State: *New York* **Filing Company:** *Health Insurance Plan of Greater New York*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2013 HIP SG Prior Approval Rate Filing*
Project Name/Number: */*

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	2013 Q1 Rate Manuals with Approved Rates		
Comments:			
Attachment(s):			
2013 HIP SG 1Q Rate Manual work copy final.pdf 2013 HIP SG 1Q Rate Manual Rate Change final.pdf			

		Item Status:	Status Date:
Satisfied - Item:	2013 Q2 - Q4 Rate Manuals with Approved Rates		
Comments:			
Attachment(s):			
2013 HIP SG 2Q Rate Manual work copy final.pdf 2013 HIP SG 2Q Rate Manual Rate Change final.pdf 2013 HIP SG 3Q Rate Manual work copy final.pdf 2013 HIP SG 3Q Rate Manual Rate Change final.pdf 2013 HIP SG 4Q Rate Manual work copy final.pdf 2013 HIP SG 4Q Rate Manual Rate Change final.pdf			

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small 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

Small Groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Inpatient Mental Health Subsidy
+	Outpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Outpatient Mental Health Subsidy
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor
x	Sole Proprientor Factor

Example: Small Group HMO Individual Employee Rate Example

=	668.87	1st Quarter	(Base Rate
+	(5.49)	$10 Specialist visit copay	Optional Base Benefit Variables (excluding Mental Health)
+	6.96	30 Days	Inpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	30 Days	Small Group Inpatient Mental Health Subsidy
+	6.03	$10 copay, 20 visits	Outpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	$10 copay, 20 visits	Small Group Outpatient Mental Health Subsidy
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.00	Standard Coverage	Optional Dependent Care Coverage
x	1.00	Standard Coverage	Network Area Factor
x	1.00	> 1 Employee Group	Sole Proprientor Factor
	676.37		Individual Employee Rate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL

HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS

January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 01/01/2013 - 03/31/2013 (With WH & Autism)							
Small Group*	668.87	1,805.95	na	na	1,237.41	1,571.84	2,006.61
Classic*	477.39	1,288.95	na	na	883.17	1,121.87	1,432.17
Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)							
Small Group*	662.25	1,788.08	na	na	1,225.16	1,556.29	1,986.75
Classic*	472.66	1,276.18	na	na	874.42	1,110.75	1,417.98

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

**** Downstate region includes Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester counties**

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	na	na	0.00	0.00	0.00
$5	(3.76)	(10.15)	na	na	(6.96)	(8.84)	(11.28)
$10	(7.89)	(21.30)	na	na	(14.60)	(18.54)	(23.67)
$15	(13.11)	(35.40)	na	na	(24.25)	(30.81)	(39.33)
$20	(20.23)	(54.62)	na	na	(37.43)	(47.54)	(60.69)
$25	(26.67)	(72.01)	na	na	(49.34)	(62.67)	(80.01)
$30	(33.71)	(91.02)	na	na	(62.36)	(79.22)	(101.13)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.15)	(5.81)	na	na	(3.98)	(5.05)	(6.45)
$10	(4.51)	(12.18)	na	na	(8.34)	(10.60)	(13.53)
$15	(7.51)	(20.28)	na	na	(13.89)	(17.65)	(22.53)
$20	(11.59)	(31.29)	na	na	(21.44)	(27.24)	(34.77)
$25	(15.27)	(41.23)	na	na	(28.25)	(35.88)	(45.81)
$30	(19.32)	(52.16)	na	na	(35.74)	(45.40)	(57.96)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.65)	(7.16)	na	na	(4.90)	(6.23)	(7.95)
$10	(5.49)	(14.82)	na	na	(10.16)	(12.90)	(16.47)
$15	(8.59)	(23.19)	na	na	(15.89)	(20.19)	(25.77)
$20	(12.12)	(32.72)	na	na	(22.42)	(28.48)	(36.36)
$25	(15.99)	(43.17)	na	na	(29.58)	(37.58)	(47.97)
$30	(20.36)	(54.97)	na	na	(37.67)	(47.85)	(61.08)
$35	(24.48)	(66.10)	na	na	(45.29)	(57.53)	(73.44)
$40	(33.06)	(89.26)	na	na	(61.16)	(77.69)	(99.18)
$45	(33.22)	(89.69)	na	na	(61.46)	(78.07)	(99.66)
$50	(37.93)	(102.41)	na	na	(70.17)	(89.14)	(113.79)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	na	na	0.00	0.00	0.00
$5	(2.24)	(6.05)	na	na	(4.14)	(5.26)	(6.72)
$10	(4.64)	(12.53)	na	na	(8.58)	(10.90)	(13.92)
$15	(7.27)	(19.63)	na	na	(13.45)	(17.08)	(21.81)
$20	(10.25)	(27.68)	na	na	(18.96)	(24.09)	(30.75)
$25	(13.51)	(36.48)	na	na	(24.99)	(31.75)	(40.53)
$30	(17.22)	(46.49)	na	na	(31.86)	(40.47)	(51.66)
$35	(20.69)	(55.86)	na	na	(38.28)	(48.62)	(62.07)
$40	(27.95)	(75.47)	na	na	(51.71)	(65.68)	(83.85)
$45	(28.09)	(75.84)	na	na	(51.97)	(66.01)	(84.27)
$50	(32.07)	(86.59)	na	na	(59.33)	(75.36)	(96.21)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.02)	(5.45)	na	na	(3.74)	(4.75)	(6.06)
$150	(3.33)	(8.99)	na	na	(6.16)	(7.83)	(9.99)
$200	(4.75)	(12.83)	na	na	(8.79)	(11.16)	(14.25)
$250	(6.80)	(18.36)	na	na	(12.58)	(15.98)	(20.40)
$500	(16.30)	(44.01)	na	na	(30.16)	(38.31)	(48.90)
$750	(28.02)	(75.65)	na	na	(51.84)	(65.85)	(84.06)
$1,000	(42.14)	(113.78)	na	na	(77.96)	(99.03)	(126.42)
Copay/Day							
$50 w/3 Day Max	(2.45)	(6.62)	na	na	(4.53)	(5.76)	(7.35)
$50 w/5 Day Max	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)
$100 w/3 Day Max	(6.12)	(16.52)	na	na	(11.32)	(14.38)	(18.36)
$100 w/5 Day Max	(8.83)	(23.84)	na	na	(16.34)	(20.75)	(26.49)
$250 w/3 Day Max	(20.30)	(54.81)	na	na	(37.56)	(47.71)	(60.90)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.11)	(3.00)	na	na	(2.05)	(2.61)	(3.33)
$75	(1.80)	(4.86)	na	na	(3.33)	(4.23)	(5.40)
$100	(2.57)	(6.94)	na	na	(4.75)	(6.04)	(7.71)
$125	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)
$150	(4.21)	(11.37)	na	na	(7.79)	(9.89)	(12.63)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	na	na	0.00	0.00	0.00
$15	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$25	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
$35	(1.17)	(3.16)	na	na	(2.16)	(2.75)	(3.51)
$50	(2.01)	(5.43)	na	na	(3.72)	(4.72)	(6.03)
$60	(2.55)	(6.89)	na	na	(4.72)	(5.99)	(7.65)
$75	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)
$100	(4.77)	(12.88)	na	na	(8.82)	(11.21)	(14.31)
$125	(5.87)	(15.85)	na	na	(10.86)	(13.79)	(17.61)
$150	(7.02)	(18.95)	na	na	(12.99)	(16.50)	(21.06)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.60	1.62	na	na	1.11	1.41	1.80
60	1.13	3.05	na	na	2.09	2.66	3.39
90	1.71	4.62	na	na	3.16	4.02	5.13
120	2.01	5.43	na	na	3.72	4.72	6.03
Unlimited	2.58	6.97	na	na	4.77	6.06	7.74
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
40/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
40/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.53)	(1.95)
40/$25 copay	(0.84)	(2.27)	na	na	(1.55)	(1.97)	(2.52)
60	0.31	0.84	na	na	0.57	0.73	0.93
100	0.75	2.03	na	na	1.39	1.76	2.25
200	2.01	5.43	na	na	3.72	4.72	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	(1.19)	(3.21)	na	na	(2.20)	(2.80)	(3.57)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.78	2.11	na	na	1.44	1.83	2.34
90	1.65	4.46	na	na	3.05	3.88	4.95
# Visits			**Outpatient Therapies Limit [std: 30 visits]** **[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.70	1.89	na	na	1.30	1.65	2.10
90	1.30	3.51	na	na	2.41	3.06	3.90
120	2.08	5.62	na	na	3.85	4.89	6.24

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.00)	(2.70)	na	na	(1.85)	(2.35)	(3.00)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.30	0.81	na	na	0.56	0.71	0.90
30	0.46	1.24	na	na	0.85	1.08	1.38
Unlimited	0.70	1.89	na	na	1.30	1.65	2.10
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.53	9.53	na	na	6.53	8.30	10.59
60	4.13	11.15	na	na	7.64	9.71	12.39
90	4.94	13.34	na	na	9.14	11.61	14.82
Unlimited	5.01	13.53	na	na	9.27	11.77	15.03
	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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.76)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
60/$20 copay	(0.61)	(1.65)	na	na	(1.13)	(1.43)	(1.83)
60/$25 copay	(0.72)	(1.94)	na	na	(1.33)	(1.69)	(2.16)
120/$0 copay	0.63	1.70	na	na	1.17	1.48	1.89
120/$5 copay	0.46	1.24	na	na	0.85	1.08	1.38
120/$10 copay	0.28	0.76	na	na	0.52	0.66	0.84
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
Unlimited/$0 copay	0.71	1.92	na	na	1.31	1.67	2.13
Unlimited/$5 copay	0.56	1.51	na	na	1.04	1.32	1.68
Unlimited/$10 copay	0.35	0.95	na	na	0.65	0.82	1.05
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	0.21	0.57	na	na	0.39	0.49	0.63
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.24)	(0.65)	na	na	(0.44)	(0.56)	(0.72)
$25	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
$15	(0.46)	(1.24)	na	na	(0.85)	(1.08)	(1.38)
$20	(0.67)	(1.81)	na	na	(1.24)	(1.57)	(2.01)
$25	(0.88)	(2.38)	na	na	(1.63)	(2.07)	(2.64)
$30	(1.06)	(2.86)	na	na	(1.96)	(2.49)	(3.18)
$35	(1.26)	(3.40)	na	na	(2.33)	(2.96)	(3.78)
$40	(1.45)	(3.92)	na	na	(2.68)	(3.41)	(4.35)
$45	(1.66)	(4.48)	na	na	(3.07)	(3.90)	(4.98)
$50	(1.84)	(4.97)	na	na	(3.40)	(4.32)	(5.52)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
$15	(0.51)	(1.38)	na	na	(0.94)	(1.20)	(1.53)
$20	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
$25	(1.02)	(2.75)	na	na	(1.89)	(2.40)	(3.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.23)	(0.62)	na	na	(0.43)	(0.54)	(0.69)
$50	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$60	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$75	(0.58)	(1.57)	na	na	(1.07)	(1.36)	(1.74)
$100	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$60	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
$75	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$100	(0.51)	(1.38)	na	na	(0.94)	(1.20)	(1.53)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.19)	(8.61)	na	na	(5.90)	(7.50)	(9.57)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(4.93)	(13.31)	na	na	(9.12)	(11.59)	(14.79)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	3.91	10.56	na	na	7.23	9.19	11.73
60	5.52	14.90	na	na	10.21	12.97	16.56
90	6.55	17.69	na	na	12.12	15.39	19.65
Unlimited	6.63	17.90	na	na	12.27	15.58	19.89
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	6.96	18.79	na	na	12.88	16.36	20.88
60	7.36	19.87	na	na	13.62	17.30	22.08
90	7.63	20.60	na	na	14.12	17.93	22.89
Unlimited	7.70	20.79	na	na	14.25	18.10	23.10
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.31	14.34	na	na	9.82	12.48	15.93
30	6.31	17.04	na	na	11.67	14.83	18.93
40	6.95	18.77	na	na	12.86	16.33	20.85
60	7.60	20.52	na	na	14.06	17.86	22.80
Unlimited	7.66	20.68	na	na	14.17	18.00	22.98
SMALL GROUP	**$5 Copay**						
20	5.00	13.50	na	na	9.25	11.75	15.00
30	5.93	16.01	na	na	10.97	13.94	17.79
40	6.54	17.66	na	na	12.10	15.37	19.62
60	7.15	19.31	na	na	13.23	16.80	21.45
Unlimited	7.22	19.49	na	na	13.36	16.97	21.66

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$10 Copay**			
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.53	14.93	na	na	10.23	13.00	16.59
40	6.09	16.44	na	na	11.27	14.31	18.27
60	6.66	17.98	na	na	12.32	15.65	19.98
Unlimited	6.73	18.17	na	na	12.45	15.82	20.19
SMALL GROUP				**$15 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	5.20	14.04	na	na	9.62	12.22	15.60
40	5.73	15.47	na	na	10.60	13.47	17.19
60	6.25	16.88	na	na	11.56	14.69	18.75
Unlimited	6.32	17.06	na	na	11.69	14.85	18.96
SMALL GROUP				**$20 Copay**			
20	4.10	11.07	na	na	7.59	9.64	12.30
30	4.87	13.15	na	na	9.01	11.44	14.61
40	5.37	14.50	na	na	9.93	12.62	16.11
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.91	15.96	na	na	10.93	13.89	17.73
SMALL GROUP				**$25 Copay**			
20	3.83	10.34	na	na	7.09	9.00	11.49
30	4.54	12.26	na	na	8.40	10.67	13.62
40	5.01	13.53	na	na	9.27	11.77	15.03
60	5.47	14.77	na	na	10.12	12.85	16.41
Unlimited	5.53	14.93	na	na	10.23	13.00	16.59
SMALL GROUP				**$30 Copay**			
20	3.67	9.91	na	na	6.79	8.62	11.01
30	4.39	11.85	na	na	8.12	10.32	13.17
40	4.83	13.04	na	na	8.94	11.35	14.49
60	5.28	14.26	na	na	9.77	12.41	15.84
Unlimited	5.33	14.39	na	na	9.86	12.53	15.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$35 Copay**			
20	3.57	9.64	na	na	6.60	8.39	10.71
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.69	12.66	na	na	8.68	11.02	14.07
60	5.13	13.85	na	na	9.49	12.06	15.39
Unlimited	5.17	13.96	na	na	9.56	12.15	15.51
SMALL GROUP				**$40 Copay**			
20	3.49	9.42	na	na	6.46	8.20	10.47
30	4.12	11.12	na	na	7.62	9.68	12.36
40	4.54	12.26	na	na	8.40	10.67	13.62
60	4.98	13.45	na	na	9.21	11.70	14.94
Unlimited	5.02	13.55	na	na	9.29	11.80	15.06
SMALL GROUP				**$45 Copay**			
20	3.36	9.07	na	na	6.22	7.90	10.08
30	4.00	10.80	na	na	7.40	9.40	12.00
40	4.41	11.91	na	na	8.16	10.36	13.23
60	4.82	13.01	na	na	8.92	11.33	14.46
Unlimited	4.85	13.10	na	na	8.97	11.40	14.55
SMALL GROUP				**$50 Copay**			
20	3.27	8.83	na	na	6.05	7.68	9.81
30	3.88	10.48	na	na	7.18	9.12	11.64
40	4.27	11.53	na	na	7.90	10.03	12.81
60	4.68	12.64	na	na	8.66	11.00	14.04
Unlimited	4.70	12.69	na	na	8.70	11.05	14.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	6.88	18.58	na	na	12.73	16.17	20.64
30	7.57	20.44	na	na	14.00	17.79	22.71
40	8.00	21.60	na	na	14.80	18.80	24.00
60	8.45	22.82	na	na	15.63	19.86	25.35
Unlimited	8.54	23.06	na	na	15.80	20.07	25.62
SMALL GROUP				**$5 Copay**			
20	6.47	17.47	na	na	11.97	15.20	19.41
30	7.13	19.25	na	na	13.19	16.76	21.39
40	7.52	20.30	na	na	13.91	17.67	22.56
60	7.96	21.49	na	na	14.73	18.71	23.88
Unlimited	8.03	21.68	na	na	14.86	18.87	24.09
SMALL GROUP				**$10 Copay**			
20	6.03	16.28	na	na	11.16	14.17	18.09
30	6.63	17.90	na	na	12.27	15.58	19.89
40	7.01	18.93	na	na	12.97	16.47	21.03
60	7.40	19.98	na	na	13.69	17.39	22.20
Unlimited	7.48	20.20	na	na	13.84	17.58	22.44
SMALL GROUP				**$15 Copay**			
20	5.68	15.34	na	na	10.51	13.35	17.04
30	6.24	16.85	na	na	11.54	14.66	18.72
40	6.58	17.77	na	na	12.17	15.46	19.74
60	6.95	18.77	na	na	12.86	16.33	20.85
Unlimited	7.02	18.95	na	na	12.99	16.50	21.06

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.33	14.39	na	na	9.86	12.53	15.99
30	5.85	15.80	na	na	10.82	13.75	17.55
40	6.18	16.69	na	na	11.43	14.52	18.54
60	6.53	17.63	na	na	12.08	15.35	19.59
Unlimited	6.58	17.77	na	na	12.17	15.46	19.74
SMALL GROUP				**$25 Copay**			
20	4.96	13.39	na	na	9.18	11.66	14.88
30	5.45	14.72	na	na	10.08	12.81	16.35
40	5.76	15.55	na	na	10.66	13.54	17.28
60	6.08	16.42	na	na	11.25	14.29	18.24
Unlimited	6.14	16.58	na	na	11.36	14.43	18.42
SMALL GROUP				**$30 Copay**			
20	4.78	12.91	na	na	8.84	11.23	14.34
30	5.26	14.20	na	na	9.73	12.36	15.78
40	5.56	15.01	na	na	10.29	13.07	16.68
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.90	15.93	na	na	10.92	13.87	17.70
SMALL GROUP				**$35 Copay**			
20	4.64	12.53	na	na	8.58	10.90	13.92
30	5.12	13.82	na	na	9.47	12.03	15.36
40	5.39	14.55	na	na	9.97	12.67	16.17
60	5.71	15.42	na	na	10.56	13.42	17.13
Unlimited	5.74	15.50	na	na	10.62	13.49	17.22
SMALL GROUP				**$40 Copay**			
20	4.50	12.15	na	na	8.33	10.58	13.50
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.22	14.09	na	na	9.66	12.27	15.66
60	5.53	14.93	na	na	10.23	13.00	16.59
Unlimited	5.57	15.04	na	na	10.30	13.09	16.71

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$45 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	4.79	12.93	na	na	8.86	11.26	14.37
40	5.07	13.69	na	na	9.38	11.91	15.21
60	5.36	14.47	na	na	9.92	12.60	16.08
Unlimited	5.40	14.58	na	na	9.99	12.69	16.20
SMALL GROUP				**$50 Copay**			
20	4.23	11.42	na	na	7.83	9.94	12.69
30	4.65	12.56	na	na	8.60	10.93	13.95
40	4.93	13.31	na	na	9.12	11.59	14.79
60	5.19	14.01	na	na	9.60	12.20	15.57
Unlimited	5.22	14.09	na	na	9.66	12.27	15.66
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL

HIP HMO GROUP CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM

January 01, 2013 - March 31, 2013 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

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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

Full-time Students

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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%

