243.77)	(372.86)
$1,000	(143.83)	(352.38)	(262.63)	(418.12)	(267.52)	(287.66)	(439.99)
$1,500	(177.08)	(433.84)	(323.34)	(514.77)	(329.35)	(354.15)	(541.69)
$2,000	(192.16)	(470.79)	(350.87)	(558.61)	(357.41)	(384.30)	(587.82)
$2,500	(207.22)	(507.69)	(378.37)	(602.39)	(385.42)	(414.43)	(633.89)
$5,000	(250.37)	(613.40)	(457.16)	(727.82)	(465.67)	(500.72)	(765.87)
$10,000	(285.97)	(700.60)	(522.15)	(831.30)	(531.88)	(571.91)	(874.76)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(35.71)	(87.49)	(65.21)	(103.81)	(66.42)	(71.42)	(109.24)
$250	(42.60)	(104.37)	(77.79)	(123.85)	(79.24)	(85.21)	(130.32)
$300	(49.50)	(121.26)	(90.38)	(143.89)	(92.06)	(99.00)	(151.41)
$350	(56.38)	(138.13)	(102.94)	(163.90)	(104.87)	(112.76)	(172.46)
$400	(62.15)	(152.25)	(113.47)	(180.65)	(115.59)	(124.29)	(190.10)
$500	(73.56)	(180.22)	(134.32)	(213.85)	(136.82)	(147.11)	(225.02)
$750	(95.98)	(235.14)	(175.24)	(279.00)	(178.51)	(191.94)	(293.59)
$1,000	(113.64)	(278.42)	(207.50)	(330.35)	(211.36)	(227.27)	(347.61)
$1,500	(140.20)	(343.49)	(255.99)	(407.55)	(260.76)	(280.39)	(428.86)
$2,000	(153.96)	(377.18)	(281.11)	(447.55)	(286.34)	(307.90)	(470.94)
$2,500	(167.73)	(410.94)	(306.27)	(487.59)	(311.97)	(335.45)	(513.09)
$5,000	(210.64)	(516.05)	(384.62)	(612.32)	(391.77)	(421.26)	(644.34)
$10,000	(246.08)	(602.88)	(449.32)	(715.34)	(457.69)	(492.14)	(752.74)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(24.55)	(60.13)	(44.82)	(71.35)	(45.65)	(49.09)	(75.09)
$250	(29.41)	(72.06)	(53.71)	(85.50)	(54.71)	(58.82)	(89.97)
$300	(34.31)	(84.06)	(62.65)	(99.74)	(63.82)	(68.62)	(104.96)
$350	(39.18)	(95.99)	(71.54)	(113.89)	(72.87)	(78.36)	(119.84)
$400	(43.42)	(106.37)	(79.28)	(126.21)	(80.76)	(86.84)	(132.82)
$500	(51.86)	(127.05)	(94.69)	(150.75)	(96.46)	(103.72)	(158.63)
$750	(68.05)	(166.71)	(124.25)	(197.81)	(126.56)	(136.08)	(208.15)
$1,000	(81.20)	(198.93)	(148.26)	(236.04)	(151.02)	(162.38)	(248.38)
$1,500	(101.48)	(248.63)	(185.30)	(295.00)	(188.75)	(202.95)	(310.43)
$2,000	(112.28)	(275.08)	(205.02)	(326.40)	(208.83)	(224.55)	(343.47)
$2,500	(123.10)	(301.59)	(224.77)	(357.86)	(228.96)	(246.19)	(376.56)
$5,000	(165.42)	(405.28)	(302.05)	(480.89)	(307.67)	(330.84)	(506.03)
$10,000	(200.34)	(490.83)	(365.81)	(582.39)	(372.62)	(400.66)	(612.84)
LARGE GROUP							
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(51.75)	(126.80)	(94.49)	(150.45)	(96.26)	(103.51)	(158.31)
$1,500	(56.45)	(138.31)	(103.08)	(164.11)	(105.00)	(112.91)	(172.69)
$2,000	(58.88)	(144.24)	(107.51)	(171.16)	(109.50)	(117.75)	(180.10)
$3,000	(61.13)	(149.78)	(111.62)	(177.72)	(113.70)	(122.27)	(187.00)
$4,000	(62.06)	(152.05)	(113.33)	(180.41)	(115.44)	(124.13)	(189.84)
$5,000	(62.55)	(153.26)	(114.21)	(181.84)	(116.34)	(125.11)	(191.35)
$7,000	(63.17)	(154.76)	(115.34)	(183.63)	(117.49)	(126.34)	(193.24)
$7,500	(63.68)	(156.01)	(116.28)	(185.12)	(118.44)	(127.35)	(194.79)
$10,000	(65.54)	(160.57)	(119.68)	(190.52)	(121.90)	(131.07)	(200.49)
$20,000	(68.20)	(167.10)	(124.53)	(198.27)	(126.85)	(136.40)	(208.63)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(60.26)	(147.64)	(110.03)	(175.18)	(112.08)	(120.52)	(184.34)
$250	(71.91)	(176.18)	(131.31)	(209.04)	(133.75)	(143.82)	(219.97)
$300	(83.57)	(204.75)	(152.60)	(242.94)	(155.44)	(167.14)	(255.64)
$350	(95.23)	(233.31)	(173.89)	(276.83)	(177.13)	(190.46)	(291.31)
$400	(104.38)	(255.73)	(190.60)	(303.43)	(194.15)	(208.76)	(319.30)
$500	(122.70)	(300.62)	(224.05)	(356.69)	(228.22)	(245.40)	(375.34)
$750	(159.34)	(390.38)	(290.95)	(463.20)	(296.37)	(318.68)	(487.42)
$1,000	(187.57)	(459.55)	(342.50)	(545.27)	(348.88)	(375.14)	(573.78)
$1,500	(230.71)	(565.24)	(421.28)	(670.67)	(429.12)	(461.42)	(705.74)
$2,000	(248.36)	(608.48)	(453.51)	(721.98)	(461.95)	(496.72)	(759.73)
$2,500	(266.08)	(651.90)	(485.86)	(773.49)	(494.91)	(532.16)	(813.94)
$5,000	(312.80)	(766.36)	(571.17)	(909.31)	(581.81)	(625.60)	(956.86)
$10,000	(351.38)	(860.88)	(641.62)	(1,021.46)	(653.57)	(702.76)	(1,074.87)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(49.39)	(121.01)	(90.19)	(143.58)	(91.87)	(98.78)	(151.08)
$250	(58.93)	(144.38)	(107.61)	(171.31)	(109.61)	(117.86)	(180.27)
$300	(68.48)	(167.78)	(125.04)	(199.07)	(127.37)	(136.96)	(209.48)
$350	(77.99)	(191.08)	(142.41)	(226.72)	(145.06)	(155.98)	(238.57)
$400	(85.67)	(209.89)	(156.43)	(249.04)	(159.35)	(171.34)	(262.06)
$500	(101.03)	(247.52)	(184.48)	(293.69)	(187.92)	(202.06)	(309.05)
$750	(131.42)	(321.98)	(239.97)	(382.04)	(244.44)	(262.84)	(402.01)
$1,000	(155.07)	(379.92)	(283.16)	(450.79)	(288.43)	(310.14)	(474.36)
$1,500	(190.92)	(467.75)	(348.62)	(555.00)	(355.11)	(381.84)	(584.02)
$2,000	(207.18)	(507.59)	(378.31)	(602.27)	(385.35)	(414.36)	(633.76)
$2,500	(223.43)	(547.40)	(407.98)	(649.51)	(415.58)	(446.86)	(683.47)
$5,000	(269.95)	(661.38)	(492.93)	(784.74)	(502.11)	(539.90)	(825.78)
$10,000	(308.33)	(755.41)	(563.01)	(896.32)	(573.49)	(616.66)	(943.18)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(38.50)	(94.33)	(70.30)	(111.92)	(71.61)	(77.00)	(117.77)
$250	(45.93)	(112.53)	(83.87)	(133.52)	(85.43)	(91.86)	(140.50)
$300	(53.38)	(130.78)	(97.47)	(155.18)	(99.29)	(106.76)	(163.29)
$350	(60.78)	(148.91)	(110.98)	(176.69)	(113.05)	(121.56)	(185.93)
$400	(67.01)	(164.17)	(122.36)	(194.80)	(124.64)	(134.02)	(204.98)
$500	(79.31)	(194.31)	(144.82)	(230.55)	(147.52)	(158.62)	(242.61)
$750	(103.48)	(253.53)	(188.95)	(300.82)	(192.47)	(206.96)	(316.55)
$1,000	(122.52)	(300.17)	(223.72)	(356.17)	(227.89)	(245.04)	(374.79)
$1,500	(151.16)	(370.34)	(276.02)	(439.42)	(281.16)	(302.32)	(462.40)
$2,000	(166.01)	(406.72)	(303.13)	(482.59)	(308.78)	(332.02)	(507.82)
$2,500	(180.85)	(443.08)	(330.23)	(525.73)	(336.38)	(361.70)	(553.22)
$5,000	(227.11)	(556.42)	(414.70)	(660.21)	(422.42)	(454.22)	(694.73)
$10,000	(265.32)	(650.03)	(484.47)	(771.29)	(493.50)	(530.64)	(811.61)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(26.47)	(64.85)	(48.33)	(76.95)	(49.23)	(52.94)	(80.97)
$250	(31.71)	(77.69)	(57.90)	(92.18)	(58.98)	(63.42)	(97.00)
$300	(36.99)	(90.63)	(67.54)	(107.53)	(68.80)	(73.98)	(113.15)
$350	(42.24)	(103.49)	(77.13)	(122.79)	(78.57)	(84.48)	(129.21)
$400	(46.81)	(114.68)	(85.48)	(136.08)	(87.07)	(93.62)	(143.19)
$500	(55.91)	(136.98)	(102.09)	(162.53)	(103.99)	(111.82)	(171.03)
$750	(73.37)	(179.76)	(133.97)	(213.29)	(136.47)	(146.74)	(224.44)
$1,000	(87.54)	(214.47)	(159.85)	(254.48)	(162.82)	(175.08)	(267.78)
$1,500	(109.41)	(268.05)	(199.78)	(318.05)	(203.50)	(218.82)	(334.69)
$2,000	(121.06)	(296.60)	(221.06)	(351.92)	(225.17)	(242.12)	(370.32)
$2,500	(132.72)	(325.16)	(242.35)	(385.82)	(246.86)	(265.44)	(405.99)
$5,000	(178.35)	(436.96)	(325.67)	(518.46)	(331.73)	(356.70)	(545.57)
$10,000	(216.01)	(529.22)	(394.43)	(627.94)	(401.78)	(432.02)	(660.77)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(55.79)	(136.69)	(101.87)	(162.18)	(103.77)	(111.58)	(170.66)
$1,500	(60.85)	(149.08)	(111.11)	(176.89)	(113.18)	(121.70)	(186.14)
$2,000	(63.48)	(155.53)	(115.91)	(184.54)	(118.07)	(126.96)	(194.19)
$3,000	(65.91)	(161.48)	(120.35)	(191.60)	(122.59)	(131.82)	(201.62)
$4,000	(66.91)	(163.93)	(122.18)	(194.51)	(124.45)	(133.82)	(204.68)
$5,000	(67.44)	(165.23)	(123.15)	(196.05)	(125.44)	(134.88)	(206.30)
$7,000	(68.11)	(166.87)	(124.37)	(198.00)	(126.68)	(136.22)	(208.35)
$7,500	(68.66)	(168.22)	(125.37)	(199.59)	(127.71)	(137.32)	(210.03)
$10,000	(70.67)	(173.14)	(129.04)	(205.44)	(131.45)	(141.34)	(216.18)
$20,000	(73.54)	(180.17)	(134.28)	(213.78)	(136.78)	(147.08)	(224.96)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	(4.36)	(10.69)	(7.96)	(12.68)	(8.11)	(8.72)	(13.34)
$250	(5.22)	(12.79)	(9.53)	(15.17)	(9.71)	(10.45)	(15.97)
$300	(6.06)	(14.85)	(11.07)	(17.62)	(11.28)	(12.13)	(18.54)
$350	(6.91)	(16.93)	(12.62)	(20.09)	(12.85)	(13.83)	(21.14)
$400	(7.57)	(18.54)	(13.82)	(22.00)	(14.08)	(15.15)	(23.16)
$500	(8.90)	(21.83)	(16.26)	(25.89)	(16.57)	(17.82)	(27.25)
$750	(11.56)	(28.32)	(21.11)	(33.60)	(21.51)	(23.12)	(35.36)
$1,000	(13.61)	(33.36)	(24.86)	(39.58)	(25.33)	(27.24)	(41.65)
$1,500	(16.73)	(41.00)	(30.56)	(48.63)	(31.13)	(33.48)	(51.18)
$2,000	(18.01)	(44.14)	(32.91)	(52.37)	(33.52)	(36.04)	(55.11)
$2,500	(19.30)	(47.31)	(35.26)	(56.11)	(35.93)	(38.62)	(59.06)
$5,000	(22.68)	(55.57)	(41.42)	(65.93)	(42.20)	(45.37)	(69.38)
$10,000	(25.48)	(62.45)	(46.55)	(74.09)	(47.43)	(51.00)	(77.97)
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	(3.58)	(8.77)	(6.54)	(10.41)	(6.66)	(7.16)	(10.94)
$250	(4.28)	(10.50)	(7.83)	(12.46)	(7.97)	(8.57)	(13.11)
$300	(4.97)	(12.17)	(9.07)	(14.44)	(9.24)	(9.93)	(15.20)
$350	(5.65)	(13.85)	(10.33)	(16.43)	(10.51)	(11.31)	(17.29)
$400	(6.22)	(15.23)	(11.35)	(18.08)	(11.58)	(12.44)	(19.02)
$500	(7.32)	(17.93)	(13.37)	(21.28)	(13.63)	(14.65)	(22.39)
$750	(9.53)	(23.35)	(17.40)	(27.71)	(17.74)	(19.07)	(29.15)
$1,000	(11.24)	(27.54)	(20.53)	(32.67)	(20.91)	(22.48)	(34.37)
$1,500	(13.84)	(33.91)	(25.28)	(40.23)	(25.76)	(27.69)	(42.33)
$2,000	(15.02)	(36.80)	(27.44)	(43.66)	(27.94)	(30.06)	(45.94)
$2,500	(16.21)	(39.71)	(29.61)	(47.12)	(30.16)	(32.43)	(49.58)
$5,000	(19.58)	(47.98)	(35.77)	(56.92)	(36.44)	(39.18)	(59.91)
$10,000	(22.36)	(54.81)	(40.86)	(65.02)	(41.61)	(44.75)	(68.42)
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	(2.79)	(6.84)	(5.09)	(8.11)	(5.19)	(5.58)	(8.53)
$250	(3.33)	(8.16)	(6.08)	(9.67)	(6.19)	(6.65)	(10.18)
$300	(3.88)	(9.52)	(7.09)	(11.29)	(7.23)	(7.76)	(11.88)
$350	(4.40)	(10.78)	(8.04)	(12.79)	(8.18)	(8.80)	(13.47)
$400	(4.86)	(11.92)	(8.89)	(14.15)	(9.05)	(9.73)	(14.88)
$500	(5.75)	(14.09)	(10.50)	(16.70)	(10.70)	(11.51)	(17.59)
$750	(7.50)	(18.39)	(13.71)	(21.82)	(13.96)	(15.02)	(22.96)
$1,000	(8.88)	(21.75)	(16.22)	(25.82)	(16.53)	(17.77)	(27.18)
$1,500	(10.96)	(26.85)	(20.03)	(31.87)	(20.40)	(21.93)	(33.54)
$2,000	(12.05)	(29.54)	(22.02)	(35.04)	(22.44)	(24.12)	(36.88)
$2,500	(13.12)	(32.14)	(23.96)	(38.14)	(24.41)	(26.25)	(40.13)
$5,000	(16.47)	(40.37)	(30.08)	(47.89)	(30.65)	(32.96)	(50.39)
$10,000	(19.24)	(47.15)	(35.15)	(55.95)	(35.81)	(38.50)	(58.87)
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	(1.92)	(4.72)	(3.51)	(5.60)	(3.58)	(3.85)	(5.88)
$250	(2.30)	(5.63)	(4.19)	(6.68)	(4.27)	(4.60)	(7.03)
$300	(2.68)	(6.57)	(4.89)	(7.79)	(4.98)	(5.36)	(8.19)
$350	(3.06)	(7.50)	(5.59)	(8.90)	(5.70)	(6.12)	(9.37)
$400	(3.39)	(8.31)	(6.20)	(9.87)	(6.31)	(6.78)	(10.37)
$500	(4.05)	(9.93)	(7.40)	(11.78)	(7.53)	(8.10)	(12.40)
$750	(5.32)	(13.05)	(9.72)	(15.48)	(9.91)	(10.66)	(16.29)
$1,000	(6.34)	(15.54)	(11.59)	(18.44)	(11.80)	(12.70)	(19.40)
$1,500	(7.93)	(19.42)	(14.48)	(23.05)	(14.75)	(15.87)	(24.26)
$2,000	(8.78)	(21.52)	(16.04)	(25.52)	(16.34)	(17.57)	(26.85)
$2,500	(9.62)	(23.57)	(17.58)	(27.96)	(17.90)	(19.25)	(29.43)
$5,000	(12.93)	(31.68)	(23.62)	(37.57)	(24.06)	(25.86)	(39.54)
$10,000	(15.67)	(38.39)	(28.62)	(45.55)	(29.16)	(31.36)	(47.93)
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	(4.04)	(9.89)	(7.38)	(11.73)	(7.51)	(8.07)	(12.35)
$1,500	(4.40)	(10.77)	(8.03)	(12.78)	(8.18)	(8.79)	(13.45)
$2,000	(4.60)	(11.29)	(8.40)	(13.38)	(8.57)	(9.21)	(14.09)
$3,000	(4.78)	(11.70)	(8.73)	(13.88)	(8.89)	(9.55)	(14.62)
$4,000	(4.85)	(11.88)	(8.85)	(14.10)	(9.01)	(9.69)	(14.84)
$5,000	(4.89)	(11.97)	(8.94)	(14.21)	(9.10)	(9.77)	(14.95)
$7,000	(4.94)	(12.11)	(9.03)	(14.37)	(9.19)	(9.88)	(15.11)
$7,500	(4.98)	(12.21)	(9.09)	(14.47)	(9.27)	(9.97)	(15.24)
$10,000	(5.13)	(12.57)	(9.36)	(14.92)	(9.55)	(10.27)	(15.69)
$20,000	(5.34)	(13.07)	(9.75)	(15.51)	(9.93)	(10.68)	(16.33)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP							
Deductible			**Deductible Credits - 80% Coinsurance**				
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible			**Deductible Credits - 75% Coinsurance**				
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible			**Deductible Credits - 70% Coinsurance**				
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Deductible			**Deductible Credits - 50% Coinsurance**				
$200	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$250	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$300	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$350	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$400	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$750	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum			**Coinsurance Maximum Credits - 80% Coinsurance**				
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(50.02)	(122.55)	(91.33)	(145.40)	(93.03)	(100.04)	(153.01)
$1,500	(55.59)	(136.19)	(101.50)	(161.59)	(103.39)	(111.17)	(170.04)
$2,000	(58.68)	(143.76)	(107.14)	(170.57)	(109.14)	(117.36)	(179.49)
$3,000	(61.73)	(151.23)	(112.71)	(179.44)	(114.81)	(123.46)	(188.82)
$4,000	(63.10)	(154.58)	(115.21)	(183.42)	(117.36)	(126.19)	(193.01)
$5,000	(63.87)	(156.47)	(116.63)	(185.67)	(118.79)	(127.73)	(195.38)
$7,000	(64.61)	(158.29)	(117.97)	(187.83)	(120.17)	(129.21)	(197.65)
$7,500	(65.16)	(159.65)	(118.99)	(189.44)	(121.20)	(130.32)	(199.34)
$10,000	(67.46)	(165.28)	(123.19)	(196.11)	(125.47)	(134.91)	(206.37)
$20,000	(70.98)	(173.91)	(129.61)	(206.35)	(132.02)	(141.95)	(217.14)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(48.29)	(118.30)	(88.16)	(140.37)	(89.80)	(96.57)	(147.71)
$1,500	(54.75)	(134.14)	(99.98)	(159.16)	(101.84)	(109.50)	(167.48)
$2,000	(58.49)	(143.30)	(106.80)	(170.03)	(108.79)	(116.98)	(178.92)
$3,000	(62.36)	(152.76)	(113.86)	(181.27)	(115.98)	(124.71)	(190.74)
$4,000	(64.11)	(157.07)	(117.06)	(186.37)	(119.24)	(128.21)	(196.11)
$5,000	(65.14)	(159.60)	(118.94)	(189.37)	(121.16)	(130.28)	(199.28)
$7,000	(66.06)	(161.85)	(120.63)	(192.05)	(122.87)	(132.12)	(202.09)
$7,500	(66.65)	(163.28)	(121.69)	(193.74)	(123.96)	(133.29)	(203.87)
$10,000	(69.17)	(169.46)	(126.29)	(201.06)	(128.64)	(138.32)	(211.57)
$20,000	(73.66)	(180.45)	(134.49)	(214.12)	(136.99)	(147.30)	(225.31)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(54.65)	(133.88)	(99.78)	(158.85)	(101.64)	(109.29)	(167.16)
$1,500	(65.10)	(159.50)	(118.87)	(189.25)	(121.09)	(130.19)	(199.14)
$2,000	(71.86)	(176.06)	(131.21)	(208.90)	(133.65)	(143.71)	(219.82)
$3,000	(80.03)	(196.07)	(146.12)	(232.64)	(148.85)	(160.04)	(244.80)
$4,000	(84.53)	(207.09)	(154.34)	(245.72)	(157.21)	(169.05)	(258.57)
$5,000	(87.29)	(213.85)	(159.38)	(253.74)	(162.34)	(174.56)	(267.01)
$7,000	(90.14)	(220.83)	(164.59)	(262.03)	(167.65)	(180.27)	(275.73)
$7,500	(91.19)	(223.42)	(166.51)	(265.10)	(169.61)	(182.38)	(278.96)
$10,000	(95.43)	(233.81)	(174.26)	(277.42)	(177.50)	(190.86)	(291.93)
$20,000	(104.36)	(255.69)	(190.56)	(303.38)	(194.11)	(208.72)	(319.24)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.41	1.00	0.74	1.18	0.76	0.81	1.24
$1,000,000	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
$50,000	(5.36)	(13.13)	(9.79)	(15.57)	(9.96)	(10.72)	(16.39)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.41)	(1.00)	(0.74)	(1.18)	(0.76)	(0.81)	(1.24)
75%	(0.34)	(0.85)	(0.63)	(1.00)	(0.64)	(0.69)	(1.05)
70%	(0.30)	(0.74)	(0.55)	(0.88)	(0.56)	(0.61)	(0.93)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(53.94)	(132.15)	(98.49)	(156.80)	(100.33)	(107.88)	(165.00)
$1,500	(59.95)	(146.88)	(109.47)	(174.27)	(111.51)	(119.90)	(183.39)
$2,000	(63.27)	(155.01)	(115.53)	(183.93)	(117.68)	(126.54)	(193.54)
$3,000	(66.56)	(163.07)	(121.54)	(193.49)	(123.80)	(133.12)	(203.61)
$4,000	(68.03)	(166.67)	(124.22)	(197.76)	(126.54)	(136.06)	(208.10)
$5,000	(68.86)	(168.71)	(125.74)	(200.18)	(128.08)	(137.72)	(210.64)
$7,000	(69.66)	(170.67)	(127.20)	(202.50)	(129.57)	(139.32)	(213.09)
$7,500	(70.26)	(172.14)	(128.29)	(204.25)	(130.68)	(140.52)	(214.93)
$10,000	(72.74)	(178.21)	(132.82)	(211.46)	(135.30)	(145.48)	(222.51)
$20,000	(76.53)	(187.50)	(139.74)	(222.47)	(142.35)	(153.06)	(234.11)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(52.06)	(127.55)	(95.06)	(151.34)	(96.83)	(104.12)	(159.25)
$1,500	(59.03)	(144.62)	(107.79)	(171.60)	(109.80)	(118.06)	(180.57)
$2,000	(63.06)	(154.50)	(115.15)	(183.32)	(117.29)	(126.12)	(192.90)
$3,000	(67.23)	(164.71)	(122.76)	(195.44)	(125.05)	(134.46)	(205.66)
$4,000	(69.12)	(169.34)	(126.21)	(200.93)	(128.56)	(138.24)	(211.44)
$5,000	(70.24)	(172.09)	(128.26)	(204.19)	(130.65)	(140.48)	(214.86)
$7,000	(71.23)	(174.51)	(130.07)	(207.07)	(132.49)	(142.46)	(217.89)
$7,500	(71.86)	(176.06)	(131.22)	(208.90)	(133.66)	(143.72)	(219.82)
$10,000	(74.57)	(182.70)	(136.16)	(216.77)	(138.70)	(149.14)	(228.11)
$20,000	(79.42)	(194.58)	(145.02)	(230.87)	(147.72)	(158.84)	(242.95)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(58.93)	(144.38)	(107.61)	(171.31)	(109.61)	(117.86)	(180.27)
$1,500	(70.19)	(171.97)	(128.17)	(204.04)	(130.55)	(140.38)	(214.71)
$2,000	(77.48)	(189.83)	(141.48)	(225.23)	(144.11)	(154.96)	(237.01)
$3,000	(86.29)	(211.41)	(157.57)	(250.85)	(160.50)	(172.58)	(263.96)
$4,000	(91.15)	(223.32)	(166.44)	(264.97)	(169.54)	(182.30)	(278.83)
$5,000	(94.11)	(230.57)	(171.84)	(273.58)	(175.04)	(188.22)	(287.88)
$7,000	(97.19)	(238.12)	(177.47)	(282.53)	(180.77)	(194.38)	(297.30)
$7,500	(98.32)	(240.88)	(179.53)	(285.82)	(182.88)	(196.64)	(300.76)
$10,000	(102.89)	(252.08)	(187.88)	(299.10)	(191.38)	(205.78)	(314.74)
$20,000	(112.52)	(275.67)	(205.46)	(327.10)	(209.29)	(225.04)	(344.20)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.45	1.10	0.82	1.31	0.84	0.90	1.38
$1,000,000	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$50,000	(5.78)	(14.16)	(10.55)	(16.80)	(10.75)	(11.56)	(17.68)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
75%	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
70%	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	(3.92)	(9.60)	(7.16)	(11.40)	(7.30)	(7.84)	(11.99)
$1,500	(4.36)	(10.69)	(7.97)	(12.68)	(8.12)	(8.73)	(13.35)
$2,000	(4.59)	(11.25)	(8.39)	(13.36)	(8.54)	(9.18)	(14.05)
$3,000	(4.83)	(11.84)	(8.83)	(14.05)	(8.99)	(9.66)	(14.79)
$4,000	(4.93)	(12.09)	(9.01)	(14.34)	(9.18)	(9.87)	(15.09)
$5,000	(4.99)	(12.24)	(9.11)	(14.51)	(9.29)	(9.99)	(15.26)
$7,000	(5.05)	(12.38)	(9.23)	(14.67)	(9.40)	(10.11)	(15.44)
$7,500	(5.10)	(12.49)	(9.30)	(14.81)	(9.48)	(10.20)	(15.59)
$10,000	(5.28)	(12.93)	(9.63)	(15.35)	(9.83)	(10.57)	(16.14)
$20,000	(5.55)	(13.59)	(10.13)	(16.12)	(10.33)	(11.11)	(16.97)
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	(3.77)	(9.25)	(6.90)	(10.97)	(7.03)	(7.55)	(11.54)
$1,500	(4.28)	(10.48)	(7.81)	(12.44)	(7.96)	(8.56)	(13.09)
$2,000	(4.57)	(11.20)	(8.35)	(13.29)	(8.50)	(9.14)	(13.98)
$3,000	(4.87)	(11.95)	(8.90)	(14.17)	(9.07)	(9.75)	(14.92)
$4,000	(5.01)	(12.27)	(9.15)	(14.56)	(9.32)	(10.03)	(15.33)
$5,000	(5.10)	(12.49)	(9.32)	(14.82)	(9.49)	(10.20)	(15.58)
$7,000	(5.17)	(12.66)	(9.44)	(15.02)	(9.62)	(10.34)	(15.80)
$7,500	(5.21)	(12.78)	(9.53)	(15.16)	(9.70)	(10.43)	(15.95)
$10,000	(5.40)	(13.24)	(9.87)	(15.71)	(10.06)	(10.82)	(16.54)
$20,000	(5.76)	(14.13)	(10.53)	(16.75)	(10.73)	(11.54)	(17.64)
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	(4.28)	(10.50)	(7.83)	(12.46)	(7.97)	(8.57)	(13.11)
$1,500	(5.09)	(12.47)	(9.30)	(14.79)	(9.46)	(10.19)	(15.57)
$2,000	(5.62)	(13.77)	(10.27)	(16.33)	(10.46)	(11.25)	(17.19)
$3,000	(6.26)	(15.34)	(11.45)	(18.21)	(11.65)	(12.54)	(19.16)
$4,000	(6.62)	(16.23)	(12.10)	(19.25)	(12.33)	(13.25)	(20.26)
$5,000	(6.82)	(16.72)	(12.46)	(19.84)	(12.70)	(13.66)	(20.87)
$7,000	(7.05)	(17.29)	(12.88)	(20.50)	(13.12)	(14.11)	(21.57)
$7,500	(7.13)	(17.46)	(13.02)	(20.72)	(13.27)	(14.26)	(21.80)
$10,000	(7.46)	(18.27)	(13.62)	(21.68)	(13.88)	(14.92)	(22.81)
$20,000	(8.16)	(19.98)	(14.90)	(23.72)	(15.18)	(16.32)	(24.96)
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	0.04	0.10	0.08	0.13	0.08	0.09	0.14
$1,000,000	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
$50,000	(0.42)	(1.03)	(0.76)	(1.23)	(0.79)	(0.84)	(1.29)
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	(0.04)	(0.10)	(0.08)	(0.13)	(0.08)	(0.09)	(0.14)
75%	(0.04)	(0.08)	(0.06)	(0.10)	(0.07)	(0.07)	(0.11)
70%	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Maximum			**Coinsurance Maximum Credits - 75% Coinsurance**				
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum			**Coinsurance Maximum Credits - 70% Coinsurance**				
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum			**Coinsurance Maximum Credits - 50% Coinsurance**				
$1,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$1,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$2,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$3,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$4,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$5,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$7,500	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$10,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$20,000	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Maximum			**Annual Benefit Maximum [$5,000,000 standard]**				
Unlimited	9.8%	10.0%	10.8%	11.0%	10.5%	11.1%	11.3%
$1,000,000	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
$50,000	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.9%
OON Coins			**Out Of Network Outpatient Therapies - 50% Coinsurance, 30 Day Maximum**				
80%	9.8%	10.0%	10.8%	11.0%	10.5%	11.1%	11.3%
75%	11.8%	9.4%	9.5%	10.0%	10.9%	10.1%	10.5%
70%	13.3%	12.2%	12.7%	12.5%	12.5%	11.5%	11.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2010 RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2010 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed]