Class II Dependents

	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
January 01, 2013 - March 31, 2013 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	12.34	na	na	8.45	10.74	13.71
$0/Max $5000	4.35	11.75	na	na	8.05	10.22	13.05
$0/Max $2500	4.07	10.99	na	na	7.53	9.56	12.21
$25	4.35	11.75	na	na	8.05	10.22	13.05
$50	4.07	10.99	na	na	7.53	9.56	12.21
$100	3.72	10.04	na	na	6.88	8.74	11.16
$500	1.78	4.81	na	na	3.29	4.18	5.34
$5,000	0.30	0.81	na	na	0.56	0.71	0.90
Coinsurance							
80%	3.65	9.86	na	na	6.75	8.58	10.95
75%	3.43	9.26	na	na	6.35	8.06	10.29
70%	3.21	8.67	na	na	5.94	7.54	9.63
Deductible			**Orthotics Riders**				
$0	0.77	2.08	na	na	1.42	1.81	2.31
$0/Max $5000	0.74	2.00	na	na	1.37	1.74	2.22
$0/Max $2500	0.70	1.89	na	na	1.30	1.65	2.10
$25	0.74	2.00	na	na	1.37	1.74	2.22
$50	0.70	1.89	na	na	1.30	1.65	2.10
$100	0.64	1.73	na	na	1.18	1.50	1.92
$500	0.32	0.86	na	na	0.59	0.75	0.96
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.64	1.73	na	na	1.18	1.50	1.92
75%	0.61	1.65	na	na	1.13	1.43	1.83
70%	0.58	1.57	na	na	1.07	1.36	1.74

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Optical Riders							
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.48	4.00	na	na	2.74	3.48	4.44
12 Months	2.39	6.45	na	na	4.42	5.62	7.17
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.32	6.26	na	na	4.29	5.45	6.96
12 Months	3.71	10.02	na	na	6.86	8.72	11.13
Private Duty Nursing Riders							
In Full	0.56	1.51	na	na	1.04	1.32	1.68
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
Dental Network Access							
	0.45	1.22	na	na	0.83	1.06	1.35
Limit			**Infertility Rider**				
2 IVF	9.67	26.11	na	na	17.89	22.72	29.01
3 IVF	11.67	31.51	na	na	21.59	27.42	35.01
Applicable to Classic only							
Complementary Alternative Medicine (CAM)							
$20 Copay	4.45	12.02	na	na	8.23	10.46	13.35
Health Club Reimbursement							
$200 per year	1.15	3.11	na	na	2.13	2.70	3.45
Nurse Advice Line Rider							
	0.30	0.81	na	na	0.56	0.71	0.90
Wellness Rider							
	0.76	2.05	na	na	1.41	1.79	2.28

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Effective 01/01/2013 - 03/31/2013 (With WH & Autism)						
Small Group *	495.44	1,407.05	na	na	916.56	1,164.28	1,486.32
	Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)						
Small Group *	490.54	1,393.13	na	na	907.50	1,152.77	1,471.62

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	na	na	0.00	0.00	0.00
$5	(4.32)	(12.27)	na	na	(7.99)	(10.15)	(12.96)
$10	(9.06)	(25.73)	na	na	(16.76)	(21.29)	(27.18)
$15	(14.02)	(39.82)	na	na	(25.94)	(32.95)	(42.06)
$20	(20.19)	(57.34)	na	na	(37.35)	(47.45)	(60.57)
$25	(37.47)	(106.41)	na	na	(69.32)	(88.05)	(112.41)
$30	(59.52)	(169.04)	na	na	(110.11)	(139.87)	(178.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.47)	(7.01)	na	na	(4.57)	(5.80)	(7.41)
$10	(5.20)	(14.77)	na	na	(9.62)	(12.22)	(15.60)
$15	(8.03)	(22.81)	na	na	(14.86)	(18.87)	(24.09)
$20	(11.58)	(32.89)	na	na	(21.42)	(27.21)	(34.74)
$25	(21.47)	(60.97)	na	na	(39.72)	(50.45)	(64.41)
$30	(34.13)	(96.93)	na	na	(63.14)	(80.21)	(102.39)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.06)	(8.69)	na	na	(5.66)	(7.19)	(9.18)
$10	(6.27)	(17.81)	na	na	(11.60)	(14.73)	(18.81)
$15	(9.52)	(27.04)	na	na	(17.61)	(22.37)	(28.56)
$20	(12.95)	(36.78)	na	na	(23.96)	(30.43)	(38.85)
$25	(19.23)	(54.61)	na	na	(35.58)	(45.19)	(57.69)
$30	(27.15)	(77.11)	na	na	(50.23)	(63.80)	(81.45)
$35	(35.51)	(100.85)	na	na	(65.69)	(83.45)	(106.53)
$40	(44.91)	(127.54)	na	na	(83.08)	(105.54)	(134.73)
$45	(55.41)	(157.36)	na	na	(102.51)	(130.21)	(166.23)
$50	(67.02)	(190.34)	na	na	(123.99)	(157.50)	(201.06)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.56)	(7.27)	na	na	(4.74)	(6.02)	(7.68)
$10	(5.30)	(15.05)	na	na	(9.81)	(12.46)	(15.90)
$15	(8.04)	(22.83)	na	na	(14.87)	(18.89)	(24.12)
$20	(10.95)	(31.10)	na	na	(20.26)	(25.73)	(32.85)
$25	(16.26)	(46.18)	na	na	(30.08)	(38.21)	(48.78)
$30	(22.93)	(65.12)	na	na	(42.42)	(53.89)	(68.79)
$35	(30.01)	(85.23)	na	na	(55.52)	(70.52)	(90.03)
$40	(37.99)	(107.89)	na	na	(70.28)	(89.28)	(113.97)
$45	(46.84)	(133.03)	na	na	(86.65)	(110.07)	(140.52)
$50	(56.67)	(160.94)	na	na	(104.84)	(133.17)	(170.01)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

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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	na	na	0.00	0.00	0.00
$100	(2.44)	(6.93)	na	na	(4.51)	(5.73)	(7.32)
$150	(4.08)	(11.59)	na	na	(7.55)	(9.59)	(12.24)
$200	(5.88)	(16.70)	na	na	(10.88)	(13.82)	(17.64)
$250	(8.49)	(24.11)	na	na	(15.71)	(19.95)	(25.47)
$500	(20.87)	(59.27)	na	na	(38.61)	(49.04)	(62.61)
$750	(36.54)	(103.77)	na	na	(67.60)	(85.87)	(109.62)
$1,000	(55.81)	(158.50)	na	na	(103.25)	(131.15)	(167.43)
Copay/Day							
$50 w/3 Day Max	(3.51)	(9.97)	na	na	(6.49)	(8.25)	(10.53)
$50 w/5 Day Max	(4.76)	(13.52)	na	na	(8.81)	(11.19)	(14.28)
$100 w/3 Day Max	(7.50)	(21.30)	na	na	(13.88)	(17.63)	(22.50)
$100 w/5 Day Max	(12.77)	(36.27)	na	na	(23.62)	(30.01)	(38.31)
$250 w/3 Day Max	(24.78)	(70.38)	na	na	(45.84)	(58.23)	(74.34)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.37)	(3.89)	na	na	(2.53)	(3.22)	(4.11)
$75	(2.39)	(6.79)	na	na	(4.42)	(5.62)	(7.17)
$100	(3.59)	(10.20)	na	na	(6.64)	(8.44)	(10.77)
$125	(4.99)	(14.17)	na	na	(9.23)	(11.73)	(14.97)
$150	(6.61)	(18.77)	na	na	(12.23)	(15.53)	(19.83)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.88)	(2.50)	na	na	(1.63)	(2.07)	(2.64)
$35	(1.48)	(4.20)	na	na	(2.74)	(3.48)	(4.44)
$50	(2.45)	(6.96)	na	na	(4.53)	(5.76)	(7.35)
$60	(3.11)	(8.83)	na	na	(5.75)	(7.31)	(9.33)
$75	(4.01)	(11.39)	na	na	(7.42)	(9.42)	(12.03)
$100	(5.62)	(15.96)	na	na	(10.40)	(13.21)	(16.86)
$125	(7.37)	(20.93)	na	na	(13.63)	(17.32)	(22.11)
$150	(9.29)	(26.38)	na	na	(17.19)	(21.83)	(27.87)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.67	1.90	na	na	1.24	1.57	2.01
60	1.30	3.69	na	na	2.41	3.06	3.90
90	1.94	5.51	na	na	3.59	4.56	5.82
120	2.27	6.45	na	na	4.20	5.33	6.81
Unlimited	2.90	8.24	na	na	5.37	6.82	8.70

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.52)	(1.48)	na	na	(0.96)	(1.22)	(1.56)
40/$20 copay	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
40/$25 copay	(0.95)	(2.70)	na	na	(1.76)	(2.23)	(2.85)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.84	2.39	na	na	1.55	1.97	2.52
200	2.28	6.48	na	na	4.22	5.36	6.84
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.35)	(3.83)	na	na	(2.50)	(3.17)	(4.05)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.90	2.56	na	na	1.67	2.12	2.70
90	1.87	5.31	na	na	3.46	4.39	5.61
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.24	na	na	1.46	1.86	2.37
90	1.47	4.17	na	na	2.72	3.45	4.41
120	2.35	6.67	na	na	4.35	5.52	7.05
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.54	1.53	na	na	1.00	1.27	1.62
Unlimited	0.79	2.24	na	na	1.46	1.86	2.37
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.01	11.39	na	na	7.42	9.42	12.03
60	4.70	13.35	na	na	8.70	11.05	14.10
90	5.60	15.90	na	na	10.36	13.16	16.80
Unlimited	5.68	16.13	na	na	10.51	13.35	17.04

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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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.65)	(1.85)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.75)	(2.13)	na	na	(1.39)	(1.76)	(2.25)
120/$0 copay	0.71	2.02	na	na	1.31	1.67	2.13
120/$5 copay	0.56	1.59	na	na	1.04	1.32	1.68
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.81	2.30	na	na	1.50	1.90	2.43
Unlimited/$5 copay	0.66	1.87	na	na	1.22	1.55	1.98
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.71)	(2.02)	na	na	(1.31)	(1.67)	(2.13)
$25	(0.90)	(2.56)	na	na	(1.67)	(2.12)	(2.70)
$30	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
$35	(1.32)	(3.75)	na	na	(2.44)	(3.10)	(3.96)
$40	(1.51)	(4.29)	na	na	(2.79)	(3.55)	(4.53)
$45	(1.73)	(4.91)	na	na	(3.20)	(4.07)	(5.19)
$50	(1.93)	(5.48)	na	na	(3.57)	(4.54)	(5.79)

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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	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
$20	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.07)	(3.04)	na	na	(1.98)	(2.51)	(3.21)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.61)	(1.73)	na	na	(1.13)	(1.43)	(1.83)
$100	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)

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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]							
	(3.31)	(9.40)	na	na	(6.12)	(7.78)	(9.93)
Diagnostic and Therapeutic Radiology [std: $0]							
Copay per procedure of minimum (20%, $100); $500 annual maximum							
	(5.17)	(14.68)	na	na	(9.56)	(12.15)	(15.51)
Diagnostic Testing [std: $0]							
Copay per procedure minimum of [20%, $100], $500 annual maximum							
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.36	12.38	na	na	8.07	10.25	13.08
60	5.21	14.80	na	na	9.64	12.24	15.63
90	5.77	16.39	na	na	10.67	13.56	17.31
Unlimited	5.85	16.61	na	na	10.82	13.75	17.55
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.07	20.08	na	na	13.08	16.61	21.21
60	7.46	21.19	na	na	13.80	17.53	22.38
90	7.75	22.01	na	na	14.34	18.21	23.25
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.91	16.78	na	na	10.93	13.89	17.73
30	6.94	19.71	na	na	12.84	16.31	20.82
40	7.61	21.61	na	na	14.08	17.88	22.83
60	8.26	23.46	na	na	15.28	19.41	24.78
Unlimited	8.35	23.71	na	na	15.45	19.62	25.05
SMALL GROUP	**$5 Copay**						
20	5.57	15.82	na	na	10.30	13.09	16.71
30	6.52	18.52	na	na	12.06	15.32	19.56
40	7.15	20.31	na	na	13.23	16.80	21.45
60	7.76	22.04	na	na	14.36	18.24	23.28
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**$10 Copay**						
20	5.19	14.74	na	na	9.60	12.20	15.57
30	6.08	17.27	na	na	11.25	14.29	18.24
40	6.66	18.91	na	na	12.32	15.65	19.98
60	7.23	20.53	na	na	13.38	16.99	21.69
Unlimited	7.33	20.82	na	na	13.56	17.23	21.99

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$15 Copay**			
20	4.87	13.83	na	na	9.01	11.44	14.61
30	5.70	16.19	na	na	10.55	13.40	17.10
40	6.25	17.75	na	na	11.56	14.69	18.75
60	6.80	19.31	na	na	12.58	15.98	20.40
Unlimited	6.86	19.48	na	na	12.69	16.12	20.58
SMALL GROUP				**$20 Copay**			
20	4.58	13.01	na	na	8.47	10.76	13.74
30	5.37	15.25	na	na	9.93	12.62	16.11
40	5.88	16.70	na	na	10.88	13.82	17.64
60	6.40	18.18	na	na	11.84	15.04	19.20
Unlimited	6.46	18.35	na	na	11.95	15.18	19.38
SMALL GROUP				**$25 Copay**			
20	4.27	12.13	na	na	7.90	10.03	12.81
30	5.00	14.20	na	na	9.25	11.75	15.00
40	5.45	15.48	na	na	10.08	12.81	16.35
60	5.93	16.84	na	na	10.97	13.94	17.79
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP				**$30 Copay**			
20	4.10	11.64	na	na	7.59	9.64	12.30
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.76	16.36	na	na	10.66	13.54	17.28
Unlimited	5.80	16.47	na	na	10.73	13.63	17.40
SMALL GROUP				**$35 Copay**			
20	3.99	11.33	na	na	7.38	9.38	11.97
30	4.67	13.26	na	na	8.64	10.97	14.01
40	5.14	14.60	na	na	9.51	12.08	15.42
60	5.57	15.82	na	na	10.30	13.09	16.71
Unlimited	5.61	15.93	na	na	10.38	13.18	16.83
SMALL GROUP				**$40 Copay**			
20	3.88	11.02	na	na	7.18	9.12	11.64
30	4.54	12.89	na	na	8.40	10.67	13.62
40	4.97	14.11	na	na	9.19	11.68	14.91
60	5.39	15.31	na	na	9.97	12.67	16.17
Unlimited	5.44	15.45	na	na	10.06	12.78	16.32

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	3.76	10.68	na	na	6.96	8.84	11.28
30	4.40	12.50	na	na	8.14	10.34	13.20
40	4.81	13.66	na	na	8.90	11.30	14.43
60	5.23	14.85	na	na	9.68	12.29	15.69
Unlimited	5.26	14.94	na	na	9.73	12.36	15.78
SMALL GROUP				**$50 Copay**			
20	3.64	10.34	na	na	6.73	8.55	10.92
30	4.28	12.16	na	na	7.92	10.06	12.84
40	4.67	13.26	na	na	8.64	10.97	14.01
60	5.06	14.37	na	na	9.36	11.89	15.18
Unlimited	5.12	14.54	na	na	9.47	12.03	15.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.01	19.91	na	na	12.97	16.47	21.03
30	7.62	21.64	na	na	14.10	17.91	22.86
40	7.97	22.63	na	na	14.74	18.73	23.91
60	8.37	23.77	na	na	15.48	19.67	25.11
Unlimited	8.46	24.03	na	na	15.65	19.88	25.38
SMALL GROUP				**$5 Copay**			
20	6.59	18.72	na	na	12.19	15.49	19.77
30	7.16	20.33	na	na	13.25	16.83	21.48
40	7.50	21.30	na	na	13.88	17.63	22.50
60	7.87	22.35	na	na	14.56	18.49	23.61
Unlimited	7.96	22.61	na	na	14.73	18.71	23.88
SMALL GROUP				**$10 Copay**			
20	6.16	17.49	na	na	11.40	14.48	18.48
30	6.67	18.94	na	na	12.34	15.67	20.01
40	7.00	19.88	na	na	12.95	16.45	21.00
60	7.35	20.87	na	na	13.60	17.27	22.05
Unlimited	7.42	21.07	na	na	13.73	17.44	22.26
SMALL GROUP				**$15 Copay**			
20	5.78	16.42	na	na	10.69	13.58	17.34
30	6.26	17.78	na	na	11.58	14.71	18.78
40	6.56	18.63	na	na	12.14	15.42	19.68
60	6.88	19.54	na	na	12.73	16.17	20.64
Unlimited	6.97	19.79	na	na	12.89	16.38	20.91

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$20 Copay**			
20	5.43	15.42	na	na	10.05	12.76	16.29
30	5.88	16.70	na	na	10.88	13.82	17.64
40	6.17	17.52	na	na	11.41	14.50	18.51
60	6.48	18.40	na	na	11.99	15.23	19.44
Unlimited	6.55	18.60	na	na	12.12	15.39	19.65
SMALL GROUP				**$25 Copay**			
20	5.04	14.31	na	na	9.32	11.84	15.12
30	5.46	15.51	na	na	10.10	12.83	16.38
40	5.75	16.33	na	na	10.64	13.51	17.25
60	6.03	17.13	na	na	11.16	14.17	18.09
Unlimited	6.09	17.30	na	na	11.27	14.31	18.27
SMALL GROUP				**$30 Copay**			
20	4.88	13.86	na	na	9.03	11.47	14.64
30	5.27	14.97	na	na	9.75	12.38	15.81
40	5.56	15.79	na	na	10.29	13.07	16.68
60	5.82	16.53	na	na	10.77	13.68	17.46
Unlimited	5.87	16.67	na	na	10.86	13.79	17.61
SMALL GROUP				**$35 Copay**			
20	4.72	13.40	na	na	8.73	11.09	14.16
30	5.14	14.60	na	na	9.51	12.08	15.42
40	5.37	15.25	na	na	9.93	12.62	16.11
60	5.63	15.99	na	na	10.42	13.23	16.89
Unlimited	5.69	16.16	na	na	10.53	13.37	17.07
SMALL GROUP				**$40 Copay**			
20	4.59	13.04	na	na	8.49	10.79	13.77
30	4.99	14.17	na	na	9.23	11.73	14.97
40	5.21	14.80	na	na	9.64	12.24	15.63
60	5.46	15.51	na	na	10.10	12.83	16.38
Unlimited	5.54	15.73	na	na	10.25	13.02	16.62
SMALL GROUP				**$45 Copay**			
20	4.45	12.64	na	na	8.23	10.46	13.35
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.05	14.34	na	na	9.34	11.87	15.15
60	5.30	15.05	na	na	9.81	12.46	15.90
Unlimited	5.35	15.19	na	na	9.90	12.57	16.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$50 Copay**			
20	4.32	12.27	na	na	7.99	10.15	12.96
30	4.67	13.26	na	na	8.64	10.97	14.01
40	4.90	13.92	na	na	9.07	11.52	14.70
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.19	14.74	na	na	9.60	12.20	15.57
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL

HIP COMPREHEALTH HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
January 01, 2013 - March 31, 2013 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				
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
			Full-time Students				
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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
January 01, 2013 - March 31, 2013 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	5.19	14.74	na	na	9.60	12.20	15.57
$0/Max $5000	4.90	13.92	na	na	9.07	11.52	14.70
$0/Max $2500	4.60	13.06	na	na	8.51	10.81	13.80
$25	4.90	13.92	na	na	9.07	11.52	14.70
$50	4.60	13.06	na	na	8.51	10.81	13.80
$100	4.23	12.01	na	na	7.83	9.94	12.69
$500	2.04	5.79	na	na	3.77	4.79	6.12
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.15	11.79	na	na	7.68	9.75	12.45
25%	3.90	11.08	na	na	7.22	9.17	11.70
30%	3.63	10.31	na	na	6.72	8.53	10.89
Deductible			**Orthotics Riders**				
$0	0.90	2.56	na	na	1.67	2.12	2.70
$0/Max $5000	0.83	2.36	na	na	1.54	1.95	2.49
$0/Max $2500	0.79	2.24	na	na	1.46	1.86	2.37
$25	0.83	2.36	na	na	1.54	1.95	2.49
$50	0.79	2.24	na	na	1.46	1.86	2.37
$100	0.72	2.04	na	na	1.33	1.69	2.16
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
20%	0.72	2.04	na	na	1.33	1.69	2.16
25%	0.69	1.96	na	na	1.28	1.62	2.07
30%	0.65	1.85	na	na	1.20	1.53	1.95
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.72	4.88	na	na	3.18	4.04	5.16
12 Months	2.75	7.81	na	na	5.09	6.46	8.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.69	7.64	na	na	4.98	6.32	8.07
12 Months	4.28	12.16	na	na	7.92	10.06	12.84