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
CALENDAR YEAR 2011 MONTHLY PREMIUMS

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	1.039	1.077	1.148
$250	1.038	1.075	1.144
$300	1.037	1.073	1.140
$350	1.036	1.071	1.136
$400	1.036	1.070	1.134
$500	1.035	1.067	1.129
$750	1.034	1.062	1.116
$1,000	1.032	1.057	1.106
$1,500	1.031	1.051	1.087
$2,000	1.027	1.048	1.082
$2,500	1.022	1.044	1.077
$5,000	1.019	1.036	1.060
$10,000	1.017	1.032	1.052

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	1.017	1.034	1.069
$1,500	1.014	1.024	1.047
$2,000	1.012	1.021	1.040
$3,000	1.009	1.017	1.031
$4,000	1.008	1.015	1.027
$5,000	1.007	1.014	1.024
$7,000	1.006	1.011	1.019
$7,500	1.006	1.011	1.019
$10,000	1.005	1.009	1.015
$20,000	1.002	1.004	1.007

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	0.964
90th Percentile of HIAA	1.036

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 RATE MANUAL
HIP access II POS LARGE GROUP CONTRACT
OUT-OF-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Family Deductible Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

Individual Deductible	Fam. Ded= 2.25 x Ind. Ded	Fam. Ded= 2.5 x Ind. Ded	Fam. Ded= 3.0. x Ind. Ded
$200	-	-	-
$250	-	-	-
$300	-	-	-
$350	-	-	-
$400	-	-	-
$500	-	-	-
$750	-	-	-
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$5,000	-	-	-
$10,000	-	-	-

Family Coinsurance Maximum Factors [std: 2x Individual Ded]
Expressed as a % add on to each deductible credit rate

	Fam. Co. Max.= 2.25 x Ind. Co. Max.	Fam. Co. Max.= 2.5 x Ind. Co. Max.	Fam. Co. Max.= 3.0. x Ind. Co. Max.
$1,000	-	-	-
$1,500	-	-	-
$2,000	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
$7,000	-	-	-
$7,500	-	-	-
$10,000	-	-	-
$20,000	-	-	-

Out Of Network Fee Schedule Reimbursement
[std: 80th percentile of HIAA]
Expressed as a % add on to each premium rate otherwise computed

Schedule	
70th Percentile of HIAA	-
90th Percentile of HIAA	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.26)	(5.53)	(4.12)	(6.56)	(4.20)	(4.51)	(6.90)
$10	(4.73)	(11.59)	(8.64)	(13.76)	(8.80)	(9.46)	(14.48)
$15	(7.86)	(19.27)	(14.36)	(22.86)	(14.63)	(15.73)	(24.05)
$20	(12.14)	(29.74)	(22.16)	(35.28)	(22.57)	(24.27)	(37.13)
$25	(15.98)	(39.15)	(29.18)	(46.46)	(29.73)	(31.96)	(48.88)
$30	(20.21)	(49.52)	(36.90)	(58.75)	(37.59)	(40.42)	(61.82)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.27)	(3.12)	(2.33)	(3.71)	(2.37)	(2.55)	(3.90)
$10	(2.71)	(6.63)	(4.94)	(7.86)	(5.03)	(5.41)	(8.27)
$15	(4.50)	(11.03)	(8.22)	(13.09)	(8.38)	(9.00)	(13.77)
$20	(6.95)	(17.01)	(12.68)	(20.19)	(12.92)	(13.89)	(21.24)
$25	(9.16)	(22.45)	(16.72)	(26.62)	(17.04)	(18.32)	(28.02)
$30	(11.57)	(28.36)	(21.13)	(33.64)	(21.53)	(23.15)	(35.40)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.64)	(4.02)	(3.00)	(4.76)	(3.05)	(3.28)	(5.01)
$10	(3.39)	(8.31)	(6.19)	(9.87)	(6.31)	(6.79)	(10.38)
$15	(5.33)	(13.05)	(9.72)	(15.49)	(9.91)	(10.65)	(16.29)
$20	(7.50)	(18.37)	(13.69)	(21.80)	(13.94)	(15.00)	(22.94)
$25	(9.91)	(24.28)	(18.10)	(28.82)	(18.43)	(19.82)	(30.32)
$30	(12.63)	(30.94)	(23.06)	(36.71)	(23.49)	(25.26)	(38.62)
$35	(15.17)	(37.15)	(27.69)	(44.09)	(28.21)	(30.33)	(46.40)
$40	(17.81)	(43.63)	(32.51)	(51.76)	(33.12)	(35.62)	(54.48)
$45	(20.60)	(50.46)	(37.61)	(59.88)	(38.31)	(41.19)	(63.00)
$50	(23.50)	(57.57)	(42.91)	(68.32)	(43.71)	(47.00)	(71.89)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.40)	(3.43)	(2.56)	(4.07)	(2.60)	(2.80)	(4.28)
$10	(2.87)	(7.04)	(5.24)	(8.35)	(5.34)	(5.74)	(8.78)
$15	(4.50)	(11.03)	(8.22)	(13.09)	(8.38)	(9.00)	(13.77)
$20	(6.35)	(15.56)	(11.59)	(18.46)	(11.81)	(12.70)	(19.43)
$25	(8.38)	(20.52)	(15.29)	(24.35)	(15.58)	(16.75)	(25.62)
$30	(10.68)	(26.17)	(19.51)	(31.06)	(19.88)	(21.37)	(32.68)
$35	(12.85)	(31.47)	(23.46)	(37.35)	(23.90)	(25.69)	(39.30)
$40	(15.06)	(36.90)	(27.50)	(43.78)	(28.01)	(30.12)	(46.07)
$45	(17.41)	(42.66)	(31.79)	(50.62)	(32.38)	(34.82)	(53.26)
$50	(19.88)	(48.69)	(36.30)	(57.78)	(36.96)	(39.75)	(60.80)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.84)	(2.05)	(1.52)	(2.43)	(1.56)	(1.67)	(2.56)
$150	(1.35)	(3.30)	(2.46)	(3.92)	(2.51)	(2.69)	(4.13)
$200	(1.93)	(4.73)	(3.53)	(5.62)	(3.59)	(3.86)	(5.91)
$250	(2.75)	(6.73)	(5.01)	(7.99)	(5.11)	(5.49)	(8.41)
$500	(6.62)	(16.22)	(12.10)	(19.25)	(12.31)	(13.24)	(20.25)
$750	(11.37)	(27.87)	(20.76)	(33.07)	(21.15)	(22.75)	(34.79)
$1,000	(17.12)	(41.94)	(31.26)	(49.77)	(31.84)	(34.24)	(52.37)
Copay/Day							
$50 w/3 Day Max	(1.00)	(2.45)	(1.83)	(2.91)	(1.87)	(2.01)	(3.07)
$50 w/5 Day Max	(1.38)	(3.37)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$100 w/3 Day Max	(2.50)	(6.12)	(4.55)	(7.26)	(4.65)	(4.99)	(7.64)
$100 w/5 Day Max	(3.60)	(8.83)	(6.58)	(10.48)	(6.71)	(7.21)	(11.02)
$250 w/3 Day Max	(8.24)	(20.19)	(15.05)	(23.96)	(15.32)	(16.48)	(25.21)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.45)	(1.10)	(0.83)	(1.31)	(0.84)	(0.90)	(1.38)
$75	(0.70)	(1.71)	(1.27)	(2.04)	(1.31)	(1.40)	(2.14)
$100	(1.00)	(2.45)	(1.83)	(2.91)	(1.87)	(2.01)	(3.07)
$125	(1.30)	(3.18)	(2.36)	(3.76)	(2.41)	(2.59)	(3.96)
$150	(1.63)	(3.99)	(2.98)	(4.73)	(3.03)	(3.26)	(4.98)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.32)	(0.51)	(0.33)	(0.36)	(0.54)
$25	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
$35	(0.55)	(1.36)	(1.01)	(1.61)	(1.03)	(1.11)	(1.69)
$50	(0.95)	(2.33)	(1.73)	(2.77)	(1.77)	(1.90)	(2.90)
$60	(1.19)	(2.91)	(2.17)	(3.46)	(2.21)	(2.38)	(3.65)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.43)	(5.95)	(4.44)	(7.06)	(4.52)	(4.86)	(7.43)
$10	(5.10)	(12.50)	(9.31)	(14.83)	(9.49)	(10.20)	(15.60)
$15	(8.48)	(20.78)	(15.48)	(24.65)	(15.77)	(16.96)	(25.94)
$20	(13.09)	(32.07)	(23.90)	(38.05)	(24.35)	(26.18)	(40.04)
$25	(17.23)	(42.21)	(31.46)	(50.09)	(32.05)	(34.46)	(52.71)
$30	(21.79)	(53.39)	(39.79)	(63.34)	(40.53)	(43.58)	(66.66)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$10	(2.91)	(7.13)	(5.31)	(8.46)	(5.41)	(5.82)	(8.90)
$15	(4.86)	(11.91)	(8.87)	(14.13)	(9.04)	(9.72)	(14.87)
$20	(7.49)	(18.35)	(13.68)	(21.77)	(13.93)	(14.98)	(22.91)
$25	(9.87)	(24.18)	(18.02)	(28.69)	(18.36)	(19.74)	(30.19)
$30	(12.47)	(30.55)	(22.77)	(36.25)	(23.19)	(24.94)	(38.15)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.76)	(4.31)	(3.21)	(5.12)	(3.27)	(3.52)	(5.38)
$10	(3.66)	(8.97)	(6.68)	(10.64)	(6.81)	(7.32)	(11.20)
$15	(5.75)	(14.09)	(10.50)	(16.72)	(10.70)	(11.50)	(17.59)
$20	(8.09)	(19.82)	(14.77)	(23.52)	(15.05)	(16.18)	(24.75)
$25	(10.69)	(26.19)	(19.52)	(31.08)	(19.88)	(21.38)	(32.70)
$30	(13.61)	(33.34)	(24.85)	(39.56)	(25.31)	(27.22)	(41.63)
$35	(16.35)	(40.06)	(29.86)	(47.53)	(30.41)	(32.70)	(50.01)
$40	(19.20)	(47.04)	(35.06)	(55.81)	(35.71)	(38.40)	(58.73)
$45	(22.21)	(54.41)	(40.56)	(64.56)	(41.31)	(44.42)	(67.94)
$50	(25.34)	(62.08)	(46.27)	(73.66)	(47.13)	(50.68)	(77.52)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$10	(3.10)	(7.60)	(5.66)	(9.01)	(5.77)	(6.20)	(9.48)
$15	(4.86)	(11.91)	(8.87)	(14.13)	(9.04)	(9.72)	(14.87)
$20	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$25	(9.04)	(22.15)	(16.51)	(26.28)	(16.81)	(18.08)	(27.65)
$30	(11.51)	(28.20)	(21.02)	(33.46)	(21.41)	(23.02)	(35.21)
$35	(13.85)	(33.93)	(25.29)	(40.26)	(25.76)	(27.70)	(42.37)
$40	(16.24)	(39.79)	(29.65)	(47.21)	(30.21)	(32.48)	(49.68)
$45	(18.77)	(45.99)	(34.27)	(54.56)	(34.91)	(37.54)	(57.42)
$50	(21.43)	(52.50)	(39.13)	(62.30)	(39.86)	(42.86)	(65.55)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$150	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
$200	(2.09)	(5.12)	(3.82)	(6.08)	(3.89)	(4.18)	(6.39)
$250	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
$500	(7.14)	(17.49)	(13.04)	(20.76)	(13.28)	(14.28)	(21.84)
$750	(12.26)	(30.04)	(22.39)	(35.64)	(22.80)	(24.52)	(37.50)
$1,000	(18.46)	(45.23)	(33.71)	(53.66)	(34.34)	(36.92)	(56.47)
Copay/Day							
$50 w/3 Day Max	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$50 w/5 Day Max	(1.50)	(3.68)	(2.74)	(4.36)	(2.79)	(3.00)	(4.59)
$100 w/3 Day Max	(2.70)	(6.62)	(4.93)	(7.85)	(5.02)	(5.40)	(8.26)
$100 w/5 Day Max	(3.88)	(9.51)	(7.08)	(11.28)	(7.22)	(7.76)	(11.87)
$250 w/3 Day Max	(8.89)	(21.78)	(16.23)	(25.84)	(16.54)	(17.78)	(27.19)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$75	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$100	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
$125	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
$150	(1.75)	(4.29)	(3.20)	(5.09)	(3.26)	(3.50)	(5.35)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$25	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$35	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$50	(1.03)	(2.52)	(1.88)	(2.99)	(1.92)	(2.06)	(3.15)
$60	(1.27)	(3.11)	(2.32)	(3.69)	(2.36)	(2.54)	(3.88)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.17)	(0.42)	(0.32)	(0.50)	(0.32)	(0.35)	(0.53)
$10	(0.37)	(0.91)	(0.67)	(1.07)	(0.69)	(0.74)	(1.12)
$15	(0.62)	(1.51)	(1.12)	(1.79)	(1.14)	(1.23)	(1.89)
$20	(0.95)	(2.33)	(1.74)	(2.77)	(1.78)	(1.91)	(2.91)
$25	(1.25)	(3.06)	(2.28)	(3.63)	(2.32)	(2.50)	(3.83)
$30	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.84)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.21)	(0.15)	(0.24)	(0.16)	(0.17)	(0.26)
$10	(0.20)	(0.50)	(0.37)	(0.60)	(0.38)	(0.41)	(0.63)
$15	(0.36)	(0.88)	(0.65)	(1.04)	(0.66)	(0.72)	(1.10)
$20	(0.54)	(1.34)	(1.00)	(1.58)	(1.01)	(1.09)	(1.67)
$25	(0.71)	(1.73)	(1.30)	(2.07)	(1.32)	(1.42)	(2.17)
$30	(0.90)	(2.19)	(1.64)	(2.61)	(1.66)	(1.79)	(2.75)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.29)	(0.21)	(0.36)	(0.22)	(0.24)	(0.37)
$10	(0.27)	(0.66)	(0.49)	(0.77)	(0.50)	(0.53)	(0.82)
$15	(0.42)	(1.04)	(0.78)	(1.23)	(0.79)	(0.85)	(1.30)
$20	(0.59)	(1.45)	(1.08)	(1.72)	(1.11)	(1.18)	(1.81)
$25	(0.78)	(1.91)	(1.42)	(2.26)	(1.45)	(1.56)	(2.38)
$30	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.01)
$35	(1.18)	(2.91)	(2.17)	(3.44)	(2.20)	(2.37)	(3.61)
$40	(1.39)	(3.41)	(2.55)	(4.05)	(2.59)	(2.78)	(4.25)
$45	(1.61)	(3.95)	(2.95)	(4.68)	(3.00)	(3.23)	(4.94)
$50	(1.84)	(4.51)	(3.36)	(5.34)	(3.42)	(3.68)	(5.63)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.29)	(0.22)	(0.35)	(0.23)	(0.24)	(0.37)
$10	(0.23)	(0.56)	(0.42)	(0.66)	(0.43)	(0.46)	(0.70)
$15	(0.36)	(0.88)	(0.65)	(1.04)	(0.66)	(0.72)	(1.10)
$20	(0.50)	(1.22)	(0.92)	(1.45)	(0.93)	(1.00)	(1.52)
$25	(0.66)	(1.63)	(1.22)	(1.93)	(1.23)	(1.33)	(2.03)
$30	(0.83)	(2.03)	(1.51)	(2.40)	(1.53)	(1.65)	(2.53)
$35	(1.00)	(2.46)	(1.83)	(2.91)	(1.86)	(2.01)	(3.07)
$40	(1.18)	(2.89)	(2.15)	(3.43)	(2.20)	(2.36)	(3.61)
$45	(1.36)	(3.33)	(2.48)	(3.94)	(2.53)	(2.72)	(4.16)
$50	(1.55)	(3.81)	(2.83)	(4.52)	(2.90)	(3.11)	(4.75)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.08)	(0.20)	(0.16)	(0.24)	(0.15)	(0.17)	(0.25)
$150	(0.12)	(0.30)	(0.22)	(0.35)	(0.22)	(0.25)	(0.37)
$200	(0.16)	(0.39)	(0.29)	(0.46)	(0.30)	(0.32)	(0.48)
$250	(0.21)	(0.52)	(0.39)	(0.61)	(0.40)	(0.43)	(0.64)
$500	(0.52)	(1.27)	(0.94)	(1.51)	(0.97)	(1.04)	(1.59)
$750	(0.89)	(2.17)	(1.63)	(2.57)	(1.65)	(1.77)	(2.71)
$1,000	(1.34)	(3.29)	(2.45)	(3.89)	(2.50)	(2.68)	(4.10)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.15)	(0.23)
$50 w/5 Day Max	(0.12)	(0.31)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$100 w/3 Day Max	(0.20)	(0.50)	(0.38)	(0.59)	(0.37)	(0.41)	(0.62)
$100 w/5 Day Max	(0.28)	(0.68)	(0.50)	(0.80)	(0.51)	(0.55)	(0.85)
$250 w/3 Day Max	(0.65)	(1.59)	(1.18)	(1.88)	(1.22)	(1.30)	(1.98)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.04)	(0.10)	(0.06)	(0.11)	(0.07)	(0.08)	(0.12)
$75	(0.04)	(0.10)	(0.08)	(0.11)	(0.07)	(0.08)	(0.12)
$100	(0.08)	(0.20)	(0.14)	(0.23)	(0.14)	(0.15)	(0.23)
$125	(0.11)	(0.27)	(0.21)	(0.34)	(0.21)	(0.23)	(0.35)
$150	(0.12)	(0.30)	(0.22)	(0.36)	(0.23)	(0.24)	(0.37)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	(0.01)	(0.01)	0.00	0.00	(0.01)
$25	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
$35	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$50	(0.08)	(0.19)	(0.15)	(0.22)	(0.15)	(0.16)	(0.25)
$60	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.23)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Copay	**PCP Office Visit Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.5%	7.6%	7.8%	7.6%	7.6%	7.8%	7.7%
$10	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%	7.7%
$15	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.9%
$20	7.8%	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.1%	6.7%	6.4%	6.5%	6.8%	6.7%	6.7%
$10	7.4%	7.5%	7.5%	7.6%	7.6%	7.6%	7.6%
$15	8.0%	8.0%	7.9%	7.9%	7.9%	8.0%	8.0%
$20	7.8%	7.9%	7.9%	7.8%	7.8%	7.8%	7.9%
$25	7.8%	7.7%	7.8%	7.8%	7.7%	7.8%	7.7%
$30	7.8%	7.7%	7.8%	7.8%	7.7%	7.7%	7.8%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	7.3%	7.2%	7.0%	7.6%	7.2%	7.3%	7.4%
$10	8.0%	7.9%	7.9%	7.8%	7.9%	7.8%	7.9%
$15	7.9%	8.0%	8.0%	7.9%	8.0%	8.0%	8.0%
$20	7.9%	7.9%	7.9%	7.9%	8.0%	7.9%	7.9%
$25	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%	7.8%
$30	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
$35	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	8.6%	8.5%	8.6%	8.6%	8.8%	8.6%	8.6%
$10	8.0%	8.0%	8.0%	7.9%	8.1%	8.0%	8.0%
$15	8.0%	8.0%	7.9%	7.9%	7.9%	8.0%	8.0%
$20	7.9%	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%
$25	7.9%	7.9%	8.0%	7.9%	7.9%	7.9%	7.9%
$30	7.8%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
$35	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$40	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
$45	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	9.5%	9.8%	10.5%	9.9%	9.6%	10.2%	9.8%
$150	8.9%	9.1%	8.9%	8.9%	8.8%	9.3%	9.0%
$200	8.3%	8.2%	8.2%	8.2%	8.4%	8.3%	8.1%
$250	7.6%	7.7%	7.8%	7.6%	7.8%	7.8%	7.6%
$500	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%	7.9%
$750	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
$1,000	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
Copay/Day							
$50 w/3 Day Max	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$50 w/5 Day Max	8.7%	9.2%	8.7%	8.7%	8.6%	8.7%	8.8%
$100 w/3 Day Max	8.0%	8.2%	8.4%	8.1%	8.0%	8.2%	8.1%
$100 w/5 Day Max	7.8%	7.7%	7.6%	7.6%	7.6%	7.6%	7.7%
$250 w/3 Day Max	7.9%	7.9%	7.8%	7.8%	8.0%	7.9%	7.9%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$50	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
$75	5.7%	5.8%	6.3%	5.4%	5.3%	5.7%	5.6%
$100	8.0%	8.2%	7.7%	7.9%	7.5%	7.5%	7.5%
$125	8.5%	8.5%	8.9%	9.0%	8.7%	8.9%	8.8%
$150	7.4%	7.5%	7.4%	7.6%	7.6%	7.4%	7.4%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	3.1%	2.0%	0.0%	0.0%	1.9%
$25	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
$35	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
$50	8.4%	8.2%	8.7%	7.9%	8.5%	8.4%	8.6%
$60	6.7%	6.9%	6.9%	6.6%	6.8%	6.7%	6.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.58)	(3.86)	(2.88)	(4.59)	(2.93)	(3.15)	(4.83)
$100	(2.25)	(5.50)	(4.10)	(6.53)	(4.18)	(4.49)	(6.87)
$125	(2.75)	(6.73)	(5.01)	(7.99)	(5.11)	(5.49)	(8.41)
$150	(3.30)	(8.08)	(6.03)	(9.60)	(6.14)	(6.60)	(10.10)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.45	1.10	0.83	1.31	0.84	0.90	1.38
60	0.87	2.12	1.59	2.52	1.61	1.73	2.65
90	1.28	3.14	2.35	3.74	2.39	2.57	3.93
120	1.51	3.71	2.77	4.41	2.82	3.03	4.64
Unlimited	1.95	4.78	3.56	5.68	3.63	3.91	5.97
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.31)	(0.76)	(0.57)	(0.91)	(0.58)	(0.63)	(0.96)
40/$20 copay	(0.43)	(1.04)	(0.78)	(1.24)	(0.79)	(0.86)	(1.31)
40/$25 copay	(0.55)	(1.36)	(1.01)	(1.61)	(1.03)	(1.11)	(1.69)
60	0.20	0.49	0.37	0.57	0.37	0.40	0.61
100	0.50	1.23	0.92	1.46	0.93	1.00	1.54
200	1.32	3.23	2.40	3.82	2.44	2.63	4.02
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.91)	(2.22)	(1.66)	(2.64)	(1.69)	(1.82)	(2.78)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.60	1.46	1.09	1.73	1.11	1.19	1.82
90	1.22	3.00	2.24	3.55	2.28	2.44	3.74
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.52	1.27	0.95	1.51	0.97	1.04	1.60
90	0.97	2.38	1.78	2.82	1.81	1.94	2.97
120	1.57	3.83	2.86	4.55	2.91	3.13	4.79
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.74)	(1.82)	(1.36)	(2.15)	(1.38)	(1.48)	(2.27)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.39	0.61	0.39	0.42	0.64
30	0.36	0.87	0.65	1.03	0.66	0.71	1.09
Unlimited	0.52	1.27	0.95	1.51	0.97	1.04	1.60
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.32	5.68	4.23	6.74	4.31	4.64	7.09
60	2.73	6.67	4.98	7.93	5.07	5.45	8.33
90	3.25	7.96	5.93	9.44	6.04	6.50	9.93
Unlimited	3.30	8.08	6.03	9.60	6.14	6.60	10.10
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.32)	(0.79)	(0.60)	(0.94)	(0.61)	(0.65)	(0.99)
60/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$25 copay	(0.55)	(1.36)	(1.01)	(1.61)	(1.03)	(1.11)	(1.69)
120/$0 copay	0.47	1.15	0.86	1.37	0.88	0.94	1.44
120/$5 copay	0.36	0.87	0.65	1.03	0.66	0.71	1.09
120/$10 copay	0.20	0.49	0.37	0.57	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.33)	(0.25)	(0.40)	(0.25)	(0.27)	(0.42)
120/$25 copay	(0.25)	(0.62)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
Unlimited/$0 copay	0.54	1.33	0.99	1.58	1.01	1.09	1.66
Unlimited/$5 copay	0.42	1.02	0.76	1.21	0.77	0.84	1.27
Unlimited/$10 copay	0.25	0.62	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.16	0.11	0.18	0.11	0.13	0.19
Unlimited/$20 copay	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
Unlimited/$25 copay	(0.21)	(0.51)	(0.39)	(0.61)	(0.39)	(0.42)	(0.64)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.14	0.33	0.25	0.40	0.25	0.27	0.42
$5	0.06	0.16	0.11	0.18	0.11	0.13	0.19