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Private Duty Nursing Riders				
In Full	0.69	1.96	na	na	1.28	1.62	2.07
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.52	1.48	na	na	0.96	1.22	1.56
Limit			**Infertility Rider**				
2 IVF	10.95	31.10	na	na	20.26	25.73	32.85
3 IVF	13.24	37.60	na	na	24.49	31.11	39.72
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.52	12.84	na	na	8.36	10.62	13.56
			Health Club Reimbursement				
$200 per year	1.30	3.69	na	na	2.41	3.06	3.90
			Wellness Rider				
Inclusion	1.06	3.01	na	na	1.96	2.49	3.18
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
January 01, 2013 - March 31, 2013

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not available**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
January 01, 2013 - March 31, 2013 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[g]
+ applicable pmpm for Women's Preventive Services Table 4 [h]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS

MONTHLY PREMIUMS EFFECTIVE 2011 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*

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 Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
1Q2010-1Q2011	2.5%
2Q2011	4.1%
3Q2011-4Q2011	3.0%
1Q2012	3.0%
2Q 2012 - 4Q 2012	3.0%
1Q2013 HMO/POS	-6.3%
1Q2013 CH	0.0%
[h] Mandatory Women's Preventive Services HMO/POS	$0.56
[h] Mandatory Women's Preventive Services CompreHealth HMO	$0.60

Table 5: Tier Conversion Factors

	HIP	Emblem Coordinated Care Plans
	Small Group	**Small Group**
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

Health Insurance Plan of Greater New York
and HIP Insurance Company of New York

Rating Region Definitions

County	Region
Bronx	Downstate
Kings	Downstate
Nassau	Downstate
New York	Downstate
Orange	Downstate
Queens	Downstate
Richmond	Downstate
Rockland	Downstate
Suffolk	Downstate
Westchester	Downstate

Commissions Schedule

Please see SERFF filing # HPHP-127874918

HEALTH INSURANCE PLAN OF GREATER NEW YORK

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

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group*	646.80	1,746.36	na	na	1,196.58	1,519.98	1,940.40
Classic*	461.64	1,246.43	na	na	854.03	1,084.85	1,384.92
Small Group*	646.80	1,746.36	na	na	1,196.58	1,519.98	1,940.40
Classic*	461.64	1,246.43	na	na	854.03	1,084.85	1,384.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 01/01/2013 - 03/31/2013 (With WH & Autism)							
Small Group*	668.87	1,805.95	na	na	1,237.41	1,571.84	2,006.61
Classic*	477.39	1,288.95	na	na	883.17	1,121.87	1,432.17
Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)							
Small Group*	662.25	1,788.08	na	na	1,225.16	1,556.29	1,986.75
Classic*	472.66	1,276.18	na	na	874.42	1,110.75	1,417.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 01/01/2013 - 03/31/2013 (With WH & Autism)							
Small Gro	22.07	59.59	na	na	40.83	51.86	66.21
Classic*	15.75	42.52	na	na	29.14	37.02	47.25
Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)							
Classic*	15.45	41.72	na	na	28.58	36.31	46.35
Classic*	11.02	29.75	na	na	20.39	25.90	33.06

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 01/01/2013 - 03/31/2013 (With WH & Autism)							
Small Gro	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Classic*	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)							
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%

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

Rockland, Suffolk and Westchester counties

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	na	na	0.00	0.00	0.00
$5	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$10	(7.70)	(20.79)	na	na	(14.25)	(18.10)	(23.10)
$15	(12.80)	(34.56)	na	na	(23.68)	(30.08)	(38.40)
$20	(19.76)	(53.35)	na	na	(36.56)	(46.44)	(59.28)
$25	(26.05)	(70.34)	na	na	(48.19)	(61.22)	(78.15)
$30	(32.92)	(88.88)	na	na	(60.90)	(77.36)	(98.76)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.10)	(5.67)	na	na	(3.89)	(4.94)	(6.30)
$10	(4.40)	(11.88)	na	na	(8.14)	(10.34)	(13.20)
$15	(7.33)	(19.79)	na	na	(13.56)	(17.23)	(21.99)
$20	(11.32)	(30.56)	na	na	(20.94)	(26.60)	(33.96)
$25	(14.92)	(40.28)	na	na	(27.60)	(35.06)	(44.76)
$30	(18.87)	(50.95)	na	na	(34.91)	(44.34)	(56.61)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.59)	(6.99)	na	na	(4.79)	(6.09)	(7.77)
$10	(5.36)	(14.47)	na	na	(9.92)	(12.60)	(16.08)
$15	(8.39)	(22.65)	na	na	(15.52)	(19.72)	(25.17)
$20	(11.83)	(31.94)	na	na	(21.89)	(27.80)	(35.49)
$25	(15.61)	(42.15)	na	na	(28.88)	(36.68)	(46.83)
$30	(19.89)	(53.70)	na	na	(36.80)	(46.74)	(59.67)
$35	(23.91)	(64.56)	na	na	(44.23)	(56.19)	(71.73)
$40	(32.28)	(87.16)	na	na	(59.72)	(75.86)	(96.84)
$45	(32.45)	(87.62)	na	na	(60.03)	(76.26)	(97.35)
$50	(37.05)	(100.04)	na	na	(68.54)	(87.07)	(111.15)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.18)	(5.89)	na	na	(4.03)	(5.12)	(6.54)
$10	(4.53)	(12.23)	na	na	(8.38)	(10.65)	(13.59)
$15	(7.10)	(19.17)	na	na	(13.14)	(16.69)	(21.30)
$20	(10.01)	(27.03)	na	na	(18.52)	(23.52)	(30.03)
$25	(13.19)	(35.61)	na	na	(24.40)	(31.00)	(39.57)
$30	(16.82)	(45.41)	na	na	(31.12)	(39.53)	(50.46)
$35	(20.21)	(54.57)	na	na	(37.39)	(47.49)	(60.63)
$40	(27.30)	(73.71)	na	na	(50.51)	(64.16)	(81.90)
$45	(27.44)	(74.09)	na	na	(50.76)	(64.48)	(82.32)
$50	(31.32)	(84.56)	na	na	(57.94)	(73.60)	(93.96)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(1.98)	(5.35)	na	na	(3.66)	(4.65)	(5.94)
$150	(3.25)	(8.78)	na	na	(6.01)	(7.64)	(9.75)
$200	(4.64)	(12.53)	na	na	(8.58)	(10.90)	(13.92)
$250	(6.64)	(17.93)	na	na	(12.28)	(15.60)	(19.92)
$500	(15.92)	(42.98)	na	na	(29.45)	(37.41)	(47.76)
$750	(27.36)	(73.87)	na	na	(50.62)	(64.30)	(82.08)
$1,000	(41.16)	(111.13)	na	na	(76.15)	(96.73)	(123.48)
Copay/Day							
$50 w/3 Day Max	(2.39)	(6.45)	na	na	(4.42)	(5.62)	(7.17)
$50 w/5 Day Max	(3.29)	(8.88)	na	na	(6.09)	(7.73)	(9.87)
$100 w/3 Day Max	(5.98)	(16.15)	na	na	(11.06)	(14.05)	(17.94)
$100 w/5 Day Max	(8.62)	(23.27)	na	na	(15.95)	(20.26)	(25.86)
$250 w/3 Day Max	(19.83)	(53.54)	na	na	(36.69)	(46.60)	(59.49)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.09)	(2.94)	na	na	(2.02)	(2.56)	(3.27)
$75	(1.76)	(4.75)	na	na	(3.26)	(4.14)	(5.28)
$100	(2.50)	(6.75)	na	na	(4.63)	(5.88)	(7.50)
$125	(3.29)	(8.88)	na	na	(6.09)	(7.73)	(9.87)
$150	(4.11)	(11.10)	na	na	(7.60)	(9.66)	(12.33)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$25	(0.70)	(1.89)	na	na	(1.30)	(1.65)	(2.10)
$35	(1.14)	(3.08)	na	na	(2.11)	(2.68)	(3.42)
$50	(1.96)	(5.29)	na	na	(3.63)	(4.61)	(5.88)
$60	(2.49)	(6.72)	na	na	(4.61)	(5.85)	(7.47)
$75	(3.29)	(8.88)	na	na	(6.09)	(7.73)	(9.87)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 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	na	na	0.00	0.00	0.00
$5	(3.76)	(10.15)	na	na	(6.96)	(8.84)	(11.28)
$10	(7.89)	(21.30)	na	na	(14.60)	(18.54)	(23.67)
$15	(13.11)	(35.40)	na	na	(24.25)	(30.81)	(39.33)
$20	(20.23)	(54.62)	na	na	(37.43)	(47.54)	(60.69)
$25	(26.67)	(72.01)	na	na	(49.34)	(62.67)	(80.01)
$30	(33.71)	(91.02)	na	na	(62.36)	(79.22)	(101.13)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.15)	(5.81)	na	na	(3.98)	(5.05)	(6.45)
$10	(4.51)	(12.18)	na	na	(8.34)	(10.60)	(13.53)
$15	(7.51)	(20.28)	na	na	(13.89)	(17.65)	(22.53)
$20	(11.59)	(31.29)	na	na	(21.44)	(27.24)	(34.77)
$25	(15.27)	(41.23)	na	na	(28.25)	(35.88)	(45.81)
$30	(19.32)	(52.16)	na	na	(35.74)	(45.40)	(57.96)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.65)	(7.16)	na	na	(4.90)	(6.23)	(7.95)
$10	(5.49)	(14.82)	na	na	(10.16)	(12.90)	(16.47)
$15	(8.59)	(23.19)	na	na	(15.89)	(20.19)	(25.77)
$20	(12.12)	(32.72)	na	na	(22.42)	(28.48)	(36.36)
$25	(15.99)	(43.17)	na	na	(29.58)	(37.58)	(47.97)
$30	(20.36)	(54.97)	na	na	(37.67)	(47.85)	(61.08)
$35	(24.48)	(66.10)	na	na	(45.29)	(57.53)	(73.44)
$40	(33.06)	(89.26)	na	na	(61.16)	(77.69)	(99.18)
$45	(33.22)	(89.69)	na	na	(61.46)	(78.07)	(99.66)
$50	(37.93)	(102.41)	na	na	(70.17)	(89.14)	(113.79)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.24)	(6.05)	na	na	(4.14)	(5.26)	(6.72)
$10	(4.64)	(12.53)	na	na	(8.58)	(10.90)	(13.92)
$15	(7.27)	(19.63)	na	na	(13.45)	(17.08)	(21.81)
$20	(10.25)	(27.68)	na	na	(18.96)	(24.09)	(30.75)
$25	(13.51)	(36.48)	na	na	(24.99)	(31.75)	(40.53)
$30	(17.22)	(46.49)	na	na	(31.86)	(40.47)	(51.66)
$35	(20.69)	(55.86)	na	na	(38.28)	(48.62)	(62.07)
$40	(27.95)	(75.47)	na	na	(51.71)	(65.68)	(83.85)
$45	(28.09)	(75.84)	na	na	(51.97)	(66.01)	(84.27)
$50	(32.07)	(86.59)	na	na	(59.33)	(75.36)	(96.21)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.02)	(5.45)	na	na	(3.74)	(4.75)	(6.06)
$150	(3.33)	(8.99)	na	na	(6.16)	(7.83)	(9.99)
$200	(4.75)	(12.83)	na	na	(8.79)	(11.16)	(14.25)
$250	(6.80)	(18.36)	na	na	(12.58)	(15.98)	(20.40)
$500	(16.30)	(44.01)	na	na	(30.16)	(38.31)	(48.90)
$750	(28.02)	(75.65)	na	na	(51.84)	(65.85)	(84.06)
$1,000	(42.14)	(113.78)	na	na	(77.96)	(99.03)	(126.42)
Copay/Day							
$50 w/3 Day Max	(2.45)	(6.62)	na	na	(4.53)	(5.76)	(7.35)
$50 w/5 Day Max	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)
$100 w/3 Day Max	(6.12)	(16.52)	na	na	(11.32)	(14.38)	(18.36)
$100 w/5 Day Max	(8.83)	(23.84)	na	na	(16.34)	(20.75)	(26.49)
$250 w/3 Day Max	(20.30)	(54.81)	na	na	(37.56)	(47.71)	(60.90)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.11)	(3.00)	na	na	(2.05)	(2.61)	(3.33)
$75	(1.80)	(4.86)	na	na	(3.33)	(4.23)	(5.40)
$100	(2.57)	(6.94)	na	na	(4.75)	(6.04)	(7.71)
$125	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)
$150	(4.21)	(11.37)	na	na	(7.79)	(9.89)	(12.63)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$25	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
$35	(1.17)	(3.16)	na	na	(2.16)	(2.75)	(3.51)
$50	(2.01)	(5.43)	na	na	(3.72)	(4.72)	(6.03)
$60	(2.55)	(6.89)	na	na	(4.72)	(5.99)	(7.65)
$75	(3.36)	(9.07)	na	na	(6.22)	(7.90)	(10.08)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
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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	-	-	na	na	-	-	-
$0	(0.09)	(0.24)	na	na	(0.17)	(0.22)	(0.27)
$0	(0.19)	(0.51)	na	na	(0.35)	(0.44)	(0.57)
$0	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
$0	(0.47)	(1.27)	na	na	(0.87)	(1.10)	(1.41)
$0	(0.62)	(1.67)	na	na	(1.15)	(1.45)	(1.86)
$0	(0.79)	(2.14)	na	na	(1.46)	(1.86)	(2.37)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
$0	(0.18)	(0.49)	na	na	(0.33)	(0.42)	(0.54)
$0	(0.27)	(0.73)	na	na	(0.50)	(0.64)	(0.81)
$0	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
$0	(0.45)	(1.21)	na	na	(0.83)	(1.06)	(1.35)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.13)	(0.35)	na	na	(0.24)	(0.30)	(0.39)
$0	(0.20)	(0.54)	na	na	(0.37)	(0.47)	(0.60)
$0	(0.29)	(0.78)	na	na	(0.53)	(0.68)	(0.87)
$0	(0.38)	(1.02)	na	na	(0.70)	(0.90)	(1.14)
$0	(0.47)	(1.27)	na	na	(0.87)	(1.11)	(1.41)
$0	(0.57)	(1.54)	na	na	(1.06)	(1.34)	(1.71)
$0	(0.78)	(2.10)	na	na	(1.44)	(1.83)	(2.34)
$0	(0.77)	(2.07)	na	na	(1.43)	(1.81)	(2.31)
$0	(0.88)	(2.37)	na	na	(1.63)	(2.07)	(2.64)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.25)	(0.33)
$0	(0.17)	(0.46)	na	na	(0.31)	(0.39)	(0.51)
$0	(0.24)	(0.65)	na	na	(0.44)	(0.57)	(0.72)
$0	(0.32)	(0.87)	na	na	(0.59)	(0.75)	(0.96)
$0	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$0	(0.48)	(1.29)	na	na	(0.89)	(1.13)	(1.44)
$0	(0.65)	(1.76)	na	na	(1.20)	(1.52)	(1.95)
$0	(0.65)	(1.75)	na	na	(1.21)	(1.53)	(1.95)
$0	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.04)	(0.10)	na	na	(0.08)	(0.10)	(0.12)
$0	(0.08)	(0.21)	na	na	(0.15)	(0.19)	(0.24)
$0	(0.11)	(0.30)	na	na	(0.21)	(0.26)	(0.33)
$0	(0.16)	(0.43)	na	na	(0.30)	(0.38)	(0.48)
$0	(0.38)	(1.03)	na	na	(0.71)	(0.90)	(1.14)
$0	(0.66)	(1.78)	na	na	(1.22)	(1.55)	(1.98)
$0	(0.98)	(2.65)	na	na	(1.81)	(2.30)	(2.94)
Copay/Day							
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.14)	(0.37)	na	na	(0.26)	(0.33)	(0.42)
$0	(0.21)	(0.57)	na	na	(0.39)	(0.49)	(0.63)
$0	(0.47)	(1.27)	na	na	(0.87)	(1.11)	(1.41)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	(0.07)	(0.19)	na	na	(0.12)	(0.16)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.10)	(0.27)	na	na	(0.19)	(0.23)	(0.30)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.4%	na	na	2.5%	2.6%	2.5%
$0	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.4%	2.5%	na	na	2.3%	2.2%	2.4%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.4%	na	na	2.4%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.8%	2.7%	na	na	2.7%	2.7%	2.8%
$0	2.4%	2.5%	na	na	2.4%	2.3%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.0%	1.9%	na	na	2.2%	2.2%	2.0%
$0	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Day							
$0	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
$0	2.1%	2.1%	na	na	2.1%	2.2%	2.1%
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.8%	2.0%	na	na	1.5%	2.0%	1.8%
$0	2.3%	2.3%	na	na	2.1%	2.2%	2.3%
$0	2.8%	2.8%	na	na	2.6%	2.7%	2.8%
$0	2.1%	2.1%	na	na	2.1%	2.2%	2.1%
$0	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.6%	na	na	0.8%	1.2%	1.4%
$0	2.6%	2.6%	na	na	2.4%	2.6%	2.6%
$0	2.6%	2.6%	na	na	2.5%	2.4%	2.6%
$0	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
$0	2.1%	2.1%	na	na	2.1%	2.2%	2.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(4.66)	(12.58)	na	na	(8.62)	(10.95)	(13.98)
$125	(5.74)	(15.50)	na	na	(10.62)	(13.49)	(17.22)
$150	(6.85)	(18.50)	na	na	(12.67)	(16.10)	(20.55)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.58	1.57	na	na	1.07	1.36	1.74
60	1.11	3.00	na	na	2.05	2.61	3.33
90	1.68	4.54	na	na	3.11	3.95	5.04
120	1.96	5.29	na	na	3.63	4.61	5.88
Unlimited	2.51	6.78	na	na	4.64	5.90	7.53
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
40/$10 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
40/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
40/$20 copay	(0.63)	(1.70)	na	na	(1.17)	(1.48)	(1.89)
40/$25 copay	(0.82)	(2.21)	na	na	(1.52)	(1.93)	(2.46)
60	0.30	0.81	na	na	0.56	0.71	0.90
100	0.74	2.00	na	na	1.37	1.74	2.22
200	1.96	5.29	na	na	3.63	4.61	5.88
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.16)	(3.13)	na	na	(2.15)	(2.73)	(3.48)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.77	2.08	na	na	1.42	1.81	2.31
90	1.61	4.35	na	na	2.98	3.78	4.83
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.69	1.86	na	na	1.28	1.62	2.07
90	1.27	3.43	na	na	2.35	2.98	3.81
120	2.04	5.51	na	na	3.77	4.79	6.12
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(0.98)	(2.65)	na	na	(1.81)	(2.30)	(2.94)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.29	0.78	na	na	0.54	0.68	0.87
30	0.46	1.24	na	na	0.85	1.08	1.38
Unlimited	0.69	1.86	na	na	1.28	1.62	2.07
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.45	9.32	na	na	6.38	8.11	10.35
60	4.04	10.91	na	na	7.47	9.49	12.12
90	4.83	13.04	na	na	8.94	11.35	14.49
Unlimited	4.89	13.20	na	na	9.05	11.49	14.67
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
60/$10 copay	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
60/$15 copay	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
60/$20 copay	(0.59)	(1.59)	na	na	(1.09)	(1.39)	(1.77)
60/$25 copay	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
120/$0 copay	0.61	1.65	na	na	1.13	1.43	1.83
120/$5 copay	0.46	1.24	na	na	0.85	1.08	1.38
120/$10 copay	0.27	0.73	na	na	0.50	0.63	0.81
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.16)	(0.43)	na	na	(0.30)	(0.38)	(0.48)
120/$25 copay	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
Unlimited/$0 copay	0.70	1.89	na	na	1.30	1.65	2.10
Unlimited/$5 copay	0.54	1.46	na	na	1.00	1.27	1.62
Unlimited/$10 copay	0.34	0.92	na	na	0.63	0.80	1.02
Unlimited/$15 copay	0.08	0.22	na	na	0.15	0.19	0.24
Unlimited/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
Unlimited/$25 copay	(0.29)	(0.78)	na	na	(0.54)	(0.68)	(0.87)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.19	0.51	na	na	0.35	0.45	0.57
$5	0.08	0.22	na	na	0.15	0.19	0.24
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(4.77)	(12.88)	na	na	(8.82)	(11.21)	(14.31)
$125	(5.87)	(15.85)	na	na	(10.86)	(13.79)	(17.61)
$150	(7.02)	(18.95)	na	na	(12.99)	(16.50)	(21.06)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.60	1.62	na	na	1.11	1.41	1.80
$60	1.13	3.05	na	na	2.09	2.66	3.39
$90	1.71	4.62	na	na	3.16	4.02	5.13
$120	2.01	5.43	na	na	3.72	4.72	6.03
Unlimited	2.58	6.97	na	na	4.77	6.06	7.74
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
40/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
40/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.53)	(1.95)
40/$25 copay	(0.84)	(2.27)	na	na	(1.55)	(1.97)	(2.52)
$60	0.31	0.84	na	na	0.57	0.73	0.93
$100	0.75	2.03	na	na	1.39	1.76	2.25
$200	2.01	5.43	na	na	3.72	4.72	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	(1.19)	(3.21)	na	na	(2.20)	(2.80)	(3.57)
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.78	2.11	na	na	1.44	1.83	2.34
$90	1.65	4.46	na	na	3.05	3.88	4.95
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.70	1.89	na	na	1.30	1.65	2.10
$90	1.30	3.51	na	na	2.41	3.06	3.90
$120	2.08	5.62	na	na	3.85	4.89	6.24
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(1.00)	(2.70)	na	na	(1.85)	(2.35)	(3.00)
$7	0.00	0.00	na	na	0.00	0.00	0.00
$21	0.30	0.81	na	na	0.56	0.71	0.90
$30	0.46	1.24	na	na	0.85	1.08	1.38
Unlimited	0.70	1.89	na	na	1.30	1.65	2.10
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$30	3.53	9.53	na	na	6.53	8.30	10.59
$60	4.13	11.15	na	na	7.64	9.71	12.39
$90	4.94	13.34	na	na	9.14	11.61	14.82
Unlimited	5.01	13.53	na	na	9.27	11.77	15.03
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.76)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
60/$20 copay	(0.61)	(1.65)	na	na	(1.13)	(1.43)	(1.83)
60/$25 copay	(0.72)	(1.94)	na	na	(1.33)	(1.69)	(2.16)
120/$0 copay	0.63	1.70	na	na	1.17	1.48	1.89
120/$5 copay	0.46	1.24	na	na	0.85	1.08	1.38
120/$10 copay	0.28	0.76	na	na	0.52	0.66	0.84
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
Unlimited/$0 copay	0.71	1.92	na	na	1.31	1.67	2.13
Unlimited/$5 copay	0.56	1.51	na	na	1.04	1.32	1.68
Unlimited/$10 copay	0.35	0.95	na	na	0.65	0.82	1.05
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.21	0.57	na	na	0.39	0.49	0.63
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
$0	(0.13)	(0.35)	na	na	(0.24)	(0.30)	(0.39)
$0	(0.17)	(0.45)	na	na	(0.32)	(0.40)	(0.51)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	-	-	na	na	-	-	-
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.03	0.08	na	na	0.05	0.07	0.09
$0	0.05	0.14	na	na	0.09	0.11	0.15
$0	0.07	0.19	na	na	0.13	0.16	0.21
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.05	0.14	na	na	0.09	0.11	0.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.04	0.11	na	na	0.07	0.10	0.12
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	0.03	0.08	na	na	0.06	0.08	0.09
$0	0.04	0.11	na	na	0.08	0.10	0.12
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	-	-	na	na	-	-	-
$0	0.08	0.21	na	na	0.15	0.19	0.24
$0	0.09	0.24	na	na	0.17	0.22	0.27
$0	0.11	0.30	na	na	0.20	0.26	0.33
$0	0.12	0.33	na	na	0.22	0.28	0.36
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.02	0.06	na	na	0.04	0.04	0.06
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.2%	2.3%
$0	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.4%	3.2%	na	na	3.7%	3.7%	3.4%
$0	1.8%	1.7%	na	na	2.0%	1.9%	1.8%
$0	1.8%	1.8%	na	na	1.6%	1.8%	1.8%
$0	2.6%	2.6%	na	na	2.5%	2.4%	2.6%
$0	2.8%	2.8%	na	na	2.8%	2.7%	2.8%
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.2%	3.5%	na	na	2.6%	3.4%	3.2%
$0	2.4%	2.7%	na	na	2.0%	2.1%	2.4%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	1.4%	1.5%	na	na	1.5%	1.1%	1.4%
$0	2.6%	2.6%	na	na	2.5%	2.4%	2.6%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	2.6%	2.6%	na	na	2.3%	2.6%	2.6%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0	2.5%	2.5%	na	na	2.3%	2.6%	2.5%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.6%	na	na	1.6%	1.9%	1.4%
$0	2.4%	2.3%	na	na	2.6%	2.7%	2.4%
$0	2.0%	2.0%	na	na	2.1%	2.1%	2.0%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	2.0%	1.9%	na	na	2.2%	2.2%	2.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.4%	3.8%	na	na	3.7%	4.4%	3.4%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.6%	na	na	1.6%	1.9%	1.4%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$0	2.2%	2.2%	na	na	2.3%	2.3%	2.2%
$0	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
$0	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%
$0	3.7%	4.1%	na	na	4.0%	4.8%	3.7%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.4%	3.8%	na	na	3.7%	2.9%	3.4%
$0	1.4%	1.0%	na	na	1.5%	1.2%	1.4%
$0	3.3%	3.0%	na	na	3.5%	3.5%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.7%	4.1%	na	na	4.0%	4.8%	3.7%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.3%	-4.7%	na	na	-6.7%	-7.9%	-6.2%
$0	2.9%	3.3%	na	na	3.2%	2.5%	2.9%
$0	1.4%	1.6%	na	na	0.8%	1.2%	1.4%
$0	3.7%	3.4%	na	na	4.0%	3.9%	3.7%
$0	2.9%	3.3%	na	na	3.2%	2.5%	2.9%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	3.4%	3.8%	na	na	3.7%	4.4%	3.4%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	10.5%	11.8%	na	na	11.4%	8.9%	10.5%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(0.23)	(0.62)	na	na	(0.43)	(0.54)	(0.69)
$25	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.46)	(1.24)	na	na	(0.85)	(1.08)	(1.38)
$20	(0.66)	(1.78)	na	na	(1.22)	(1.55)	(1.98)
$25	(0.85)	(2.30)	na	na	(1.57)	(2.00)	(2.55)
$30	(1.04)	(2.81)	na	na	(1.92)	(2.44)	(3.12)
$35	(1.23)	(3.32)	na	na	(2.28)	(2.89)	(3.69)
$40	(1.42)	(3.83)	na	na	(2.63)	(3.34)	(4.26)
$45	(1.62)	(4.37)	na	na	(3.00)	(3.81)	(4.86)
$50	(1.79)	(4.83)	na	na	(3.31)	(4.21)	(5.37)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.74)	(2.00)	na	na	(1.37)	(1.74)	(2.22)
$25	(1.00)	(2.70)	na	na	(1.85)	(2.35)	(3.00)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.22)	(0.59)	na	na	(0.41)	(0.52)	(0.66)
$50	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$60	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$75	(0.56)	(1.51)	na	na	(1.04)	(1.32)	(1.68)
$100	(0.74)	(2.00)	na	na	(1.37)	(1.74)	(2.22)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.24)	(0.65)	na	na	(0.44)	(0.56)	(0.72)
$60	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$100	(0.49)	(1.32)	na	na	(0.91)	(1.15)	(1.47)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.11)	(8.40)	na	na	(5.75)	(7.31)	(9.33)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(4.82)	(13.01)	na	na	(8.92)	(11.33)	(14.46)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.24)	(0.65)	na	na	(0.44)	(0.56)	(0.72)
$25	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
$15	(0.46)	(1.24)	na	na	(0.85)	(1.08)	(1.38)
$20	(0.67)	(1.81)	na	na	(1.24)	(1.57)	(2.01)
$25	(0.88)	(2.38)	na	na	(1.63)	(2.07)	(2.64)
$30	(1.06)	(2.86)	na	na	(1.96)	(2.49)	(3.18)
$35	(1.26)	(3.40)	na	na	(2.33)	(2.96)	(3.78)
$40	(1.45)	(3.92)	na	na	(2.68)	(3.41)	(4.35)
$45	(1.66)	(4.48)	na	na	(3.07)	(3.90)	(4.98)
$50	(1.84)	(4.97)	na	na	(3.40)	(4.32)	(5.52)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
$15	(0.51)	(1.38)	na	na	(0.94)	(1.20)	(1.53)
$20	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
$25	(1.02)	(2.75)	na	na	(1.89)	(2.40)	(3.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.23)	(0.62)	na	na	(0.43)	(0.54)	(0.69)
$50	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$60	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$75	(0.58)	(1.57)	na	na	(1.07)	(1.36)	(1.74)
$100	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$60	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
$75	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$100	(0.51)	(1.38)	na	na	(0.94)	(1.20)	(1.53)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	(3.19)	(8.61)	na	na	(5.90)	(7.50)	(9.57)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	(4.93)	(13.31)	na	na	(9.12)	(11.59)	(14.79)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	0.01	0.03	na	na	0.01	0.02	0.03
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	(0.08)	(0.21)	na	na	(0.15)	(0.19)	(0.24)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	-	-	na	na	-	-	-
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$0	0.01	0.03	na	na	0.02	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	4.3%	4.8%	na	na	2.3%	3.7%	4.3%
$0	3.2%	2.4%	na	na	3.5%	2.7%	3.2%
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.5%	1.7%	na	na	1.6%	1.3%	1.5%
$0	3.5%	3.5%	na	na	3.8%	3.5%	3.5%
$0	1.9%	1.8%	na	na	2.1%	2.0%	1.9%
$0	2.4%	2.4%	na	na	2.2%	2.4%	2.4%
$0	2.1%	2.3%	na	na	1.9%	2.1%	2.1%
$0	2.5%	2.5%	na	na	2.3%	2.4%	2.5%
$0	2.8%	2.9%	na	na	2.7%	2.6%	2.8%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	2.9%	3.3%	na	na	3.2%	2.5%	2.9%
$0	4.1%	4.5%	na	na	3.3%	4.3%	4.1%
$0	1.4%	1.5%	na	na	1.5%	1.1%	1.4%
$0	2.0%	1.9%	na	na	2.2%	2.1%	2.0%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	4.5%	5.1%	na	na	4.9%	3.8%	4.5%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.6%	4.0%	na	na	2.9%	3.0%	3.6%
$0	1.4%	1.5%	na	na	1.5%	1.1%	1.4%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	4.2%	4.6%	na	na	4.5%	5.4%	4.2%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	4.1%	4.5%	na	na	3.3%	4.3%	4.1%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	2.6%	2.5%	na	na	2.6%	2.6%	2.6%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%

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

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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
January 01, 2013 - March 31, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

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

Age							
				End of Year			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

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

Age							
				End of Year			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	3.82	10.31	na	na	7.07	8.98	11.46
60	5.39	14.55	na	na	9.97	12.67	16.17
90	6.40	17.28	na	na	11.84	15.04	19.20
Unlimited	6.48	17.50	na	na	11.99	15.23	19.44
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	6.80	18.36	na	na	12.58	15.98	20.40
60	7.18	19.39	na	na	13.28	16.87	21.54
90	7.45	20.12	na	na	13.78	17.51	22.35
Unlimited	7.52	20.30	na	na	13.91	17.67	22.56
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
npatient Mental Hlt	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	5.18	13.99	na	na	9.58	12.17	15.54
30	6.16	16.63	na	na	11.40	14.48	18.48
40	6.79	18.33	na	na	12.56	15.96	20.37
60	7.42	20.03	na	na	13.73	17.44	22.26
Unlimited	7.49	20.22	na	na	13.86	17.60	22.47
SMALL GROUP				**$5 Copay**			
20	4.88	13.18	na	na	9.03	11.47	14.64
30	5.80	15.66	na	na	10.73	13.63	17.40
40	6.39	17.25	na	na	11.82	15.02	19.17
60	6.98	18.85	na	na	12.91	16.40	20.94
Unlimited	7.06	19.06	na	na	13.06	16.59	21.18
SMALL GROUP				**$10 Copay**			
20	4.54	12.26	na	na	8.40	10.67	13.62
30	5.40	14.58	na	na	9.99	12.69	16.20
40	5.95	16.07	na	na	11.01	13.98	17.85
60	6.50	17.55	na	na	12.03	15.28	19.50
Unlimited	6.57	17.74	na	na	12.15	15.44	19.71
SMALL GROUP				**$15 Copay**			
20	4.27	11.53	na	na	7.90	10.03	12.81
30	5.08	13.72	na	na	9.40	11.94	15.24
40	5.59	15.09	na	na	10.34	13.14	16.77
60	6.11	16.50	na	na	11.30	14.36	18.33
Unlimited	6.17	16.66	na	na	11.41	14.50	18.51
SMALL GROUP				**$20 Copay**			
20	4.01	10.83	na	na	7.42	9.42	12.03
30	4.76	12.85	na	na	8.81	11.19	14.28
40	5.24	14.15	na	na	9.69	12.31	15.72
60	5.73	15.47	na	na	10.60	13.47	17.19
Unlimited	5.78	15.61	na	na	10.69	13.58	17.34
SMALL GROUP				**$25 Copay**			
20	3.74	10.10	na	na	6.92	8.79	11.22
30	4.44	11.99	na	na	8.21	10.43	13.32
40	4.89	13.20	na	na	9.05	11.49	14.67
60	5.34	14.42	na	na	9.88	12.55	16.02
Unlimited	5.40	14.58	na	na	9.99	12.69	16.20
SMALL GROUP				**$30 Copay**			
20	3.59	9.69	na	na	6.64	8.44	10.77
30	4.28	11.56	na	na	7.92	10.06	12.84
40	4.72	12.74	na	na	8.73	11.09	14.16
60	5.16	13.93	na	na	9.55	12.13	15.48
Unlimited	5.20	14.04	na	na	9.62	12.22	15.60
SMALL GROUP				**$35 Copay**			
20	3.49	9.42	na	na	6.46	8.20	10.47
30	4.15	11.21	na	na	7.68	9.75	12.45
40	4.57	12.34	na	na	8.45	10.74	13.71
60	5.01	13.53	na	na	9.27	11.77	15.03
Unlimited	5.05	13.64	na	na	9.34	11.87	15.15
SMALL GROUP				**$40 Copay**			
20	3.40	9.18	na	na	6.29	7.99	10.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	3.91	10.56	na	na	7.23	9.19	11.73
60	5.52	14.90	na	na	10.21	12.97	16.56
90	6.55	17.69	na	na	12.12	15.39	19.65
Unlimited	6.63	17.90	na	na	12.27	15.58	19.89
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	6.96	18.79	na	na	12.88	16.36	20.88
60	7.36	19.87	na	na	13.62	17.30	22.08
90	7.63	20.60	na	na	14.12	17.93	22.89
Unlimited	7.70	20.79	na	na	14.25	18.10	23.10
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	5.31	14.34	na	na	9.82	12.48	15.93
30	6.31	17.04	na	na	11.67	14.83	18.93
40	6.95	18.77	na	na	12.86	16.33	20.85
60	7.60	20.52	na	na	14.06	17.86	22.80
Unlimited	7.66	20.68	na	na	14.17	18.00	22.98
SMALL GROUP				**$5 Copay**			
20	5.00	13.50	na	na	9.25	11.75	15.00
30	5.93	16.01	na	na	10.97	13.94	17.79
40	6.54	17.66	na	na	12.10	15.37	19.62
60	7.15	19.31	na	na	13.23	16.80	21.45
Unlimited	7.22	19.49	na	na	13.36	16.97	21.66
SMALL GROUP				**$10 Copay**			
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.53	14.93	na	na	10.23	13.00	16.59
40	6.09	16.44	na	na	11.27	14.31	18.27
60	6.66	17.98	na	na	12.32	15.65	19.98
Unlimited	6.73	18.17	na	na	12.45	15.82	20.19
SMALL GROUP				**$15 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	5.20	14.04	na	na	9.62	12.22	15.60
40	5.73	15.47	na	na	10.60	13.47	17.19
60	6.25	16.88	na	na	11.56	14.69	18.75
Unlimited	6.32	17.06	na	na	11.69	14.85	18.96
SMALL GROUP				**$20 Copay**			
20	4.10	11.07	na	na	7.59	9.64	12.30
30	4.87	13.15	na	na	9.01	11.44	14.61
40	5.37	14.50	na	na	9.93	12.62	16.11
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.91	15.96	na	na	10.93	13.89	17.73
SMALL GROUP				**$25 Copay**			
20	3.83	10.34	na	na	7.09	9.00	11.49
30	4.54	12.26	na	na	8.40	10.67	13.62
40	5.01	13.53	na	na	9.27	11.77	15.03
60	5.47	14.77	na	na	10.12	12.85	16.41
Unlimited	5.53	14.93	na	na	10.23	13.00	16.59
SMALL GROUP				**$30 Copay**			
20	3.67	9.91	na	na	6.79	8.62	11.01
30	4.39	11.85	na	na	8.12	10.32	13.17
40	4.83	13.04	na	na	8.94	11.35	14.49
60	5.28	14.26	na	na	9.77	12.41	15.84
Unlimited	5.33	14.39	na	na	9.86	12.53	15.99
SMALL GROUP				**$35 Copay**			
20	3.57	9.64	na	na	6.60	8.39	10.71
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.69	12.66	na	na	8.68	11.02	14.07
60	5.13	13.85	na	na	9.49	12.06	15.39
Unlimited	5.17	13.96	na	na	9.56	12.15	15.51
SMALL GROUP				**$40 Copay**			
20	3.49	9.42	na	na	6.46	8.20	10.47