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$100	(2.42)	(5.93)	(4.42)	(7.03)	(4.50)	(4.84)	(7.40)
$125	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
$150	(3.55)	(8.70)	(6.48)	(10.32)	(6.60)	(7.10)	(10.86)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.49	1.20	0.89	1.42	0.91	0.98	1.50
60	0.95	2.33	1.73	2.76	1.77	1.90	2.91
90	1.38	3.38	2.52	4.01	2.57	2.76	4.22
120	1.63	3.99	2.98	4.74	3.03	3.26	4.99
Unlimited	2.11	5.17	3.85	6.13	3.92	4.22	6.45
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
40/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
40/$15 copay	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
40/$20 copay	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
40/$25 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
60	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100	0.54	1.32	0.99	1.57	1.00	1.08	1.65
200	1.44	3.53	2.63	4.19	2.68	2.88	4.40
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.64	1.57	1.17	1.86	1.19	1.28	1.96
90	1.30	3.19	2.37	3.78	2.42	2.60	3.98
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.56	1.37	1.02	1.63	1.04	1.12	1.71
90	1.05	2.57	1.92	3.05	1.95	2.10	3.21
120	1.69	4.14	3.09	4.91	3.14	3.38	5.17
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.21	0.51	0.38	0.61	0.39	0.42	0.64
30	0.40	0.98	0.73	1.16	0.74	0.80	1.22
Unlimited	0.56	1.37	1.02	1.63	1.04	1.12	1.71
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	2.50	6.13	4.57	7.27	4.65	5.00	7.65
60	2.93	7.18	5.35	8.52	5.45	5.86	8.96
90	3.50	8.58	6.39	10.17	6.51	7.00	10.71
Unlimited	3.55	8.70	6.48	10.32	6.60	7.10	10.86
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
60/$10 copay	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
60/$15 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
60/$20 copay	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
60/$25 copay	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
120/$0 copay	0.51	1.25	0.93	1.48	0.95	1.02	1.56
120/$5 copay	0.40	0.98	0.73	1.16	0.74	0.80	1.22
120/$10 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
120/$15 copay	0.01	0.02	0.02	0.03	0.02	0.02	0.03
120/$20 copay	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
120/$25 copay	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
Unlimited/$0 copay	0.58	1.42	1.06	1.69	1.08	1.16	1.77
Unlimited/$5 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Unlimited/$10 copay	0.25	0.61	0.46	0.73	0.47	0.50	0.76
Unlimited/$15 copay	0.06	0.15	0.11	0.17	0.11	0.12	0.18
Unlimited/$20 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
Unlimited/$25 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.14	0.34	0.26	0.41	0.26	0.28	0.43
$5	0.06	0.15	0.11	0.17	0.11	0.12	0.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	(0.12)	(0.31)	(0.22)	(0.35)	(0.23)	(0.25)	(0.37)
$100	(0.17)	(0.43)	(0.32)	(0.50)	(0.32)	(0.35)	(0.53)
$125	(0.21)	(0.52)	(0.39)	(0.61)	(0.40)	(0.43)	(0.64)
$150	(0.25)	(0.62)	(0.45)	(0.72)	(0.46)	(0.50)	(0.76)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.04	0.10	0.06	0.11	0.07	0.08	0.12
60	0.08	0.21	0.14	0.24	0.16	0.17	0.26
90	0.10	0.24	0.17	0.27	0.18	0.19	0.29
120	0.12	0.28	0.21	0.33	0.21	0.23	0.35
Unlimited	0.16	0.39	0.29	0.45	0.29	0.31	0.48
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	0.00	0.01	0.01	0.01	0.01	0.01	0.01
40/$10 copay	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
40/$15 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
40/$20 copay	(0.04)	(0.11)	(0.08)	(0.13)	(0.08)	(0.08)	(0.13)
40/$25 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
60	0.00	0.00	0.00	0.01	0.00	0.00	0.00
100	0.04	0.09	0.07	0.11	0.07	0.08	0.11
200	0.12	0.30	0.23	0.37	0.24	0.25	0.38
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.08)	(0.21)	(0.15)	(0.24)	(0.15)	(0.16)	(0.25)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.11	0.08	0.13	0.08	0.09	0.14
90	0.08	0.19	0.13	0.23	0.14	0.16	0.24
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.04	0.10	0.07	0.12	0.07	0.08	0.11
90	0.08	0.19	0.14	0.23	0.14	0.16	0.24
120	0.12	0.31	0.23	0.36	0.23	0.25	0.38
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.04)	(0.09)	(0.06)	(0.12)	(0.07)	(0.08)	(0.12)
7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
21	0.00	0.00	(0.01)	0.00	0.00	0.00	0.00
30	0.04	0.11	0.08	0.13	0.08	0.09	0.13
Unlimited	0.04	0.10	0.07	0.12	0.07	0.08	0.11
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30	0.18	0.45	0.34	0.53	0.34	0.36	0.56
60	0.20	0.51	0.37	0.59	0.38	0.41	0.63
90	0.25	0.62	0.46	0.73	0.47	0.50	0.78
Unlimited	0.25	0.62	0.45	0.72	0.46	0.50	0.76
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$5 copay	0.00	0.01	0.01	0.01	0.01	0.01	0.01
60/$10 copay	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
60/$15 copay	(0.04)	(0.09)	(0.06)	(0.11)	(0.06)	(0.07)	(0.11)
60/$20 copay	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
60/$25 copay	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
120/$0 copay	0.04	0.10	0.07	0.11	0.07	0.08	0.12
120/$5 copay	0.04	0.11	0.08	0.13	0.08	0.09	0.13
120/$10 copay	0.00	0.00	0.00	0.01	0.00	0.00	0.00
120/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120/$20 copay	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
120/$25 copay	0.00	0.01	0.00	0.00	0.00	0.00	0.00
Unlimited/$0 copay	0.04	0.09	0.07	0.11	0.07	0.07	0.11
Unlimited/$5 copay	0.04	0.11	0.08	0.13	0.09	0.08	0.14
Unlimited/$10 copay	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
Unlimited/$15 copay	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	(0.01)
Unlimited/$20 copay	0.00	0.01	0.00	0.01	0.00	0.01	0.01
Unlimited/$25 copay	0.00	0.00	0.01	0.00	0.00	0.00	0.00
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$5	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	(0.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$75	7.6%	8.0%	7.6%	7.6%	7.8%	7.9%	7.7%
$100	7.6%	7.8%	7.8%	7.7%	7.7%	7.8%	7.7%
$125	7.6%	7.7%	7.8%	7.6%	7.8%	7.8%	7.6%
$150	7.6%	7.7%	7.5%	7.5%	7.5%	7.6%	7.5%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45	8.9%	9.1%	7.2%	8.4%	8.3%	8.9%	8.7%
60	9.2%	9.9%	8.8%	9.5%	9.9%	9.8%	9.8%
90	7.8%	7.6%	7.2%	7.2%	7.5%	7.4%	7.4%
120	7.9%	7.5%	7.6%	7.5%	7.4%	7.6%	7.5%
Unlimited	8.2%	8.2%	8.1%	7.9%	8.0%	7.9%	8.0%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40/$5 copay	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
40/$10 copay	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
40/$15 copay	12.9%	13.2%	12.3%	12.1%	12.1%	11.1%	11.5%
40/$20 copay	9.3%	10.6%	10.3%	10.5%	10.1%	9.3%	9.9%
40/$25 copay	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
60	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
100	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
200	9.1%	9.3%	9.6%	9.7%	9.8%	9.5%	9.5%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	8.8%	9.5%	9.0%	9.1%	8.9%	8.8%	9.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	6.7%	7.5%	7.3%	7.5%	7.2%	7.6%	7.7%
90	6.6%	6.3%	5.8%	6.5%	6.1%	6.6%	6.4%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	6.9%
90	8.2%	8.0%	7.9%	8.2%	7.7%	8.2%	8.1%
120	7.6%	8.1%	8.0%	7.9%	7.9%	8.0%	7.9%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	5.4%	4.9%	4.4%	5.6%	5.1%	5.4%	5.3%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
30	11.1%	12.6%	12.3%	12.6%	12.1%	12.7%	11.9%
Unlimited	7.7%	7.9%	7.4%	7.9%	7.2%	7.7%	6.9%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	7.8%	7.9%	8.0%	7.9%	7.9%	7.8%	7.9%
60	7.3%	7.6%	7.4%	7.4%	7.5%	7.5%	7.6%
90	7.7%	7.8%	7.8%	7.7%	7.8%	7.7%	7.9%
Unlimited	7.6%	7.7%	7.5%	7.5%	7.5%	7.6%	7.5%
# Visits	**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
60/$0 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
60/$5 copay	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
60/$10 copay	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
60/$15 copay	12.5%	11.4%	10.0%	11.7%	9.8%	10.8%	11.1%
60/$20 copay	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
60/$25 copay	7.3%	6.6%	6.9%	6.8%	6.8%	6.3%	6.5%
120/$0 copay	8.5%	8.7%	8.1%	8.0%	8.0%	8.5%	8.3%
120/$5 copay	11.1%	12.6%	12.3%	12.6%	12.1%	12.7%	11.9%
120/$10 copay	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
120/$15 copay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
120/$20 copay	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
120/$25 copay	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$0 copay	7.4%	6.8%	7.1%	7.0%	6.9%	6.4%	6.6%
Unlimited/$5 copay	9.5%	10.8%	10.5%	10.7%	11.7%	9.5%	11.0%
Unlimited/$10 copay	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Unlimited/$15 copay	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
Unlimited/$20 copay	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
Unlimited/$25 copay	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
$5	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$20	(0.17)	(0.41)	(0.30)	(0.49)	(0.31)	(0.33)	(0.51)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.21)	(0.16)	(0.24)	(0.16)	(0.17)	(0.25)
$10	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
$15	(0.31)	(0.76)	(0.57)	(0.91)	(0.58)	(0.63)	(0.96)
$20	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$25	(0.57)	(1.41)	(1.04)	(1.67)	(1.07)	(1.15)	(1.75)
$30	(0.70)	(1.71)	(1.27)	(2.04)	(1.31)	(1.40)	(2.14)
$35	(0.84)	(2.05)	(1.52)	(2.43)	(1.56)	(1.67)	(2.56)
$40	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.93)
$45	(1.09)	(2.66)	(1.98)	(3.15)	(2.02)	(2.17)	(3.32)
$50	(1.20)	(2.95)	(2.19)	(3.49)	(2.24)	(2.40)	(3.68)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$10	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
$20	(0.50)	(1.23)	(0.92)	(1.46)	(0.93)	(1.00)	(1.54)
$25	(0.67)	(1.64)	(1.22)	(1.94)	(1.24)	(1.34)	(2.05)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.13)
$20	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.07)	(0.18)	(0.14)	(0.21)	(0.14)	(0.15)	(0.22)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.16)	(0.11)	(0.18)	(0.11)	(0.13)	(0.19)
$25	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$35	(0.15)	(0.36)	(0.27)	(0.43)	(0.27)	(0.29)	(0.45)
$50	(0.22)	(0.53)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)
$75	(0.38)	(0.92)	(0.69)	(1.10)	(0.70)	(0.75)	(1.15)
$100	(0.50)	(1.23)	(0.92)	(1.46)	(0.93)	(1.00)	(1.54)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.13)	(0.07)	(0.08)	(0.13)
$25	(0.07)	(0.18)	(0.14)	(0.21)	(0.14)	(0.15)	(0.22)
$35	(0.09)	(0.23)	(0.17)	(0.27)	(0.18)	(0.19)	(0.29)
$50	(0.16)	(0.39)	(0.28)	(0.46)	(0.29)	(0.31)	(0.48)
$60	(0.20)	(0.49)	(0.37)	(0.57)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.58)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.33)	(0.81)	(0.61)	(0.97)	(0.63)	(0.67)	(1.02)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.09)	(5.12)	(3.81)	(6.07)	(3.89)	(4.18)	(6.39)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(3.25)	(7.96)	(5.93)	(9.44)	(6.04)	(6.50)	(9.93)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.29)	(0.72)	(0.53)	(0.85)	(0.54)	(0.58)	(0.90)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$20	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$25	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$30	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$35	(0.92)	(2.25)	(1.68)	(2.67)	(1.71)	(1.84)	(2.81)
$40	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$45	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
$50	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$10	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$15	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$20	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$25	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$20	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$25	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$35	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$60	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$75	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$100	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$25	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$35	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$50	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$100	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(2.25)	(5.51)	(4.11)	(6.54)	(4.19)	(4.50)	(6.88)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(3.50)	(8.58)	(6.39)	(10.17)	(6.51)	(7.00)	(10.71)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$20	0.00	(0.01)	(0.01)	0.00	(0.01)	(0.01)	(0.01)
$25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$10	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.07)	(0.11)
$20	(0.04)	(0.10)	(0.07)	(0.11)	(0.07)	(0.08)	(0.12)
$25	(0.04)	(0.08)	(0.07)	(0.10)	(0.06)	(0.07)	(0.12)
$30	(0.04)	(0.10)	(0.08)	(0.11)	(0.07)	(0.08)	(0.12)
$35	(0.08)	(0.20)	(0.16)	(0.24)	(0.15)	(0.17)	(0.25)
$40	(0.08)	(0.20)	(0.15)	(0.23)	(0.14)	(0.16)	(0.25)
$45	(0.08)	(0.21)	(0.16)	(0.25)	(0.16)	(0.17)	(0.26)
$50	(0.08)	(0.19)	(0.15)	(0.23)	(0.14)	(0.16)	(0.24)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$10	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$15	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
$20	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$25	(0.04)	(0.10)	(0.08)	(0.12)	(0.08)	(0.08)	(0.12)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$20	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.01	0.00	0.01	0.00	0.01	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$35	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.01)	(0.01)
$50	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$60	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
$75	(0.04)	(0.11)	(0.08)	(0.12)	(0.08)	(0.09)	(0.13)
$100	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	0.00	0.00	0.00	0.01	0.00	0.00	0.01
$25	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$35	0.00	0.01	0.01	0.01	0.01	0.01	0.01
$50	0.00	0.00	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
$60	0.00	0.00	0.00	(0.01)	0.00	0.00	0.00
$75	0.00	(0.01)	0.00	0.00	0.00	0.00	0.00
$100	(0.04)	(0.10)	(0.07)	(0.11)	(0.06)	(0.07)	(0.11)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(0.16)	(0.39)	(0.30)	(0.47)	(0.30)	(0.32)	(0.49)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	(0.25)	(0.62)	(0.46)	(0.73)	(0.47)	(0.50)	(0.78)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.04)	(0.09)	(0.07)	(0.11)	(0.07)	(0.08)	(0.11)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
IN-NETWORK BENEFIT VARIABLES
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$20	0.0%	2.4%	3.3%	0.0%	3.2%	3.0%	2.0%
$25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	-4.8%	-6.3%	-4.2%	-6.3%	-5.9%	-4.0%
$10	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
$15	12.9%	13.2%	12.3%	12.1%	12.1%	11.1%	11.5%
$20	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
$25	7.0%	5.7%	6.7%	6.0%	5.6%	6.1%	6.9%
$30	5.7%	5.8%	6.3%	5.4%	5.3%	5.7%	5.6%
$35	9.5%	9.8%	10.5%	9.9%	9.6%	10.2%	9.8%
$40	8.3%	8.5%	8.6%	8.2%	7.8%	8.3%	8.5%
$45	7.3%	7.9%	8.1%	7.9%	7.9%	7.8%	7.8%
$50	6.7%	6.4%	6.8%	6.6%	6.2%	6.7%	6.5%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$10	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
$20	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
$25	6.0%	6.1%	6.6%	6.2%	6.5%	6.0%	5.9%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-7.7%	0.0%	0.0%	-7.7%
$20	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-5.6%	-7.1%	-4.8%	-7.1%	-6.7%	-4.5%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	-6.3%	0.0%	-5.6%	0.0%	-7.7%	-5.3%
$25	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$35	0.0%	2.8%	0.0%	2.3%	3.7%	3.4%	2.2%
$50	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%
$60	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%
$75	10.5%	12.0%	11.6%	10.9%	11.4%	12.0%	11.3%
$100	8.0%	7.3%	7.6%	7.5%	7.5%	8.0%	7.1%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$15	0.0%	0.0%	0.0%	-7.7%	0.0%	0.0%	-7.7%
$25	0.0%	-5.6%	-7.1%	-4.8%	-7.1%	-6.7%	-4.5%
$35	0.0%	-4.3%	-5.9%	-3.7%	-5.6%	-5.3%	-3.4%
$50	0.0%	0.0%	3.6%	2.2%	3.4%	3.2%	2.1%
$60	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
$75	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%
$100	12.1%	12.3%	11.5%	11.3%	9.5%	10.4%	10.8%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	7.7%	7.6%	7.9%	7.7%	7.7%	7.7%	7.7%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum [20%, $100]; $500 annual maximum						
	7.7%	7.8%	7.8%	7.7%	7.8%	7.7%	7.9%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	13.8%	12.5%	13.2%	12.9%	13.0%	13.8%	12.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	8.48	20.77	15.49	24.65	15.77	16.96	25.94
60	8.94	21.90	16.33	25.99	16.63	17.88	27.34
90	9.26	22.70	16.92	26.93	17.23	18.53	28.34
Unlimited	9.37	22.96	17.11	27.24	17.42	18.74	28.66
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			$0 Copay				
20	9.47	23.21	17.30	27.54	17.62	18.95	28.97
30	10.43	25.57	19.05	30.33	19.41	20.87	31.92
40	11.01	26.97	20.11	32.00	20.47	22.02	33.67
60	11.60	28.43	21.19	33.74	21.58	23.21	35.49
Unlimited	11.70	28.66	21.36	34.01	21.76	23.40	35.78
LARGE GROUP			$5 Copay				
20	8.91	21.83	16.27	25.90	16.58	17.82	27.25
30	9.80	24.00	17.89	28.48	18.23	19.59	29.97
40	10.42	25.54	19.03	30.30	19.39	20.85	31.89
60	10.90	26.72	19.91	31.70	20.28	21.81	33.36
Unlimited	11.00	26.95	20.09	31.97	20.45	22.00	33.64
LARGE GROUP			$10 Copay				
20	8.35	20.45	15.24	24.26	15.52	16.69	25.53
30	9.19	22.52	16.78	26.72	17.10	18.38	28.12
40	9.71	23.79	17.74	28.23	18.07	19.43	29.72
60	10.24	25.08	18.69	29.76	19.04	20.47	31.31
Unlimited	10.31	25.26	18.82	29.97	19.18	20.62	31.53
LARGE GROUP			$15 Copay				
20	7.83	19.19	14.30	22.77	14.57	15.67	23.96
30	8.63	21.14	15.75	25.08	16.04	17.25	26.39
40	9.14	22.39	16.69	26.57	16.99	18.28	27.96
60	9.67	23.70	17.66	28.12	17.99	19.34	29.59
Unlimited	9.74	23.88	17.80	28.33	18.12	19.49	29.81
LARGE GROUP			$20 Copay				
20	7.37	18.07	13.46	21.43	13.71	14.75	22.56
30	8.08	19.80	14.76	23.50	15.04	16.17	24.73
40	8.52	20.88	15.56	24.77	15.86	17.05	26.07
60	9.06	22.18	16.53	26.32	16.85	18.11	27.70
Unlimited	9.13	22.36	16.67	26.54	16.98	18.26	27.93
LARGE GROUP			$25 Copay				
20	6.85	16.78	12.51	19.92	12.74	13.70	20.96
30	7.53	18.45	13.75	21.89	14.01	15.06	23.04
40	8.02	19.66	14.64	23.32	14.92	16.04	24.53
60	8.44	20.68	15.41	24.53	15.70	16.88	25.82
Unlimited	8.51	20.86	15.54	24.74	15.83	17.02	26.04
LARGE GROUP			$30 Copay				
20	6.53	15.99	11.92	18.98	12.14	13.06	19.97
30	7.08	17.35	12.93	20.59	13.17	14.16	21.66
40	7.55	18.50	13.79	21.95	14.05	15.10	23.10
60	7.92	19.40	14.46	23.01	14.73	15.83	24.22
Unlimited	7.96	19.50	14.53	23.14	14.80	15.92	24.35
LARGE GROUP			$35 Copay				
20	6.21	15.23	11.34	18.07	11.56	12.43	19.01
30	6.62	16.22	12.10	19.25	12.31	13.24	20.25
40	7.06	17.30	12.89	20.52	13.13	14.12	21.60
60	7.41	18.14	13.53	21.53	13.78	14.81	22.65
Unlimited	7.46	18.27	13.62	21.68	13.87	14.92	22.81
LARGE GROUP			$40 Copay				
20	6.04	14.79	11.02	17.55	11.23	12.07	18.47
30	6.44	15.79	11.77	18.74	11.99	12.89	19.71
40	6.87	16.84	12.54	19.98	12.78	13.75	21.03
60	7.24	17.74	13.21	21.05	13.46	14.48	22.14
Unlimited	7.30	17.89	13.33	21.22	13.58	14.60	22.33
LARGE GROUP			$45 Copay				
20	5.87	14.38	10.72	17.07	10.91	11.74	17.95

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	9.14	22.39	16.69	26.57	17.00	18.28	27.96
60	9.64	23.62	17.60	28.02	17.93	19.28	29.49
90	9.99	24.48	18.24	29.04	18.58	19.98	30.56
Unlimited	10.10	24.75	18.44	29.36	18.79	20.20	30.90
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			$0 Copay				
20	10.21	25.01	18.64	29.68	18.99	20.42	31.23
30	11.25	27.56	20.54	32.70	20.93	22.50	34.41
40	11.87	29.08	21.67	34.51	22.08	23.74	36.31
60	12.50	30.63	22.83	36.34	23.25	25.00	38.24
Unlimited	12.62	30.92	23.04	36.69	23.47	25.24	38.60
LARGE GROUP			$5 Copay				
20	9.61	23.54	17.55	27.94	17.87	19.22	29.40
30	10.57	25.90	19.30	30.73	19.66	21.14	32.33
40	11.24	27.54	20.52	32.67	20.91	22.48	34.38
60	11.76	28.81	21.47	34.19	21.87	23.52	35.97
Unlimited	11.86	29.06	21.66	34.48	22.06	23.72	36.28
LARGE GROUP			$10 Copay				
20	9.00	22.05	16.43	26.16	16.74	18.00	27.53
30	9.90	24.26	18.08	28.78	18.41	19.80	30.28
40	10.47	25.65	19.12	30.44	19.47	20.94	32.03
60	11.04	27.05	20.16	32.09	20.53	22.08	33.77
Unlimited	11.12	27.24	20.31	32.33	20.68	22.24	34.02
LARGE GROUP			$15 Copay				
20	8.44	20.68	15.41	24.54	15.70	16.88	25.82
30	9.30	22.79	16.98	27.04	17.30	18.60	28.45
40	9.85	24.13	17.99	28.63	18.32	19.70	30.13
60	10.42	25.53	19.03	30.29	19.38	20.84	31.87
Unlimited	10.51	25.75	19.19	30.55	19.55	21.02	32.15
LARGE GROUP			$20 Copay				
20	7.95	19.48	14.52	23.11	14.79	15.90	24.32
30	8.71	21.34	15.90	25.32	16.20	17.42	26.64
40	9.18	22.49	16.76	26.69	17.07	18.36	28.08
60	9.77	23.94	17.84	28.40	18.17	19.54	29.89
Unlimited	9.84	24.11	17.97	28.60	18.30	19.68	30.10
LARGE GROUP			$25 Copay				
20	7.39	18.11	13.49	21.48	13.75	14.78	22.61
30	8.12	19.89	14.83	23.60	15.10	16.24	24.84
40	8.65	21.19	15.79	25.15	16.09	17.30	26.46
60	9.10	22.30	16.62	26.45	16.93	18.20	27.84
Unlimited	9.17	22.47	16.74	26.66	17.06	18.34	28.05
LARGE GROUP			$30 Copay				
20	7.04	17.25	12.86	20.47	13.09	14.08	21.54
30	7.63	18.69	13.93	22.18	14.19	15.26	23.34
40	8.14	19.94	14.86	23.66	15.14	16.28	24.90
60	8.54	20.92	15.59	24.83	15.88	17.08	26.12
Unlimited	8.58	21.02	15.67	24.94	15.96	17.16	26.25
LARGE GROUP			$35 Copay				
20	6.69	16.39	12.22	19.45	12.44	13.38	20.46
30	7.14	17.49	13.04	20.76	13.28	14.28	21.84
40	7.61	18.64	13.90	22.12	14.15	15.22	23.28
60	7.99	19.58	14.59	23.23	14.86	15.98	24.44
Unlimited	8.04	19.70	14.68	23.37	14.95	16.08	24.59
LARGE GROUP			$40 Copay				
20	6.51	15.95	11.89	18.92	12.11	13.02	19.91
30	6.94	17.00	12.67	20.17	12.91	13.88	21.23
40	7.41	18.15	13.53	21.54	13.78	14.82	22.67
60	7.81	19.13	14.26	22.70	14.53	15.62	23.89
Unlimited	7.87	19.28	14.37	22.88	14.64	15.74	24.07
LARGE GROUP			$45 Copay				
20	6.33	15.51	11.56	18.40	11.77	12.66	19.36

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	0.66	1.62	1.20	1.92	1.23	1.32	2.02
60	0.70	1.72	1.27	2.03	1.30	1.40	2.15
90	0.73	1.78	1.32	2.11	1.35	1.45	2.22
Unlimited	0.73	1.79	1.33	2.12	1.37	1.46	2.24
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			$0 Copay				
20	0.74	1.80	1.34	2.14	1.37	1.47	2.26
30	0.82	1.99	1.49	2.37	1.52	1.63	2.49
40	0.86	2.11	1.56	2.51	1.61	1.72	2.64
60	0.90	2.20	1.64	2.60	1.67	1.79	2.75
Unlimited	0.92	2.26	1.68	2.68	1.71	1.84	2.82
LARGE GROUP			$5 Copay				
20	0.70	1.71	1.28	2.04	1.29	1.40	2.15
30	0.77	1.90	1.41	2.25	1.43	1.55	2.36
40	0.82	2.00	1.49	2.37	1.52	1.63	2.49
60	0.86	2.09	1.56	2.49	1.59	1.71	2.61
Unlimited	0.86	2.11	1.57	2.51	1.61	1.72	2.64
LARGE GROUP			$10 Copay				
20	0.65	1.60	1.19	1.90	1.22	1.31	2.00
30	0.71	1.74	1.30	2.06	1.31	1.42	2.16
40	0.76	1.86	1.38	2.21	1.40	1.51	2.31
60	0.80	1.97	1.47	2.33	1.49	1.61	2.46
Unlimited	0.81	1.98	1.49	2.36	1.50	1.62	2.49
LARGE GROUP			$15 Copay				
20	0.61	1.49	1.11	1.77	1.13	1.21	1.86
30	0.67	1.65	1.23	1.96	1.26	1.35	2.06
40	0.71	1.74	1.30	2.06	1.33	1.42	2.17
60	0.75	1.83	1.37	2.17	1.39	1.50	2.28
Unlimited	0.77	1.87	1.39	2.22	1.43	1.53	2.34
LARGE GROUP			$20 Copay				
20	0.58	1.41	1.06	1.68	1.08	1.15	1.76
30	0.63	1.54	1.14	1.82	1.16	1.25	1.91
40	0.66	1.61	1.20	1.92	1.21	1.31	2.01
60	0.71	1.76	1.31	2.08	1.32	1.43	2.19
Unlimited	0.71	1.75	1.30	2.06	1.32	1.42	2.17
LARGE GROUP			$25 Copay				
20	0.54	1.33	0.98	1.56	1.01	1.08	1.65
30	0.59	1.44	1.08	1.71	1.09	1.18	1.80
40	0.63	1.53	1.15	1.83	1.17	1.26	1.93
60	0.66	1.62	1.21	1.92	1.23	1.32	2.02
Unlimited	0.66	1.61	1.20	1.92	1.23	1.32	2.01
LARGE GROUP			$30 Copay				
20	0.51	1.26	0.94	1.49	0.95	1.02	1.57
30	0.55	1.34	1.00	1.59	1.02	1.10	1.68
40	0.59	1.44	1.07	1.71	1.09	1.18	1.80
60	0.62	1.52	1.13	1.82	1.15	1.25	1.90
Unlimited	0.62	1.52	1.14	1.80	1.16	1.24	1.90
LARGE GROUP			$35 Copay				
20	0.48	1.16	0.88	1.38	0.88	0.95	1.45
30	0.52	1.27	0.94	1.51	0.97	1.04	1.59
40	0.55	1.34	1.01	1.60	1.02	1.10	1.68
60	0.58	1.44	1.06	1.70	1.08	1.17	1.79
Unlimited	0.58	1.43	1.06	1.69	1.08	1.16	1.78
LARGE GROUP			$40 Copay				
20	0.47	1.16	0.87	1.37	0.88	0.95	1.44
30	0.50	1.21	0.90	1.43	0.92	0.99	1.52
40	0.54	1.31	0.99	1.56	1.00	1.07	1.64
60	0.57	1.39	1.05	1.65	1.07	1.14	1.75
Unlimited	0.57	1.39	1.04	1.66	1.06	1.14	1.74
LARGE GROUP			$45 Copay				
20	0.46	1.13	0.84	1.33	0.86	0.92	1.41

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 30 days with unlimited BIO and CSED] [Copay same as Inpatient Facility]							
LARGE GROUP # Days							
30	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%	7.9%
90	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [minimum mandatory coverage: 20 visits with unlimited Bio and CSED] [Copay same or less than Specialist Physician Office Visit]							
# Visits							
LARGE GROUP			$0 Copay				
20	7.8%	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%
30	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
60	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
Unlimited	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
LARGE GROUP			$5 Copay				
20	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%	7.9%
30	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%
40	7.9%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.9%	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%	7.8%
LARGE GROUP			$10 Copay				
20	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
30	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
40	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
60	7.8%	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%
Unlimited	7.9%	7.8%	7.9%	7.9%	7.8%	7.9%	7.9%
LARGE GROUP			$15 Copay				
20	7.8%	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%
30	7.8%	7.8%	7.8%	7.8%	7.9%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.7%	7.8%	7.7%	7.7%	7.8%	7.7%
Unlimited	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%	7.8%
LARGE GROUP			$20 Copay				
20	7.9%	7.8%	7.9%	7.8%	7.9%	7.8%	7.8%
30	7.8%	7.8%	7.7%	7.7%	7.7%	7.7%	7.7%
40	7.7%	7.7%	7.7%	7.8%	7.6%	7.7%	7.7%
60	7.8%	7.9%	7.9%	7.9%	7.8%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP			$25 Copay				
20	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%	7.9%
30	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
40	7.9%	7.8%	7.9%	7.8%	7.8%	7.9%	7.9%
60	7.8%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
Unlimited	7.8%	7.7%	7.7%	7.8%	7.8%	7.8%	7.7%
LARGE GROUP			$30 Copay				
20	7.8%	7.9%	7.9%	7.9%	7.8%	7.8%	7.9%
30	7.8%	7.7%	7.7%	7.7%	7.7%	7.8%	7.8%
40	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.8%	7.8%	7.9%	7.8%	7.9%	7.8%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP			$35 Copay				
20	7.7%	7.6%	7.8%	7.6%	7.6%	7.6%	7.6%
30	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%	7.9%
40	7.8%	7.7%	7.8%	7.8%	7.8%	7.8%	7.8%
60	7.8%	7.9%	7.8%	7.9%	7.8%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP			$40 Copay				
20	7.8%	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%
30	7.8%	7.7%	7.6%	7.6%	7.7%	7.7%	7.7%
40	7.9%	7.8%	7.9%	7.8%	7.8%	7.8%	7.8%
60	7.9%	7.8%	7.9%	7.8%	7.9%	7.9%	7.9%
Unlimited	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
LARGE GROUP			$45 Copay				
20	7.8%	7.9%	7.8%	7.8%	7.9%	7.8%	7.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.27	15.35	11.45	18.22	11.66	12.53	19.17
40	6.70	16.40	12.22	19.46	12.45	13.39	20.48
60	7.07	17.33	12.91	20.56	13.15	14.14	21.63
Unlimited	7.10	17.40	12.97	20.65	13.21	14.20	21.73
LARGE GROUP			**$50 Copay**				
20	5.71	14.00	10.43	16.61	10.62	11.43	17.47
30	6.10	14.95	11.13	17.74	11.34	12.20	18.65
40	6.53	15.99	11.92	18.98	12.14	13.06	19.97
60	6.89	16.89	12.59	20.04	12.83	13.79	21.09
Unlimited	6.94	16.99	12.66	20.16	12.90	13.87	21.21

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	6.76	16.56	12.34	19.65	12.57	13.52	20.68
40	7.22	17.69	13.18	20.99	13.43	14.44	22.09
60	7.62	18.67	13.91	22.15	14.17	15.24	23.31
Unlimited	7.65	18.74	13.97	22.24	14.23	15.30	23.40
LARGE GROUP				**$50 Copay**			
20	6.15	15.07	11.23	17.88	11.44	12.30	18.81
30	6.58	16.12	12.02	19.13	12.24	13.16	20.13
40	7.04	17.25	12.86	20.47	13.09	14.08	21.54
60	7.43	18.20	13.57	21.60	13.82	14.86	22.73
Unlimited	7.48	18.33	13.66	21.74	13.91	14.96	22.88

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	0.49	1.21	0.89	1.43	0.91	0.99	1.51
40	0.52	1.29	0.96	1.53	0.98	1.05	1.61
60	0.55	1.34	1.00	1.59	1.02	1.10	1.68
Unlimited	0.55	1.34	1.00	1.59	1.02	1.10	1.67
LARGE GROUP				**$50 Copay**			
20	0.44	1.07	0.80	1.27	0.82	0.87	1.34
30	0.48	1.17	0.89	1.39	0.90	0.96	1.48
40	0.51	1.26	0.94	1.49	0.95	1.02	1.57
60	0.54	1.31	0.98	1.56	0.99	1.07	1.64
Unlimited	0.54	1.34	1.00	1.58	1.01	1.09	1.67

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIPaccess II POS LARGE GROUP CONTRACT
MENTAL HEALTH
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	7.8%	7.9%	7.8%	7.8%	7.8%	7.9%	7.9%
40	7.8%	7.9%	7.9%	7.9%	7.9%	7.8%	7.9%
60	7.8%	7.7%	7.7%	7.7%	7.8%	7.8%	7.8%
Unlimited	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
LARGE GROUP				**$50 Copay**			
20	7.7%	7.6%	7.7%	7.6%	7.7%	7.6%	7.7%
30	7.9%	7.8%	8.0%	7.8%	7.9%	7.9%	7.9%
40	7.8%	7.9%	7.9%	7.9%	7.8%	7.8%	7.9%
60	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.8%
Unlimited	7.8%	7.9%	7.9%	7.8%	7.8%	7.9%	7.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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2011 Rate Manual
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
30	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Dependent Coverage				
			Grandchildren				
% add-on	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
			Class II Dependents				
% add-on	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
DOLLAR CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP POS access II LARGE GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL POS access II PREMIUM
PERCENTAGE CHANGE IN RATES

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individua	Family	Two Persons	Family	Employee & Child(rer	Employee & Spouse	Family
Dependent Coverage							
Expressed as % add-on to each premium rate otherwise computed							
Dependent Children [std: covered to 19 end of month]							
Age			**End of Month**				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Year				
19	na	na	na	na	na	na	na
20	na	na	na	na	na	na	na
21	na	na	na	na	na	na	na
22	na	na	na	na	na	na	na
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			End of Month				
23	na	na	na	na	na	na	na
24	na	na	na	na	na	na	na
25	na	na	na	na	na	na	na
26	na	na	na	na	na	na	na
			Grandchildren				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	6.72	16.45	12.26	19.52	12.49	13.43	20.54
$25	6.31	15.46	11.52	18.34	11.73	12.62	19.30
$50	5.94	14.56	10.85	17.28	11.05	11.89	18.18
$100	5.33	13.05	9.72	15.49	9.91	10.65	16.29
$500	2.62	6.42	4.78	7.62	4.88	5.24	8.02
Coinsurance							
80%	5.34	13.08	9.74	15.51	9.92	10.67	16.33
75%	5.02	12.30	9.17	14.60	9.35	10.05	15.36
70%	4.69	11.49	8.56	13.63	8.72	9.38	14.34
Deductible			**Orthotics Riders**				
$0	1.14	2.79	2.08	3.31	2.12	2.28	3.48
$25	1.10	2.68	2.01	3.19	2.04	2.19	3.35
$50	1.04	2.56	1.91	3.04	1.94	2.09	3.20
$100	0.95	2.33	1.73	2.77	1.77	1.90	2.90
$500	0.46	1.13	0.84	1.34	0.86	0.92	1.41
Coinsurance							
80%	0.95	2.33	1.73	2.77	1.77	1.90	2.90
75%	0.88	2.15	1.60	2.55	1.63	1.75	2.68
70%	0.83	2.03	1.50	2.40	1.54	1.65	2.53
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.41	3.46	2.58	4.09	2.62	2.82	4.31
12 Months	2.25	5.50	4.10	6.53	4.18	4.49	6.87
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.19	5.37	4.00	6.37	4.08	4.39	6.71
12 Months	3.50	8.58	6.39	10.17	6.51	7.00	10.71
			Private Duty Nursing Riders				
In Full	0.78	1.92	1.43	2.28	1.45	1.57	2.39
80% hrs 73-504	0.14	0.33	0.25	0.40	0.25	0.27	0.42
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.44	1.08	0.80	1.27	0.81	0.88	1.34
Limit			**Infertility Rider**				
2 IVF	14.69	35.98	26.81	42.69	27.31	29.37	44.92
3 IVF	17.63	43.20	32.19	51.25	32.80	35.26	53.94

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	7.25	17.76	13.24	21.08	13.49	14.50	22.18
$25	6.80	16.66	12.42	19.77	12.65	13.60	20.80
$50	6.40	15.68	11.69	18.60	11.90	12.80	19.58
$100	5.75	14.09	10.50	16.72	10.70	11.50	17.59
$500	2.82	6.91	5.15	8.20	5.25	5.64	8.63
Coinsurance							
80%	5.76	14.11	10.52	16.74	10.71	11.52	17.62
75%	5.42	13.28	9.90	15.76	10.08	10.84	16.58
70%	5.05	12.37	9.22	14.68	9.39	10.10	15.45
Deductible			**Orthotics Riders**				
$0	1.22	2.99	2.23	3.55	2.27	2.44	3.73
$25	1.18	2.89	2.15	3.43	2.19	2.36	3.61
$50	1.12	2.74	2.05	3.26	2.08	2.24	3.43
$100	1.03	2.52	1.88	2.99	1.92	2.06	3.15
$500	0.50	1.23	0.91	1.45	0.93	1.00	1.53
Coinsurance							
80%	1.03	2.52	1.88	2.99	1.92	2.06	3.15
75%	0.96	2.35	1.75	2.79	1.79	1.92	2.94
70%	0.91	2.23	1.66	2.65	1.69	1.82	2.78
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	3.75	2.79	4.45	2.85	3.06	4.68
12 Months	2.42	5.93	4.42	7.03	4.50	4.84	7.40
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.35	5.76	4.29	6.83	4.37	4.70	7.19
12 Months	3.78	9.26	6.90	10.99	7.03	7.56	11.56
			Private Duty Nursing Riders				
In Full	0.85	2.08	1.55	2.47	1.58	1.70	2.60
80% hrs 73-504	0.14	0.34	0.26	0.41	0.26	0.28	0.43
100% hrs 73-504	0.23	0.56	0.42	0.67	0.43	0.46	0.70
			Dental Network Access				
	0.48	1.18	0.88	1.40	0.89	0.96	1.47
Limit			**Infertility Rider**				
2 IVF	15.84	38.81	28.92	46.05	29.46	31.68	48.45
3 IVF	19.00	46.55	34.69	55.23	35.34	38.00	58.12

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
DOLLAR CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	0.53	1.31	0.98	1.56	1.00	1.07	1.64
$25	0.49	1.20	0.90	1.43	0.92	0.98	1.50
$50	0.46	1.12	0.84	1.32	0.85	0.91	1.40
$100	0.42	1.04	0.78	1.23	0.79	0.85	1.30
$500	0.20	0.49	0.37	0.58	0.37	0.40	0.61
Coinsurance							
80%	0.42	1.03	0.78	1.23	0.79	0.85	1.29
75%	0.40	0.98	0.73	1.16	0.73	0.79	1.22
70%	0.36	0.88	0.66	1.05	0.67	0.72	1.11
Deductible			**Orthotics Riders**				
$0	0.08	0.20	0.15	0.24	0.15	0.16	0.25
$25	0.08	0.21	0.14	0.24	0.15	0.17	0.26
$50	0.08	0.18	0.14	0.22	0.14	0.15	0.23
$100	0.08	0.19	0.15	0.22	0.15	0.16	0.25
$500	0.04	0.10	0.07	0.11	0.07	0.08	0.12
Coinsurance							
80%	0.08	0.19	0.15	0.22	0.15	0.16	0.25
75%	0.08	0.20	0.15	0.24	0.16	0.17	0.26
70%	0.08	0.20	0.16	0.25	0.15	0.17	0.25
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.12	0.29	0.21	0.36	0.23	0.24	0.37
12 Months	0.17	0.43	0.32	0.50	0.32	0.35	0.53
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.16	0.39	0.29	0.46	0.29	0.31	0.48
12 Months	0.28	0.68	0.51	0.82	0.52	0.56	0.85
			Private Duty Nursing Riders				
In Full	0.07	0.16	0.12	0.19	0.13	0.13	0.21
80% hrs 73-504	0.00	0.01	0.01	0.01	0.01	0.01	0.01
100% hrs 73-504	0.00	0.00	0.00	0.00	0.00	0.00	0.00
			Dental Network Access				
	0.04	0.10	0.08	0.13	0.08	0.08	0.13
Limit			**Infertility Rider**				
2 IVF	1.15	2.83	2.11	3.36	2.15	2.31	3.53
3 IVF	1.37	3.35	2.50	3.98	2.54	2.74	4.18

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HIP*access* II POS LARGE GROUP CONTRACT - RIDERS
PERCENTAGE CHANGE IN RATES

Rider	ALL TIERS Individual	TWO TIER Family	THREE TIER Two Persons	THREE TIER Family	FOUR TIER Employee & Child(ren)	FOUR TIER Employee & Spouse	FOUR TIER Family
Deductible			**Durable Medical Equipment Riders**				
$0	7.9%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
$25	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
$50	7.7%	7.7%	7.7%	7.6%	7.7%	7.7%	7.7%
$100	7.9%	8.0%	8.0%	7.9%	8.0%	8.0%	8.0%
$500	7.6%	7.6%	7.7%	7.6%	7.6%	7.6%	7.6%
Coinsurance							
80%	7.9%	7.9%	8.0%	7.9%	8.0%	8.0%	7.9%
75%	8.0%	8.0%	8.0%	7.9%	7.8%	7.9%	7.9%
70%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
Deductible			**Orthotics Riders**				
$0	7.0%	7.2%	7.2%	7.3%	7.1%	7.0%	7.2%
$25	7.3%	7.8%	7.0%	7.5%	7.4%	7.8%	7.8%
$50	7.7%	7.0%	7.3%	7.2%	7.2%	7.2%	7.2%
$100	8.4%	8.2%	8.7%	7.9%	8.5%	8.4%	8.6%
$500	8.7%	8.8%	8.3%	8.2%	8.1%	8.7%	8.5%
Coinsurance							
80%	8.4%	8.2%	8.7%	7.9%	8.5%	8.4%	8.6%
75%	9.1%	9.3%	9.4%	9.4%	9.8%	9.7%	9.7%
70%	9.6%	9.9%	10.7%	10.4%	9.7%	10.3%	9.9%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	8.5%	8.4%	8.1%	8.8%	8.8%	8.5%	8.6%
12 Months	7.6%	7.8%	7.8%	7.7%	7.7%	7.8%	7.7%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	7.3%	7.3%	7.3%	7.2%	7.1%	7.1%	7.2%
12 Months	8.0%	7.9%	8.0%	8.1%	8.0%	8.0%	7.9%
			Private Duty Nursing Riders				
In Full	9.0%	8.3%	8.4%	8.3%	9.0%	8.3%	8.8%
80% hrs 73-504	0.0%	3.0%	4.0%	2.5%	4.0%	3.7%	2.4%
100% hrs 73-504	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
			Dental Network Access				
	9.1%	9.3%	10.0%	10.2%	9.9%	9.1%	9.7%
Limit			**Infertility Rider**				
2 IVF	7.8%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%
3 IVF	7.8%	7.8%	7.8%	7.8%	7.7%	7.8%	7.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2011 Rate Manual
LARGE GROUP HMO
VHLI - LGRP - 01
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	550.71	1,433.05
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.07	5.07
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.29	3.15
Outpatient Mental Health: 20 Visits	5.72	14.03
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.05	2.56
Other Riders		
Durable Medical Equipment	1.52	3.59
Chiropractic: $5 Copay	4.04	10.62
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	134.90	350.74
Infertility Drug Coverage: $7 Brand Copay	3.15	8.24
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	21.08
Inpatient Substance Abuse Rehab: Unlimited days	4.34	10.63
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.61	1.49
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.47	1.15

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	593.76	1,545.11
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.23	5.47
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.39	3.39
Outpatient Mental Health: 20 Visits	5.72	14.03
	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.13	2.76
Other Riders		
Durable Medical Equipment	1.64	3.87
Chiropractic: $5 Copay	4.36	11.45
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	145.44	378.16
Infertility Drug Coverage: $7 Brand Copay	3.39	8.89
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	22.73
Inpatient Substance Abuse Rehab: Unlimited days	4.68	11.46
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.65	1.61
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.51	1.23

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.0%	7.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	43.05	112.06
Mental Health Coverage		
Inpatient Mental Health: 30 Days	0.16	0.40
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.10	0.24
Outpatient Mental Health: 20 Visits	0.00	0.00
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	0.08	0.20
Other Riders		
Durable Medical Equipment	0.12	0.28
Chiropractic: $5 Copay	0.32	0.83
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	10.54	27.42
Infertility Drug Coverage: $7 Brand Copay	0.24	0.65
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	1.65
Inpatient Substance Abuse Rehab: Unlimited days	0.34	0.83
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.04	0.12
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.04	0.08

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	0.00	0.00

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates	7.8%	7.8%
Mental Health Coverage		
Inpatient Mental Health: 30 Days	7.7%	7.9%
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	7.8%	7.6%
Outpatient Mental Health: 20 Visits	0.0%	0.0%
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	7.6%	7.8%
Other Riders		
Durable Medical Equipment	7.9%	7.8%
Chiropractic: $5 Copay	7.9%	7.8%
Drug Rider: $5 Generic Copay $15 Brand Copay & Carveouts	7.8%	7.8%
Infertility Drug Coverage: $7 Brand Copay	7.6%	7.9%
Unmarried Dependents to 19 EOM & Unmarried Students to 23 EOY	N/A	N/A
Inpatient Substance Abuse Rehab: Unlimited days	7.8%	7.8%
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	6.6%	8.1%
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	8.5%	7.0%

Dependent Children [std: covered to 19 end of month]

Age	End of Month	
30	#DIV/0!	0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
4th QUARTER 2012 LARGE GROUP RATE MANUAL

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	1.000	1.074
POS, HIP*access* II	1.000	1.044
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	1.000	1.028
POS, HIP*access* II	1.000	1.017

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
October 1, 2012 - December 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area*/Plans	HIP Prime	VYTRA Premium
Long Island		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-
New York City, Westchester, Rockland and Orange Counties		
HMO, HIP*access* I	-	-
POS, HIP*access* II	-	-

*** Based on employer location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
Effective OCTOBER 1, 2011 - DECEMBER 30, 2011

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2010 1st QUARTER

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
4th QUARTER 2012 LARGE GROUP RATE MANUAL

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	27.61	0.00	0.00
$750 *	27.61	23.70	2.48
$1,000	27.61	31.60	3.30
$2,000	27.61	47.60	5.40
$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
$5,000	27.61	70.10	9.30
Unlimited	27.61	96.69	20.58

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	1.536	0.000	0.000	0.000
$750 *	1.306	0.349	0.000	0.026
$1,000	1.229	0.465	0.000	0.034
$2,000	1.229	0.838	0.106	0.056
$2,500	1.229	0.986	0.191	0.063
$3,000	1.229	1.111	0.224	0.071
$4,000	1.229	1.311	0.253	0.079
$5,000	1.229	1.446	0.298	0.086
Unlimited	1.229	2.196	0.329	0.150

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.012	0.000	0.447	0.000
$750 *	0.014	0.006	0.532	0.026
$1,000	0.015	0.008	0.560	0.035
$2,000	0.020	0.010	0.841	0.063
$2,500	0.021	0.014	0.981	0.072
$3,000	0.022	0.015	1.121	0.081
$4,000	0.024	0.015	1.401	0.096
$5,000	0.024	0.017	1.680	0.104
Unlimited	0.028	0.018	2.801	0.227

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.00	0.00	0.00
$750 *	0.00	0.00	0.00
$1,000	0.00	0.00	0.00
$2,000	0.00	0.00	0.00
$2,500	0.00	0.00	0.00
$3,000	0.00	0.00	0.00
$4,000	0.00	0.00	0.00
$5,000	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.00	0.00	0.00	0.00
$750 *	0.00	0.00	0.00	0.00
$1,000	0.00	0.00	0.00	0.00
$2,000	0.00	0.00	0.00	0.00
$2,500	0.00	0.00	0.00	0.00
$3,000	0.00	0.00	0.00	0.00
$4,000	0.00	0.00	0.00	0.00
$5,000	0.00	0.00	0.00	0.00
Unlimited	0.00	0.00	0.00	0.00

** Available to EmblemHealth Coordinated Care Plans only*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2011 Rate Manual
GROUP CONTRACT - DRUG RIDERS
CALENDAR YEAR 2011 MONTHLY PREMIUMS

BENEFIT PARAMETER	BENEFIT OPTIONS
Deductibles	$0, $50, $100, $150, $200, $250, $300, $400 or $500
Generic Drug Copay	$0, $1, $2 ,$2.50, $5, $7, $10, $15, $20 or $25
Brand Drug Copay	$0, $1, $2, $2.50, $5, $7, $10, $12, $15, $20, $25, $30, $35 or not available
Coinsurance	0%, 10%, 20% or 30% [for HealthPass only: 25% for Brand Drugs]
Non-Formulary Copay/Coinsurance	$1, $2.50, $5, $7, $10, $15, $20, $25, $30, $35, $40, $50, 50% or not available [for HealthPass only: 50% not to exceed $100]
Calendar Year Max	$750, $1,000, $2,000, $2,500, $3,000, $4,000, $5,000 or unlimited The calendar year maximum can apply to brand only or to all drugs.

DRUG RIDER PREMIUM RATE FORMULA

Drug Rider Premium pmpm =
+ Base Generic PMPM Value (Table 1a)
+ Base Formulary Brand PMPM Value (Table 1b)
+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
- Minimum of (Brand Formulary Copay or $35) x Brand Formulary Copay PMPM Value (Table 2b)
- Maximum of [(Brand Formulary Copay - $35) or $0] x Brand Formulary Copay PMPM Value (Table 2c)
- Brand Non-Formulary Copay x Brand Non-Formulary Copay PMPM Value (Table 2d)
- Deductible x Deductible Unit PMPM Value (Table 3a or 3b)
+ (Deductible - 50) / 1.1 x Deductible Unit PMPM Value (if Generic Only and Deductible > 0)
+ (Deductible - 50) / 1.4 x Deductible Unit PMPM Value (if Brand Included and Deductible > 0)
- Coinsurance % x 100 x Coinsurance Unit PMPM Value (Table 3c)
- Non-Form. Brand Coinsurance % x 100 x Non-Form. Coinsurance Unit PMPM Value (Table 3d)

Drug Rider Tier Premium Rates =
+ Drug Rider Premium pmpm (from above)
x applicable percentage adjustments from Table 4[a] through 4[d]
x tier conversion factors

Table 1: Drug Rider Base Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand	(c) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%

Table 2: Drug Rider Copay Values pmpm

Brand Maximum	(a) Generic	(b) Formulary Brand up to $35	(c) Formulary Brand in excess of $35	(d) Non-Formulary Brand
$0	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
$750 *	0.0%	0.0%	#DIV/0!	0.0%
$1,000	0.0%	0.0%	#DIV/0!	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

Table 3: Other Drug Rider Values pmpm

Brand Maximum	(a) Deductible incl Generics	(b) Deductible excl Generics	(c) Generic & Brand Formulary Coinsurance	(d) Non-Formulary Brand Coinsurance
$0	0.0%	#DIV/0!	0.0%	#DIV/0!
$750 *	0.0%	0.0%	0.0%	0.0%
$1,000	0.0%	0.0%	0.0%	0.0%
$2,000	0.0%	0.0%	0.0%	0.0%
$2,500	0.0%	0.0%	0.0%	0.0%
$3,000	0.0%	0.0%	0.0%	0.0%
$4,000	0.0%	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	0.0%	0.0%
Unlimited	0.0%	0.0%	0.0%	0.0%

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter 2Q2010-2Q2011	2.5%

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	0.0000
Family	1.2179
Three Tier	
Individual EE	0.0000
Two Persons	1.2179
Family	2.2238
Four Tier	
Individual EE	0.0000
EE + Child(ren)	1.2179
EE + Spouse	2.2652
Family	2.4357

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustme Applies only to New York City account	-2.0%
[f] Product Fact HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	**2.5%**
3Q2011	**1.9%**
4Q2011	**1.9%**
1Q2012-4Q2012	**1.9%**

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.2179
Family	2.9838
Three Tier	
Individual EE	1.2179
Two Persons	2.2238
Family	3.5404
Four Tier	
Individual EE	1.2179
EE + Child(ren)	2.2652
EE + Spouse	2.4357
Family	3.7255

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.00
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.00
$2,000 (Brand & Generic)	0.00
$2,500 (Brand & Generic)	0.00
$3,000 (Brand & Generic)	0.00
$4,000 (Brand & Generic)	0.00
$5,000 (Brand & Generic)	0.00
[c] Non Formulary Coverage, Generic Only Plans	0.00
[d] PICA Adjustm Applies only to New York City account	0.00
[e] IC Adjustme Applies only to New York City account	0.00
[f] Product Fact HMO, Access I, and EPO	0.00
POS, Access II, and PPO	0.00
[g] Trend per Quarter	(0.03)
2Q2010-2Q2011	0.03
3Q2011	0.02
4Q2011	0.02
1Q2012-4Q2012	0.02

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	1.22
Family	1.77
Three Tier	
Individual EE	1.22
Two Persons	1.01
Family	1.32
Four Tier	
Individual EE	1.22
EE + Child(ren)	1.05
EE + Spouse	0.17
Family	1.29

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	0.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	0.0%
$2,000 (Brand & Generic)	0.0%
$2,500 (Brand & Generic)	0.0%
$3,000 (Brand & Generic)	0.0%
$4,000 (Brand & Generic)	0.0%
$5,000 (Brand & Generic)	0.0%
[c] Non Formulary Coverage, Generic Only Plans	0.0%
[d] PICA Adjustm Applies only to New York City account	0.0%
[e] IC Adjustme Applies only to New York City account	0.0%
[f] Product Fact HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
2Q2010-2Q2011	#DIV/0!
3Q2011	#DIV/0!
4Q2011	#DIV/0!
1Q2012-4Q2012	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Large Group
Two Tier	
Individual EE	#DIV/0!
Family	145.0%
Three Tier	
Individual EE	#DIV/0!
Two Persons	82.6%
Family	59.2%
Four Tier	
Individual EE	#DIV/0!
EE + Child(ren)	86.0%
EE + Spouse	7.5%
Family	53.0%

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)

Comments:

Attachment:

Checklist 2012 HIP LG.pdf

Item Status: **Status Date:**

Satisfied - Item: Actuarial Memorandum/Actuarial Certification

Comments:

Attachments:

HIP LG 2012 Act Memo.pdf

HIP LG Supporting Exhibits.pdf

HIP LG Supporting Exhibits.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 1 - General Information

Comments:

Attachment:

Exhibit 1 HIP LG.pdf

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 2 - FOIL Exemption Request

Comments:

Attachment:

Exhibit 2 HIP LG.pdf

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 3 - Narrative Summary

Comments:

Attachment:

HIP_GR_WEB_5529_2012 HIP LG Rate Narr_FINAL_7-15-11.pdf

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 4 - Summary of Proposed Percentage Rate Changes

Comments:

Attachments:

Exhibit 4 HIP LG.pdf

Exhibit 4 HIP LG.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 5 - Distribution of Contracts Affected by Proposed Rate Adjustments

Comments:

Attachments:

Exhibit 5 HIP LG.pdf

Exhibit 5 HIP LG.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 6 - Summary of Policy Form and Product Changes

Comments:

Attachments:

Exhibit 6 HIP LG.pdf
Exhibit 6 HIP LG.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 7 - Historical Data

Comments:

Attachments:

Exhibit 7 HIP LG.pdf
Exhibit 7 HIP LG.xls

Item Status: **Status Date:**

Satisfied - Item: Initial Notice of Proposed Rate Adjustment

Comments:

Attachment:

HIP_LG_ initial_notice.pdf

Item Status: **Status Date:**

Satisfied - Item: Final Notice of Proposed Rate Adjustment

Comments:

Attachment:

HIP_LG_final_notice.pdf

Item Status: **Status Date:**

Satisfied - Item: Commission Schedule

Comments:

Attachment:

Broker Schedule HIP 05072010.pdf

Item Status: **Status**

Date:

Satisfied - Item: Underwriting Guidelines

Comments:

Attachment:

HIP_LG Guidelines_8.13.10.pdf

NEW YORK INSURANCE DEPARTMENT

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

As of 5/24/2011

Use this Checklist for all rate adjustment filings submitted pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law. One of the following two SERFF filing type codes must be used to properly denote such a filing. A rate submission with the wrong filing type code will be rejected and will need to be resubmitted with the correct filing type code.

Rate Adjustment Pursuant to Section 3231(e)(1): This filing type is used for Article 42 insurers that are submitting a rate adjustment only filing for a hospital and/or medical coverage (including Medicare Supplemental insurance) for small groups and individuals under the Section 3231(e)(1) prior approval process. This filing type cannot be used for form filings, initial rate filings, or by Article 43 Corporations or Health Maintenance Organizations (HMOs).

Rate Adjustment Pursuant to Section 4308(c): This filing type is used for Article 43 Corporations and HMOs that are submitting a rate adjustment only filing for any policy form that uses a community rating structure as described in Section 4317(a) of the Insurance Law. This includes hospital and/or medical policy forms, or separate stand-alone dental policy forms, that are not required to be community rated but for which the corporation voluntarily community rates as described in Section 4317(a) of the Insurance Law. This also includes the HMO portion of large group Point of Service business where an approved experience rating formula is not used. This filing code cannot be used for form filings, initial rate filings, or by commercial insurers.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) can include an expansion of an existing rate table to include new benefit options (such as rates for additional copays or deductibles) provided that: (a) the already approved contract language includes the new benefit options being added, (b) the actuarial memorandum clearly identifies the new benefit options being added and provides appropriate actuarial support for the new rates, and (c) approved contract language pages and the Department's approval letter are included with the rate filing documenting that the benefit options being added are included in the already approved contract language. No Section 3231(e)(1) or Section 4308(c) rate adjustment filing can include rates that require contract language approval where such approval has not already been received.

A change to existing rating region differentials is a rate adjustment filing pursuant to Section 3231(e)(1) or Section 4308(c). A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot reflect an expansion to a new service area. A service area expansion, and the rate applicable to that new service area, must be submitted as a separate rate filing using the "Normal Pre-Approval" SERFF filing type code. A Section 3231(e)(1) or Section 4308(c) filing cannot be used to withdraw from a service area.

If a company wishes to eliminate some of its approved benefit options included in the current rate manual, this cannot be done pursuant to a Section 3231(e)(1) or Section 4308(c) rate adjustment application. Such elimination is to be implemented by submitting a form and rate filing using the "Normal Pre-Approval" SERFF filing type code and the filing is to include a revised statement of variables for the benefit options that are available along with revised rate manual pages reflecting the revised benefit options.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing (a new form or a revision to an existing form) must be a separate filing from the rate adjustment filing. Once a new rate has been approved (for a new policy form or for a revision to an existing policy form), such new rate can be incorporated into the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing.

The "Normal Pre-Approval" SERFF filing type code triggers the traditional Department review (generally by the Albany Health Bureau unit) and would be used for all form and rate filings, form only filings, experience rating formula filings, or commercial insurer rate only filings other than filings submitted pursuant to Section 3231(e)(1), or Article 43 Corporation and HMO rate only filings other than filings submitted pursuant to Section 4308(c). The "Normal Pre-Approval" SERFF filing type

code would also be used for old individual medical policy forms that are not community rated. Rate revisions for products subject to Section 3231(e)(1) or 4308(c) incorporated into a form and rate filing that adjusts an existing policy form for a change in benefit language can only reflect rate changes due to the benefit revision and can not reflect any adjustment for experience or trend. A "Normal Pre-Approval" SERFF type filing for a product subject to Section 3231(e)(1) or 4308(c) can not include rolling rate tables that extend beyond the period included in the most recent approved or pending Section 3231(e)(1) or Section 4308(c) rate adjustment submission (for example, the last rate adjustment submission included quarterly rolling rate tables for each calendar quarter of 2011; a benefit revision is submitted January 2011 to be effective July 1, 2011; this form and rate filing can include rolling rate tables for third and fourth quarter 2011, but not beyond fourth quarter 2011).

New or revised commission schedules or broker fee schedules must first be placed on file using a rate filing with a "Normal Pre-Approval" SERFF filing type code. Once the new or revised schedule has been placed on file, any rate impact can be included with the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing and the change and its impact on the premium rates is to be discussed in the actuarial memorandum.

It is recommended that a Section 3231(e)(1) or Section 4308(c) rate filing application be submitted at least 150 days before the proposed effective date, however, in determining how far in advance to submit such a rate filing, the company should consider: the time needed to load final rates into its computer system; produce the final rate notice, which is to be sent at least 60 days before the scheduled rate change effective date of the renewal cohort; the 60 days the Department has to review the material; and the time the clock may be stopped while the company responds to issues raised by the Department about the rate filing.

It is recommended that a rate adjustment submission not be submitted more than 180 days prior to the proposed rate effective date. It is recommended that a rate adjustment submission not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing. If a company can not send the required final notice at least 60 days in advance of the rate change date for a particular renewal cohort, then the rate change implementation date for such renewal cohort will need to be deferred. Contract terms will dictate whether the rate change can be deferred to a later implementation date for that renewal cohort (e.g., for the July 2012 renewal cohort, deferring the rate change to August 2012, while retaining the next rate change date as July 2013), or deferring implementation of the newly approved rates to a later renewal cohort (e.g., assuming quarterly rolling rates are used: renewing the July 2012 renewal cohort using the previously approved second quarter 2012 rate tables, and implementing the newly approved rates with the August 2012 renewal cohort).

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2003, Microsoft Excel 2003, or Adobe Acrobat 9.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
DEFINITIONS	a.	**Company** refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing. b. A company's **commercial book of business** includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus. c. **Loss ratio** refers to incurred claims divided by earned premiums for a given period of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered	

		lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses. Earned premiums do not include any adjustment for assessments or taxes. d. **Market segment** refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc. e. **Product street name** refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department. f. **Rate applicability period** refers to the length of time in which the rates in a rate table are assumed to remain in effect. (i) Example 1: A non-rolling rate table is developed to be effective January 1, 2012 and is expected to be revised January 1, 2013. The rate applicability period for this table is January 1, 2012 through December 31, 2012. (ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2012 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2012 (mid renewal date) through February 14, 2013. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2012 through January 31, 2013. g. **Standardized earned premium** is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). (i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarters 2011 and 1st and 2nd quarters 2012. The 2nd quarter 2011 rates have already been approved. Therefore, the 2nd quarter 2011 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2nd quarter 2011 rate level. If the 2nd quarter 2011 rate table included a 2% increase due to the addition of a new benefit that is being added to all policyholders at renewal, the standardization for periods prior to April 1, 2011 would not reflect this 2% increase since the incurred claims for this earlier period did not reflect this additional benefit. (ii) Example: An insurance company uses a quarterly rolling rate structure and has been raising rates 4% each quarter as of the beginning of a new quarter. The first quarter 2010 rate for plan design A is $100, the first quarter 2011 rate is $116.99, and the second quarter 2011 rate is $121.67. These increases reflect	

		no revision to the underlying covered benefits. The second quarter 2011 rate table is the standard rate level. Contract X was paying $100 per month for January-December 2010. At renewal January 1, 2011, the premium was scheduled to increase to $116.99 but a change to plan design B occurred that reduced the premium by 5% to $111.14 for January 2011 and later. The second quarter 2011 rate for plan design A is $121.67 and the second quarter 2011 rate for plan design B is $115.58 ($121.67 x 0.95). The earned premium for this contract for each month from January through December 2010 is standardized to the second quarter 2011 level by adjusting by 121.67/100.00, and the January 2011 earned premium is standardized to the second quarter 2011 level by adjusting by 115.58/111.14.	
ROLLING RATE STRUCTURE	a.	Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates). b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period. c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates).	See Rate/Rule Schedule tab in SERFF submission.
CHANGES TO PREVIOUSLY APPROVED RATE TABLES	a.	Beginning with rate adjustment filings that include rate tables to be effective January 1, 2012 or later, the rate adjustment filing must include all community rated policy forms within a given market segment (such as all small group products) whether or not a premium rate adjustment is requested for a particular product or rider in that market segment. All entities within the same holding company system are to submit filings for a given market segment at the same time; the filings can be submitted under different SERFF filings, but all the applicable filings must be submitted within a total of seven calendar days. b. A company can revise a previously approved non-rolling rate table provided that: (i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or (ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing. c. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii)	See Rate/Rule Schedule tab in SERFF submission.

		the first two quarterly rate tables, or the first six monthly rate tables, included in the previously approved rate adjustment filing are not revised, and (iii) policyholders in the renewal cohort(s) affected by the change to the previously approved rate tables did not receive a final 60 day notice informing them of the approved rates from the previously approved rate adjustment filing. The revised rate adjustment filing must include a year's worth of rates as discussed in the "Rolling Rate Structure" section above. (Example: A rolling rate filing was submitted and approved that included quarterly rolling rate tables for 1st, 2nd, 3rd and 4th quarter of 2011. The company can not revise the 1st and 2nd quarter 2011 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3rd and 4th quarter 2011 and 1st and 2nd quarter 2012.) The Department may waive these requirements if the company can demonstrate to the Superintendent's satisfaction that the solvency of the corporation is threatened.	
STANDARD EXHIBITS 1 - 7	Introduction	Exhibits 1 through 7 must be submitted as part of each rate adjustment application. For some of the exhibits the format is defined, while for other exhibits the format is illustrative and the company will need to tailor the material included for the specific rate submission.	
Exhibit 1		**General information about the rate adjustment submission.** a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit. b. For Type of Insurer, select from the drop down list (HMO, Article 42, Article 43) or make an entry. c. For "For Profit" or "Non Profit" click on the applicable box and a check mark will appear. d. Item D – the "new rate effective date" must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day final rate notice. This date would usually be the first date the proposed rates would affect renewing policyholders. So a 1/1/2012 effective date would imply that the first renewal cohort affected by the rate submission would be January 2012. e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected. f. This exhibit may be submitted as an Adobe PDF file or as an Excel file.	See Supporting Documentation tab of SERFF submission.
Exhibit 2		**FOIL Exemption Request.** a. A request that the Department exempt from public disclosure any information included in this rate submission, pursuant to New York Public Officers Law Section 87(2)(d) (the "Trade Secret/Competitive Injury Exemption"), must be made by completing this exhibit. b. A request that the Department apply the Trade Secret/Competitive Injury	See Supporting Documentation tab of SERFF submission.

		Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department. c. In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to protect the exempt information. Therefore, the Company should submit to the Department both the original document and a redacted version of the original document, which omits or blocks the information it wishes to exempt from disclosure. The Department will accept the redacted version of the original document within one week after the original rate filing was submitted. d. The exhibit format is illustrative but the company must include the information indicated in sections A, B, C, D and E. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. e. Enter in section A the insurer information requested. f. Enter in section B the information requested regarding the FOIL contact person at the company. g. Enter in section C the list of documents, exhibits and attachments separately, including the file names of the computer files that are included with the application. Indicate with an asterisk (*) those documents that the company believes contains information subject to the Trade Secret/Competitive Injury Exemption. Any document without an asterisk will be deemed to be a public document. h. Enter in section D the list of all documents, exhibits, and attachments, of which a portion has been redacted, including the file names of computer files that are included with the application. The unredacted portion(s) of the redacted documents may be deemed to be public. i. Enter in section E the statement of necessity. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that: (i) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied; (ii) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and (iii) where applicable, indicates where redactions would suffice to protect the exempt information.	
Exhibit 3		**Narrative Summary.** a. The format of the exhibit is illustrative, but must include the required material. The	

		exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. b. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company's policyholders and subscribers to help them understand why a rate increase is needed. c. The narrative summary will be a public document. d. It is suggested that once reviewed by the Department, the company post the narrative summary on its website. Any changes to the narrative summary subsequent to the posting are to be submitted to the Department. e. The narrative summary should include, but not be limited to, the following information: (i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application. (ii) A summary of the proposed rate adjustments. This can be a range as long as the range is consistent with the range(s) stated in the initial notice to policyholders for the various products and rating regions. A range can be no wider than five percentage points. (iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the "street name" of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy). (iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples: (a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy. (b) A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder's next anniversary on or after mm/dd/yyyy. (v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission. (vi) An explanation, in plan language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type. Each page of the narrative summary should be numbered (i.e., [page] of [pages]).	See Supporting Documentation tab of SERFF submission.

Exhibit 4		**Summary of Proposed Percentage Rate Change to Existing Rate.** a. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. b. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is essentially fixed, but additional rows can be inserted as needed or additional tabs for several such exhibits can be added to the workbook. c. This exhibit is to summarize the proposed percentage rate changes. The percentage rate change is the percentage change from the rate the subscriber is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which are not being revised by the current rate application) to the proposed rate that this subscriber would be paying at the subscriber's next rate change date according to the new rate application. Example 1: the rate structure is quarterly rolling rates, has a 12 month rate guarantee period, and the rate adjustment application is for second quarter 2012 issues and renewals. The rate change would be the percentage change from the second quarter 2011 rates to proposed second quarter 2012 rates. Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2012. The prior rate application included quarterly rolling rates for each quarter of 2011. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2011 before all the third and fourth quarter 2011 renewals have taken place. The proposed percentage change for fourth quarter 2012 would be the change from the fourth quarter 2011 rates to the proposed fourth quarter 2012 rates. d. If the subscriber will need to change to a different plan design at renewal (i.e., a required change from the current plan design whether mandated by a government entity or not, but not due to the discontinuation of the current policy form or discontinuation of a particular plan design), a supplement to Exhibit 4 is to be included. The supplemental exhibit is to indicate (i) a high level summary of the difference in covered benefits and cost sharing between the current and replacement plan, and (ii) the estimated pricing percentage change due solely to the difference in the plan designs between the replacement plan and the existing plan. This supplemental exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. e. The weighted averages may be based on membership instead of premium volume. f. The values entered in Sections A and B should follow the organization of the rate manual. If the drug rate is included with the rates in the medical rate table, the combined result is entered in Section A. If the drug rate is a separate rate table associated with a drug rider, then the medical changes are shown in Section A and	Exhibits 4 and 5: See Supporting Documentation tab of SERFF submission.

		the drug rider changes are shown in Section B. g. Section A summarizes the proposed changes for the base medical rate tables and excludes the impact of all optional riders. The lowest and highest values indicate for a given market segment, region, policy form, product combination the lowest percentage change that applies to a renewing subscriber/contract holder and the highest percentage change that applies to a renewing subscriber/contract holder. This difference could be due to different percentage changes proposed by rating tier or by plan design within a particular product. Example: The rate adjustment application is only for small group PPO and within this product there are only two product designs. The proposed rate changes for design A are: employee only = 10%, employee+child(ren) = 8%, employee+spouse = 13% and employee+family = 11%. The proposed rate change for design B are: employee only = 9%, employee+child(ren) = 7%, employee+spouse = 12% and employee+family = 10%. The lowest change proposed is 7% and the highest change proposed is 13%. The weighted average change would reflect the distribution of contracts by plan design and rating tier. h. Section B summarizes the proposed changes just for the traditional drug riders. <u>Exclude</u> minor drug related riders such as a rider to include oral contraceptives. All the drug riders available with a given base medical product can be aggregated into one row. Example 1: Drug riders D1 to D99 are available with the PPO product. The proposed changes on the drug riders vary from 10% to 16%. There would be one row for the PPO policy form/product. The lowest change proposed is 10% and the highest change proposed is 16%. The weighted average change would reflect the distribution of contracts by plan design and rating tier. Example 2: As in Example 1, but drug riders HD1-HD19 are available with the HSA high deductible PPO product. There would be another row for the high deductible PPO policy form/product indicating the lowest, highest, and weighted average changes among the HD1-HD19 drug riders. i. A separate exhibit should be completed for each market segment. If the percentage rate change for sole proprietor is different from small group, then a separate market segment of sole proprietor is to be reported. j. Where rate changes differ by rating region within a market segment, separate exhibits are to be submitted by market segment/rating region combination. k. Separate information should be submitted for each rolling rate table of a rolling rate structure. For example: if a calendar quarterly rolling rate structure is used and the rate adjustment filing includes proposed rate tables for first, second, third and fourth quarters 2012, separate information should be submitted for section A and section B for the impact of the first quarter 2012 rate changes, the impact of the second quarter 2012 rate changes, the impact of the third quarter 2012 rate	

		changes, and the impact of the fourth quarter 2012 rate changes.	
Exhibit 5		**Distribution of Contracts Affected by the Proposed Rate Adjustments.** a. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is essentially fixed, but the company can edit the worksheet to add more rows or tabs as needed. b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. c. This exhibit indicates the distribution of the proposed rate changes for each market segment, rating region and product, as well as the weighted average rate change impact for that segment/region/product combination. If the same percentage rate change applies to each rating region, then a separate break out by rating region is not necessary and the results can be shown for all rating regions combined. d. The distribution basis can be by number of contracts or by number of members. The same basis is to be used for all products within a given rate adjustment submission. The company should indicate the distribution basis used (number of contracts or number of members). The weighted averages can be calculated using the distribution basis chosen instead of on premium volume. e. The percentage rate change reflects the expected change in premium rate that would apply to that subscriber/contract holder on that subscriber/contract holder's next rate change date according to the new rate application. This would reflect the percentage rate change from the rate the contract holder is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application) to the proposed rate that this contract holder would be paying at the contract holder's next rate change date according to the new rate application The rate change reflects the impact of the base medical plans and all riders applicable to that contract. f. Enter in section A the information for the various products that do not use a rolling rate structure. g. Enter in section B the information for the various products that use a rolling rate structure. Separate exhibits are to be prepared and submitted for each rolling rate cohort. For example, if the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2012, then separate section B information would be entered for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.	
Exhibit 6		**Summary of Policy Form and Product Changes.** a. This exhibit summarizes all rate changes filed pursuant to sections of the New	Supp. Documentation tab in SERFF filing.

		York Insurance Law other than Section 3231(e)(1) or Section 4308(c) that impact the policyholders affected by this rate adjustment submission and which affect the percentage changes shown on Exhibits 4 or 5. b. The format of the exhibit is essentially fixed. Extend the worksheet to add more rows as needed. This exhibit must be submitted as a Word document file or an Excel file, even if it is submitted as an Adobe PDF file. c. In section A, list all rate filings that have been approved since the prior Section 3231(e)(1) or Section 4308(c) rate filing that impact the percentage rate change of the policyholders affected by this rate adjustment submission. The actuarial memorandum should include a brief description of such changes, when the changes were implemented, and the impact on the rate changes in Exhibits 4 and 5. d. In section B, list all rate filings currently pending with the Department that if approved would impact the percentage rate change of the policyholders affected by this rate adjustment submission. This includes any pending request to discontinue a policy form, product, or plan design option. e. In section C, list any "file and use" rate submissions which impact the rate tables in this filing. If the current rates were implemented by a file and use rate filing, and these current rates are being revised with this Section 3231(e)(1) or Section 4308(c) rate filing, or if the percentage changes reported in Exhibits 4 or 5 are impacted by a file and use filing, then list the applicable file and use rate filing(s).	
Exhibit 7		**Historical Data by Each Policy Form Included in the Rate Adjustment Filing (formerly the Summary Template).** a. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is fixed; add more columns to the right as needed; copy to additional tabs in the Excel workbook as needed to create additional exhibits. b. A separate exhibit is to be submitted for each rating pool (i.e., permitted aggregation of base medical policy forms). Create additional tabs as needed. Data is to be submitted for each base medical policy form included in the rate adjustment filing even if no rate adjustment is proposed for that base medical policy form. c. Indicate the company name, the NAIC code number for that entity, and the SERFF filing number for the applicable rate filing in the spaces indicated. d. Indicate for each base medical policy form the form number, the product name as in the rate manual, and the street product name. Also indicate the other base medical policy forms this form is aggregated with for rate setting. Add additional columns as needed. Add a rightmost column with aggregate values for the entire rating pool (for the appropriate rows). Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar	

		policy forms for small group policy forms and for individual policy forms. e. Indicate for each base medical policy form if the policy form aggregation has changed from the previous rate filing. If yes, the actuarial memorandum must include an explanation of the change, the rationale for the change, and the percentage rate impact this change has on this policy form and on the policy forms previously aggregated with this policy form. f. The effective date of rate change refers to the proposed effective date of the non-rolling rate table, and/or the proposed effective date of the first rolling rate period of a rolling rate structure. g. The rate guarantee period refers to a non-rolling rate table and/or to the first rate table of a rolling rate structure. (If the rate guarantee period for the rolling rate structure is not the same for each rolling rate period, the actuarial memorandum must discuss this and explain why the length of the rate guarantee periods are not the same.) h. The weighted average rate change percentage proposed (from the rate currently charged the policyholder [or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application] to the proposed rate to be charged to that same cohort of policyholders) for the indicated base medical policy form, including all associated riders. The weighting should be based on members. For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for the 1st, 2nd, 3rd, and 4th quarters of 2012. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2011 rate tables to the 1st quarter 2012 rate tables.) i. For the number of policyholders affected and the number of covered lives affected, indicate the effect of all the rate tables of a rolling rate structure included in the rate filing (but not more than 12 months of issues and renewals if more than 12 months of rolling rate tables are included in the rate filing). For group business, "policyholders" is referring to the number of groups, not the number of subscribers or contracts. j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the expected loss ratio incorporated into the rate tables of the first rolling rate period of the rolling rate structure. k. The experience entered for the two indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.	See Supporting Documentation tab in SERFF submission.

		(i) Each experience period is to be for 12 months (or shorter if a new form). (ii) The ending date of the recent experience period cannot be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2012. The recent experience period cannot have an ending date earlier than June 30, 2011, i.e., 12 months prior to July 1, 2012.). (iii) The prior period is the immediately prior 12 month experience period (or shorter period if a new form). (iv) The incurred claims for each of the two experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims. l. Enter the annual composite medical trend assumption used for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown. m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology is to be included as part of the actuarial memorandum. The same standard rate level is used for both of the experience periods. n. If the rating differential between the New York rating regions is being revised with this rate filing, separate versions of Exhibit 7 are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined.	
ACTUARIAL MEMORANDUM	11NYCRR 52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meets the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	See Supporting Documentation tab in SERFF submission.
Justification of Rates	§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b)	a. Description of proposed changes in rates, including the following: (i) The member weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to that policy form (or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application). This is to be	See Actuarial Memorandum and supporting exhibits in Supporting Documentation tab of SERFF submission.

	11NYCRR 360.11	shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. (The percentage change is comparable to the percentage change developed for Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months. (ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2011. The change from each of the 2nd quarter 2011 rolling rate tables to the corresponding 3rd quarter 2011 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated. (iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment submission, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive quarterly rate tables). (iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio. (v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes. (vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage	

		changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an exhibit showing how this variance and the percentage impact of this variance were developed. (viii) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition. b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department's approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table. c. Include the following: (i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2011 and first and second quarter 2012. Rates are for 12 month periods. Show the rates for the third quarter 2010, the proposed rates for the third quarter 2011, and the dollar and percentage change from third quarter 2010 to the proposed third quarter 2011 rates. Show a similar table for the proposed fourth quarter 2011, and first and second quarter 2012 rates as well.) d. Discuss the standard premium development used in Exhibit 7. See discussion above on Exhibit 7. e. Discuss the source data used to develop the projected incurred claims for the renewal rate applicability period. (i) If the source data is actual claims experience, the experience period is to be at	

		least 12 months long, and the unpaid claim reserve is to be based on at least 3 months of claims run-out beyond the end of the experience period. (ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data. (iii) Discuss the credibility of such source data. Since the NAIC and HHS have adopted for the federal MLR rebate calculation 75,000 life years (900,000 member months) as required for full credibility and less than 1,000 life years (12,000 member months) as non credible, the credibility of the source data should be discussed consistent with these parameters. (iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected incurred claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment. f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool). (i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission. (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for	

		a rolling rate structure, how the percentage change from the existing 2nd quarter 2011 rate table to the proposed 3rd quarter 2011 rate table was developed for each rating element in the proposed rate table.) This demonstration must clearly show how the proposed rate change was developed from the projected source data, current rate level, and expected loss ratio. Provide justification for the percentage change proposed. (ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3rd quarter 2011 rate table to the 4th quarter 2011 rate table). Provide justification for these changes between the rolling rate tables. (iii) Clearly show how the proposed rate development, as applicable, reflects recoveries from the standard direct pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327), and discuss how the recovery amounts used were developed. (iv) Clearly show how the proposed rate development, as applicable, reflects payments to, or receipts from, the Department Regulation 146 (11 NYCRR 361) and New York Insurance Law Section 3233 marketing stabilization pool. Clearly discuss how the corporation has been complying with 11 NYCRR 361 (Regulation 146), Section 361.6(g), and include in the rate application any new plan pursuant to Section 361.6(g)(2)(i). Such discussion should include an exhibit showing how all monies received from the Regulation 146 pool from calendar years 2007 to date have been used to benefit consumers pursuant to the requirements of Section 361.6(g). h. If the percentage rate change by benefit option differs within a particular policy form (or rider form), include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. Any assumed variation in utilization by benefit option within a particular policy form (or rider form) must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the policy form, and cannot be based on differences due to age, sex, health status or industry among the members selecting the different benefit options. i. If the percentage rate change by policy form differs within a permitted aggregation of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within	

		the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and cannot be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms. j. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions. k. Indicate for each permitted policy form aggregation, within each rating region aggregation, the non-claim expense components incorporated into the current premium rates and into the proposed premium rates as a percentage of gross premiums and as $pmpm. This is to be shown for the non-rolling rate tables and/or the first rate table of each rolling rate structure. Include the following components: (i) Regulatory authority licenses and fees, including New York State 332 assessment expenses; (ii) Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplemental Health Care Exhibit; (iii) Commissions and broker fees; (iv) Premium taxes; (v) Other administrative expenses; (vi) After-tax underwriting margin (profit/contribution to surplus); (vii) State income taxes (and applicable state income tax rate); (viii) Federal income taxes (and applicable federal income tax rate); (ix) Reduction for net investment income, if any; and (x) Net of the above. Discuss how administrative expenses are allocated to the various market segments and product lines.	
Minimum Loss Ratio Requirements	§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)	a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010. b. The minimum loss ratio for the official Medicare Supplemental products is: (i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance	Actuarial Memorandum and supporting exhibits in Supporting Documentation tab of SERFF submission.

		Law, as amended by Chapter 107 of the Laws of 2010; and (ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52).	
Actuarial Certification	11NYCRR 52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	See Supporting Documentation tab in SERFF submission.
REVISED RATE MANUAL PAGES	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	**Rate Manual.** a. Table of contents. b. Rate pages, including a page indicating the composition of each rating region. c. Insurer/corporation name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts, as applicable. g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual, to the extent applicable. j. Expected loss ratio(s).	See Rate/Rule Schedule tab in SERFF submission.
NOTICES TO POLICYHOLDERS Initial & Final Circular Letter No. XX (2011) Pending	§3231(e)(1)(A) §4308(c)(2)	a. A sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Insurance Department. (i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Insurance Department. (ii) A range can be used to indicate the rate change provided that the range is no wider than 5 percentage points. (iii) If different notices are used for different products or different rating regions, submit a sample for each such product and/or each such rating region.	See Supporting Documentation tab of SERFF filing.

		b. A sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.	Supp. Documentation tab of SERFF filing.
RATE FILINGS THAT ARE SUBJECT TO REVIEW	PPACA §1003	HHS has defined a "rate filing that is subject to review" as any rate filing where the rate increase over the prior 12 months equals or exceeds a stated threshold. For rate filings that HHS has defined to be a "rate filing that is subject to review", submit a copy of all documentation required to be submitted to HHS for such rate filing.	

Health Plan of Greater New York (HIP)

Actuarial Memorandum
Large Group Rates for HIP Products
Effective January 1st, 2012

HIP is submitting a prior approval rate filing for its Large Group Community Rated products. The proposed premium rates are based on a rolling rate structure with effective dates of January - March 2012 (1Q12), April – June 2012 (2Q12), July – September 2012 (3Q12), and October - December 2012 (4Q12).

The proposed rates for 1Q12 represent increases of **1.9%** for HIP HMO/POS products 4Q11 rates. Proposed quarterly rate step-ups are **1.9%** for the second, third and fourth quarters of 2012. These increases apply to all plans and riders within each product type as well as across all rate tiers.

See Appendix A: Premium Rate Increases for the rate increases for renewing groups for each benefit plan within each form number as well as historical rate increase history. Note that the 2011 rates include the approved rate adjustments for PPACA benefits which average 2.1%. The resulting overall annual increases are 8.6% for 1Q12 over 1Q11.

Justification

In order to calculate the quarterly rate increase needed for 1st quarter 2012 community rated products, we compared the projected claims with our target loss ratio to the 4th quarter 2011 standardized premium. The following chart shows how we developed our needed rate increase.

2010 Medical PMPM	345.23
2011 Projected Trend	11.4%
2012 Projected Trend	9.6%
1Q12 Cohort Projected Medical PMPM	424.76
Target Loss Ratio	85.0%
Required Premium PMPM	499.72
4Q11 Standardized Premium	465.48
Needed Rate Increase	7.4%
Proposed Rate Increase	1.9%

For this derivation, all PMPMs are using a projected 2012 membership distribution. Using a target loss ratio of 85%, this methodology produces a needed quarterly increase of 7.4% over 4Q11. As mentioned above, we are proposing a 1.9% increase from 4Q11 to 1Q12 rates; a 1.9% increase from 1Q12 to 2Q12 rates; a 1.9% increase from 2Q12 to 3Q12 rates, and a 1.9% increase from 3Q12 to 4Q12 rates. These increases will be applied to all base products and riders, across all rate tiers and regions.

There is no change to the tier structure relationships or conversion factor used to convert PMPM results to subscriber results included in this rate filing. .

Policy Form Aggregations

We use the following policy form aggregations for this filing:

- Large Group HMO/POS – HMO Prime, Access I, POS Prime, Access II, and Vytra HMO

The experience for these policy forms as well as the experience for each aggregation can be found in Exhibit 7: Historical Data. The HIP HMO/POS policy aggregation is fully credible under NAIC guidelines.

HIP has two HMO policy forms – HIP HMO Prime and Access I. HMO Prime is our standard gatekeeper HMO product. The Access I product allows a member access to a par specialist without having to go through the gatekeeper. Otherwise, all benefits are identical. In addition HIP has two POS group policy forms – POS Prime and Access II. POS Prime is our standard POS plan which requires a gatekeeper for access to in-network benefits. The Access II product allows a member to go to a par specialist without having to go through the gatekeeper. Otherwise, all benefits are identical. Lastly, Vytra HMO is a closed product that is still renewed on Vytra contracts. It is similar in benefits to the HMO Prime product. These five products are priced based on a common rating platform and constitute HIP's large group community pool.

Description of Provider Networks and Benefits

HIP's provider network consists of three medical delivery systems with distinct financial arrangements. The largest is the fee-for-service network (FFS). This is followed by the HIP Medical Groups (MG) which are generally based in HIP owned medical facilities and are capitated for most professional and some outpatient services for HMO and POS products. The last delivery system HIP employs is the global risk (GR) network which capitates almost all medical expenses associated with those members.

Source Data

The source data for this filing is experience from January 2010 through December 2010 with recast adjustments to reflect claims run out through April 2011. The prior experience period is January 2009 through December 2009 with recast adjustments through April 2010.

The buildup of the projected claims is shown in Appendix B: Source Data. We start with the base experience paid through 12/31/2010 and then adjust for recast based on paid claims from 1/1/2011 through 4/30/2011. The recast adjusted base experience was then projected 12 months

using 2011/2010 trends, and 13 months using 2012/2011 trends. These trends are described below.

Trends

As noted above, the trends used to project the base experience two years are segmented into two time periods. Using projected 2012 member months, in aggregate they produce an 11.4% trend for 2011 and a 9.6% trend for 2012 for HIP's Large Group HMO/POS products.

Medical Fee For Service Trends

The 2010 through 2012 trends used in the claim projections for claims paid on a fee for service basis are summarized in Appendix E. This section splits the total trend into utilization and unit cost trends for the following claim types:

- Inpatient claims for members in the FFS network
- Inpatient claims for members in the MG network
- Outpatient claims for members in the FFS network
- Outpatient claims for members in the MG network*
- Professional claims for members in the FFS network
- Professional claims for members in the MG network*

* claims not covered under the MG capitation arrangement but paid on a fee for service basis

Due to the lack of credibility for the smaller coverages (i.e. the Point of Service), Large Group Community Rated experience in total was the basis for projected trend assumptions for all Community Rated lines of business. The source data includes 4,548,159 member months, which is fully creditable according to federal MLR guidelines.

In Appendix E, we have displayed actual 2010/2009 medical expense PMPM trends. The exhibit includes all HIP and HIPIC commercial business but only the HIP HMO large group trends are used for this filing. Note that these trends are based upon calendar year incurred data with three months of runout.

The development of the 2011 and 2012 projected trend is discussed below:

Contracted Cost:

- Facility: The contracted cost trend component for inpatient and outpatient services was determined using expected contracted increases for our most frequently utilized facilities, and determining a composite increase weighted by 2010 provider-specific dollar weights. The facility specific increases are displayed in Appendix F-1 for inpatient facilities and Appendix F-2 for outpatient facilities.
- Professional: For our physician services, we assumed a 2.0% contracted cost increase for 2011 and a 4.8% contracted cost increase for 2012. Appendix F-3 provides provider specific 2011 increases. HIP has many professional fee schedules. Our direct schedule, which mainly applies to independent and small

physician groups, has a majority of CPT-4 code payment amounts tied to RBRVS values. We also have many fee schedules which are negotiated with larger IPA physician groups. These typically provide for a mixture of CPT codes paid at stated percentages of RBRVS as well as some CPT codes paid at negotiated levels.

- Pharmacy: For Rx claims, we analyzed emerging ingredient cost trend for our community rated commercial products -- see Appendices G-1 and G-2 which show 2009 and 2010 drug experience by product at various levels of detail. 2010 ingredient cost trend was 7.4% for 2010. Projected 2011 contracted cost trend are expected to emerge at 5% and 2012 should emerge somewhat lower at 4%.

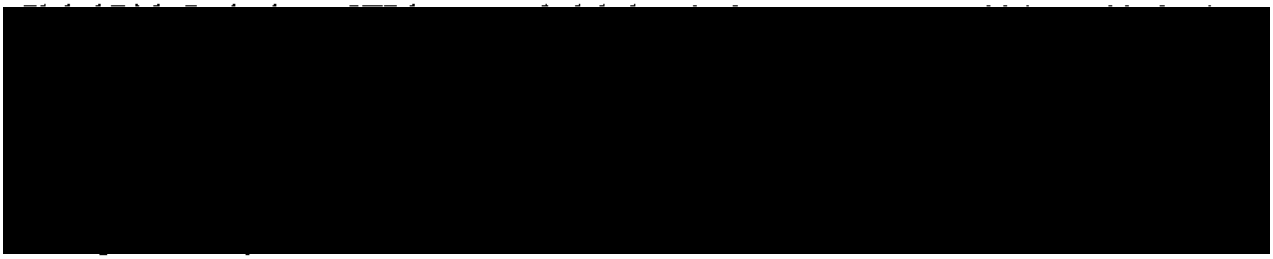
Utilization: The 2011 and 2012 utilization components for all service types were based on the actual 2010 utilization.

CMI/Age Sex: This component is to account for the aging of the covered population and the increase in the intensity of services beyond what is accounted for in the aging. Appendix H calculates the impact that aging has had over time.

For each product, composite medical trends were applied using the following formula to derive the claims PMPM projections:

1Q12 claims PMPM = [2010 PMPM]*[1+ 2011 trend %]*[1 + 2012 trend %]^(13/12)
2Q12 claims PMPM = [1Q12 claims PMPM*[1 + 2012 trend %]^(3/12)
3Q12 claims PMPM = [2Q12 claims PMPM]*[1 + 2012 trend %]^(3/12)
4Q12 claims PMPM = [3Q12 claims PMPM]*[1 + 2012 trend %]^(3/12)

Capitation Expenses



[redacted]

Implementation of Trends

The base experience PMPMs (January 2010 – December 2010) broken into expense categories were trended forward 12 months using the 2011/2010 trends discussed above. Once a 2011 level was established we trended the 2011 PMPMs by the 2012/2011 trends for 13 months which result in the projected PMPMs (January 2012 – March 2013).

Standardized Premium Development

Appendix C: Standardized Premium Calculation provides the support for the development of standardized premiums for the experience periods.

Standardized Premium Development

For the Base Experience, factors for each policy form and market segment grouping were developed to determine the relationship between Base Earned Premiums and December 2011 Standardized Premiums. All rates used in this development were from the 2008 through 2012 HIP Rate Manual base rates, and it was assumed that rate increases applied to base rates were reflective of rate increases applied to total premium which includes both base rate premium and rider premium.

In this development, January 2009 – December 2009 Average Weighted Base Rates were used as a proxy for the prior base period Earned Premium PMPMs. These were developed first by calculating a blended base rate for each month of renewal. For example, for a February 2009 renewal, the average prior period rate reflects one month of the 1st Quarter 2008 Base Rate and 11 months of the 1st Quarter 2009 Base Rate as displayed below:

February 2009 Average Rate = [(1 * Q1 2008 Base Rate) + (11 * Q1 2009 Base Rate)] / 12

Once the blended base rate premium was developed for each renewal month, these were assigned weights based upon the proportion of total premiums received by renewal month. This weighting of the blended base rates resulted in the prior period Average Weighted Base Rate.

The 4th Quarter 2011 HIP Rate Manual base rates were then divided by the 2009 Average Weighted Base Rates to develop factors at the policy form and market segment level of detail described above. These factors were multiplied by the prior base period Earned Premium in order to calculate the Standardized Premium at the same level of detail and which are summarized in the Prior experience period section of the Summary template.

The same approach was used to develop factors measuring the relationship between 4th Quarter 2011 HIP Rate Manual individual base rates and the base period Average Weighted Rates. These factors were similarly applied to the January 2010 – December 2010 Earned Premiums in order to develop the Standardized Premium in the Most Recent experience period section of the Summary template.

Note that the Standardized Premium calculation does not reflect shifts in membership or changes in underlying benefits experienced over the last several years.

Expected Loss Ratios

Based upon the trend development outlined above and the proposed premium increases, the expected loss ratios for the various HIP large group community rated products are as follows:

1Q12:	89.6%
2Q12:	89.9%
3Q12	90.3%
4Q12	90.6%

Administrative Expenses and Contribution to Surplus

The table below displays projected 2011 HIP Large Group HMO/POS administrative expense by component.

2011 Admin	% of Prem	PMPM
Regulatory authority fees	0.9%	3.85
Health care quality admin	0.3%	1.12
Commissions	0.8%	3.28
Premium Taxes	0.0%	-
Other Admin	9.4%	41.20
State income Taxes	0.0%	-
Federal income taxes	0.0%	-
Reduction for net investment income	0.0%	-
Net	**11.3%**	**49.45**

The table below displays projected 2012 HIP Large Group HMO/POS administrative expense by component. We have added provision for contribution to surplus, risk charge, and after tax underwriting margin.

2012 Admin	% of Prem	PMPM
Regulatory authority fees	0.9%	$4.42
Health care quality admin	0.3%	$1.20
Commissions	0.8%	$3.56
Premium Taxes	0.0%	$0.00
Other Admin	8.8%	$41.57
Statutory contribution to surplus	0.0%	$0.00
Risk charge	0.0%	$0.00
After Tax UW margin	0.0%	$0.00
State income Taxes	0.0%	$0.00
Federal income taxes	0.0%	$0.00
Reduction for net investment income	0.0%	$0.00
Net	**10.7%**	**$50.76**

EmblemHealth Administrative Expense Allocation Process

Activities produce administrative expenses (Admin), which are either indirectly or directly related to the consumer (internal or external) receiving them. Therefore, we allocate a business unit's (BU) Admin down to a consumer level. As consumers are tied directly to a line of business (LOB), market (Mkt) and delivery system (DS); we are able to allocate our Admin to this level of detail based on activities of said business unit. This is done through a set of drivers or business metrics recorded during the reporting period. These drivers "track" activities based on the activity focused on (i.e. Billing may use Revenue).

The Activity Based Costing (ABC) model is focused on the activities incurred by specific cost centers (CC). A cost center is defined as a "department" or "sub-department" which may contain one or more activities related to the overall business objective of the BU. A cost center's activity(ies) are determined based on its respective business partner management. CCs are divided into two distinct categories "direct" or "supporting/indirect". A direct CC generally services an external customer and focuses on meeting the objectives of the BU whether this be claims processing, billing, marketing, etc. An indirect CC generally services the BU as a whole or specific direct cost centers examples would include Finance, Human Resources or IT.

An important attribute of the ABC model is the customization component. Certain CCs focus heavily on specific LOBs. The ABC model takes this into consideration. For example, there may be multiple Marketing CCs each focused on a specific segment of business. The model allows for restrictions to be placed on CC activities that would allow expenses to only be allocated to specific LOBs. Additionally, CCs which weigh heavily in a certain Mkt or LOB may have a weight adjustment driver or weighed activities. These drivers' formulas are based on senior management's direction and allow the allocation to correspond to the business the CC performs.

Initial costs are assigned directly to a CC and BU. From this point indirect CC costs are processed to direct CCs based on a series of indirect drivers (HR may use FTEs, Finance may use Total BU Expenses). After this first allocation is done, the expenses are considered fully loaded and reside solely in direct CCs. This is where the business managers' logic in conjunction with the driver metrics is utilized. Expenses are then allocated to the LOB, Mkt and DS levels based on the driver information.

Actuarial Certification

I certify that the premium rates derived according to the above methodology are reasonable in relation to the benefits provided, make adequate provision for both the claim costs and administrative expense costs associated with these plans, and are not unfairly discriminatory. I further certify that to the best of my knowledge this filing is in compliance with all applicable laws and regulations of the State of New York, and is also in compliance with Actuarial Standard of Practice No. 8.

The anticipated loss ratios for the Large Groups receiving the premium rates proposed under this rate filing are in excess of the minimum loss ratio of 82% applicable to this business under New York State requirements.

All required information as specified in the Insurance Department's "Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law" are included in this SERFF submission under the "Supporting Documentation" tab. With the exception of the rating manual pages, please keep all information contained in this cover letter and attachments confidential as per Article 6 of the New York Public Officer's Law (FOIL).

Please let me know if there are any questions or if any additional information is needed.