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.09	0.25	na	na	0.16	0.21	0.27
60	0.13	0.35	na	na	0.24	0.30	0.39
90	0.15	0.41	na	na	0.28	0.35	0.45
Unlimited	0.15	0.40	na	na	0.28	0.35	0.45
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.16	0.43	na	na	0.30	0.38	0.48
60	0.18	0.48	na	na	0.34	0.43	0.54
90	0.18	0.48	na	na	0.34	0.42	0.54
Unlimited	0.18	0.49	na	na	0.34	0.43	0.54
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	0.13	0.35	na	na	0.24	0.31	0.39
30	0.15	0.41	na	na	0.27	0.35	0.45
40	0.16	0.44	na	na	0.30	0.37	0.48
60	0.18	0.49	na	na	0.33	0.42	0.54
Unlimited	0.17	0.46	na	na	0.31	0.40	0.51
SMALL GROUP				**$5 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.31	0.39
40	0.15	0.41	na	na	0.28	0.35	0.45
60	0.17	0.46	na	na	0.32	0.40	0.51
Unlimited	0.16	0.43	na	na	0.30	0.38	0.48
SMALL GROUP				**$10 Copay**			
20	0.11	0.30	na	na	0.20	0.26	0.33
30	0.13	0.35	na	na	0.24	0.31	0.39
40	0.14	0.37	na	na	0.26	0.33	0.42
60	0.16	0.43	na	na	0.29	0.37	0.48
Unlimited	0.16	0.43	na	na	0.30	0.38	0.48
SMALL GROUP				**$15 Copay**			
20	0.11	0.30	na	na	0.20	0.26	0.33
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.14	0.38	na	na	0.26	0.33	0.42
Unlimited	0.15	0.40	na	na	0.28	0.35	0.45
SMALL GROUP				**$20 Copay**			
20	0.09	0.24	na	na	0.17	0.22	0.27
30	0.11	0.30	na	na	0.20	0.25	0.33
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.32	0.42
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$25 Copay**			
20	0.09	0.24	na	na	0.17	0.21	0.27
30	0.10	0.27	na	na	0.19	0.24	0.30
40	0.12	0.33	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.30	0.39
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$30 Copay**			
20	0.08	0.22	na	na	0.15	0.18	0.24
30	0.11	0.29	na	na	0.20	0.26	0.33
40	0.11	0.30	na	na	0.21	0.26	0.33
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$35 Copay**			
20	0.08	0.22	na	na	0.14	0.19	0.24
30	0.09	0.24	na	na	0.16	0.21	0.27
40	0.12	0.32	na	na	0.23	0.28	0.36
60	0.12	0.32	na	na	0.22	0.29	0.36
Unlimited	0.12	0.32	na	na	0.22	0.28	0.36
SMALL GROUP				**$40 Copay**			
20	0.09	0.24	na	na	0.17	0.21	0.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
90	2.3%	2.4%	na	na	2.4%	2.3%	2.3%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
90	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
SMALL GROUP				**$5 Copay**			
20	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
30	2.2%	2.2%	na	na	2.2%	2.3%	2.2%
40	2.3%	2.4%	na	na	2.4%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$10 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
Unlimited	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
SMALL GROUP				**$15 Copay**			
20	2.6%	2.6%	na	na	2.5%	2.6%	2.6%
30	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
SMALL GROUP				**$20 Copay**			
20	2.2%	2.2%	na	na	2.3%	2.3%	2.2%
30	2.3%	2.3%	na	na	2.3%	2.2%	2.3%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
Unlimited	2.2%	2.2%	na	na	2.2%	2.3%	2.2%
SMALL GROUP				**$25 Copay**			
20	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$30 Copay**			
20	2.2%	2.3%	na	na	2.3%	2.1%	2.2%
30	2.6%	2.5%	na	na	2.5%	2.6%	2.6%
40	2.3%	2.4%	na	na	2.4%	2.3%	2.3%
60	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$35 Copay**			
20	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
30	2.2%	2.1%	na	na	2.1%	2.2%	2.2%
40	2.6%	2.6%	na	na	2.7%	2.6%	2.6%
60	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
Unlimited	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$40 Copay**			
20	2.6%	2.6%	na	na	2.7%	2.6%	2.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
30	4.03	10.88	na	na	7.46	9.47	12.09
40	4.44	11.99	na	na	8.21	10.43	13.32
60	4.86	13.12	na	na	8.99	11.42	14.58
Unlimited	4.90	13.23	na	na	9.07	11.52	14.70
SMALL GROUP				**$45 Copay**			
20	3.29	8.88	na	na	6.09	7.73	9.87
30	3.91	10.56	na	na	7.23	9.19	11.73
40	4.31	11.64	na	na	7.97	10.13	12.93
60	4.70	12.69	na	na	8.70	11.05	14.10
Unlimited	4.74	12.80	na	na	8.77	11.14	14.22
SMALL GROUP				**$50 Copay**			
20	3.19	8.61	na	na	5.90	7.50	9.57
30	3.79	10.23	na	na	7.01	8.91	11.37
40	4.17	11.26	na	na	7.71	9.80	12.51
60	4.56	12.31	na	na	8.44	10.72	13.68
Unlimited	4.59	12.39	na	na	8.49	10.79	13.77
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	6.72	18.14	na	na	12.43	15.79	20.16
30	7.39	19.95	na	na	13.67	17.37	22.17
40	7.82	21.11	na	na	14.47	18.38	23.46
60	8.25	22.28	na	na	15.26	19.39	24.75
Unlimited	8.33	22.49	na	na	15.41	19.58	24.99
SMALL GROUP				**$5 Copay**			
20	6.31	17.04	na	na	11.67	14.83	18.93
30	6.96	18.79	na	na	12.88	16.36	20.88
40	7.35	19.85	na	na	13.60	17.27	22.05
60	7.78	21.01	na	na	14.39	18.28	23.34
Unlimited	7.84	21.17	na	na	14.50	18.42	23.52
SMALL GROUP				**$10 Copay**			
20	5.89	15.90	na	na	10.90	13.84	17.67
30	6.48	17.50	na	na	11.99	15.23	19.44
40	6.84	18.47	na	na	12.65	16.07	20.52
60	7.23	19.52	na	na	13.38	16.99	21.69
Unlimited	7.30	19.71	na	na	13.51	17.16	21.90
SMALL GROUP				**$15 Copay**			
20	5.54	14.96	na	na	10.25	13.02	16.62
30	6.10	16.47	na	na	11.29	14.34	18.30
40	6.43	17.36	na	na	11.90	15.11	19.29
60	6.79	18.33	na	na	12.56	15.96	20.37
Unlimited	6.85	18.50	na	na	12.67	16.10	20.55
SMALL GROUP				**$20 Copay**			
20	5.20	14.04	na	na	9.62	12.22	15.60
30	5.71	15.42	na	na	10.56	13.42	17.13
40	6.04	16.31	na	na	11.17	14.19	18.12
60	6.38	17.23	na	na	11.80	14.99	19.14
Unlimited	6.43	17.36	na	na	11.90	15.11	19.29
SMALL GROUP				**$25 Copay**			
20	4.84	13.07	na	na	8.95	11.37	14.52
30	5.33	14.39	na	na	9.86	12.53	15.99
40	5.63	15.20	na	na	10.42	13.23	16.89
60	5.94	16.04	na	na	10.99	13.96	17.82
Unlimited	5.99	16.17	na	na	11.08	14.08	17.97
SMALL GROUP				**$30 Copay**			
20	4.67	12.61	na	na	8.64	10.97	14.01
30	5.14	13.88	na	na	9.51	12.08	15.42
40	5.43	14.66	na	na	10.05	12.76	16.29
60	5.73	15.47	na	na	10.60	13.47	17.19
Unlimited	5.77	15.58	na	na	10.67	13.56	17.31
SMALL GROUP				**$35 Copay**			
20	4.53	12.23	na	na	8.38	10.65	13.59
30	5.00	13.50	na	na	9.25	11.75	15.00
40	5.26	14.20	na	na	9.73	12.36	15.78
60	5.57	15.04	na	na	10.30	13.09	16.71
Unlimited	5.61	15.15	na	na	10.38	13.18	16.83

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	4.12	11.12	na	na	7.62	9.68	12.36
40	4.54	12.26	na	na	8.40	10.67	13.62
60	4.98	13.45	na	na	9.21	11.70	14.94
Unlimited	5.02	13.55	na	na	9.29	11.80	15.06
SMALL GROUP				**$45 Copay**			
20	3.36	9.07	na	na	6.22	7.90	10.08
30	4.00	10.80	na	na	7.40	9.40	12.00
40	4.41	11.91	na	na	8.16	10.36	13.23
60	4.82	13.01	na	na	8.92	11.33	14.46
Unlimited	4.85	13.10	na	na	8.97	11.40	14.55
SMALL GROUP				**$50 Copay**			
20	3.27	8.83	na	na	6.05	7.68	9.81
30	3.88	10.48	na	na	7.18	9.12	11.64
40	4.27	11.53	na	na	7.90	10.03	12.81
60	4.68	12.64	na	na	8.66	11.00	14.04
Unlimited	4.70	12.69	na	na	8.70	11.05	14.10
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	6.88	18.58	na	na	12.73	16.17	20.64
30	7.57	20.44	na	na	14.00	17.79	22.71
40	8.00	21.60	na	na	14.80	18.80	24.00
60	8.45	22.82	na	na	15.63	19.86	25.35
Unlimited	8.54	23.06	na	na	15.80	20.07	25.62
SMALL GROUP				**$5 Copay**			
20	6.47	17.47	na	na	11.97	15.20	19.41
30	7.13	19.25	na	na	13.19	16.76	21.39
40	7.52	20.30	na	na	13.91	17.67	22.56
60	7.96	21.49	na	na	14.73	18.71	23.88
Unlimited	8.03	21.68	na	na	14.86	18.87	24.09
SMALL GROUP				**$10 Copay**			
20	6.03	16.28	na	na	11.16	14.17	18.09
30	6.63	17.90	na	na	12.27	15.58	19.89
40	7.01	18.93	na	na	12.97	16.47	21.03
60	7.40	19.98	na	na	13.69	17.39	22.20
Unlimited	7.48	20.20	na	na	13.84	17.58	22.44
SMALL GROUP				**$15 Copay**			
20	5.68	15.34	na	na	10.51	13.35	17.04
30	6.24	16.85	na	na	11.54	14.66	18.72
40	6.58	17.77	na	na	12.17	15.46	19.74
60	6.95	18.77	na	na	12.86	16.33	20.85
Unlimited	7.02	18.95	na	na	12.99	16.50	21.06
SMALL GROUP				**$20 Copay**			
20	5.33	14.39	na	na	9.86	12.53	15.99
30	5.85	15.80	na	na	10.82	13.75	17.55
40	6.18	16.69	na	na	11.43	14.52	18.54
60	6.53	17.63	na	na	12.08	15.35	19.59
Unlimited	6.58	17.77	na	na	12.17	15.46	19.74
SMALL GROUP				**$25 Copay**			
20	4.96	13.39	na	na	9.18	11.66	14.88
30	5.45	14.72	na	na	10.08	12.81	16.35
40	5.76	15.55	na	na	10.66	13.54	17.28
60	6.08	16.42	na	na	11.25	14.29	18.24
Unlimited	6.14	16.58	na	na	11.36	14.43	18.42
SMALL GROUP				**$30 Copay**			
20	4.78	12.91	na	na	8.84	11.23	14.34
30	5.26	14.20	na	na	9.73	12.36	15.78
40	5.56	15.01	na	na	10.29	13.07	16.68
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.90	15.93	na	na	10.92	13.87	17.70
SMALL GROUP				**$35 Copay**			
20	4.64	12.53	na	na	8.58	10.90	13.92
30	5.12	13.82	na	na	9.47	12.03	15.36
40	5.39	14.55	na	na	9.97	12.67	16.17
60	5.71	15.42	na	na	10.56	13.42	17.13
Unlimited	5.74	15.50	na	na	10.62	13.49	17.22

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	0.09	0.24	na	na	0.16	0.21	0.27
40	0.10	0.27	na	na	0.19	0.24	0.30
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.12	0.32	na	na	0.22	0.28	0.36
SMALL GROUP				**$45 Copay**			
20	0.07	0.19	na	na	0.13	0.17	0.21
30	0.09	0.24	na	na	0.17	0.21	0.27
40	0.10	0.27	na	na	0.19	0.23	0.30
60	0.12	0.32	na	na	0.22	0.28	0.36
Unlimited	0.11	0.30	na	na	0.20	0.26	0.33
SMALL GROUP				**$50 Copay**			
20	0.08	0.22	na	na	0.15	0.18	0.24
30	0.09	0.25	na	na	0.17	0.21	0.27
40	0.10	0.27	na	na	0.19	0.23	0.30
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.11	0.30	na	na	0.21	0.26	0.33
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	0.16	0.44	na	na	0.30	0.38	0.48
30	0.18	0.49	na	na	0.33	0.42	0.54
40	0.18	0.49	na	na	0.33	0.42	0.54
60	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.21	0.57	na	na	0.39	0.49	0.63
SMALL GROUP				**$5 Copay**			
20	0.16	0.43	na	na	0.30	0.37	0.48
30	0.17	0.46	na	na	0.31	0.40	0.51
40	0.17	0.45	na	na	0.31	0.40	0.51
60	0.18	0.48	na	na	0.34	0.43	0.54
Unlimited	0.19	0.51	na	na	0.36	0.45	0.57
SMALL GROUP				**$10 Copay**			
20	0.14	0.38	na	na	0.26	0.33	0.42
30	0.15	0.40	na	na	0.28	0.35	0.45
40	0.17	0.46	na	na	0.32	0.40	0.51
60	0.17	0.46	na	na	0.31	0.40	0.51
Unlimited	0.18	0.49	na	na	0.33	0.42	0.54
SMALL GROUP				**$15 Copay**			
20	0.14	0.38	na	na	0.26	0.33	0.42
30	0.14	0.38	na	na	0.25	0.32	0.42
40	0.15	0.41	na	na	0.27	0.35	0.45
60	0.16	0.44	na	na	0.30	0.37	0.48
Unlimited	0.17	0.45	na	na	0.32	0.40	0.51
SMALL GROUP				**$20 Copay**			
20	0.13	0.35	na	na	0.24	0.31	0.39
30	0.14	0.38	na	na	0.26	0.33	0.42
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.15	0.40	na	na	0.28	0.36	0.45
Unlimited	0.15	0.41	na	na	0.27	0.35	0.45
SMALL GROUP				**$25 Copay**			
20	0.12	0.32	na	na	0.23	0.29	0.36
30	0.12	0.33	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.33	0.42
Unlimited	0.15	0.41	na	na	0.28	0.35	0.45
SMALL GROUP				**$30 Copay**			
20	0.11	0.30	na	na	0.20	0.26	0.33
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.32	0.42
Unlimited	0.13	0.35	na	na	0.25	0.31	0.39
SMALL GROUP				**$35 Copay**			
20	0.11	0.30	na	na	0.20	0.25	0.33
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.33	0.42
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	2.2%	2.2%	na	na	2.1%	2.2%	2.2%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$45 Copay**			
20	2.1%	2.1%	na	na	2.1%	2.2%	2.1%
30	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
40	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
60	2.6%	2.5%	na	na	2.5%	2.5%	2.6%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$50 Copay**			
20	2.5%	2.6%	na	na	2.5%	2.4%	2.5%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.5%	2.3%	2.4%
60	2.6%	2.7%	na	na	2.6%	2.6%	2.6%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$5 Copay**			
20	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
SMALL GROUP				**$10 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
SMALL GROUP				**$15 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.3%	2.3%	na	na	2.2%	2.2%	2.3%
40	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
Unlimited	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$20 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
Unlimited	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$25 Copay**			
20	2.5%	2.4%	na	na	2.6%	2.6%	2.5%
30	2.3%	2.3%	na	na	2.2%	2.2%	2.3%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$30 Copay**			
20	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
Unlimited	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$35 Copay**			
20	2.4%	2.5%	na	na	2.4%	2.3%	2.4%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.4%	2.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	4.39	11.85	na	na	8.12	10.32	13.17
30	4.84	13.07	na	na	8.95	11.37	14.52
40	5.10	13.77	na	na	9.44	11.99	15.30
60	5.40	14.58	na	na	9.99	12.69	16.20
Unlimited	5.44	14.69	na	na	10.06	12.78	16.32
SMALL GROUP				**$45 Copay**			
20	4.27	11.53	na	na	7.90	10.03	12.81
30	4.68	12.64	na	na	8.66	11.00	14.04
40	4.95	13.37	na	na	9.16	11.63	14.85
60	5.23	14.12	na	na	9.68	12.29	15.69
Unlimited	5.27	14.23	na	na	9.75	12.38	15.81
SMALL GROUP				**$50 Copay**			
20	4.13	11.15	na	na	7.64	9.71	12.39
30	4.54	12.26	na	na	8.40	10.67	13.62
40	4.82	13.01	na	na	8.92	11.33	14.46
60	5.07	13.69	na	na	9.38	11.91	15.21
Unlimited	5.10	13.77	na	na	9.44	11.99	15.30
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$40 Copay**			
20	4.50	12.15	na	na	8.33	10.58	13.50
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.22	14.09	na	na	9.66	12.27	15.66
60	5.53	14.93	na	na	10.23	13.00	16.59
Unlimited	5.57	15.04	na	na	10.30	13.09	16.71
SMALL GROUP				**$45 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	4.79	12.93	na	na	8.86	11.26	14.37
40	5.07	13.69	na	na	9.38	11.91	15.21
60	5.36	14.47	na	na	9.92	12.60	16.08
Unlimited	5.40	14.58	na	na	9.99	12.69	16.20
SMALL GROUP				**$50 Copay**			
20	4.23	11.42	na	na	7.83	9.94	12.69
30	4.65	12.56	na	na	8.60	10.93	13.95
40	4.93	13.31	na	na	9.12	11.59	14.79
60	5.19	14.01	na	na	9.60	12.20	15.57
Unlimited	5.22	14.09	na	na	9.66	12.27	15.66
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
5	0.00	0.00	na	na	0.00	0.00	0.00
10	0.00	0.00	na	na	0.00	0.00	0.00
15	0.00	0.00	na	na	0.00	0.00	0.00
20	0.00	0.00	na	na	0.00	0.00	0.00
25	0.00	0.00	na	na	0.00	0.00	0.00
30	0.00	0.00	na	na	0.00	0.00	0.00
35	0.00	0.00	na	na	0.00	0.00	0.00
40	0.00	0.00	na	na	0.00	0.00	0.00
45	0.00	0.00	na	na	0.00	0.00	0.00
50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	0.11	0.30	na	na	0.21	0.26	0.33
30	0.12	0.32	na	na	0.23	0.29	0.36
40	0.12	0.32	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$45 Copay**			
20	0.11	0.30	na	na	0.20	0.26	0.33
30	0.11	0.29	na	na	0.20	0.26	0.33
40	0.12	0.32	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$50 Copay**			
20	0.10	0.27	na	na	0.19	0.23	0.30
30	0.11	0.30	na	na	0.20	0.26	0.33
40	0.11	0.30	na	na	0.20	0.26	0.33
60	0.12	0.32	na	na	0.22	0.29	0.36
Unlimited	0.12	0.32	na	na	0.22	0.28	0.36
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
30	2.5%	2.4%	na	na	2.6%	2.6%	2.5%
40	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$45 Copay**			
20	2.6%	2.6%	na	na	2.5%	2.6%	2.6%
30	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$50 Copay**			
20	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
60	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
Unlimited	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
4TH QUARTER 2010 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	4.47	12.07	na	na	8.27	10.50	13.41
$0/Max $5000	4.24	11.45	na	na	7.84	9.96	12.72
$0/Max $2500	3.97	10.72	na	na	7.34	9.33	11.91
$25	4.24	11.45	na	na	7.84	9.96	12.72
$50	3.97	10.72	na	na	7.34	9.33	11.91
$100	3.63	9.80	na	na	6.72	8.53	10.89
$500	1.74	4.70	na	na	3.22	4.09	5.22
$5,000	0.29	0.78	na	na	0.54	0.68	0.87
Coinsurance							
80%	3.57	9.64	na	na	6.60	8.39	10.71
75%	3.35	9.05	na	na	6.20	7.87	10.05
70%	3.14	8.48	na	na	5.81	7.38	9.42
Deductible			**Orthotics Riders**				
$0	0.76	2.05	na	na	1.41	1.79	2.28
$0/Max $5000	0.73	1.97	na	na	1.35	1.72	2.19
$0/Max $2500	0.69	1.86	na	na	1.28	1.62	2.07
$25	0.73	1.97	na	na	1.35	1.72	2.19
$50	0.69	1.86	na	na	1.28	1.62	2.07
$100	0.62	1.67	na	na	1.15	1.46	1.86
$500	0.31	0.84	na	na	0.57	0.73	0.93
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.62	1.67	na	na	1.15	1.46	1.86
75%	0.59	1.59	na	na	1.09	1.39	1.77
70%	0.56	1.51	na	na	1.04	1.32	1.68
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.45	3.92	na	na	2.68	3.41	4.35
12 Months	2.34	6.32	na	na	4.33	5.50	7.02
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.27	6.13	na	na	4.20	5.33	6.81
12 Months	3.62	9.77	na	na	6.70	8.51	10.86
			Private Duty Nursing Riders				
In Full	0.54	1.46	na	na	1.00	1.27	1.62
80% hrs 73-504	0.08	0.22	na	na	0.15	0.19	0.24
100% hrs 73-504	0.15	0.41	na	na	0.28	0.35	0.45
			Dental Network Access				
	0.45	1.22	na	na	0.83	1.06	1.35
Limit			**Infertility Rider**				
2 IVF	9.45	25.52	na	na	17.48	22.21	28.35
3 IVF	11.40	30.78	na	na	21.09	26.79	34.20
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.35	11.75	na	na	8.05	10.22	13.05
Health Club Reimbursement							
$200 per year	1.13	3.05	na	na	2.09	2.66	3.39
			Nurse Advice Line Rider				
	0.29	0.78	na	na	0.54	0.68	0.87