Senior Director, EmblemHealth Actuarial Services
July 18, 2011

Appendix A: Premium Rate Increases

			1Q 2010 / 1Q 2009	2Q 2010 / 2Q 2009	3Q 2010 / 3Q 2009	4Q 2010 / 4Q 2009	1Q 2011 / 1Q 2010	2Q 2011 / 2Q 2010	3Q 2011 / 3Q 2010	4Q 2011 / 4Q 2010	1Q 2012 / 1Q 2011	2Q 2012 / 2Q 2011	3Q 2012 / 3Q 2011	4Q 2012 / 4Q 2011
HMO	LG	Prime	12.9%	12.9%	9.2%	10.4%	9.0%	9.0%	9.9%	8.7%	8.6%	8.5%	8.5%	7.8%
HMO	LG	Access 1	12.9%	12.9%	8.1%	10.4%	9.0%	9.0%	10.4%	8.7%	8.6%	8.5%	8.5%	7.8%
Vytra HMO	LG	Vytra	na	na	13.8%	na	na	na	0.0%	na	na	na	6.4%	na
POS	LG	Prime	31.0%	31.0%	25.4%	28.1%	9.0%	9.0%	10.4%	8.7%	8.6%	8.5%	8.5%	7.8%
POS	LG	Access 2	28.9%	29.1%	23.5%	26.2%	9.1%	9.0%	10.5%	8.7%	8.6%	8.5%	8.5%	7.8%

			1Q 2010 / 4Q 2009	2Q 2010 / 1Q 2010	3Q 2010 / 2Q 2010	4Q 2010 / 3Q 2010	1Q 2011 / 4Q 2010	2Q 2011 / 1Q 2011	3Q 2011 / 2Q 2011	4Q 2011 / 3Q 2011	1Q 2012 / 4Q 2011	2Q 2012 / 1Q 2012	3Q 2012 / 2Q 2012	4Q 2012 / 3Q 2012
HMO	LG	Prime	3.4%	2.0%	1.1%	3.6%	2.0%	2.0%	1.9%	2.5%	1.9%	1.9%	1.9%	1.9%
HMO	LG	Access 1	3.3%	2.0%	0.6%	4.1%	2.0%	2.0%	1.9%	2.5%	1.9%	1.9%	1.9%	1.9%
Vytra HMO	LG	Vytra	na	na	13.8%	na	na	na	0.0%	na	na	na	6.4%	na
POS	LG	Prime	19.9%	2.0%	0.6%	4.1%	2.0%	2.0%	1.9%	2.5%	1.9%	1.9%	1.9%	1.9%
POS	LG	Access 2	18.0%	2.1%	0.5%	4.2%	2.0%	2.0%	1.9%	2.5%	1.9%	1.9%	1.9%	1.9%

Appendix B: Source Data

	HMO LG Prime	HMO LG Access 1	HMO LG Vytra	POS LG Prime	POS LG Access 2
Base Member Months	**4,414,522**	**78,745**	**41,304**	**10,054**	**3,534**
Base Experience 2010 a/o 12/31/2010					
Professional Claims	297,421,666	9,875,276	9,327,125	1,582,797	674,153
Inpatient Claims	327,687,046	6,271,794	4,991,950	931,603	341,116
Outpatient Claims	180,569,721	4,207,651	3,808,529	640,682	183,585
Medical Group Capitations	235,979,469	-	-	261,292	-
Ancillary Capitations	13,525,417	386,337	285,935	46,927	16,373
Global Capitations	251,922,147	2,983,447	-	257,916	92,461
RX Claims	104,215,028	3,347,674	1,883,874	707,436	377,950
HCRA Pool Expenses	108,391,523	1,670,493	1,014,154	195,632	75,012
Total Expenses	**1,519,712,016**	**28,742,673**	**21,311,567**	**4,624,285**	**1,760,650**
Base Recast a/o 4/30/2010					
Professional Claims	2,208,336	85,759	38,646	(18,507)	(5,070)
Inpatient Claims	(6,131,458)	(46,847)	(81,841)	4,264	1,302
Outpatient Claims	132,949	1,435	(12,611)	2,995	337
Total Recast	**(3,790,173)**	**40,347**	**(55,807)**	**(11,247)**	**(3,430)**
Total Expenses with Recast	**1,515,921,843**	**28,783,020**	**21,255,760**	**4,613,039**	**1,757,219**
Base PMPMs					
Professional Claims	67.87	126.50	226.75	155.59	189.33
Inpatient Claims	72.84	79.05	118.88	93.08	96.89
Outpatient Claims	40.93	53.45	91.90	64.02	52.04
Medical Group Capitations	53.46	-	-	25.99	-
Ancillary Capitations	3.06	4.91	6.92	4.67	4.63
Global Capitations	57.07	37.89	-	25.65	26.16
RX Claims	23.61	42.51	45.61	70.36	106.95
HCRA Pool Expenses	24.55	21.21	24.55	19.46	21.23
Total Base PMPM	**343.39**	**365.52**	**514.62**	**458.83**	**497.23**
2011/2010 Trends					
Professional Claims	2.9%	5.8%	5.4%	12.0%	11.6%
Inpatient Claims	13.8%	13.5%	12.8%	21.7%	22.9%
Outpatient Claims	20.8%	20.7%	20.1%	29.8%	27.0%
Medical Group Capitations	23.8%	0.0%	0.0%	15.0%	0.0%
Ancillary Capitations	21.6%	15.8%	12.6%	17.6%	18.0%
Global Capitations	6.0%	6.0%	0	4.0%	4.0%
RX Claims	2.0%	2.0%	2.0%	2.9%	2.9%
HCRA Pool Expenses	6.6%	9.0%	6.6%	13.9%	15.7%
Aggregate Trend	**11.5%**	**9.5%**	**9.6%**	**14.9%**	**13.4%**
2012/2011 Trends					
Professional Claims	9.1%	9.2%	8.5%	11.9%	11.3%
Inpatient Claims	12.2%	11.9%	10.3%	17.8%	18.1%
Outpatient Claims	15.0%	15.0%	14.8%	23.2%	20.7%
Medical Group Capitations	4.9%	0.0%	0.0%	5.1%	0.0%
Ancillary Capitations	3.3%	4.2%	4.4%	3.2%	3.5%
Global Capitations	9.7%	9.7%	0	0	12.5%
RX Claims	7.7%	7.7%	7.7%	7.7%	7.7%
HCRA Pool Expenses	5.9%	7.8%	5.5%	12.3%	13.2%
Aggregate Trend	**9.5%**	**10.5%**	**9.9%**	**14.0%**	**13.2%**
2012 Projected Claims					
Professional Claims	76.22	146.07	259.20	195.02	235.22
Inpatient Claims	93.03	100.43	147.89	133.53	140.52
Outpatient Claims	56.86	74.24	126.71	102.41	79.80
Medical Group Capitations	69.36	-	-	31.43	-
Ancillary Capitations	3.85	5.92	8.14	5.67	5.66
Global Capitations	66.39	44.08	-	30.01	30.61
RX Claims	25.92	46.69	50.09	77.97	118.51
HCRA Pool Expenses	27.72	24.92	27.62	24.89	27.81
Total Projected PMPM	**419.36**	**442.34**	**619.66**	**600.92**	**638.11**

Large Group HMO Prime

2009 Earned Premium PMPM	363.44	
2010 Earned Premium PMPM	404.81	
1Q 2008 Base Rate Ratio	1.000	
2Q 2008 Rate Ratio	1.020	
3Q 2008 Rate Ratio	1.040	
4Q 2008 Rate Ratio	1.061	
1Q 2009 Rate Ratio	1.086	
2Q 2009 Rate Ratio	1.108	
3Q 2009 Rate Ratio	1.157	
4Q 2009 Rate Ratio	1.187	
1Q 2010 Rate Ratio	1.226	
2Q 2010 Rate Ratio	1.251	
3Q 2010 Rate Ratio	1.264	
4Q 2010 Rate Ratio	1.310	
1Q 2011 Rate Ratio	1.336	
2Q 2011 Rate Ratio	1.363	
3Q 2011 Rate Ratio	1.389	
4Q 2011 Rate Ratio	**1.424**	
1Q 2012 Rate Ratio	1.451	1.9%
2Q 2012 Rate Ratio	1.478	1.9%
3Q 2012 Rate Ratio	1.506	1.9%
4Q 2012 Rate Ratio	1.535	1.9%

Renewal Distribution	
Jan	26.7%
Feb	1.1%
Mar	1.0%
Apr	1.3%
May	0.5%
Jun	0.1%
Jul	68.2%
Aug	0.1%
Sep	0.1%
Oct	0.1%
Nov	0.2%
Dec	0.7%

Average 2009 Rate by renewal month	
Jan	1.086
Feb	1.079
Mar	1.072
Apr	1.086
May	1.079
Jun	1.071
Jul	1.099
Aug	1.089
Sep	1.079
Oct	1.093
Nov	1.082
Dec	1.072
Average 2009 Rate Ratio	**1.094**

A Feburay case would have 1 month at the 1Q2008 rate and 11 months at the 1Q2009 rate

Average 2010 Rate by renewal month	
Jan	1.226
Feb	1.215
Mar	1.203
Apr	1.215
May	1.203
Jun	1.191
Jul	1.211
Aug	1.202
Sep	1.193
Oct	1.217
Nov	1.207
Dec	1.197
Average 2010 Rate Ratio	**1.215**

2009 Standardized Premium	
Average 2009 Rate Ratio	1.094
4Q 2011 Rate Ratio	1.424
% Change	1.301
Standardized Premium PMPM	**472.79**

2010 Standardized Premium	
Average 2010 Rate Ratio	1.215
4Q 2011 Rate Ratio	1.424
% Change	1.172
Standardized Premium PMPM	**474.45**

APPENDIX D-1
Source Data Exhibit / 2012 Projection Development

Product Type	Product Name	Standardized Premium PMPM	2010 Member Months	2012 Quarterly Increases	1Q12 Cohort Projected Premium	2Q12 Cohort Projected Premium	3Q12 Cohort Projected Premium	4Q12 Cohort Projected Premium
Large Group	HMO Prime	$465.16	4,414,522	1.9%/1.9%/1.9%/1.9%	474.00	483.00	492.18	501.53
Large Group	HMO Access 1	$490.62	78,745	1.9%/1.9%/1.9%/1.9%	499.94	509.44	519.12	528.99
Large Group	HMO Vytra	$428.55	41,304	1.9%/1.9%/1.9%/1.9%	436.70	444.99	453.45	462.06
Large Group	POS Prime	$517.05	10,054	1.9%/1.9%/1.9%/1.9%	526.87	536.88	547.08	557.48
Large Group	POS Access 2	$506.28	3,534	1.9%/1.9%/1.9%/1.9%	515.90	525.70	535.69	545.87
Large Group		**$465.41**	**4,548,159**	**1.9%/1.9%/1.9%/1.9%**	**$474.26**	**$483.27**	**$492.45**	**$501.80**

Product Type	Product Name	2010 Incurred Claims PMPM	Annualized Medical 2011 Trend	Annualized Medical 2012 Trend	Projected Re-class Expense PMPM	1Q12 Cohort Projected Clms PMPM	2Q12 Cohort Projected Clms PMPM	3Q12 Cohort Projected Clms PMPM	4Q12 Cohort Projected Clms PMPM
Large Group	HMO Prime	$343.39	11.5%	9.5%	$0.00	422.55	432.29	442.25	452.44
Large Group	HMO Access 1	$365.52	9.5%	10.5%	$0.00	446.03	457.28	468.82	480.66
Large Group	HMO Vytra	$490.06	9.6%	9.9%	$0.00	594.75	608.94	623.48	638.36
Large Group	POS Prime	$458.83	14.9%	14.0%	$0.00	607.51	627.69	648.55	670.10
Large Group	POS Access 2	$497.23	13.4%	13.2%	$0.00	644.74	665.04	685.98	707.58
Large Group		**$345.48**	**11.4%**	**9.6%**	**$0.00**	**$425.10**	**$434.94**	**$445.00**	**$455.29**

Product Type	Product Name	1Q12 Expected MLR	2Q12 Expected MLR	3Q12 Expected MLR	4Q12 Expected MLR
Large Group	HMO Prime	89.1%	89.5%	89.9%	90.2%
Large Group	HMO Access 1	89.2%	89.8%	90.3%	90.9%
Large Group	HMO Vytra	136.2%	136.8%	137.5%	138.2%
Large Group	POS Prime	115.3%	116.9%	118.5%	120.2%
Large Group	POS Access 2	125.0%	126.5%	128.1%	129.6%
Large Group		**89.6%**	**90.0%**	**90.4%**	**90.7%**

*Total Large Group 1Q12 - 4Q12 Projected Premium and Claims PMPM weighted by 2010 projected membership
**Projected expenses reclassified from Administrative expense to Medical expense are added to projected 2012 claims

APPENDIX D-2
Source Data Exhibit / 2012 Projection Development

Product Type	Product Name	2010 Member Months	Standardized Premium PMPM	2012 Projected Member Months	2012 Quarterly Increases	1Q12 Cohort Projected Premium	2Q12 Cohort Projected Premium	3Q12 Cohort Projected Premium	4Q12 Cohort Projected Premium
Large Group	HMO Prime	4,414,522	$465.16	3,635,196	1.9%/1.9%/1.9%/1.9%	474.00	483.00	492.18	501.53
Large Group	HMO Access 1	78,745	$490.62	74,240	1.9%/1.9%/1.9%/1.9%	499.94	509.44	519.12	528.99
Large Group	HMO Vytra	41,304	$428.55	28,851	1.9%/1.9%/1.9%/1.9%	436.70	444.99	453.45	462.06
Large Group	POS Prime	10,054	$517.05	5,650	1.9%/1.9%/1.9%/1.9%	526.87	536.88	547.08	557.48
Large Group	POS Access 2	3,534	$506.28	2,383	1.9%/1.9%/1.9%/1.9%	515.90	525.70	535.69	545.87
Large Group		**4,548,159**	**$465.48**	**3,746,321**	**1.9%/1.9%/1.9%/1.9%**	**$474.33**	**$483.34**	**$492.52**	**$501.88**

Product Type	Product Name	2010 Incurred Claims PMPM	Annualized Medical 2011 Trend	Annualized Medical 2012 Trend	Projected Re-class Expense PMPM	1Q12 Cohort Projected Clms PMPM	2Q12 Cohort Projected Clms PMPM	3Q12 Cohort Projected Clms PMPM	4Q12 Cohort Projected Clms PMPM
Large Group	HMO Prime	$343.39	11.5%	9.5%	$0.00	422.55	432.29	442.25	452.44
Large Group	HMO Access 1	$365.52	9.5%	10.5%	$0.00	446.03	457.28	468.82	480.66
Large Group	HMO Vytra	$490.06	9.6%	9.9%	$0.00	594.75	608.94	623.48	638.36
Large Group	POS Prime	$458.83	14.9%	14.0%	$0.00	607.51	627.69	648.55	670.10
Large Group	POS Access 2	$497.23	13.4%	13.2%	$0.00	644.74	665.04	685.98	707.58
Large Group		**$345.23**	**11.4%**	**9.6%**	**$0.00**	**$424.76**	**$434.59**	**$444.63**	**$454.92**

Product Type	Product Name	1Q12 Expected MLR	2Q12 Expected MLR	3Q12 Expected MLR	4Q12 Expected MLR
Large Group	HMO Prime	89.1%	89.5%	89.9%	90.2%
Large Group	HMO Access 1	89.2%	89.8%	90.3%	90.9%
Large Group	HMO Vytra	136.2%	136.8%	137.5%	138.2%
Large Group	POS Prime	115.3%	116.9%	118.5%	120.2%
Large Group	POS Access 2	125.0%	126.5%	128.1%	129.6%
Large Group		**89.6%**	**89.9%**	**90.3%**	**90.6%**

*Total Large Group 1Q12 - 4Q12 Projected Premium and Claims PMPM weighted by 2012 projected membership
**Projected expenses reclassified from Administrative expense to Medical expense are added to projected 2012 claims

PRELIMINARY RATE FILING HIP Community Rated Commercial Projected Trends (excl. PPACA)

Product	Avg 2010 Members	2010/2009 Trends			2011/2010 Projected Trends				2012/ 2011 Projected Trends			
		Total Trend	Utiliza-tion	Total Cost	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend
		Inpatient Facility - FFS										
HMO Large Group	141,974	**10.2%**	-0.4%	10.6%	1.3%	11.5%	0.0%	**13.0%**	1.0%	9.3%	0.0%	**10.3%**
HMO Small Group	7,601	**6.8%**	-1.0%	7.9%	9.6%	11.5%	0.0%	**22.3%**	6.8%	9.3%	0.0%	16.7%
HMO Direct Pay	2,556	36.0%	12.5%	20.9%	5.1%	11.5%	0.0%	17.2%	3.6%	9.3%	0.0%	13.2%
HMO Comprehealth	3,257	271.1%	119.1%	69.4%	19.6%	11.5%	0.0%	33.4%	16.9%	9.3%	0.0%	27.7%
HMO Healthy New York	3,012	86.8%	27.1%	47.0%	3.0%	11.5%	0.0%	14.9%	4.4%	9.3%	0.0%	14.1%
POS Large Group	941	-19.3%	-16.6%	-3.3%	11.2%	10.7%	0.0%	23.1%	8.0%	9.5%	0.0%	18.2%
POS Small Group	1,088	9.2%	19.7%	-8.7%	15.2%	10.7%	0.0%	27.5%	10.8%	9.5%	0.0%	21.3%
POS Direct Pay	55	-16.8%	53.5%	-45.8%	15.2%	10.7%	0.0%	27.5%	10.8%	9.5%	0.0%	21.3%
EPO Large Group	589	-30.2%	10.3%	-36.7%	59.7%	10.7%	0.0%	76.9%	42.7%	9.0%	0.0%	55.5%
EPO Small Group	12,019	**12.7%**	0.7%	11.9%	7.2%	10.7%	0.0%	**18.7%**	5.1%	9.0%	0.0%	**14.6%**
PPO Large Group	51	-9.8%	122.6%	-59.5%	2.0%	12.3%	0.0%	14.6%	1.4%	10.3%	0.0%	11.9%
PPO Small Group	4,960	**24.3%**	8.7%	14.3%	2.2%	12.3%	0.0%	**14.8%**	1.6%	10.3%	0.0%	**12.1%**
		Outpatient Facility - FFS										
HMO Large Group		**16.3%**	1.6%	14.5%	6.3%	10.8%	2.0%	**20.1%**	3.3%	9.0%	2.0%	**14.8%**
HMO Small Group		**10.5%**	2.2%	8.2%	10.0%	10.8%	2.0%	**24.3%**	5.2%	9.0%	2.0%	17.0%
HMO Direct Pay		31.9%	4.7%	26.0%	8.8%	10.8%	2.0%	23.0%	4.6%	9.0%	2.0%	16.3%
HMO Comprehealth		115.9%	52.8%	41.3%	20.0%	10.8%	2.0%	35.6%	15.2%	9.0%	2.0%	28.1%
HMO Healthy New York		16.8%	5.2%	11.0%	6.4%	10.8%	2.0%	20.2%	6.4%	9.0%	2.0%	18.3%
POS Large Group		-34.5%	-26.2%	-11.3%	12.0%	11.2%	2.0%	27.0%	7.9%	9.7%	2.0%	20.7%
POS Small Group		33.0%	7.9%	23.3%	15.2%	11.2%	2.0%	30.6%	10.0%	9.7%	2.0%	23.0%
POS Direct Pay		-46.0%	-22.9%	-30.0%	15.2%	11.2%	2.0%	30.6%	10.0%	9.7%	2.0%	23.0%
EPO Large Group		12.5%	10.5%	1.8%	22.4%	10.6%	2.0%	38.0%	7.2%	9.7%	2.0%	20.0%
EPO Small Group		**35.8%**	20.9%	12.4%	13.2%	10.6%	2.0%	**27.7%**	8.6%	9.7%	2.0%	**21.6%**
PPO Large Group		-32.0%	-10.5%	-24.0%	13.0%	10.8%	2.0%	27.7%	8.5%	9.5%	2.0%	21.2%
PPO Small Group		**43.8%**	0.3%	43.4%	15.2%	10.8%	2.0%	**30.2%**	10.0%	9.5%	2.0%	**22.8%**
		Professional - FFS										
HMO Large Group		**5.1%**	-1.7%	6.9%	3.2%	2.0%	2.0%	**7.4%**	1.7%	4.8%	2.0%	**8.7%**
HMO Small Group		**6.1%**	-1.6%	7.8%	5.1%	2.0%	2.0%	**9.3%**	2.6%	4.8%	2.0%	9.8%
HMO Direct Pay		4.6%	-1.0%	5.6%	8.0%	2.0%	2.0%	12.4%	4.2%	4.8%	2.0%	11.4%
HMO Comprehealth		41.6%	56.8%	-9.7%	15.1%	2.0%	2.0%	19.7%	12.6%	4.8%	2.0%	20.4%
HMO Healthy New York		11.7%	-1.1%	12.9%	6.2%	2.0%	2.0%	10.5%	6.2%	4.8%	2.0%	13.6%
POS Large Group		-5.2%	-6.4%	1.2%	10.1%	2.0%	2.0%	14.5%	4.8%	4.8%	2.0%	12.1%
POS Small Group		18.9%	-5.0%	25.2%	5.2%	2.0%	2.0%	9.4%	2.5%	4.8%	2.0%	9.6%
POS Direct Pay		-6.4%	-12.5%	7.0%	5.2%	2.0%	2.0%	9.4%	2.5%	4.8%	2.0%	9.6%
EPO Large Group		-3.9%	-8.1%	4.6%	23.1%	2.0%	2.0%	28.1%	5.2%	4.8%	2.0%	12.5%
EPO Small Group		**10.6%**	1.1%	9.5%	8.2%	2.0%	2.0%	**12.6%**	3.9%	4.8%	2.0%	**11.1%**
PPO Large Group		0.0%	-1.3%	1.3%	2.0%	2.0%	2.0%	6.1%	1.0%	4.8%	2.0%	8.0%
PPO Small Group		**8.6%**	0.3%	8.3%	1.2%	2.0%	2.0%	**5.3%**	0.6%	4.8%	2.0%	**7.6%**

PRELIMINARY RATE FILING HIP Community Rated Commercial Projected Trends (excl. PPACA)

Product	Avg 2010 Members	2010/2009 Trends			2011/2010 Projected Trends				2012/ 2011 Projected Trends			
		Total Trend	Utiliza-tion	Total Cost	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend
		Inpatient Facility - MG HIP										
HMO Large Group	158,819	**20.4%**	5.6%	14.0%	2.4%	11.5%	0.0%	**14.2%**	4.0%	9.3%	0.0%	**13.6%**
HMO Small Group	3,934	**17.4%**	-0.5%	18.0%	1.7%	11.5%	0.0%	**13.4%**	2.8%	9.3%	0.0%	12.3%
HMO Direct Pay	1,184	51.8%	61.6%	-6.0%	2.7%	11.5%	0.0%	14.5%	4.4%	9.3%	0.0%	14.1%
HMO Comprehealth	2,696	71.6%	13.1%	51.8%	11.7%	11.5%	0.0%	24.6%	12.8%	9.3%	0.0%	23.2%
HMO Healthy New York	588	72.9%	16.9%	47.9%	5.1%	11.5%	0.0%	17.2%	5.1%	9.3%	0.0%	14.8%
POS Large Group	123	92.2%	25.7%	53.0%	5.5%	10.7%	0.0%	16.8%	7.4%	9.5%	0.0%	17.5%
POS Small Group	68	-64.9%	-76.3%	48.0%	5.7%	10.7%	0.0%	17.0%	7.6%	9.5%	0.0%	17.8%
POS Direct Pay	11	0.0%	-14.2%	0.0%	5.7%	10.7%	0.0%	17.0%	7.6%	9.5%	0.0%	17.8%
		Outpatient Facility - MG HIP										
HMO Large Group		**12.0%**	0.2%	11.7%	7.8%	10.8%	2.0%	**21.9%**	3.8%	9.0%	2.0%	**15.4%**
HMO Small Group		**35.5%**	-0.9%	36.6%	6.3%	10.8%	2.0%	**20.1%**	3.0%	9.0%	2.0%	14.5%
HMO Direct Pay		24.4%	1.1%	23.0%	6.1%	10.8%	2.0%	19.9%	2.9%	9.0%	2.0%	14.4%
HMO Comprehealth		38.0%	27.7%	8.1%	16.3%	10.8%	2.0%	31.4%	13.0%	9.0%	2.0%	25.7%
HMO Healthy New York		16.2%	6.3%	9.3%	5.6%	10.8%	2.0%	19.4%	5.6%	9.0%	2.0%	17.4%
POS Large Group		60.0%	45.8%	9.7%	22.0%	11.2%	2.0%	38.3%	16.6%	9.7%	2.0%	30.5%
POS Small Group		-68.0%	-24.3%	-57.7%	22.2%	11.2%	2.0%	38.6%	16.7%	9.7%	2.0%	30.6%
POS Direct Pay		0.0%	42.9%	0.0%	22.2%	11.2%	2.0%	38.6%	16.7%	9.7%	2.0%	30.6%
		Professional - MG HIP										
HMO Large Group		**5.6%**	-4.6%	10.7%	7.4%	2.0%	2.0%	**11.7%**	3.0%	4.8%	2.0%	**10.2%**
HMO Small Group		**-0.3%**	-10.7%	11.7%	5.8%	2.0%	2.0%	**10.0%**	2.3%	4.8%	2.0%	9.4%
HMO Direct Pay		14.8%	-1.6%	16.7%	9.5%	2.0%	2.0%	14.0%	3.9%	4.8%	2.0%	11.1%
HMO Comprehealth		22.7%	-41.4%	109.4%	15.8%	2.0%	2.0%	20.4%	12.3%	4.8%	2.0%	20.1%
HMO Healthy New York		-4.8%	-15.7%	13.0%	6.2%	2.0%	2.0%	10.5%	6.2%	4.8%	2.0%	13.6%
POS Large Group		-1.7%	22.8%	-19.9%	15.4%	2.0%	2.0%	20.0%	15.4%	4.8%	2.0%	23.4%
POS Small Group		-40.0%	-12.0%	-31.8%	15.4%	2.0%	2.0%	20.0%	15.4%	4.8%	2.0%	23.4%
POS Direct Pay		-21.2%	-21.3%	0.1%	0.0%	2.0%	2.0%	4.0%	0.0%	4.8%	2.0%	6.9%

PRELIMINARY RATE FILING HIP Community Rated Commercial Projected Trends (excl. PPACA)

		2010/2009 Trends			2011/2010 Projected Trends				2012/ 2011 Projected Trends			
Product	Avg 2010 Members	Total Trend	Utiliza-tion	Total Cost	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend	Utiliza-tion[2]	Contracted Cost[1]	CMI / AgeSex	Total Trend
		Pharmacy[3][4]										
HMO Large Group	183,691	6.2%	-0.6%	6.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
HMO Small Group					3.0%	5.0%	2.0%	10.3%	3.0%	4.0%	2.0%	9.3%
HMO Direct Pay					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
HMO Comprehealth					13.0%	5.0%	2.0%	21.0%	13.0%	4.0%	2.0%	19.9%
HMO Healthy New York					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Large Group	24,979	12.5%	9.3%	2.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Direct Pay					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
EPO Large Group	31,274	20.5%	8.1%	11.4%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
EPO Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
PPO Large Group	9,483	26.2%	9.8%	14.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
PPO Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%

(1) Contracted Cost assumptions from Provider Relations
(2) Projected utilization assumptions from Medical Management
(3) Pharmacy data and trend assumptions from Medical Management
(4) 2010 Rx Members include Community Rated & Experience Rated members with a Pharmacy benefit

APPENDIX F-1

HIP/HIPIC COMMUNITY RATED Inpatient Facility Mix Study

Jan 2010 - Dec 2010 Incurrals with 3 months runout

			HMO			Point of Service			EPO			PPO			TOTAL		
PROVNUM	TAXIDNUM	PROVIDER NAME	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase

[redacted]

[redacted]

TOTAL Top Contracted IP Facilities	**285,078,941**	**11.5%**	**9.3%**	**2,173,205**	**10.7%**	**9.5%**	**11,672,293**	**10.7%**	**9.0%**	**4,401,881**	**12.3%**	**10.3%**	**303,326,321**	**11.5%**	**9.3%**

APPENDIX F-2

HIP/HIPIC COMMUNITY RATED Outpatient Facility Mix Study

Jan 2010 - Dec 2010 Incurrals with 3 months runout

			HMO			Point of Service			EPO			PPO			TOTAL		
PROVNUM	TAXIDNUM	PROVIDER NAME	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase

TOTAL Top Contracted OP Facilities	**136,314,388**	**10.8%**	**9.0%**	**1,207,783**	**11.2%**	**9.7%**	**7,971,014**	**10.6%**	**9.7%**	**2,241,031**	**10.8%**	**9.5%**	**147,734,216**	**10.8%**	**9.1%**

Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	HIP Standard	$67,840,580	43%	0.0%	$67,840,580	Evergreen	Closed	1.5%	$1,017,609	1.5%	$1,017,609
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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Appendix F-3

EmblemHealth — *HIP Commercial HMO 2011*

Professional Bank Account Summary by Line of Business

				Unit Cost				CMS Impact		Total	
Medical Product	*IPA/PC*	*Annual Spend**	*Percent of Annual Spend Total*	*Result: Negotiated Percent Increase*	*Negotiated Projected Annual Spend*	*Agreement Status*	*Open/ Closed*	*Projected 2011 CMS Update*	*Projected CMS Incremental Impact*	*Total Projected Percent Increase*	*Total Projected Incremental Increase*
Commercial	[redacted]										
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COMMERCIAL HMO TOTAL		**$157,248,402**			**$158,393,653**				**$1,998,665**		**$3,143,916**

PROJECTED NEGOTIATED UNIT COST TREND INCREASE	**0.7%**
PROJECTED CMS TREND INCREASE	**1.3%**
PROJECTED TOTAL UNIT COST AND CMS TREND INCREASE	**2.0%**

Excludes COB, Non-NY and Non-Physician claims (DME, Anesthesia, Lab, Radiology, MH/SA and ER physician claims). IPA's/large groups encompass 5 or more providers.