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
4TH QUARTER 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	4.57	12.34	na	na	8.45	10.74	13.71
$0/Max $5000	4.35	11.75	na	na	8.05	10.22	13.05
$0/Max $2500	4.07	10.99	na	na	7.53	9.56	12.21
$25	4.35	11.75	na	na	8.05	10.22	13.05
$50	4.07	10.99	na	na	7.53	9.56	12.21
$100	3.72	10.04	na	na	6.88	8.74	11.16
$500	1.78	4.81	na	na	3.29	4.18	5.34
$5,000	0.30	0.81	na	na	0.56	0.71	0.90
Coinsurance							
80%	3.65	9.86	na	na	6.75	8.58	10.95
75%	3.43	9.26	na	na	6.35	8.06	10.29
70%	3.21	8.67	na	na	5.94	7.54	9.63
Deductible			**Orthotics Riders**				
$0	0.77	2.08	na	na	1.42	1.81	2.31
$0/Max $5000	0.74	2.00	na	na	1.37	1.74	2.22
$0/Max $2500	0.70	1.89	na	na	1.30	1.65	2.10
$25	0.74	2.00	na	na	1.37	1.74	2.22
$50	0.70	1.89	na	na	1.30	1.65	2.10
$100	0.64	1.73	na	na	1.18	1.50	1.92
$500	0.32	0.86	na	na	0.59	0.75	0.96
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.64	1.73	na	na	1.18	1.50	1.92
75%	0.61	1.65	na	na	1.13	1.43	1.83
70%	0.58	1.57	na	na	1.07	1.36	1.74
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.48	4.00	na	na	2.74	3.48	4.44
12 Months	2.39	6.45	na	na	4.42	5.62	7.17
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.32	6.26	na	na	4.29	5.45	6.96
12 Months	3.71	10.02	na	na	6.86	8.72	11.13
			Private Duty Nursing Riders				
In Full	0.56	1.51	na	na	1.04	1.32	1.68
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
			Dental Network Access				
	0.45	1.22	na	na	0.83	1.06	1.35
Limit			**Infertility Rider**				
2 IVF	9.67	26.11	na	na	17.89	22.72	29.01
3 IVF	11.67	31.51	na	na	21.59	27.42	35.01
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.45	12.02	na	na	8.23	10.46	13.35
Health Club Reimbursement							
$200 per year	1.15	3.11	na	na	2.13	2.70	3.45
			Nurse Advice Line Rider				
	0.30	0.81	na	na	0.56	0.71	0.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO 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	0.10	0.27	na	na	0.18	0.24	0.30
$0/Max $5000	0.11	0.30	na	na	0.21	0.26	0.33
$0/Max $2500	0.10	0.27	na	na	0.19	0.23	0.30
$25	0.11	0.30	na	na	0.21	0.26	0.33
$50	0.10	0.27	na	na	0.19	0.23	0.30
$100	0.09	0.24	na	na	0.16	0.21	0.27
$500	0.04	0.11	na	na	0.07	0.09	0.12
$5,000	0.01	0.03	na	na	0.02	0.03	0.03
Coinsurance							
80%	0.08	0.22	na	na	0.15	0.19	0.24
75%	0.08	0.21	na	na	0.15	0.19	0.24
70%	0.07	0.19	na	na	0.13	0.16	0.21
Deductible			**Orthotics Riders**				
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0/Max $5000	0.01	0.03	na	na	0.02	0.02	0.03
$0/Max $2500	0.01	0.03	na	na	0.02	0.03	0.03
$25	0.01	0.03	na	na	0.02	0.02	0.03
$50	0.01	0.03	na	na	0.02	0.03	0.03
$100	0.02	0.06	na	na	0.03	0.04	0.06
$500	0.01	0.02	na	na	0.02	0.02	0.03
$5,000	-	-	na	na	-	-	-
Coinsurance							
80%	0.02	0.06	na	na	0.03	0.04	0.06
75%	0.02	0.06	na	na	0.04	0.04	0.06
70%	0.02	0.06	na	na	0.03	0.04	0.06
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.03	0.08	na	na	0.06	0.07	0.09
12 Months	0.05	0.13	na	na	0.09	0.12	0.15
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.05	0.13	na	na	0.09	0.12	0.15
12 Months	0.09	0.25	na	na	0.16	0.21	0.27
			Private Duty Nursing Riders				
In Full	0.02	0.05	na	na	0.04	0.05	0.06
80% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
100% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
			Dental Network Access				
	-	-	na	na	-	-	-
Limit			**Infertility Rider**				
2 IVF	0.22	0.59	na	na	0.41	0.51	0.66
3 IVF	0.27	0.73	na	na	0.50	0.63	0.81
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	0.10	0.27	na	na	0.18	0.24	0.30
Health Club Reimbursement							
$200 per year	0.02	0.06	na	na	0.04	0.04	0.06
			Nurse Advice Line Rider				
	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
HIP HMO 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	2.2%	2.2%	na	na	2.2%	2.3%	2.2%
$0/Max $5000	2.6%	2.6%	na	na	2.7%	2.6%	2.6%
$0/Max $2500	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
$25	2.6%	2.6%	na	na	2.7%	2.6%	2.6%
$50	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
$100	2.5%	2.4%	na	na	2.4%	2.5%	2.5%
$500	2.3%	2.3%	na	na	2.2%	2.2%	2.3%
$5,000	3.4%	3.8%	na	na	3.7%	4.4%	3.4%
Coinsurance							
80%	2.2%	2.3%	na	na	2.3%	2.3%	2.2%
75%	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
70%	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
Deductible			**Orthotics Riders**				
$0	1.3%	1.5%	na	na	0.7%	1.1%	1.3%
$0/Max $5000	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
$0/Max $2500	1.4%	1.6%	na	na	1.6%	1.9%	1.4%
$25	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
$50	1.4%	1.6%	na	na	1.6%	1.9%	1.4%
$100	3.2%	3.6%	na	na	2.6%	2.7%	3.2%
$500	3.2%	2.4%	na	na	3.5%	2.7%	3.2%
$5,000	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Coinsurance							
80%	3.2%	3.6%	na	na	2.6%	2.7%	3.2%
75%	3.4%	3.8%	na	na	3.7%	2.9%	3.4%
70%	3.6%	4.0%	na	na	2.9%	3.0%	3.6%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	2.1%	2.0%	na	na	2.2%	2.1%	2.1%
12 Months	2.1%	2.1%	na	na	2.1%	2.2%	2.1%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.2%	2.1%	na	na	2.1%	2.3%	2.2%
12 Months	2.5%	2.6%	na	na	2.4%	2.5%	2.5%
			Private Duty Nursing Riders				
In Full	3.7%	3.4%	na	na	4.0%	3.9%	3.7%
80% hrs 73-504	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
100% hrs 73-504	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
			Dental Network Access				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Limit			**Infertility Rider**				
2 IVF	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
3 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
Health Club Reimbursement							
$200 per year	1.8%	2.0%	na	na	1.9%	1.5%	1.8%
			Nurse Advice Line Rider				
24 Months	3.4%	3.8%	na	na	3.7%	4.4%	3.4%

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

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group *	448.91	1,274.90	na	na	830.48	1,054.94	1,346.73
Small Group *	448.91	1,274.90	na	na	830.48	1,054.94	1,346.73

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee Child(ren	Employee & Spouse	Family
			Effective 01/01/2013 - 03/31/2013 (With WH & Autism)				
Small Group *	495.44	1,407.05	na	na	916.56	1,164.28	1,486.32
			Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)				
	490.54	1,393.13	na	na	907.50	1,152.77	1,471.62

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 01/01/2013 - 03/31/2013 (With WH & Autism)				
Small Group *	46.53	132.15	na	na	86.08	109.34	139.59
			Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)				
Small Group *	41.63	118.23	na	na	77.02	97.83	124.89