APPENDIX G-1
HIP/HIPIC COMMERCIAL COMMUNITY RATED CY 2009 ACTUALS

Table 1	RETAIL						MAIL						TOTAL					
	Number of Scripts by Drug Category for 2009 per 1000 members						Number of Scripts by Drug Category for 2009 per 1000 members						Number of Scripts by Drug Category for 2009 per 1000 members					
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months
HMO	[redacted]																	
POS																		
EPO																		
PPO																		

Table 4	RETAIL					MAIL					TOTAL				
	Allowed Cost per Script for 2009					Allowed Cost per Script for 2009					Allowed Cost per Script for 2009				
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total
HMO	[redacted]														
POS															
EPO															
PPO															

Table 8	RETAIL				MAIL				TOTAL			
	Dispensing Fees for 2009				Dispensing Fees for 2009				Dispensing Fees for 2009			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO	[redacted]											
POS												
EPO												
PPO												

Table 10	RETAIL				MAIL				TOTAL			
	Rebate % for 2009				Rebate % for 2009				Rebate % for 2009			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO	[redacted]											
POS												
EPO												
PPO												

APPENDIX G-2
HIP/HIPIC COMMERCIAL COMMUNITY RATED CY 2010 ACTUALS

Table 1	RETAIL						MAIL						TOTAL						
	Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						2010/2009 Util %
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	
HMO	[redacted]																		
POS																			
EPO																			
PPO																			
																		Total	1.12%

Table 4	RETAIL					MAIL					TOTAL						
	Allowed Cost per Script for 2010					Allowed Cost per Script for 2010					Allowed Cost per Script for 2010						2010/2009 Cost %
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total		
HMO	[redacted]																
POS																	
EPO																	
PPO																	
																Total	7.4%

Table 8	RETAIL				MAIL				TOTAL			
	Dispensing Fees for 2010				Dispensing Fees for 2010				Dispensing Fees for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO	[redacted]											
POS												
EPO												
PPO												

Table 10	RETAIL				MAIL				TOTAL			
	Rebate % for 2010				Rebate % for 2010				Rebate % for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO	[redacted]											
POS												
EPO												
PPO												

APPENDIX H-1
HIP/HIPIC Large Group Community Rated Age/Sex Factors
Calculated Using Milliman Age Bands and Factors

	HMO Fee-for-service		HMO Medical Group		POS Fee-for-service		POS Medical Group		Total HIP (2009 Member Mix)		EPO		PPO		Total HIPIC (2009 Member Mix)		Total HIP & HIPIC (2009 Member Mix)	
Month	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor
Jan-09	148,610	1.144	174,516		1,090	1.391	150	1.419	324,766	1.242	1,479	1.223	135	1.269	1,614	1.227	326,380	
Feb-09	147,907	1.141	174,636		1,080	1.392	150	1.424	323,473	1.242	1,484	1.220	136	1.278	1,620	1.225	325,093	
Mar-09	147,593	1.142	174,714		1,060	1.374	142	1.427	322,909	1.243	1,473	1.215	132	1.295	1,605	1.222	324,514	
Apr-09	144,838	1.141	174,671		1,030	1.380	149	1.386	320,688	1.242	1,443	1.225	132	1.245	1,575	1.226	322,263	
May-09	145,017	1.142	174,608		1,015	1.375	147	1.411	320,187	1.243	1,430	1.232	135	1.244	1,565	1.233	321,752	
Jun-09	144,799	1.143	173,708		1,023	1.378	147	1.406	319,677	1.244	1,370	1.216	125	1.260	1,495	1.220	321,172	
Jul-09	145,118	1.143	173,897		1,050	1.356	140	1.434	318,605	1.244	1,380	1.229	126	1.297	1,506	1.234	320,111	
Aug-09	145,061	1.143	173,868		1,096	1.366	137	1.446	318,162	1.244	1,388	1.236	123	1.318	1,511	1.243	319,673	
Sep-09	145,542	1.144	173,905		1,043	1.359	128	1.510	317,618	1.245	1,149	1.234	77	1.355	1,226	1.242	318,844	
Oct-09	145,354	1.145	173,207		1,100	1.347	127	1.497	316,888	1.246	946	1.218	78	1.337	1,024	1.227	317,912	
Nov-09	145,544	1.146	169,341		1,077	1.348	119	1.487	316,255	1.248	926	1.217	77	1.302	1,003	1.223	317,258	
Dec-09	145,358	1.147	169,321		1,107	1.351	117	1.500	315,803	1.249	786	1.231	73	1.279	859	1.235	316,662	
Jan-10	146,415	1.149	164,244		1,104	1.345	121	1.488	324,766	1.255	586	1.263	66	1.352	1,614	1.270	326,380	
Feb-10	144,302	1.156	160,172		1,063	1.377	117	1.545	323,473	1.267	548	1.302	68	1.342	1,620	1.306	325,093	
Mar-10	143,947	1.156	160,541		1,074	1.389	121	1.553	322,909	1.266	602	1.269	56	1.462	1,605	1.285	324,514	
Apr-10	142,614	1.157	160,590		1,032	1.382	121	1.555	320,688	1.266	644	1.257	54	1.420	1,575	1.271	322,263	
May-10	142,382	1.159	160,562		1,038	1.384	117	1.584	320,187	1.267	652	1.246	52	1.369	1,565	1.257	321,752	
Jun-10	141,993	1.160	159,574		950	1.363	116	1.590	319,677	1.269	649	1.228	52	1.385	1,495	1.241	321,172	
Jul-10	140,587	1.162	158,280		906	1.418	135	1.645	318,605	1.269	653	1.210	49	1.309	1,506	1.219	320,111	
Aug-10	140,027	1.163	157,671		879	1.428	128	1.627	318,162	1.271	623	1.195	49	1.309	1,511	1.205	319,673	
Sep-10	140,659	1.164	156,822		808	1.444	126	1.638	317,618	1.272	659	1.201	42	1.359	1,226	1.211	318,844	
Oct-10	140,920	1.163	156,758		826	1.441	125	1.647	316,888	1.273	624	1.226	40	1.382	1,024	1.238	317,912	
Nov-10	140,208	1.165	155,609		810	1.448	126	1.675	316,255	1.274	594	1.245	39	1.388	1,003	1.256	317,258	
Dec-10	139,531	1.165	155,916		803	1.435	127	1.702	315,803	1.275	584	1.262	39	1.388	859	1.273	316,662	
Jan-11	131,134	1.170	139,966		769	1.451	119	1.713	324,766	1.293	607	1.269	38	1.417	1,614	1.281	326,380	
Feb-11	127,477	1.174	137,589		724	1.468	128	1.613	323,473	1.288	622	1.248	35	1.351	1,620	1.257	325,093	
Mar-11	127,469	1.172	136,479		718	1.483	122	1.568	322,909	1.288	514	1.279	38	1.439	1,605	1.292	324,514	
Apr-11	127,698	1.170	135,964		740	1.458	118	1.619	320,688	1.289	502	1.309	37	1.434	1,575	1.320	322,263	

Age/Sex Factors

	Apr 09, 10, 11 Experience					
Product	**Apr 09**	**Apr 10**	**Apr 11**	**Trend**	**Trend**	**Rate Filing Trend**
HMO FFS	1.141	1.157	1.170	1.3%	1.2%	**2.0%**
HMO MG	1.325	1.355	1.386	2.3%	2.3%	**2.0%**
POS FFS	1.380	1.382	1.458	0.2%	5.5%	**2.0%**
POS MG	1.386	1.555	1.619	12.2%	4.1%	**2.0%**
Total HIP (Apr 09 Member Mix)	1.242	1.266	1.289	1.9%	1.8%	**2.0%**
EPO	1.225	1.257	1.309	2.6%	4.2%	**2.0%**
PPO	1.245	1.420	1.434	14.1%	1.0%	**2.0%**
Total HIPIC (Apr 09 Member Mix)	1.226	1.271	1.320	3.6%	3.9%	**2.0%**
Total HIP/HIPIC (Apr 09 Member Mix)	**1.242**	**1.266**	**1.289**	**1.9%**	**1.9%**	**2.0%**

Milliman Factors

Age Band	Male	Female
0-1	1.754	1.754
2-6	0.305	0.305
7-18	0.364	0.364
19-22	0.566	0.566
23-24	0.476	1.120
25-29	0.487	1.277
30-34	0.578	1.327
35-39	0.702	1.236
40-44	0.889	1.182
45-49	1.177	1.288
50-54	1.613	1.574
55-59	2.233	1.932
60-64	2.992	2.491
65+	4.033	3.377

APPENDIX H-2
HIP/HIPIC Small Group, Sole P, & Direct Pay Community Rated Age/Sex Factors
Calculated Using Milliman Age Bands and Factors

	HMO & Healthy New York Fee-for-service		HMO & Healthy New York Medical Group		POS Fee-for-service		POS Medical Group		Total HIP (2009 Member Mix)		EPO		PPO		Total HIPIC (2009 Member Mix)		Total HIP & HIPIC (2009 Member Mix)	
Month	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor	Members	Avg AS Factor
Jan-09	22,516	1.420	9,448	1.429	2,251	1.360	183	1.480	34,398	1.419	18,022	1.091	7,838	1.335	25,860	1.165	60,258	1.310
Feb-09	21,986	1.419	9,142	1.430	2,187	1.364	167	1.492	33,482	1.418	18,037	1.096	7,816	1.337	25,853	1.169	59,335	1.310
Mar-09	21,563	1.422	9,002	1.429	2,109	1.362	165	1.498	32,839	1.420	18,077	1.097	7,656	1.347	25,733	1.172	58,572	1.311
Apr-09	20,602	1.427	9,022	1.418	2,037	1.352	142	1.469	31,803	1.420	18,133	1.099	7,404	1.353	25,537	1.173	57,340	1.310
May-09	20,428	1.431	8,975	1.418	2,026	1.348	138	1.452	31,567	1.422	18,135	1.101	7,155	1.356	25,290	1.173	56,857	1.311
Jun-09	19,848	1.432	8,778	1.427	1,891	1.366	133	1.458	30,650	1.427	17,803	1.107	6,958	1.364	24,761	1.180	55,411	1.316
Jul-09	19,214	1.440	8,697	1.424	1,848	1.357	125	1.453	29,884	1.430	17,621	1.111	6,826	1.371	24,447	1.183	54,331	1.319
Aug-09	18,800	1.443	8,681	1.425	1,785	1.371	112	1.489	29,378	1.433	17,513	1.116	6,696	1.376	24,209	1.188	53,587	1.322
Sep-09	18,451	1.444	8,539	1.426	1,667	1.375	107	1.534	28,764	1.435	17,450	1.118	6,442	1.385	23,892	1.190	52,656	1.324
Oct-09	18,096	1.453	8,600	1.414	1,583	1.385	102	1.494	28,381	1.438	17,273	1.122	6,297	1.392	23,570	1.194	51,951	1.327
Nov-09	17,711	1.457	8,430	1.425	1,537	1.394	100	1.502	27,778	1.444	17,096	1.125	6,187	1.392	23,283	1.196	51,061	1.331
Dec-09	17,304	1.466	8,408	1.419	1,519	1.397	100	1.523	27,331	1.448	17,209	1.134	6,017	1.401	23,226	1.203	50,557	1.336
Jan-10	17,091	1.468	8,114	1.427	1,449	1.402	85	1.541	34,398	1.453	16,959	1.139	5,877	1.409	25,860	1.221	60,258	1.353
Feb-10	16,753	1.482	8,069	1.427	1,366	1.423	88	1.556	33,482	1.463	16,639	1.148	5,709	1.427	25,853	1.232	59,335	1.362
Mar-10	16,562	1.482	7,827	1.437	1,309	1.421	84	1.568	32,839	1.466	16,413	1.152	5,627	1.425	25,733	1.233	58,572	1.364
Apr-10	16,508	1.473	7,977	1.430	1,255	1.425	82	1.512	31,803	1.458	16,441	1.151	5,340	1.445	25,537	1.236	57,340	1.359
May-10	16,487	1.465	8,036	1.424	1,223	1.420	81	1.507	31,567	1.451	16,535	1.150	5,120	1.444	25,290	1.234	56,857	1.354
Jun-10	16,589	1.459	8,279	1.411	1,151	1.426	80	1.496	30,650	1.444	16,892	1.150	4,962	1.450	24,761	1.234	55,411	1.350
Jul-10	16,482	1.457	8,547	1.392	1,079	1.462	78	1.495	29,884	1.439	16,869	1.152	4,799	1.461	24,447	1.238	54,331	1.349
Aug-10	15,923	1.461	8,304	1.402	1,032	1.479	76	1.453	29,378	1.444	16,782	1.155	4,676	1.470	24,209	1.242	53,587	1.353
Sep-10	16,204	1.452	8,730	1.385	1,028	1.480	75	1.456	28,764	1.433	16,989	1.160	4,541	1.474	23,892	1.245	52,656	1.348
Oct-10	15,996	1.455	8,694	1.382	968	1.482	74	1.464	28,381	1.434	16,693	1.163	4,429	1.480	23,570	1.248	51,951	1.350
Nov-10	16,259	1.451	9,004	1.374	945	1.496	71	1.459	27,778	1.430	16,513	1.165	4,290	1.486	23,283	1.250	51,061	1.348
Dec-10	16,247	1.448	9,251	1.363	902	1.483	70	1.487	27,331	1.424	16,515	1.167	4,155	1.500	23,226	1.253	50,557	1.346
Jan-11	16,244	1.438	9,216	1.356	798	1.462	59	1.410	34,398	1.417	16,326	1.171	4,074	1.493	25,860	1.269	60,258	1.353
Feb-11	13,874	1.492	12,042	1.294	745	1.481	64	1.410	33,482	1.437	13,458	1.162	6,245	1.409	25,853	1.237	59,335	1.349
Mar-11	14,383	1.470	12,473	1.282	709	1.476	62	1.405	32,839	1.418	13,902	1.162	5,642	1.430	25,733	1.242	58,572	1.341
Apr-11	15,212	1.442	11,857	1.292	694	1.483	59	1.446	31,803	1.402	14,161	1.162	5,186	1.452	25,537	1.246	57,340	1.333

Age/Sex Factors

	Apr 09, 10, 11 Experience					
Product	**Apr 09**	**Apr 10**	**Apr 11**	**Trend**	**Trend**	**Rate Filing Trend**
HMO FFS	1.427	1.473	1.442	3.2%	-2.1%	**2.0%**
HMO MG	1.418	1.430	1.292	0.9%	-9.7%	**2.0%**
POS FFS	1.352	1.425	1.483	5.3%	4.1%	**2.0%**
POS MG	1.469	1.512	1.446	3.0%	-4.4%	**2.0%**
Total HIP (Nov 10 Member Mix)	1.420	1.458	1.402	2.7%	-3.8%	**2.0%**
EPO	1.099	1.151	1.162	4.7%	0.9%	**2.0%**
PPO	1.353	1.445	1.452	6.8%	0.5%	**2.0%**
Total HIPIC (Nov 10 Member Mix)	1.173	1.236	1.246	5.4%	0.8%	**2.0%**
Total HIP/HIPIC (Nov 10 Member Mix)	**1.310**	**1.359**	**1.333**	**3.8%**	**-2.0%**	**2.0%**

Milliman Factors

Age Band	Male	Female
0-1	1.754	1.754
2-6	0.305	0.305
7-18	0.364	0.364
19-22	0.566	0.566
23-24	0.476	1.120
25-29	0.487	1.277
30-34	0.578	1.327
35-39	0.702	1.236
40-44	0.889	1.182
45-49	1.177	1.288
50-54	1.613	1.574
55-59	2.233	1.932
60-64	2.992	2.491
65+	4.033	3.377

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:

Health Insurance Plan of Greater New York	Article 43	☐ For Profit ☑ Non Profit 55247
Company submitting the rate adjustment request	Type of insurer	Company NAIC Code

55 Water St. New York, NY, 10041

Company mailing address

B. Contact Person:

[redacted]	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information (See Note #1):

1/1/2012-12/31/2012	01/01/2012	HPHP-127306459
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): Large Group

F. Provide responses for the following questions:

	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Yes
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes

Notes:

(1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date.
It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date.
It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.

(2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.

Use the following SERFF filing types for rate adjustment filings:

* For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
* For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
* For all other prior approval filings: Normal Pre-Approval

(3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

EXHIBIT 2: FOIL EXEMPTION REQUEST

Instructions:

1. **A request that the New York State Insurance Department ("Department") exempt from public disclosure any information included in this submission, pursuant to New York Public Officers Law § 87(2)(d) (the "Trade Secret/Competitive Injury Exemption"), must be made by completing this exhibit.**
2. **A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department.**
3. **A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that:**
   - **(a) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied;**
   - **(b) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and**
   - **(c) where applicable, indicates where redactions would suffice to protect the exempt information.**
4. **In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to protect the exempt information. Therefore, the Company should submit to the Department both the original document and a redacted version of the original document, which omits or blocks the information it wishes to exempt from disclosure. (The Department will accept the redacted version of the original document within one week after original filing was submitted.)**

A. Insurer Information:

Company submitting the rate adjustment request	Company NAIC Code	SERFF tracking number
Health Insurance Plan of Greater New York	55247	HPHP-127306459

B. FOIL Contact Person:

Name, title	Phone number	Email address
[redacted]	[redacted]	[redacted]

Mailing address	Fax number
[redacted]	[redacted]

C. List all documents, exhibits, and attachments separately, including the file names of computer files that are included with the application. Please indicate with an asterisk (*) those documents that you believe contain information subject to the Trade Secret/Competitive Injury Exemption. Any document without an asterisk will be deemed to be a public document.

We request that the actuarial memorandum accompanying this application, signed by [redacted] to be exempt from disclosure pursuant to FOIL in its entirety.

We request that a portion of Exhibit 4, Exhibit 5, Exhibit 6 and Exhibit 7, and any computer files referenced therein, be deemed exempt from disclosure under FOIL as set forth in the redacted version of these exhibits submitted on July 22, 2011, after the initial application, as instructed above. A more detailed list of exhibits, computer files and attachments will be provided at that time with a revised version of this Exhibit 2.

D. Provide a separate list of all documents, exhibits, and attachments, of which a portion has been redacted, including the file names of computer files that are included with the application. The unredacted portion(s) of the redacted documents may be deemed to be public.

See response to item C above.

E. Statement of necessity as discussed in Instructions # 3, above.

All of the items listed in the items C and D above related to the HIP community rated product application contain trade secret information, which if disclosed would cause substantial injury to the competitive position of HIP. The exhibits to the rate application listed above contain the claims data, medical loss ratio information, along with the proposed rates. The supporting exhibits set forth the claims experience by product, forms and the trend over the past two years. Both the presentation and data provided are not available at this level of detail by product in any other disclosure or regulatory filing. Release of such information to competitors would permit them to price products and target markets in a way that causes clients of HIP's current book of business to shift to other plans.

The actuarial memos referenced above, summarize the overall rate impact across all products in the community rated category. As with the schedules discussed above, this information is not available through any other public or regulatory disclosure. Revealing this information will permit competition to access the overall financial performance of HIPIC's community rated products. This information may be used by competition to market to the disadvantage of HIP.

Information About 2012 Large Group Rates for Your HIP Prime® HMO, HIP Prime® POS, HIP*access*®I or HIP*access*®II Plan

Health Insurance Plan of Greater New York (HIP) is part of the EmblemHealth group of companies. It is a not-for-profit health service corporation organized under Article 43 of the New York Insurance Law and certified to operate a Health Maintenance Organization (HMO) under Article 44 of the New York Public Health Law. HIP provides benefit plans that enable its members to access covered health care services. Income generated is used to benefit members, either as claim payments or to provide administrative services for the necessary operations of the company. HIP covers over 800,000 members, of which approximately 333,000 are members of large groups, located mostly in the greater New York metropolitan area.

The Components of Your Premium Rate

Your premium rate consists of two components: the costs of providing medical care and administrative expenses. By far, the largest component is the cost of medical care. Medical costs are represented in the minimum loss ratio (MLR), which is the percentage of the premium used to pay for medical care. New York State law requires that the MLR must be at least 82 percent of the premium charged.

Administrative expenses include: costs for processing claims and appeals; maintenance and upgrading of systems needed to comply with HIPAA, federal health reform mandates and other legal requirements; costs for consumer education, wellness programs and programs for managing chronic and complex medical conditions; costs of maintaining our provider network; costs to operate Web-based information and services for members, brokers and providers; costs associated with conducting medical reviews; taxes and other fees.

Before we apply for a rate increase, we thoroughly review claims data and expenses to determine future costs and expenses.

The Components of Our 2012 Rate Increase

HIP is requesting premium rate increases for its large group business, effective for the first, second, third and fourth quarters of 2012. The reason for the requested rate increase is that health care costs have risen dramatically during the past year. The major factors driving rising health care costs are the increased use of health care services, the growing needs of an aging population that is to a larger extent living with chronic conditions, and the development of costly new medical technologies and prescription drugs.

If these premium rate increases are approved, they will be added to your final 2011 renewal premium rates. These increases will apply to all groups renewing in the first, second, third and fourth quarters of 2012.

The premium rate increases we are requesting are summarized below, by product.

Average Community-Rated Percent Increase from First Quarter 2011 to First Quarter 2012 for Plans Renewing January 1, 2012 through March 30, 2012, by rate tier:

Plan Individual	
HIP Prime® HMO	8.6%
HIP*access*® I	8.6%
HIP Prime® POS	8.6%
HIP*access*® II	8.6%

Average Community-Rated Percent Increase from Second Quarter 2011 to Second Quarter 2012 for Plans Renewing April 1, 2012 through June 30, 2012, by rate tier:

Plan Individual	
HIP Prime® HMO	8.5%
HIP*access*® I	8.5%
HIP Prime® POS	8.5%
HIP*access*® II	8.5%

Average Community-Rated Percent Increase from Third Quarter of 2011 to Third Quarter 2012 for Plans Renewing July 1, 2012 through September 30, 2012:

Plan %	Increase
HIP Prime® HMO	8.5%
HIP*access*® I	8.5%
HIP Prime® POS	8.5%
HIP*access*® II	8.5%

Average Community-Rated Percent Increase from Fourth Quarter 2011 to Fourth Quarter 2012 for Plans Renewing October 1, 2012 through December 31, 2012:

Plan %	Increase
HIP Prime® HMO	7.8%
HIP*access*® I	7.8%
HIP Prime® POS	7.8%
HIP*access*® II	7.8%

Final Rate Increase

Your group's final renewal rate may be different from the proposed increases shown above. NYSID may approve, modify or deny them. We will notify you of your final, approved rates approximately 60 days before your renewal date. This will give you an opportunity to discuss with your broker a variety of EmblemHealth plan options that might enable you to reduce your premiums.

At this time, we have not filed any benefit changes to these plans with the New York State Insurance Department (NYSID). In the event that we file benefit changes to these plans – for example due to new benefits mandated by New York State law – those benefit changes may also impact your final premium rates.

EXHIBIT 4: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

Health Insurance Plan of Greater New York
Company submitting the rate adjustment request

Company NAIC Code
55247

HPHP-127306459
SERFF tracking number

=> Use this Exhibit for the policy forms/products included in the rate adjustment submission.

=> Submit separate exhibits by market segment such as Large Group, Small Group, Sole Proprietor, Individual, etc. If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is to be reported.
Submit separate exhibits by rating region if the rate changes differ by rating region.
Submit separate exhibits for each rolling rate table of a rolling rate structure.

=> This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

=> The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.

=> The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).

=> If one policy form is used for more than one products, then a separate row should be entered for each policy form/product name/product street name combination.

=> The format of this exhibit is discussed below and should be tailored to the specific rate filing submission. Extend the worksheet to add more rows or tabs as needed.

A. BASE MEDICAL PLAN

Market Segment: Large Group

Rating Region: ALL

=> Provide a list of proposed rate changes for each base medical plan type, by product name/street name.

=> The "proposed rate change" is just for the base medical product, excluding the impact of any riders.
- Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
- Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
- The weighted average should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

Non Rolling Rate Product

Policy Form #	Product Name	Product Street Name	Effective Date of New Rate	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg

Rolling Rate Product

Policy Form #	Product Name	Product Street Name	Effective Period of New Rolling Rate *	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg
155-23-grphmo	HMO Prime	HMO Prime	Jan-Mar 2012	8.6%	8.6%	8.6%
155-23-grpoahmo	HMO Access 1	HMO Access 1	Jan-Mar 2012	8.6%	8.6%	8.6%
155-23-grphmo, 200-2	POS Prime	POS Prime	Jan-Mar 2012	8.6%	8.6%	8.6%
155-23-grpoahmo, 200	POS Access 2	POS Access 2	Jan-Mar 2012	8.6%	8.6%	8.6%
155-23-grphmo	HMO Prime	HMO Prime	Apr-Jun 2012	8.5%	8.5%	8.5%
155-23-grpoahmo	HMO Access 1	HMO Access 1	Apr-Jun 2012	8.5%	8.5%	8.5%
155-23-grphmo, 200-2	POS Prime	POS Prime	Apr-Jun 2012	8.5%	8.5%	8.5%
155-23-grpoahmo, 200	POS Access 2	POS Access 2	Apr-Jun 2012	8.5%	8.5%	8.5%
155-23-grphmo	HMO Prime	HMO Prime	Jul-Sept 2012	8.5%	8.5%	8.5%
155-23-grpoahmo	HMO Access 1	HMO Access 1	Jul-Sept 2012	8.5%	8.5%	8.5%
155-23-grphmo, 200-2	POS Prime	POS Prime	Jul-Sept 2012	8.5%	8.5%	8.5%
155-23-grpoahmo, 200	POS Access 2	POS Access 2	Jul-Sept 2012	8.5%	8.5%	8.5%
VHLI-LGRP-01	Vytra HMO	Vytra HMO	Jul-Sept 2012	6.4%	6.4%	6.4%
155-23-grphmo	HMO Prime	HMO Prime	Oct-Dec 2012	7.8%	7.8%	7.8%
155-23-grpoahmo	HMO Access 1	HMO Access 1	Oct-Dec 2012	7.8%	7.8%	7.8%
155-23-grphmo, 200-2	POS Prime	POS Prime	Oct-Dec 2012	7.8%	7.8%	7.8%
155-23-grpoahmo, 200	POS Access 2	POS Access 2	Oct-Dec 2012	7.8%	7.8%	7.8%

* The effective period of a new rolling rate may vary depending on the rolling structure (e.g., "January - March 2012" for a quarterly rolling rate structure.)

B. DRUG RIDERS

Market Segment: Large Group

Rating Region: ALL

=> Provide a list of proposed rate changes for drug riders available with base medical products.

=> The "proposed percentage rate change" is just for the drug riders available with the indicated base medical product and excludes the impact of the base medical plan rates and non-drug riders.
The lowest, highest, and weighted average are just among the drug riders available to the indicated base medical product.

=> This is for the traditional drug riders, but not for minor drug related riders such as, the inclusion of oral contraceptives.

Non Rolling Rate Product

Drug Rider	Base Medical Policy Form #	Base Medical Product Name	Effective Date of New Rate	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg

EXHIBIT 4: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

=> Use this Exhibit for the policy forms/products included in the rate adjustment submission.

=> Submit separate exhibits by market segment such as Large Group, Small Group, Sole Proprietor, Individual, etc. If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is to be reported.

Submit separate exhibits by rating region if the rate changes differ by rating region.

Submit separate exhibits for each rolling rate table of a rolling rate structure.

=> This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

=> The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.

=> The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).

Health Insurance Plan of Greater New York
Company submitting the rate adjustment request

Company NAIC Code
55247

HPHP-127306459
SERFF tracking number

Rolling Rate Product

Drug Rider	Base Medical Policy Form #	Base Medical Product Name	Effective Period of New Rolling Rate *	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg
155-23-RX (03/09)	155-23-grphmo	HMO Prime	Jan-Mar 2012	8.6%	8.6%	8.6%
155-OA-RX (03/09)	155-23-grpoahmo	HMO Access 1	Jan-Mar 2012	8.6%	8.6%	8.6%
200-23-RX (03/09)	155-23-grphmo, 200-23-grppol	POS Prime	Jan-Mar 2012	8.6%	8.6%	8.6%
200-OA-RX (03/09)	155-23-grpoahmo, 200-23-grppoloa	POS Access 2	Jan-Mar 2012	8.6%	8.6%	8.6%
155-23-RX (03/09)	155-23-grphmo	HMO Prime	Apr-Jun 2012	8.5%	8.5%	8.5%
155-OA-RX (03/09)	155-23-grpoahmo	HMO Access 1	Apr-Jun 2012	8.5%	8.5%	8.5%
200-23-RX (03/09)	155-23-grphmo, 200-23-grppol	POS Prime	Apr-Jun 2012	8.5%	8.5%	8.5%
200-OA-RX (03/09)	155-23-grpoahmo, 200-23-grppoloa	POS Access 2	Apr-Jun 2012	8.5%	8.5%	8.5%
155-23-RX (03/09)	155-23-grphmo	HMO Prime	Jul-Sept 2012	8.5%	8.5%	8.5%
155-OA-RX (03/09)	155-23-grpoahmo	HMO Access 1	Jul-Sept 2012	8.5%	8.5%	8.5%
200-23-RX (03/09)	155-23-grphmo, 200-23-grppol	POS Prime	Jul-Sept 2012	8.5%	8.5%	8.5%
200-OA-RX (03/09)	155-23-grpoahmo, 200-23-grppoloa	POS Access 2	Jul-Sept 2012	8.5%	8.5%	8.5%
155-23-RX (03/09)	155-23-grphmo	HMO Prime	Oct-Dec 2012	7.8%	7.8%	7.8%
155-OA-RX (03/09)	155-23-grpoahmo	HMO Access 1	Oct-Dec 2012	7.8%	7.8%	7.8%
200-23-RX (03/09)	155-23-grphmo, 200-23-grppol	POS Prime	Oct-Dec 2012	7.8%	7.8%	7.8%
200-OA-RX (03/09)	155-23-grpoahmo, 200-23-grppoloa	POS Access 2	Oct-Dec 2012	7.8%	7.8%	7.8%

EXHIBIT 5: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS

Company Name: Health Insurance Plan of Greater New York
NAIC Code: 55247
SERFF Tracking #: HPHP-127306459

Instructions:

1) The percentage rate change reported in Sections A and B reflect the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
2) The distribution is by number of contracts or number of members . The Company should indicate which basis, either number of contracts or number of members, is used in this Exhibit.
3) The Weighted Average Percentage should be developed based on the distribution of contracts or members for that market segment/product and for the market segment in total.
4) The distribution table should be grouped by market segment (e.g., Large Group, Small Group, Individual, Sole Proprietor, Healthy NY). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is to be reported. Use the drop down list for entries of Market Segment or make your own entry.
5) Under each market segment, the table should provide the distribution by broad product type (e.g., HMO, POS, EPO, PPO, Indemnity, High Deductible/Consumer Driven, Medicare Supplement, etc.).
6) In Section A, provide the distribution of contracts or members affected by proposed rate change for all non-rolling rate contracts by market segment/product.
7) In Section B, provide distribution information for each rolling rate cohort of a rolling rate structure contract affected by this rate submission (e.g., by quarter of renewal for a quarterly rolling rate structure).
8) Edit the worksheet to add more rows as needed.
9) This exhibit must be submitted as an Excel file, even if a version is submitted as a PDF file.