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee Child(ren	Employee & Spouse	Family
			Effective 01/01/2013 - 03/31/2013 (With WH & Autism)				
Small Group *	10.4%	10.4%	n/a	n/a	10.4%	10.4%	10.4%
			Effective 01/01/2013 - 03/31/2013 (Without WH & Autism)				
Small Group *	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 2010 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	na	na	0.00	0.00	0.00
$5	(3.95)	(11.22)	na	na	(7.31)	(9.28)	(11.85)
$10	(8.29)	(23.54)	na	na	(15.34)	(19.48)	(24.87)
$15	(12.83)	(36.44)	na	na	(23.74)	(30.15)	(38.49)
$20	(18.48)	(52.48)	na	na	(34.19)	(43.43)	(55.44)
$25	(34.29)	(97.38)	na	na	(63.44)	(80.58)	(102.87)
$30	(54.48)	(154.72)	na	na	(100.79)	(128.03)	(163.44)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.26)	(6.42)	na	na	(4.18)	(5.31)	(6.78)
$10	(4.76)	(13.52)	na	na	(8.81)	(11.19)	(14.28)
$15	(7.35)	(20.87)	na	na	(13.60)	(17.27)	(22.05)
$20	(10.59)	(30.08)	na	na	(19.59)	(24.89)	(31.77)
$25	(19.64)	(55.78)	na	na	(36.33)	(46.15)	(58.92)
$30	(31.23)	(88.69)	na	na	(57.78)	(73.39)	(93.69)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.80)	(7.95)	na	na	(5.18)	(6.58)	(8.40)
$10	(5.74)	(16.30)	na	na	(10.62)	(13.49)	(17.22)
$15	(8.71)	(24.74)	na	na	(16.11)	(20.47)	(26.13)
$20	(11.84)	(33.63)	na	na	(21.90)	(27.82)	(35.52)
$25	(17.60)	(49.98)	na	na	(32.56)	(41.36)	(52.80)
$30	(24.84)	(70.55)	na	na	(45.95)	(58.37)	(74.52)
$35	(32.50)	(92.30)	na	na	(60.13)	(76.38)	(97.50)
$40	(41.10)	(116.72)	na	na	(76.04)	(96.59)	(123.30)
$45	(50.71)	(144.02)	na	na	(93.81)	(119.17)	(152.13)
$50	(61.33)	(174.18)	na	na	(113.46)	(144.13)	(183.99)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.35)	(6.67)	na	na	(4.35)	(5.52)	(7.05)
$10	(4.85)	(13.77)	na	na	(8.97)	(11.40)	(14.55)
$15	(7.36)	(20.90)	na	na	(13.62)	(17.30)	(22.08)
$20	(10.02)	(28.46)	na	na	(18.54)	(23.55)	(30.06)
$25	(14.88)	(42.26)	na	na	(27.53)	(34.97)	(44.64)
$30	(20.98)	(59.58)	na	na	(38.81)	(49.30)	(62.94)
$35	(27.47)	(78.01)	na	na	(50.82)	(64.55)	(82.41)
$40	(34.77)	(98.75)	na	na	(64.32)	(81.71)	(104.31)
$45	(42.87)	(121.75)	na	na	(79.31)	(100.74)	(128.61)
$50	(51.86)	(147.28)	na	na	(95.94)	(121.87)	(155.58)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.23)	(6.33)	na	na	(4.13)	(5.24)	(6.69)
$150	(3.73)	(10.59)	na	na	(6.90)	(8.77)	(11.19)
$200	(5.38)	(15.28)	na	na	(9.95)	(12.64)	(16.14)
$250	(7.77)	(22.07)	na	na	(14.37)	(18.26)	(23.31)
$500	(19.10)	(54.24)	na	na	(35.34)	(44.89)	(57.30)
$750	(33.45)	(95.00)	na	na	(61.88)	(78.61)	(100.35)
$1,000	(51.07)	(145.04)	na	na	(94.48)	(120.01)	(153.21)
Copay/Day							
$50 w/3 Day Max	(3.21)	(9.12)	na	na	(5.94)	(7.54)	(9.63)
$50 w/5 Day Max	(4.36)	(12.38)	na	na	(8.07)	(10.25)	(13.08)
$100 w/3 Day Max	(6.86)	(19.48)	na	na	(12.69)	(16.12)	(20.58)
$100 w/5 Day Max	(11.69)	(33.20)	na	na	(21.63)	(27.47)	(35.07)
$250 w/3 Day Max	(22.68)	(64.41)	na	na	(41.96)	(53.30)	(68.04)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.25)	(3.55)	na	na	(2.31)	(2.94)	(3.75)
$75	(2.18)	(6.19)	na	na	(4.03)	(5.12)	(6.54)
$100	(3.29)	(9.34)	na	na	(6.09)	(7.73)	(9.87)
$125	(4.56)	(12.95)	na	na	(8.44)	(10.72)	(13.68)
$150	(6.05)	(17.18)	na	na	(11.19)	(14.22)	(18.15)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.45)	(1.28)	na	na	(0.83)	(1.06)	(1.35)
$25	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
$35	(1.36)	(3.86)	na	na	(2.52)	(3.20)	(4.08)
$50	(2.24)	(6.36)	na	na	(4.14)	(5.26)	(6.72)
$60	(2.84)	(8.07)	na	na	(5.25)	(6.67)	(8.52)
$75	(3.67)	(10.42)	na	na	(6.79)	(8.62)	(11.01)
$100	(5.15)	(14.63)	na	na	(9.53)	(12.10)	(15.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 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	na	na	0.00	0.00	0.00
$5	(4.32)	(12.27)	na	na	(7.99)	(10.15)	(12.96)
$10	(9.06)	(25.73)	na	na	(16.76)	(21.29)	(27.18)
$15	(14.02)	(39.82)	na	na	(25.94)	(32.95)	(42.06)
$20	(20.19)	(57.34)	na	na	(37.35)	(47.45)	(60.57)
$25	(37.47)	(106.41)	na	na	(69.32)	(88.05)	(112.41)
$30	(59.52)	(169.04)	na	na	(110.11)	(139.87)	(178.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.47)	(7.01)	na	na	(4.57)	(5.80)	(7.41)
$10	(5.20)	(14.77)	na	na	(9.62)	(12.22)	(15.60)
$15	(8.03)	(22.81)	na	na	(14.86)	(18.87)	(24.09)
$20	(11.58)	(32.89)	na	na	(21.42)	(27.21)	(34.74)
$25	(21.47)	(60.97)	na	na	(39.72)	(50.45)	(64.41)
$30	(34.13)	(96.93)	na	na	(63.14)	(80.21)	(102.39)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.06)	(8.69)	na	na	(5.66)	(7.19)	(9.18)
$10	(6.27)	(17.81)	na	na	(11.60)	(14.73)	(18.81)
$15	(9.52)	(27.04)	na	na	(17.61)	(22.37)	(28.56)
$20	(12.95)	(36.78)	na	na	(23.96)	(30.43)	(38.85)
$25	(19.23)	(54.61)	na	na	(35.58)	(45.19)	(57.69)
$30	(27.15)	(77.11)	na	na	(50.23)	(63.80)	(81.45)
$35	(35.51)	(100.85)	na	na	(65.69)	(83.45)	(106.53)
$40	(44.91)	(127.54)	na	na	(83.08)	(105.54)	(134.73)
$45	(55.41)	(157.36)	na	na	(102.51)	(130.21)	(166.23)
$50	(67.02)	(190.34)	na	na	(123.99)	(157.50)	(201.06)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.56)	(7.27)	na	na	(4.74)	(6.02)	(7.68)
$10	(5.30)	(15.05)	na	na	(9.81)	(12.46)	(15.90)
$15	(8.04)	(22.83)	na	na	(14.87)	(18.89)	(24.12)
$20	(10.95)	(31.10)	na	na	(20.26)	(25.73)	(32.85)
$25	(16.26)	(46.18)	na	na	(30.08)	(38.21)	(48.78)
$30	(22.93)	(65.12)	na	na	(42.42)	(53.89)	(68.79)
$35	(30.01)	(85.23)	na	na	(55.52)	(70.52)	(90.03)
$40	(37.99)	(107.89)	na	na	(70.28)	(89.28)	(113.97)
$45	(46.84)	(133.03)	na	na	(86.65)	(110.07)	(140.52)
$50	(56.67)	(160.94)	na	na	(104.84)	(133.17)	(170.01)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.44)	(6.93)	na	na	(4.51)	(5.73)	(7.32)
$150	(4.08)	(11.59)	na	na	(7.55)	(9.59)	(12.24)
$200	(5.88)	(16.70)	na	na	(10.88)	(13.82)	(17.64)
$250	(8.49)	(24.11)	na	na	(15.71)	(19.95)	(25.47)
$500	(20.87)	(59.27)	na	na	(38.61)	(49.04)	(62.61)
$750	(36.54)	(103.77)	na	na	(67.60)	(85.87)	(109.62)
$1,000	(55.81)	(158.50)	na	na	(103.25)	(131.15)	(167.43)
Copay/Day							
$50 w/3 Day Max	(3.51)	(9.97)	na	na	(6.49)	(8.25)	(10.53)
$50 w/5 Day Max	(4.76)	(13.52)	na	na	(8.81)	(11.19)	(14.28)
$100 w/3 Day Max	(7.50)	(21.30)	na	na	(13.88)	(17.63)	(22.50)
$100 w/5 Day Max	(12.77)	(36.27)	na	na	(23.62)	(30.01)	(38.31)
$250 w/3 Day Max	(24.78)	(70.38)	na	na	(45.84)	(58.23)	(74.34)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.37)	(3.89)	na	na	(2.53)	(3.22)	(4.11)
$75	(2.39)	(6.79)	na	na	(4.42)	(5.62)	(7.17)
$100	(3.59)	(10.20)	na	na	(6.64)	(8.44)	(10.77)
$125	(4.99)	(14.17)	na	na	(9.23)	(11.73)	(14.97)
$150	(6.61)	(18.77)	na	na	(12.23)	(15.53)	(19.83)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.88)	(2.50)	na	na	(1.63)	(2.07)	(2.64)
$35	(1.48)	(4.20)	na	na	(2.74)	(3.48)	(4.44)
$50	(2.45)	(6.96)	na	na	(4.53)	(5.76)	(7.35)
$60	(3.11)	(8.83)	na	na	(5.75)	(7.31)	(9.33)
$75	(4.01)	(11.39)	na	na	(7.42)	(9.42)	(12.03)
$100	(5.62)	(15.96)	na	na	(10.40)	(13.21)	(16.86)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	-	-	na	na	-	-	-
$5	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$10	(0.77)	(2.19)	na	na	(1.42)	(1.81)	(2.31)
$15	(1.19)	(3.38)	na	na	(2.20)	(2.80)	(3.57)
$20	(1.71)	(4.86)	na	na	(3.16)	(4.02)	(5.13)
$25	(3.18)	(9.03)	na	na	(5.88)	(7.47)	(9.54)
$30	(5.04)	(14.32)	na	na	(9.32)	(11.84)	(15.12)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.21)	(0.59)	na	na	(0.39)	(0.49)	(0.63)
$10	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$15	(0.68)	(1.94)	na	na	(1.26)	(1.60)	(2.04)
$20	(0.99)	(2.81)	na	na	(1.83)	(2.32)	(2.97)
$25	(1.83)	(5.19)	na	na	(3.39)	(4.30)	(5.49)
$30	(2.90)	(8.24)	na	na	(5.36)	(6.82)	(8.70)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$10	(0.53)	(1.51)	na	na	(0.98)	(1.24)	(1.59)
$15	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
$20	(1.11)	(3.15)	na	na	(2.06)	(2.61)	(3.33)
$25	(1.63)	(4.63)	na	na	(3.02)	(3.83)	(4.89)
$30	(2.31)	(6.56)	na	na	(4.28)	(5.43)	(6.93)
$35	(3.01)	(8.55)	na	na	(5.56)	(7.07)	(9.03)
$40	(3.81)	(10.82)	na	na	(7.04)	(8.95)	(11.43)
$45	(4.70)	(13.34)	na	na	(8.70)	(11.04)	(14.10)
$50	(5.69)	(16.16)	na	na	(10.53)	(13.37)	(17.07)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.21)	(0.60)	na	na	(0.39)	(0.50)	(0.63)
$10	(0.45)	(1.28)	na	na	(0.84)	(1.06)	(1.35)
$15	(0.68)	(1.93)	na	na	(1.25)	(1.59)	(2.04)
$20	(0.93)	(2.64)	na	na	(1.72)	(2.18)	(2.79)
$25	(1.38)	(3.92)	na	na	(2.55)	(3.24)	(4.14)
$30	(1.95)	(5.54)	na	na	(3.61)	(4.59)	(5.85)
$35	(2.54)	(7.22)	na	na	(4.70)	(5.97)	(7.62)
$40	(3.22)	(9.14)	na	na	(5.96)	(7.57)	(9.66)
$45	(3.97)	(11.28)	na	na	(7.34)	(9.33)	(11.91)
$50	(4.81)	(13.66)	na	na	(8.90)	(11.30)	(14.43)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$100	(0.21)	(0.60)	na	na	(0.38)	(0.49)	(0.63)
$150	(0.35)	(1.00)	na	na	(0.65)	(0.82)	(1.05)
$200	(0.50)	(1.42)	na	na	(0.93)	(1.18)	(1.50)
$250	(0.72)	(2.04)	na	na	(1.34)	(1.69)	(2.16)
$500	(1.77)	(5.03)	na	na	(3.27)	(4.15)	(5.31)
$750	(3.09)	(8.77)	na	na	(5.72)	(7.26)	(9.27)
$1,000	(4.74)	(13.46)	na	na	(8.77)	(11.14)	(14.22)
Copay/Day							
$50 w/3 Day Max	(0.30)	(0.85)	na	na	(0.55)	(0.71)	(0.90)
$50 w/5 Day Max	(0.40)	(1.14)	na	na	(0.74)	(0.94)	(1.20)
$100 w/3 Day Max	(0.64)	(1.82)	na	na	(1.19)	(1.51)	(1.92)
$100 w/5 Day Max	(1.08)	(3.07)	na	na	(1.99)	(2.54)	(3.24)
$250 w/3 Day Max	(2.10)	(5.97)	na	na	(3.88)	(4.93)	(6.30)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$50	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$75	(0.21)	(0.60)	na	na	(0.39)	(0.50)	(0.63)
$100	(0.30)	(0.86)	na	na	(0.55)	(0.71)	(0.90)
$125	(0.43)	(1.22)	na	na	(0.79)	(1.01)	(1.29)
$150	(0.56)	(1.59)	na	na	(1.04)	(1.31)	(1.68)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$15	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$25	(0.07)	(0.20)	na	na	(0.13)	(0.17)	(0.21)
$35	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$50	(0.21)	(0.60)	na	na	(0.39)	(0.50)	(0.63)
$60	(0.27)	(0.76)	na	na	(0.50)	(0.64)	(0.81)
$75	(0.34)	(0.97)	na	na	(0.63)	(0.80)	(1.02)
$100	(0.47)	(1.33)	na	na	(0.87)	(1.11)	(1.41)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	9.4%	9.4%	n/a	n/a	9.3%	9.4%	9.4%
$10	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$15	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$20	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
$25	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$30	9.3%	9.3%	n/a	n/a	9.2%	9.2%	9.3%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	9.3%	9.2%	n/a	n/a	9.3%	9.2%	9.3%
$10	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$15	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$20	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$25	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$10	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
$15	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$20	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
$25	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$35	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
$40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$45	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$50	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	8.9%	9.0%	n/a	n/a	9.0%	9.1%	8.9%
$10	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
$15	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$20	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$25	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$35	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
$40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$45	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$50	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$100	9.4%	9.5%	n/a	n/a	9.2%	9.4%	9.4%
$150	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
$200	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$250	9.3%	9.2%	n/a	n/a	9.3%	9.3%	9.3%
$500	9.3%	9.3%	n/a	n/a	9.3%	9.2%	9.3%
$750	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$1,000	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Copay/Day							
$50 w/3 Day Max	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
$50 w/5 Day Max	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$100 w/3 Day Max	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
$100 w/5 Day Max	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$250 w/3 Day Max	9.3%	9.3%	n/a	n/a	9.2%	9.2%	9.3%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	9.6%	9.6%	n/a	n/a	9.5%	9.5%	9.6%
$75	9.6%	9.7%	n/a	n/a	9.7%	9.8%	9.6%
$100	9.1%	9.2%	n/a	n/a	9.0%	9.2%	9.1%
$125	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
$150	9.3%	9.3%	n/a	n/a	9.3%	9.2%	9.3%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	6.7%	6.3%	n/a	n/a	7.2%	6.6%	6.7%
$25	8.6%	8.7%	n/a	n/a	8.7%	8.9%	8.6%
$35	8.8%	8.8%	n/a	n/a	8.7%	8.7%	8.8%
$50	9.4%	9.4%	n/a	n/a	9.4%	9.5%	9.4%
$60	9.5%	9.4%	n/a	n/a	9.5%	9.6%	9.5%
$75	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
$100	9.1%	9.1%	n/a	n/a	9.1%	9.2%	9.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 2010 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
$125	(6.75)	(19.17)	na	na	(12.49)	(15.86)	(20.25)
$150	(8.50)	(24.14)	na	na	(15.73)	(19.98)	(25.50)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.61	1.73	na	na	1.13	1.43	1.83
60	1.18	3.35	na	na	2.18	2.77	3.54
90	1.78	5.06	na	na	3.29	4.18	5.34
120	2.08	5.91	na	na	3.85	4.89	6.24
Unlimited	2.66	7.55	na	na	4.92	6.25	7.98
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.32)	(0.91)	na	na	(0.59)	(0.75)	(0.96)
40/$15 copay	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
40/$20 copay	(0.67)	(1.90)	na	na	(1.24)	(1.57)	(2.01)
40/$25 copay	(0.86)	(2.44)	na	na	(1.59)	(2.02)	(2.58)
60	0.32	0.91	na	na	0.59	0.75	0.96
100	0.78	2.22	na	na	1.44	1.83	2.34
200	2.09	5.94	na	na	3.87	4.91	6.27
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.23)	(3.49)	na	na	(2.28)	(2.89)	(3.69)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.82	2.33	na	na	1.52	1.93	2.46
90	1.72	4.88	na	na	3.18	4.04	5.16
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.73	2.07	na	na	1.35	1.72	2.19
90	1.35	3.83	na	na	2.50	3.17	4.05
120	2.15	6.11	na	na	3.98	5.05	6.45
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.04)	(2.95)	na	na	(1.92)	(2.44)	(3.12)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.30	0.85	na	na	0.56	0.71	0.90
30	0.49	1.39	na	na	0.91	1.15	1.47
Unlimited	0.73	2.07	na	na	1.35	1.72	2.19
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.67	10.42	na	na	6.79	8.62	11.01
60	4.30	12.21	na	na	7.96	10.11	12.90
90	5.13	14.57	na	na	9.49	12.06	15.39
Unlimited	5.19	14.74	na	na	9.60	12.20	15.57
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
60/$15 copay	(0.41)	(1.16)	na	na	(0.76)	(0.96)	(1.23)
60/$20 copay	(0.59)	(1.68)	na	na	(1.09)	(1.39)	(1.77)
60/$25 copay	(0.69)	(1.96)	na	na	(1.28)	(1.62)	(2.07)
120/$0 copay	0.65	1.85	na	na	1.20	1.53	1.95
120/$5 copay	0.50	1.42	na	na	0.93	1.18	1.50
120/$10 copay	0.32	0.91	na	na	0.59	0.75	0.96
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
Unlimited/$0 copay	0.75	2.13	na	na	1.39	1.76	2.25
Unlimited/$5 copay	0.60	1.70	na	na	1.11	1.41	1.80
Unlimited/$10 copay	0.39	1.11	na	na	0.72	0.92	1.17
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.23)	(0.65)	na	na	(0.43)	(0.54)	(0.69)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.17	0.48	na	na	0.31	0.40	0.51
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 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
$125	(7.37)	(20.93)	na	na	(13.63)	(17.32)	(22.11)
$150	(9.29)	(26.38)	na	na	(17.19)	(21.83)	(27.87)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.67	1.90	na	na	1.24	1.57	2.01
60	1.30	3.69	na	na	2.41	3.06	3.90
90	1.94	5.51	na	na	3.59	4.56	5.82
120	2.27	6.45	na	na	4.20	5.33	6.81
Unlimited	2.90	8.24	na	na	5.37	6.82	8.70
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.52)	(1.48)	na	na	(0.96)	(1.22)	(1.56)
40/$20 copay	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
40/$25 copay	(0.95)	(2.70)	na	na	(1.76)	(2.23)	(2.85)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.84	2.39	na	na	1.55	1.97	2.52
200	2.28	6.48	na	na	4.22	5.36	6.84
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.35)	(3.83)	na	na	(2.50)	(3.17)	(4.05)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.90	2.56	na	na	1.67	2.12	2.70
90	1.87	5.31	na	na	3.46	4.39	5.61
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.24	na	na	1.46	1.86	2.37
90	1.47	4.17	na	na	2.72	3.45	4.41
120	2.35	6.67	na	na	4.35	5.52	7.05
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.54	1.53	na	na	1.00	1.27	1.62
Unlimited	0.79	2.24	na	na	1.46	1.86	2.37
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.01	11.39	na	na	7.42	9.42	12.03
60	4.70	13.35	na	na	8.70	11.05	14.10
90	5.60	15.90	na	na	10.36	13.16	16.80
Unlimited	5.68	16.13	na	na	10.51	13.35	17.04
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.65)	(1.85)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.75)	(2.13)	na	na	(1.39)	(1.76)	(2.25)
120/$0 copay	0.71	2.02	na	na	1.31	1.67	2.13
120/$5 copay	0.56	1.59	na	na	1.04	1.32	1.68
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.81	2.30	na	na	1.50	1.90	2.43
Unlimited/$5 copay	0.66	1.87	na	na	1.22	1.55	1.98
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(0.62)	(1.76)	na	na	(1.14)	(1.46)	(1.86)
$150	(0.79)	(2.24)	na	na	(1.46)	(1.85)	(2.37)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	-	-	na	na	-	-	-
45	0.06	0.17	na	na	0.11	0.14	0.18
60	0.12	0.34	na	na	0.23	0.29	0.36
90	0.16	0.45	na	na	0.30	0.38	0.48
120	0.19	0.54	na	na	0.35	0.44	0.57
Unlimited	0.24	0.69	na	na	0.45	0.57	0.72
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	-	-	na	na	-	-	-
40/$5 copay	-	-	na	na	-	-	-
40/$10 copay	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
40/$15 copay	(0.04)	(0.12)	na	na	(0.07)	(0.09)	(0.12)
40/$20 copay	(0.06)	(0.17)	na	na	(0.11)	(0.15)	(0.18)
40/$25 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60	0.03	0.08	na	na	0.06	0.07	0.09
100	0.06	0.17	na	na	0.11	0.14	0.18
200	0.19	0.54	na	na	0.35	0.45	0.57
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
30	-	-	na	na	-	-	-
60	0.08	0.23	na	na	0.15	0.19	0.24
90	0.15	0.43	na	na	0.28	0.35	0.45
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	-	-	na	na	-	-	-
60	0.06	0.17	na	na	0.11	0.14	0.18
90	0.12	0.34	na	na	0.22	0.28	0.36
120	0.20	0.56	na	na	0.37	0.47	0.60
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.09)	(0.26)	na	na	(0.17)	(0.22)	(0.27)
7	-	-	na	na	-	-	-
21	0.03	0.09	na	na	0.05	0.07	0.09
30	0.05	0.14	na	na	0.09	0.12	0.15
Unlimited	0.06	0.17	na	na	0.11	0.14	0.18
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	-	-	na	na	-	-	-
30	0.34	0.97	na	na	0.63	0.80	1.02
60	0.40	1.14	na	na	0.74	0.94	1.20
90	0.47	1.33	na	na	0.87	1.10	1.41
Unlimited	0.49	1.39	na	na	0.91	1.15	1.47
# 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	-	-	na	na	-	-	-
60/$5 copay	-	-	na	na	-	-	-
60/$10 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
60/$15 copay	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
60/$20 copay	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
60/$25 copay	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
120/$0 copay	0.06	0.17	na	na	0.11	0.14	0.18
120/$5 copay	0.06	0.17	na	na	0.11	0.14	0.18
120/$10 copay	0.03	0.08	na	na	0.06	0.07	0.09
120/$15 copay	-	-	na	na	-	-	-
120/$20 copay	-	-	na	na	-	-	-
120/$25 copay	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
Unlimited/$0 copay	0.06	0.17	na	na	0.11	0.14	0.18
Unlimited/$5 copay	0.06	0.17	na	na	0.11	0.14	0.18
Unlimited/$10 copay	0.03	0.08	na	na	0.06	0.07	0.09
Unlimited/$15 copay	-	-	na	na	-	-	-
Unlimited/$20 copay	-	-	na	na	-	-	-
Unlimited/$25 copay	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.03	0.09	na	na	0.06	0.07	0.09
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	9.2%	9.2%	n/a	n/a	9.1%	9.2%	9.2%
$150	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
45	9.8%	9.8%	n/a	n/a	9.7%	9.8%	9.8%
60	10.2%	10.1%	n/a	n/a	10.6%	10.5%	10.2%
90	9.0%	8.9%	n/a	n/a	9.1%	9.1%	9.0%
120	9.1%	9.1%	n/a	n/a	9.1%	9.0%	9.1%
Unlimited	9.0%	9.1%	n/a	n/a	9.1%	9.1%	9.0%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
40/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
40/$10 copay	9.4%	8.8%	n/a	n/a	10.2%	9.3%	9.4%
40/$15 copay	8.3%	8.8%	n/a	n/a	7.9%	8.0%	8.3%
40/$20 copay	9.0%	8.9%	n/a	n/a	8.9%	9.6%	9.0%
40/$25 copay	10.5%	10.7%	n/a	n/a	10.7%	10.4%	10.5%
60	9.4%	8.8%	n/a	n/a	10.2%	9.3%	9.4%
100	7.7%	7.7%	n/a	n/a	7.6%	7.7%	7.7%
200	9.1%	9.1%	n/a	n/a	9.0%	9.2%	9.1%
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	9.8%	9.7%	n/a	n/a	9.6%	9.7%	9.8%
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	9.8%	9.9%	n/a	n/a	9.9%	9.8%	9.8%
90	8.7%	8.8%	n/a	n/a	8.8%	8.7%	8.7%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
90	8.9%	8.9%	n/a	n/a	8.8%	8.8%	8.9%
120	9.3%	9.2%	n/a	n/a	9.3%	9.3%	9.3%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	8.7%	8.8%	n/a	n/a	8.9%	9.0%	8.7%
7	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
21	10.0%	10.6%	n/a	n/a	8.9%	9.9%	10.0%
30	10.2%	10.1%	n/a	n/a	9.9%	10.4%	10.2%
Unlimited	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
90	9.2%	9.1%	n/a	n/a	9.2%	9.1%	9.2%
Unlimited	9.4%	9.4%	n/a	n/a	9.5%	9.4%	9.4%
# 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$10 copay	12.0%	12.7%	n/a	n/a	13.0%	11.9%	12.0%
60/$15 copay	7.3%	7.8%	n/a	n/a	6.6%	7.3%	7.3%
60/$20 copay	10.2%	10.1%	n/a	n/a	10.1%	10.1%	10.2%
60/$25 copay	8.7%	8.7%	n/a	n/a	8.6%	8.6%	8.7%
120/$0 copay	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
120/$5 copay	12.0%	12.0%	n/a	n/a	11.8%	11.9%	12.0%
120/$10 copay	9.4%	8.8%	n/a	n/a	10.2%	9.3%	9.4%
120/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$25 copay	10.0%	10.6%	n/a	n/a	8.9%	9.9%	10.0%
Unlimited/$0 copay	8.0%	8.0%	n/a	n/a	7.9%	8.0%	8.0%
Unlimited/$5 copay	10.0%	10.0%	n/a	n/a	9.9%	9.9%	10.0%
Unlimited/$10 copay	7.7%	7.2%	n/a	n/a	8.3%	7.6%	7.7%
Unlimited/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$25 copay	13.0%	13.8%	n/a	n/a	11.6%	13.0%	13.0%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	17.6%	18.8%	n/a	n/a	19.4%	17.5%	17.6%
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 2010 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
$20	(0.22)	(0.62)	na	na	(0.41)	(0.52)	(0.66)
$25	(0.32)	(0.91)	na	na	(0.59)	(0.75)	(0.96)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.27)	(0.77)	na	na	(0.50)	(0.63)	(0.81)
$15	(0.46)	(1.31)	na	na	(0.85)	(1.08)	(1.38)
$20	(0.65)	(1.85)	na	na	(1.20)	(1.53)	(1.95)
$25	(0.82)	(2.33)	na	na	(1.52)	(1.93)	(2.46)
$30	(1.04)	(2.95)	na	na	(1.92)	(2.44)	(3.12)
$35	(1.20)	(3.41)	na	na	(2.22)	(2.82)	(3.60)
$40	(1.39)	(3.95)	na	na	(2.57)	(3.27)	(4.17)
$45	(1.58)	(4.49)	na	na	(2.92)	(3.71)	(4.74)
$50	(1.77)	(5.03)	na	na	(3.27)	(4.16)	(5.31)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
$25	(0.98)	(2.78)	na	na	(1.81)	(2.30)	(2.94)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.22)	(0.62)	na	na	(0.41)	(0.52)	(0.66)
$50	(0.34)	(0.97)	na	na	(0.63)	(0.80)	(1.02)
$60	(0.41)	(1.16)	na	na	(0.76)	(0.96)	(1.23)
$75	(0.55)	(1.56)	na	na	(1.02)	(1.29)	(1.65)
$100	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.23)	(0.65)	na	na	(0.43)	(0.54)	(0.69)
$60	(0.27)	(0.77)	na	na	(0.50)	(0.63)	(0.81)
$75	(0.36)	(1.02)	na	na	(0.67)	(0.85)	(1.08)
$100	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.03)	(8.61)	na	na	(5.61)	(7.12)	(9.09)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum [20%, $100]; $500 annual maximum					
	(4.73)	(13.43)	na	na	(8.75)	(11.12)	(14.19)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.40)	(1.14)	na	na	(0.74)	(0.94)	(1.20)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
4TH QUARTER 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
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.71)	(2.02)	na	na	(1.31)	(1.67)	(2.13)
$25	(0.90)	(2.56)	na	na	(1.67)	(2.12)	(2.70)
$30	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
$35	(1.32)	(3.75)	na	na	(2.44)	(3.10)	(3.96)
$40	(1.51)	(4.29)	na	na	(2.79)	(3.55)	(4.53)
$45	(1.73)	(4.91)	na	na	(3.20)	(4.07)	(5.19)
$50	(1.93)	(5.48)	na	na	(3.57)	(4.54)	(5.79)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
$20	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.07)	(3.04)	na	na	(1.98)	(2.51)	(3.21)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.61)	(1.73)	na	na	(1.13)	(1.43)	(1.83)
$100	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.31)	(9.40)	na	na	(6.12)	(7.78)	(9.93)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum [20%, $100]; $500 annual maximum					
	(5.17)	(14.68)	na	na	(9.56)	(12.15)	(15.51)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$20	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$25	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.03)	(0.08)	na	na	(0.06)	(0.08)	(0.09)
$15	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$20	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$30	(0.09)	(0.26)	na	na	(0.17)	(0.22)	(0.27)
$35	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$40	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$45	(0.15)	(0.42)	na	na	(0.28)	(0.36)	(0.45)
$50	(0.16)	(0.45)	na	na	(0.30)	(0.38)	(0.48)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$15	(0.05)	(0.14)	na	na	(0.09)	(0.12)	(0.15)
$20	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$50	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$60	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$75	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$100	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$50	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$60	(0.03)	(0.08)	na	na	(0.06)	(0.08)	(0.09)
$75	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
$100	(0.05)	(0.14)	na	na	(0.09)	(0.12)	(0.15)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(0.28)	(0.79)	na	na	(0.51)	(0.66)	(0.84)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum [20%, $100]; $500 annual maximum					
	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$20	13.6%	14.5%	n/a	n/a	12.2%	13.5%	13.6%
$25	9.4%	8.8%	n/a	n/a	10.2%	9.3%	9.4%
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	11.1%	10.4%	n/a	n/a	12.0%	12.7%	11.1%
$15	6.5%	6.1%	n/a	n/a	7.1%	6.5%	6.5%
$20	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
$25	9.8%	9.9%	n/a	n/a	9.9%	9.8%	9.8%
$30	8.7%	8.8%	n/a	n/a	8.9%	9.0%	8.7%
$35	10.0%	10.0%	n/a	n/a	9.9%	9.9%	10.0%
$40	8.6%	8.6%	n/a	n/a	8.6%	8.6%	8.6%
$45	9.5%	9.4%	n/a	n/a	9.6%	9.7%	9.5%
$50	9.0%	8.9%	n/a	n/a	9.2%	9.1%	9.0%
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	8.6%	9.1%	n/a	n/a	7.7%	8.5%	8.6%
$15	10.2%	10.1%	n/a	n/a	9.9%	10.4%	10.2%
$20	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
$25	9.2%	9.4%	n/a	n/a	9.4%	9.1%	9.2%
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	13.6%	14.5%	n/a	n/a	12.2%	13.5%	13.6%
$50	8.8%	8.2%	n/a	n/a	7.9%	8.7%	8.8%
$60	7.3%	7.8%	n/a	n/a	6.6%	7.3%	7.3%
$75	10.9%	10.9%	n/a	n/a	10.8%	10.9%	10.9%
$100	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$50	13.0%	13.8%	n/a	n/a	11.6%	13.0%	13.0%
$60	11.1%	10.4%	n/a	n/a	12.0%	12.7%	11.1%
$75	8.3%	8.8%	n/a	n/a	7.5%	8.2%	8.3%
$100	10.2%	10.1%	n/a	n/a	9.9%	10.4%	10.2%
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	9.2%	9.2%	n/a	n/a	9.1%	9.3%	9.2%
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum [20%, $100]; $500 annual maximum					
	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	7.5%	7.0%	n/a	n/a	8.1%	7.4%	7.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
January 01, 2013 - March 31, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