A. FOR A NON-ROLLING RATE STRUCTURE -- Distribution of Non Rolling Rate Contracts by Proposed Rate Adjustment

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of (*) as of mm/dd/yyyy	Number of (*) with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Market Segment Total:															

B. FOR A ROLLING RATE STRUCTURE - Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort

Effective Period of New Rolling Rate*: 1/1/2012-3/31/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of 05/31/2011	Number of Members with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Large Group	All	**HMO Prime**	**8.6%**	**81,241**				**81241**							
	Large Group	All	**HMO Access 1**	**8.6%**	**3,032**				**3032**							
	Large Group	All	**POS Prime**	**8.6%**	**353**				**353**							
	Large Group	All	**POS Access 2**	**8.6%**	**101**				**101**							
	Market Segment Total:			0.0856064	84,727	0	0	0	84727	0	0	0	0	0	0	0

Effective Period of New Rolling Rate*: 4/1/2012-6/30/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of 05/31/2011	Number of Members with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Large Group	All	**HMO Prime**	**8.5%**	**7,772**				**7772**							
	Large Group	All	**HMO Access 1**	**8.5%**	**761**				**761**							
	Large Group	All	**POS Prime**	**8.5%**	**116**				**116**							
	Large Group	All	**POS Access 2**	**8.5%**	**47**				**47**							
	Market Segment Total:			0.0845421	8,696	0	0	0	8696	0	0	0	0	0	0	0

Effective Period of New Rolling Rate*: 7/1/2012-9/30/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of 05/31/2011	Number of Members with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Large Group	All	**HMO Prime**	**8.5%**	**226,453**				**226453**							
	Large Group	All	**HMO Access 1**	**8.5%**	**2,327**				**2327**							
	Large Group	All	**POS Prime**	**8.5%**	**154**				**154**							
	Large Group	All	**POS Access 2**	**8.5%**	**59**				**59**							
	Large Group	All	**Vytra HMO**	**6.4%**	**2,864**				**2864**							
	Market Segment Total:			0.0842923	231,857	0	0	0	231857	0	0	0	0	0	0	0

Effective Period of New Rolling Rate*: 10/1/2012-12/31/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of 05/31/2011	Number of Members with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Large Group	All	**HMO Prime**	**7.8%**	**7,152**				**7152**							
	Large Group	All	**HMO Access 1**	**7.8%**	**548**				**548**							
	Large Group	All	**POS Prime**	**7.8%**	**45**				**45**							
	Large Group	All	**POS Access 2**	**7.8%**	**50**				**50**							
	Market Segment Total:			0.0781936	7,795	0	0	0	7795	0	0	0	0	0	0	0

*** The effective period of a new rolling rate may vary depending on the rolling structure (e.g., "01/01/2012 - 03/31/2012" for a quarterly rolling rate structure.)**
Use the same format to provide the same information for each rolling rate cohort under each market segment.

(*) Indicate weighted average base used: Contracts or Members

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: Health Insurance Plan of Greater New York

NAIC Code: 55247

SERFF Number: HPHP-127306459

Instructions:

- This Exhibit summarizes all benefit/rate changes filed with the Health Bureau's Albany office that impact the rate tables in this filing.
- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Extend the worksheet to add more rows as needed.

A. List of rate filings that have been approved since the prior §3231(e)(1) or §4308(c) rate filing, which impact the rate tables in this filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
HPHP-126946612	2010120109	12/14/2010	155-23-NAL(12/10)	Nurse Advise Line Rider	24/7 Nurse hotline	01/19/2011
HPHP-126946612	2010120109	12/14/2010	155-OA-NAL(12/10)	Nurse Advise Line Rider	24/7 Nurse hotline	01/19/2011
HPHP-126949718	2010120114	12/15/2010	200-23-NAL(12/10)	Nurse Advise Line Rider	24/7 Nurse hotline	02/07/2011
HPHP-126949718	2010120114	12/15/2010	200-OA-NAL(12/10)	Nurse Advise Line Rider	24/7 Nurse hotline	02/07/2011

B. List of the rate filings that are currently pending with the Department, which impact the rate tables in this filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change

C. List of remnants of the "file and use" submissions, which impact the rate tables in this filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Benefit/Rate Change Effective Date

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Health Insurance Plan of Greater New York
NAIC Code: 55247
SERFF Number: HPHP-127306459

A. Complete a separate response for each base medical policy form included in the rate adjustment filing.
- Information requested applies to New York State business only.
- Include riders that may be available with that policy form in each policy form response.
- Submit a separate exhibit for each rating pool. Create additional tabs for each rating pool as needed.
- Append additional columns to right of the existing columns (as needed) to include all base medical policy forms included in that rating pool. Add a rightmost column with the aggregate values for that entire rating pool.

B. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Driven Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.

C. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).

D. Note that many cells include a drop down list. Use the drop down list or enter applicable items.

E. If members, covered lives or member months are not known, use reasonable estimates (note methodology used).

F. This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

Data Item for Specified Base Medical Policy Form	Response	Response	Response	Response	Response	Response
1a. Base medical policy form number	155-23-grphmo	155-23-grpoahmo	(155-23-grphmo, 200-23-grppol)	(155-23-grpoahmo, 200-23-grppoloa)	VHLI-LGRP-01	
1b. Product Name as in Rate Manual	HMO Prime	Access 1	POS Prime	Access 2	Vytra HMO	HMO
1c. Product Street Name as indicated to consumers	HMO Prime	Access 1	POS Prime	Access 2	Vytra HMO	
2. Aggregated for rate development with these base medical policy form numbers	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01	155-23-grphmo,155-23-grpoahmo, 200-23-grppol, 200-23-grppoloa,VHLI-LGRP-01
3. Effective date of rate change (MM/DD/YYYY)	1/1/2012	1/1/2012	1/1/2012	1/1/2012	1/1/2012	1/1/2012
4. Market Segment (large group, small group, individual, or sole proprietor) [drop down menu]	Large Group	Large Group	Large Group	Large Group	Large Group	Large Group
5. Product type (see above for examples) [drop down menu]	HMO	HMO	HMO based POS	HMO based POS	HMO	
6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	Yes	Yes	Yes	Yes	Yes	Yes
7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	No	No	No	No	No	No
8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	Open	Open	Open	Open	Closed	
9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.)	12	12	12	12	12	12
10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	8.23%	8.41%	8.47%	8.44%	3.22%	8.19%
11. Number of policyholders affected by rate change. For group business this is number of groups.	802	88	51	26	1	968
12. Number of covered lives affected by rate change	322,618	6,668	668	257	2,864	333,075
13. Expected NY statewide loss ratio for base medical policy form including associated riders	88.6%	88.8%	114.5%	123.8%	140.1%	89.19%
Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)						
14.1 Beginning Date of the experience period (MM/DD/YYYY)	1/1/2010	1/1/2010	1/1/2010	1/1/2010	1/1/2010	1/1/2010
14.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2010	12/31/2010	12/31/2010	12/31/2010	12/31/2010	12/31/2010
14.3 Member months for experience period	4,414,522	78,745	10,054	3,534	41,304	4,548,159
14.4 Earned premiums for experience period ($)	1,787,046,693	33,712,514	4,419,695	1,547,290	16,629,981	1,843,356,172
14.5 Standardized earned premiums for experience period ($)	2,053,446,593	38,634,057	5,198,396	1,789,185	17,700,961	2,116,769,192
14.6 Paid claims for experience period ($)	1,489,376,162	28,019,250	4,553,060	1,744,178	20,096,289	1,543,788,940
14.7 Incurred claims for experience period ($)	1,515,921,843	28,783,020	4,613,039	1,757,219	20,241,606	1,571,316,727
14.8 Administrative expenses for experience period ($) (including commissions and premium taxes, but excluding federal and state income taxes)	156,254,453	3,658,591	593,516	213,466	1,688,094	162,408,120
14.9 Earned premiums for experience period ($pmpm)	404.81	428.12	439.60	437.83	402.62	405.30
14.10 Standardized premiums for experience period ($pmpm)	465.16	490.62	517.05	506.28	428.55	465.41
14.11 Paid claims for experience period ($pmpm)	337.38	355.82	452.86	493.54	486.55	339.43
14.12 Incurred claims for experience period ($pmpm)	343.39	365.52	458.83	497.23	490.06	345.48
14.13 Administrative expenses for experience period ($pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	35.40	46.46	59.03	60.40	40.87	35.71
14.14 Ratio: Incurred Claims / Earned Premiums	0.848	0.854	1.044	1.136	1.217	0.852
14.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.738	0.745	0.887	0.982	1.144	0.742
14.16 Ratio: Administration Expenses / Earned Premiums	0.087	0.109	0.134	0.138	0.102	0.088
14.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.936	0.962	1.178	1.274	1.319	0.941
Prior Experience Period (NY statewide experience, base medical policy form + associated riders)						
15.1 Beginning date of the experience period (MM/DD/YYYY)	1/1/2009	1/1/2009	1/1/2009	1/1/2009	1/1/2009	1/1/2009
15.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2009	12/31/2009	12/31/2009	12/31/2009	12/31/2009	12/31/2009
15.3 Member months for experience period	4,683,720	86,946	11,649	3,972	47,010	4,833,297
15.4 Earned premiums for experience period ($)	1,702,245,230	33,400,720	4,516,924	1,533,773	16,717,690	1,758,414,336
15.5 Standardized earned premiums for experience period ($)	2,171,013,523	43,047,430	6,764,898	2,255,809	20,191,558	2,243,273,218
15.6 Paid claims for experience period ($)	1,471,848,634	29,285,140	5,096,016	2,249,484	12,559,671	1,521,038,944
15.7 Incurred claims for experience period ($)	1,503,338,489	30,051,981	5,460,071	2,331,324	13,053,987	1,554,235,851
15.8 Administrative expenses for experience period ($) (including commissions and premium taxes, but excluding federal and state income taxes)	159,728,200	4,649,731	615,120	210,367	1,745,652	166,949,069
15.9 Earned premiums for experience period ($pmpm)	363.44	384.15	387.75	386.15	355.62	363.81
15.10 Standardized premiums for experience period ($pmpm)	463.52	495.11	580.73	567.93	429.52	464.13
15.11 Paid claims for experience period ($pmpm)	314.25	336.82	437.46	566.34	267.17	314.70
15.12 Incurred claims for experience period ($pmpm)	320.97	345.64	468.72	586.94	277.69	321.57
15.13 Administrative expenses for experience period ($pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	34.10	53.48	52.80	52.96	37.13	34.54
15.14 Ratio: Incurred Claims / Earned Premiums	0.883	0.900	1.209	1.520	0.781	0.884
15.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.692	0.698	0.807	1.033	0.647	0.693
15.16 Ratio: Administrative Expenses / Earned Premiums	0.094	0.139	0.136	0.137	0.104	0.095
15.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.977	1.039	1.345	1.657	0.885	0.979
Annualized Medical Trend Factors (%)						
16.1 All benefits combined, composite	10.01%	10.01%	14.44%	13.28%	9.73%	10.02%
16.2 Due to utilization	3.12%	3.12%	3.12%	9.78%	9.78%	3.19%
16.3 Due to unit cost	6.68%	6.68%	10.98%	3.19%	-0.05%	6.62%
Ratios: Most Recent Experience Period to Prior Period						
17.1 Member months	0.943	0.906	0.863	0.890	0.879	0.941
17.2 Earned premiums ($pmpm)	1.114	1.114	1.134	1.134	1.132	1.114
17.3 Standardized premiums ($pmpm)	1.004	0.991	0.890	0.891	0.998	1.003
17.4 Paid claims ($pmpm)	1.074	1.056	1.035	0.871	1.821	1.079
17.5 Incurred claims ($pmpm)	1.070	1.058	0.979	0.847	1.765	1.074
17.6 Administrative expenses ($pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	1.038	0.869	1.118	1.140	1.101	1.034
Ratio: Standard Premium to Earned Premium						
18.1 Most Recent Experience Period	1.149	1.146	1.176	1.156	1.064	1.148
18.2 Prior Experience Period	1.275	1.289	1.498	1.471	1.208	1.276

EmblemHealth
GHI and HIP are EmblemHealth companies

55 Water Street, New York, New York 10041-8190

Advance Notice About Changes to Your
HIP Health Plan of New York Premium Rates

«Date»

«Group Name1» «Group Name2»
«Group No»
«Contact First Name» «Contact Last Name»
«Street Add1» «Street Add2»
«City1», «State» «Zip Code»

Dear «Contact First Name» «Contact Last Name»:

State law requires us to notify you when we apply for a rate increase with the New York State Insurance Department (NYSID). Listed below are the increases for 2012 we are requesting for your **«Plan Name»** plan, by quarter. The increase for the quarter in which your plan renews applies to your group. Your plan's renewal date is shown in the paragraph below.

Renewal Date	Requested Increase
Janu ary – March 2012 8	.6%
A pril – June 2012 8	.5%
Jul y – September 2012 8.	5%
O ctober – December 2012 7	.8%

If approved by NYSID, the increase will be added to your group's NYSID-approved 2011 premium rate. Your group's final renewal rate may be different from the proposed increases shown above; NYSID may approve, modify or deny them. We will notify you of your final, approved rates about 60 days before your **«Rate Eff Date»** renewal date. You will have an opportunity to discuss with your broker a variety of EmblemHealth plan options that might enable you to reduce your premiums.

Please note that you must notify your covered employees of the proposed changes, and of any potential changes to their premium contribution, as soon after receiving this letter as possible.

To find information about the reasons for the proposed rate change, please log on to **www.emblemhealth.com/2012rates**. You can also submit written comments to us or NYSID within 30 days of the date of this letter:

EmblemHealth
EmblemHealth
Attn: Premium Rate Filings
PO Box 2890 2
New York, NY 10117-2087

New York State Insurance Department
Health Bureau-Premium Rate Adjustments
New York State Insurance Dept.
5 Beaver Street
New York, NY 10004

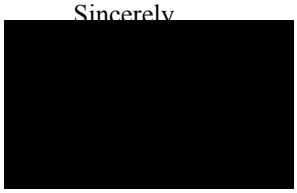
If you prefer, you may send an e-mail to:

PremiumRateFilings@emblemhealth.com

PremiumRateIncreases@.ins.state.ny.us

We greatly value our relationship with you and look forward to continuing to meet your health coverage needs.

Sincerely,



Vice President, Commercial Account Management

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Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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GHI and HIP are EmblemHealth companies

55 Water Street, New York, New York 10041-8190

Important Information About Your HIP
Health Plan Of New York Premium Rates

«Date»

«GROUPNUM»
«GROUPNAME» «GROUPNAMEEXT»
«CONTACTNAME»
«SERVSTREET»
«SERVCITY», «SERVESTATE» «SERVZIP5»

Dear «CONTACTNAME»:

A new law in New York State requires us to notify you approximately 60 days in advance of certain health plan premium rate changes. Therefore, we are writing to inform you of your premium rates for your **«PLAN»** plan under group number **«GROUP_NO»** effective **«Rate_Eff_Date»**:

Tier Type: «ratetiercd»	**Monthly Renewal Rate**
Single «	**INDIVIDUAL»**
Employee + Child(ren)	**«EMPLOYEE_AND_CHILDREN»**
Employee + Spouse	**«EMPLOYEE_AND_SPOUSE»**
Family «	**FAMILY»**

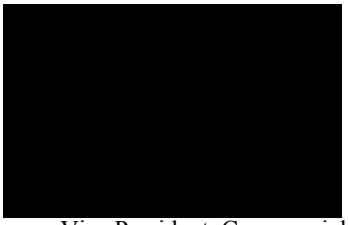
Please note that these rates reflect a XX percent increase approved by the New York State Insurance Department (NYSID).

EmblemHealth offers plan options that enable you to reduce your premiums. Cost-reduction options that are available to you, as well as information about additional riders you may wish to purchase, appear on the reverse side of this letter.

As a reminder, you are required to notify your covered employees about this rate increase and any additional premium contribution as soon after receiving this letter as possible. If your benefit plan requires your employees to make a premium contribution, the notice should include the amount your employees will be expected to contribute based on the new rates.

If you have any questions, please contact your HIP Account Manager at **«REPPHONE»**. For additional information about your premium rates, please visit us at **www.emblemhealth.com**.

We value our relationship with you and are committed to providing your group with quality health care coverage. We look forward to continuing to meet your health coverage needs.



Vice President, Commercial Account Management

Please see reverse side

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

A RANGE OF COVERAGE OPTIONS

Changes in benefits have an impact on your premium. If you are interested in making changes to your plan, EmblemHealth offers a range of coverage choices for your group, including flexible pharmacy and benefits designs and cost-sharing options designed to meet all budget levels. You have the option to offer your employees more than one EmblemHealth plan and can choose from among the EmblemHealth PPO, EPO, ConsumerDirect High-Deductible Health Plan and InBalance alternatives. Available statewide, these plans are served by the EmblemHealth national network and underwritten by GHI, an EmblemHealth company.

Please remember that if you wish to request benefit changes, they should be submitted to EmblemHealth no later than 30 days before your contract renewal date. This will ensure that your group members receive a correct ID card with the updated benefit set.

For more information about EmblemHealth products, benefits and rates, please visit **www.emblemhealth.com**. If you need guidance in choosing the combination of products that works best for your group, contact your broker or speak to your HIP Account Management representative at **«REPPHONE»**.

ADDITIONAL RIDERS YOU CAN PURCHASE AT RENEWAL

Extended Dependent Coverage extends to age 29 the coverage age limit for all eligible dependents of your group members.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

BROKER COMPENSATION
APPLICABLE TO HMO and POS PRODUCTS
EFFECTIVE JULY 1, 2010

I. Standard Broker Commission Schedule

New Business and Renewals

HMO

Small (1-50 eligible employees) and Large (51+ eligible employees) Groups

Annual Premium	Commission
First $0 - $10 million	4% of premium
Amount over $10 million	none

POS[1]

Small (1-50 eligible employees) and Large (51+ eligible employees) Groups

Annual Premium	Commission
First $0 - $10 million	4% of premium
Amount over $10 million	none

[1] Applies to the in-network portion of POS cases insured under dual HIP/HIPIC contracts

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE DUE TO REGULATORY OR PLAN INSTRUCTION

II. Standard Broker Commission Policies

A. Direct Pay

- No commissions or service fees will be paid on any direct pay product

B. Broker of Record Letter on Business Previously Written Directly by HIP

- Commissions will be p aid on any Broker of Record Letter business previously written dir ectly with H IP only when the Bro ker substantially inc reases HIP's membership to the levels stated below:

  Small Groups

  - HIP will pay Broker if option/slice is converted into total replacement

  Large Groups

  - HIP will pay commissions when account penetration is increased by the higher of the following: 25 subscribers or 50%

- Commissions will be paid using the Standard Broker Commission Schedule I

C. Broker of Record Letter on Business Currently Subject to Broker Commissions

Small and Large Groups

Annual Premium	Commission
First $0 - $5 million	4% of premium
Amount over $5 million	none

- Commissions will be paid using th e above schedule starting the first month following the date of the Broker of Record Letter

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE
DUE TO REGULATORY OR PLAN INSTRUCTION

III. Administrative Fees.

This section describes alternative compensation available to Agents who perform administrative services normally performed by HIP employees ("Administrative Services"). Such Administrative Services are compensated based upon a per contract per month methodology ("PCPM") or a per member per month ("PMPM"), as appropriate. The PCPM or PMPM amount will be between $0 and $10, depending upon the scope and extent of the services provided, the experience and reputation of the Agent and negotiated market forces. Some of the more common Administrative Services are set forth below:

i. Process insurance applications;
ii. Bill, collect and receive premium due;
iii. Generate and issue the appropriate termination documentation;
iv. Generate and issue change in enrollment/eligibility forms;
v. Perform routine services for Groups;
vi. Recruit Selling Agents;
vii. Provide other administrative functions, at HIP's discretion, consistent with HIP policies and procedures; and
viii. Provide appropriate reporting services.

ALL COMMISSIONS AND FEES ARE SUBJECT TO CHANGE
DUE TO REGULATORY OR PLAN INSTRUCTION

Large Group Community Rated Underwriting Guidelines[1]

HIP/HIPIC of New York

HIP®
an EmblemHealth company

Large Group Underwriting Guidelines

The community-rated plans of HIP Health Plan of New York and HIP Insurance Company of New York (collectively hereinafter "HIP") are available for purchase by qualified large groups that employ fifty-one or more eligible employees.

Application	▪ The initial payment equivalent to one month's premium must be made payable to HIP and submitted with the new group application form. Only business checks are acceptable forms of payment. ▪ Contract periods will begin on the 1st or 15th of a month. ▪ Documentation requested by HIP to determine group or employee eligibility must be supplied within five business days from the date of HIP's request in order to secure the requested effective date of coverage. If documentation is not supplied within five business days, HIP will establish an effective date of coverage pending receipt and verification of the data. Family verification ▪ HIP will request a Federal 1040 form and/or a marriage certificate to verify the marriage of two individuals with different last names. In addition, HIP will require a birth certificate and/or Federal 1040 Form as proof that a dependent is eligible for coverage if the dependent has a last name different from the subscriber.
Benefit Changes	Benefit downgrades A plan change is a downgrade when the premium rates for the new product are lower than the premium rates for the old product as of the requested plan change date. ▪ A group can downgrade its coverage at any time during the year. **All plan change requests must be received by HIP five business days prior to the desired effective date. Underwriting will not approve any retroactive plan changes or terminations.**
Tier Changes	▪ Rating tiers can only be changed at the group's contract anniversary date.
Domestic Partners	Domestic partner coverage is available with HIP large group community rated products. *Requirements* ▪ A domestic partner will be treated as a dependent. ▪ Eligible dependents of the domestic partner may be added. ▪ Domestic partners are not recognized by the IRS and may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts). In order to be eligible for domestic partner coverage, HIP requires: (i) Submission of a duly sworn Affidavit of Domestic Partnership; and (ii) Proof of Cohabitation; and (iii) Proof of joint responsibility for common welfare and financial obligations as demonstrated by at least two of the following:

	▪ A joint mortgage or lease. ▪ Evidence of shared rental payments of joint residence. ▪ Evidence of a common household and shared household expenses. ▪ Evidence of status of domestic partner as representative payee for the subscriber's government benefits. ▪ Evidence of joint responsibility for child care. ▪ Evidence of a shared household budget for the purpose of receiving government benefits. ▪ Designation of Domestic Partner as beneficiary for life insurance or retirement benefits; ▪ Joint wills, or will designating Domestic Partner as executor and/or primary beneficiary. ▪ Designation of Domestic Partner as the Subscriber's representative in a durable power of attorney or health care proxy. ▪ Ownership of joint bank account, joint credit card or joint ownership of a motor vehicle (or other major item of personal property) or other evidence of joint financial responsibility. ▪ Affidavit by shared creditor swearing to financial interdependence of Subscriber and Domestic Partner. ▪ Other items of proof sufficient to establish economic interdependency. A domestic partner cannot be added if either the Subscriber or the domestic partner has been a member of another domestic partnership within the last six months.
HIP Plans	▪ Ten Plan Types are available through HIP: HIP Prime® HMO, HIP Access® I, HIP Prime® EPO, HIP Select™ EPO, HIP Prime® POS, HIP Access® II, HIP Prime™ PPO, HIP Select™ PPO, HIP Classic™ , HIP SmartStart. ▪ Multiple option plans (employee choice at point of enrollment) are allowed, choosing from among any of the products available through HIP. ▪ Each group may choose up to four HIP options to be available to its employees. ▪ All HIP plans must have the same rating tier structure. If HIP does not offer the desired products on a same tier basis, then they cannot be offered as a multiple option. ▪ Employers offering multiple plans that elect to include the age 29 make available rider will have the rider applied to all HIP plans offered. ▪ A group may change the plan types offered only on the group's contract anniversary. ▪ An employee may only change the plan option elected on the group's contract anniversary.
Rating Methologies	Below are the current requirements for HIP large group products to qualify for Community Rating ▪ All large group HMO products (HIP Prime® HMO and HIP Access® I) are community rated only. ▪ For renewal business, large group POS (HIP Prime® POS, HIP Access® II), PPO (HIP Select™ PPO, HIP Prime™ PPO), and EPO (HIP Select™ EPO, HIP Prime® EPO) products will be rated based on the following: ○ From 1 – 19 enrolled employees a Community Rating methodology is used. ○ From 20 – 99 enrolled employees a Community Rating by Class (CRC) methodology will be used. ○ From 100 – 250 enrolled employees an Adjusted Community Rating (ACR) methodology will be used. ○ From 251 and greater enrolled employees an Experience Rating (ER) methodology will be used.
Rating Tiers	▪ HIP large group business (51 or more eligible employees) will be offered on either a 2-tier, 3-tier, or a 4-tier rating basis, with the exception of HIP SmartStart which is only offered on a 3-tier or 4-tier basis. This change is effective for renewals and new business effective on or after July 1, 2010.

	▪ 2-tier rates consist of Individual and Family coverage. ▪ 3-tier rates consist of Individual, Individual + 1, and Family coverage. ▪ 4-tier rates consist of individual, individual & child(ren), individual and spouse, and individual and family.

Employee Eligibility	Groups must demonstrate an employer/employee relationship for all eligible employees.
	
	HIP evaluates eligibility based on the United States Internal Revenue Service's definition of an employee of an employer group.
	
	▪ HIP only covers full-time employees. HIP defines full-time eligible employees as employees who work 20 or more hours per week, each week. If an employer requires a longer number of hours worked in order to meet eligibility, then HIP will use the employer's criteria to define full-time eligible employees.
	▪ The following categories of employees are not eligible for coverage:
	  ▪ Individuals who receive 1099 Forms and their dependents. (See section on sole proprietors).
	  ▪ Seasonal employees and their dependents.
	  ▪ Leased employees
	
	A group may need to provide proof of employment for each employee at the time of application or at the time of a periodic survey. Each employee to be enrolled must appear on a NYS-45 or NYS-45-ATT.
	
	▪ The NYS-45 or NYS-45-ATT must be the filed copy for the quarter preceding the desired effective date of coverage. The status of each employee must be indicated on the form as applicable: full-time, part-time (less than 20 hours worked per week), permanent, temporary, waiving, eligible, not-eligible, enrolling, class distinction if applicable.
	▪ In the absence of providing a NYS-45 or a NYS-45-ATT, the group must provide a signed copy of its full tax return, such as an 1120, 1065, 1120S, LLC or LLP with Schedule K-1, Schedule C or Schedule E.
	▪ If the employer has a benefit waiting period, the employer must provide documentation verifying the terms of the waiting period.

Employee Eligibility cont.	In the event that a newly hired employee is not yet listed on filed tax documentation, then a copy of the employee's W-4 or recent payroll check stub must be supplied. If a payroll check stub is supplied, it must include the company name, employee name, number of hours worked and payroll dates. The payroll dates cannot be more than 30 days prior to the date of application. ▪ The group must produce tax documents within 90 days after the effective date of coverage to substantiate a recent hire's eligibility. If acceptable documentation is not provided to HIP, then coverage will be terminated. COBRA Members ▪ COBRA enrollees must supply a letter of election and a copy of their last payroll report. ▪ Coverage for the COBRA qualifying employees ONLY will not be offered to any group. ▪ When a group terminates, COBRA must be terminated as well.

Employer Eligibility	A group must be actively operating its business at all times that HIP coverage will be in effect. A group applying for a large group community-rated plan must provide HIP with all of the following documentation: ▪ A Federal Employer Identification Number (EIN) and evidence of authority to conduct business in New York State ▪ Confirmation that the group's worksite(s) is in New York State. Street addresses must be provided even for worksite(s) with post office box listings. If a new business is not able to supply the data above, then a letter from the group's attorney or certified public accountant explaining the specific situation will temporarily suffice. Neither the attorney nor the CPA can be an employee or the relative of an employee of the group. In addition, the Letter must be accompanied by: ▪ Articles of Incorporation issued by the State of New York, or ▪ A certificate to do business issued by the State of New York and ▪ A payroll record acceptable to HIP. The group must produce tax documents within 90 days after the effective date of coverage to substantiate its business operation. Coverage will be terminated if acceptable documentation is not provided within 90 days. ▪ If a group has been terminated within the prior 12 months due to non-payment of premium, HIP will not issue the group a contract.

Enrollment Policy	▪ New enrollees must enroll as of their date of hire.
	▪ If the employer has a benefit waiting period, the employee must enroll on the first day of benefit eligibility.
	▪ New groups enrolling with HIP may waive the waiting period for all employees at the time of initial enrollment.
	
	Eligible employees and/or dependents who do not enroll on the first day of benefit eligibility will not be eligible to enroll until the employer's next annual enrollment period, except in the circumstances below. The enrollment period commences on the anniversary date of coverage and ends after 30 days.
	
	▪ The individual was covered under another plan or policy at the time the individual was initially eligible to enroll and has lost coverage under the other plan or policy as a result of exhaustion of the period of continuation under State of Federal law or
	▪ The loss of eligibility was related to one or more of the following reasons:
	  ▪ Termination of employment.
	  ▪ Termination of the other plan or contract.
	  ▪ Death of the spouse.
	  ▪ Legal separation, divorce or annulment.
	  ▪ Reduction in the number of hours of employment.
	  ▪ Contract holder contributions toward the payment of premium for the other plan or contract were terminated.
	  ▪ A court has ordered coverage be provided for a spouse or minor children under a covered employee or member's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order.

Headquarters in New York	If a group ▪ Has its principal location within New York State and ▪ Employs a minimum of fifty-one eligible employees at a worksite(s) in New York State then the group can purchase large group community-rated coverage for its eligible employees, subject to any applicable service area restrictions.

Headquarters outside New York	If a group ▪ Has its principal location outside New York State and it employs a minimum of fifty-one eligible employees at a worksite(s) in New York State, Then, ▪ The group can purchase large group community-rated coverage for its New York employees. The contract for coverage must be delivered to a New York worksite and the contract will only cover employees working at the New York worksite(s).
Ongoing Qualification	Periodic surveys of enrolled large groups may be taken by HIP and/or HIP's designated administrators to ensure that the group is actively operating its business and remains qualified to be enrolled in a large group community-rated product. The survey can include, but not be limited to, any or all of the following to verify continued eligibility: ▪ The group's most recently-filed NYS-45 or NYS-45-ATT ▪ Tax documentation as requested by HIP and/or HIP's designated administrators. ▪ Payroll information as requested by HIP and/or HIP's designated administrators.
Participation	▪ HIP Select™ PPO and HIP Select™ EPO and HIP SmartStart: if a group elects to include at least one HIP Select™ or HIP SmartStart product as one of their HIP product choices a minimum of 50% of the eligible employees in the group must enroll in a health plan offered by HIP in order for the group to be underwritten. Individuals that are otherwise eligible for coverage that waive such coverage will not be counted in determining the percentage of eligible employees required to enroll. ▪ HIP Prime® HMO, HIP Access® I, HIP Classic ™, HIP Prime® POS, and HIP Access® II and HIP SmartStart: if there is no enrollment in a PPO or EPO product, there is no minimum participation requirement. ▪ For groups with an odd number of employees, the 50% threshold will be determined by rounding up the total number of employees to the next even number and dividing by two. ▪ For groups offering multiple HIP products, the total number of individuals enrolled in all HIP products will count toward the above minimums For example, a group with nine eligible employees has three employees waiving coverage, leaving six eligible for the purposes of determining participation. Of those 6, 50%, or three employees, must enroll in a HIP product in order for the group to qualify for coverage. ▪ Valid waivers for the purposes of determining participation requirements are: o Covered under spousal coverage. o Covered by Medicare. o Covered by COBRA. o Covered through the VA.
Premium Rates	▪ Premium rates are based on HIP's filed Community Rates. ▪ Groups with a minimum of 51 eligible employees (even if only one employee actually enrolls) will receive large group premium rates.

[1] These guidelines do not encompass Government Sponsored programs that HIP may offer for sale (e.g., Medicare, Healthy New York, etc.) The product sponsor should be consulted for policies and procedures that are applicable to their products.

"EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York, GHI HMO Select Inc., The PerfectHealth Insurance Company, Connecticare of New York Inc. and EmblemHealth Services Company, L.L.C."