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

Age							
			End of Year				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
30	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%

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

Age							
			End of Year				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			Class II Dependents				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	3.99	11.33	na	na	7.38	9.38	11.97
60	4.77	13.55	na	na	8.82	11.21	14.31
90	5.28	15.00	na	na	9.77	12.41	15.84
Unlimited	5.35	15.19	na	na	9.90	12.57	16.05
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	6.47	18.37	na	na	11.97	15.20	19.41
60	6.83	19.40	na	na	12.64	16.05	20.49
90	7.09	20.14	na	na	13.12	16.66	21.27
Unlimited	7.17	20.36	na	na	13.26	16.85	21.51
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.41	15.36	na	na	10.01	12.71	16.23
30	6.35	18.03	na	na	11.75	14.92	19.05
40	6.96	19.77	na	na	12.88	16.36	20.88
60	7.56	21.47	na	na	13.99	17.77	22.68
Unlimited	7.64	21.70	na	na	14.13	17.95	22.92
SMALL GROUP	**$5 Copay**						
20	5.10	14.48	na	na	9.44	11.99	15.30
30	5.97	16.95	na	na	11.04	14.03	17.91
40	6.54	18.57	na	na	12.10	15.37	19.62
60	7.10	20.16	na	na	13.14	16.69	21.30
Unlimited	7.17	20.36	na	na	13.26	16.85	21.51
SMALL GROUP	**$10 Copay**						
20	4.75	13.49	na	na	8.79	11.16	14.25
30	5.56	15.79	na	na	10.29	13.07	16.68
40	6.10	17.32	na	na	11.29	14.34	18.30
60	6.62	18.80	na	na	12.25	15.56	19.86
Unlimited	6.71	19.06	na	na	12.41	15.77	20.13
SMALL GROUP	**$15 Copay**						
20	4.46	12.67	na	na	8.25	10.48	13.38
30	5.21	14.80	na	na	9.64	12.24	15.63
40	5.72	16.24	na	na	10.58	13.44	17.16
60	6.22	17.66	na	na	11.51	14.62	18.66
Unlimited	6.28	17.84	na	na	11.62	14.76	18.84
SMALL GROUP	**$20 Copay**						
20	4.19	11.90	na	na	7.75	9.85	12.57
30	4.91	13.94	na	na	9.08	11.54	14.73
40	5.38	15.28	na	na	9.95	12.64	16.14
60	5.85	16.61	na	na	10.82	13.75	17.55
Unlimited	5.91	16.78	na	na	10.93	13.89	17.73
SMALL GROUP	**$25 Copay**						
20	3.91	11.10	na	na	7.23	9.19	11.73
30	4.57	12.98	na	na	8.45	10.74	13.71
40	4.99	14.17	na	na	9.23	11.73	14.97
60	5.43	15.42	na	na	10.05	12.76	16.29
Unlimited	5.49	15.59	na	na	10.16	12.90	16.47
SMALL GROUP	**$30 Copay**						
20	3.75	10.65	na	na	6.94	8.81	11.25
30	4.41	12.52	na	na	8.16	10.36	13.23
40	4.82	13.69	na	na	8.92	11.33	14.46
60	5.27	14.97	na	na	9.75	12.38	15.81
Unlimited	5.31	15.08	na	na	9.82	12.48	15.93
SMALL GROUP	**$35 Copay**						
20	3.65	10.37	na	na	6.75	8.58	10.95
30	4.27	12.13	na	na	7.90	10.03	12.81
40	4.70	13.35	na	na	8.70	11.05	14.10
60	5.10	14.48	na	na	9.44	11.99	15.30
Unlimited	5.14	14.60	na	na	9.51	12.08	15.42
SMALL GROUP	**$40 Copay**						
20	3.55	10.08	na	na	6.57	8.34	10.65
30	4.16	11.81	na	na	7.70	9.78	12.48
40	4.55	12.92	na	na	8.42	10.69	13.65
60	4.93	14.00	na	na	9.12	11.59	14.79
Unlimited	4.98	14.14	na	na	9.21	11.70	14.94
SMALL GROUP	**$45 Copay**						
20	3.44	9.77	na	na	6.36	8.08	10.32
30	4.03	11.45	na	na	7.46	9.47	12.09
40	4.40	12.50	na	na	8.14	10.34	13.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.36	12.38	na	na	8.07	10.25	13.08
60	5.21	14.80	na	na	9.64	12.24	15.63
90	5.77	16.39	na	na	10.67	13.56	17.31
Unlimited	5.85	16.61	na	na	10.82	13.75	17.55
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.07	20.08	na	na	13.08	16.61	21.21
60	7.46	21.19	na	na	13.80	17.53	22.38
90	7.75	22.01	na	na	14.34	18.21	23.25
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.91	16.78	na	na	10.93	13.89	17.73
30	6.94	19.71	na	na	12.84	16.31	20.82
40	7.61	21.61	na	na	14.08	17.88	22.83
60	8.26	23.46	na	na	15.28	19.41	24.78
Unlimited	8.35	23.71	na	na	15.45	19.62	25.05
SMALL GROUP	**$5 Copay**						
20	5.57	15.82	na	na	10.30	13.09	16.71
30	6.52	18.52	na	na	12.06	15.32	19.56
40	7.15	20.31	na	na	13.23	16.80	21.45
60	7.76	22.04	na	na	14.36	18.24	23.28
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**$10 Copay**						
20	5.19	14.74	na	na	9.60	12.20	15.57
30	6.08	17.27	na	na	11.25	14.29	18.24
40	6.66	18.91	na	na	12.32	15.65	19.98
60	7.23	20.53	na	na	13.38	16.99	21.69
Unlimited	7.33	20.82	na	na	13.56	17.23	21.99
SMALL GROUP	**$15 Copay**						
20	4.87	13.83	na	na	9.01	11.44	14.61
30	5.70	16.19	na	na	10.55	13.40	17.10
40	6.25	17.75	na	na	11.56	14.69	18.75
60	6.80	19.31	na	na	12.58	15.98	20.40
Unlimited	6.86	19.48	na	na	12.69	16.12	20.58
SMALL GROUP	**$20 Copay**						
20	4.58	13.01	na	na	8.47	10.76	13.74
30	5.37	15.25	na	na	9.93	12.62	16.11
40	5.88	16.70	na	na	10.88	13.82	17.64
60	6.40	18.18	na	na	11.84	15.04	19.20
Unlimited	6.46	18.35	na	na	11.95	15.18	19.38
SMALL GROUP	**$25 Copay**						
20	4.27	12.13	na	na	7.90	10.03	12.81
30	5.00	14.20	na	na	9.25	11.75	15.00
40	5.45	15.48	na	na	10.08	12.81	16.35
60	5.93	16.84	na	na	10.97	13.94	17.79
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP	**$30 Copay**						
20	4.10	11.64	na	na	7.59	9.64	12.30
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.76	16.36	na	na	10.66	13.54	17.28
Unlimited	5.80	16.47	na	na	10.73	13.63	17.40
SMALL GROUP	**$35 Copay**						
20	3.99	11.33	na	na	7.38	9.38	11.97
30	4.67	13.26	na	na	8.64	10.97	14.01
40	5.14	14.60	na	na	9.51	12.08	15.42
60	5.57	15.82	na	na	10.30	13.09	16.71
Unlimited	5.61	15.93	na	na	10.38	13.18	16.83
SMALL GROUP	**$40 Copay**						
20	3.88	11.02	na	na	7.18	9.12	11.64
30	4.54	12.89	na	na	8.40	10.67	13.62
40	4.97	14.11	na	na	9.19	11.68	14.91
60	5.39	15.31	na	na	9.97	12.67	16.17
Unlimited	5.44	15.45	na	na	10.06	12.78	16.32
SMALL GROUP	**$45 Copay**						
20	3.76	10.68	na	na	6.96	8.84	11.28
30	4.40	12.50	na	na	8.14	10.34	13.20
40	4.81	13.66	na	na	8.90	11.30	14.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.37	1.05	na	na	0.69	0.87	1.11
60	0.44	1.25	na	na	0.82	1.03	1.32
90	0.49	1.39	na	na	0.90	1.15	1.47
Unlimited	0.50	1.42	na	na	0.92	1.18	1.50
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.60	1.71	na	na	1.11	1.41	1.80
60	0.63	1.79	na	na	1.16	1.48	1.89
90	0.66	1.87	na	na	1.22	1.55	1.98
Unlimited	0.67	1.91	na	na	1.24	1.57	2.01
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.50	1.42	na	na	0.92	1.18	1.50
30	0.59	1.68	na	na	1.09	1.39	1.77
40	0.65	1.84	na	na	1.20	1.52	1.95
60	0.70	1.99	na	na	1.29	1.64	2.10
Unlimited	0.71	2.01	na	na	1.32	1.67	2.13
SMALL GROUP	**$5 Copay**						
20	0.47	1.34	na	na	0.86	1.10	1.41
30	0.55	1.57	na	na	1.02	1.29	1.65
40	0.61	1.74	na	na	1.13	1.43	1.83
60	0.66	1.88	na	na	1.22	1.55	1.98
Unlimited	0.67	1.91	na	na	1.24	1.57	2.01
SMALL GROUP	**$10 Copay**						
20	0.44	1.25	na	na	0.81	1.04	1.32
30	0.52	1.48	na	na	0.96	1.22	1.56
40	0.56	1.59	na	na	1.03	1.31	1.68
60	0.61	1.73	na	na	1.13	1.43	1.83
Unlimited	0.62	1.76	na	na	1.15	1.46	1.86
SMALL GROUP	**$15 Copay**						
20	0.41	1.16	na	na	0.76	0.96	1.23
30	0.49	1.39	na	na	0.91	1.16	1.47
40	0.53	1.51	na	na	0.98	1.25	1.59
60	0.58	1.65	na	na	1.07	1.36	1.74
Unlimited	0.58	1.64	na	na	1.07	1.36	1.74
SMALL GROUP	**$20 Copay**						
20	0.39	1.11	na	na	0.72	0.91	1.17
30	0.46	1.31	na	na	0.85	1.08	1.38
40	0.50	1.42	na	na	0.93	1.18	1.50
60	0.55	1.57	na	na	1.02	1.29	1.65
Unlimited	0.55	1.57	na	na	1.02	1.29	1.65
SMALL GROUP	**$25 Copay**						
20	0.36	1.03	na	na	0.67	0.84	1.08
30	0.43	1.22	na	na	0.80	1.01	1.29
40	0.46	1.31	na	na	0.85	1.08	1.38
60	0.50	1.42	na	na	0.92	1.18	1.50
Unlimited	0.50	1.42	na	na	0.92	1.18	1.50
SMALL GROUP	**$30 Copay**						
20	0.35	0.99	na	na	0.65	0.83	1.05
30	0.41	1.17	na	na	0.76	0.97	1.23
40	0.44	1.25	na	na	0.81	1.03	1.32
60	0.49	1.39	na	na	0.91	1.16	1.47
Unlimited	0.49	1.39	na	na	0.91	1.15	1.47
SMALL GROUP	**$35 Copay**						
20	0.34	0.96	na	na	0.63	0.80	1.02
30	0.40	1.13	na	na	0.74	0.94	1.20
40	0.44	1.25	na	na	0.81	1.03	1.32
60	0.47	1.34	na	na	0.86	1.10	1.41
Unlimited	0.47	1.33	na	na	0.87	1.10	1.41
SMALL GROUP	**$40 Copay**						
20	0.33	0.94	na	na	0.61	0.78	0.99
30	0.38	1.08	na	na	0.70	0.89	1.14
40	0.42	1.19	na	na	0.77	0.99	1.26
60	0.46	1.31	na	na	0.85	1.08	1.38
Unlimited	0.46	1.31	na	na	0.85	1.08	1.38
SMALL GROUP	**$45 Copay**						
20	0.32	0.91	na	na	0.60	0.76	0.96
30	0.37	1.05	na	na	0.68	0.87	1.11
40	0.41	1.16	na	na	0.76	0.96	1.23

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.2%	9.2%	n/a	n/a	9.3%	9.2%	9.2%
90	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
90	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.3%	9.4%	n/a	n/a	9.4%	9.3%	9.3%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	9.2%	9.2%	n/a	n/a	9.2%	9.3%	9.2%
30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.2%	9.2%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
SMALL GROUP	**$5 Copay**						
20	9.2%	9.3%	n/a	n/a	9.1%	9.2%	9.2%
30	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
40	9.3%	9.4%	n/a	n/a	9.3%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.3%	9.4%	n/a	n/a	9.4%	9.3%	9.3%
SMALL GROUP	**$10 Copay**						
20	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
30	9.4%	9.4%	n/a	n/a	9.3%	9.3%	9.4%
40	9.2%	9.2%	n/a	n/a	9.1%	9.1%	9.2%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.2%	9.2%	n/a	n/a	9.3%	9.3%	9.2%
SMALL GROUP	**$15 Copay**						
20	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
30	9.4%	9.4%	n/a	n/a	9.4%	9.5%	9.4%
40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
SMALL GROUP	**$20 Copay**						
20	9.3%	9.3%	n/a	n/a	9.3%	9.2%	9.3%
30	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.4%	9.5%	n/a	n/a	9.4%	9.4%	9.4%
Unlimited	9.3%	9.4%	n/a	n/a	9.3%	9.3%	9.3%
SMALL GROUP	**$25 Copay**						
20	9.2%	9.3%	n/a	n/a	9.3%	9.1%	9.2%
30	9.4%	9.4%	n/a	n/a	9.5%	9.4%	9.4%
40	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
SMALL GROUP	**$30 Copay**						
20	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
30	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
40	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
60	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
Unlimited	9.2%	9.2%	n/a	n/a	9.3%	9.2%	9.2%
SMALL GROUP	**$35 Copay**						
20	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
30	9.4%	9.3%	n/a	n/a	9.4%	9.4%	9.4%
40	9.4%	9.4%	n/a	n/a	9.3%	9.3%	9.4%
60	9.2%	9.3%	n/a	n/a	9.1%	9.2%	9.2%
Unlimited	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
SMALL GROUP	**$40 Copay**						
20	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
30	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
40	9.2%	9.2%	n/a	n/a	9.1%	9.3%	9.2%
60	9.3%	9.4%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
SMALL GROUP	**$45 Copay**						
20	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
30	9.2%	9.2%	n/a	n/a	9.1%	9.2%	9.2%
40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	4.79	13.60	na	na	8.86	11.26	14.37
Unlimited	4.82	13.69	na	na	8.92	11.33	14.46
SMALL GROUP				**$50 Copay**			
20	3.33	9.46	na	na	6.16	7.83	9.99
30	3.92	11.13	na	na	7.25	9.21	11.76
40	4.27	12.13	na	na	7.90	10.03	12.81
60	4.63	13.15	na	na	8.57	10.88	13.89
Unlimited	4.69	13.32	na	na	8.68	11.02	14.07
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	6.42	18.23	na	na	11.88	15.09	19.26
30	6.97	19.79	na	na	12.89	16.38	20.91
40	7.29	20.70	na	na	13.49	17.13	21.87
60	7.66	21.75	na	na	14.17	18.00	22.98
Unlimited	7.74	21.98	na	na	14.32	18.19	23.22
SMALL GROUP				**$5 Copay**			
20	6.03	17.13	na	na	11.16	14.17	18.09
30	6.55	18.60	na	na	12.12	15.39	19.65
40	6.86	19.48	na	na	12.69	16.12	20.58
60	7.20	20.45	na	na	13.32	16.92	21.60
Unlimited	7.28	20.68	na	na	13.47	17.11	21.84
SMALL GROUP				**$10 Copay**			
20	5.64	16.02	na	na	10.43	13.25	16.92
30	6.11	17.35	na	na	11.30	14.36	18.33
40	6.41	18.20	na	na	11.86	15.06	19.23
60	6.73	19.11	na	na	12.45	15.82	20.19
Unlimited	6.79	19.28	na	na	12.56	15.96	20.37
SMALL GROUP				**$15 Copay**			
20	5.29	15.02	na	na	9.79	12.43	15.87
30	5.73	16.27	na	na	10.60	13.47	17.19
40	6.00	17.04	na	na	11.10	14.10	18.00
60	6.30	17.89	na	na	11.66	14.81	18.90
Unlimited	6.38	18.12	na	na	11.80	14.99	19.14
SMALL GROUP				**$20 Copay**			
20	4.97	14.11	na	na	9.19	11.68	14.91
30	5.38	15.28	na	na	9.95	12.64	16.14
40	5.65	16.05	na	na	10.45	13.28	16.95
60	5.93	16.84	na	na	10.97	13.94	17.79
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP				**$25 Copay**			
20	4.61	13.09	na	na	8.53	10.83	13.83
30	5.00	14.20	na	na	9.25	11.75	15.00
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.51	15.65	na	na	10.19	12.95	16.53
Unlimited	5.57	15.82	na	na	10.30	13.09	16.71
SMALL GROUP				**$30 Copay**			
20	4.47	12.69	na	na	8.27	10.50	13.41
30	4.83	13.72	na	na	8.94	11.35	14.49
40	5.09	14.46	na	na	9.42	11.96	15.27
60	5.33	15.14	na	na	9.86	12.53	15.99
Unlimited	5.37	15.25	na	na	9.93	12.62	16.11
SMALL GROUP				**$35 Copay**			
20	4.32	12.27	na	na	7.99	10.15	12.96
30	4.70	13.35	na	na	8.70	11.05	14.10
40	4.91	13.94	na	na	9.08	11.54	14.73
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.20	14.77	na	na	9.62	12.22	15.60
SMALL GROUP				**$40 Copay**			
20	4.20	11.93	na	na	7.77	9.87	12.60
30	4.56	12.95	na	na	8.44	10.72	13.68
40	4.77	13.55	na	na	8.82	11.21	14.31
60	5.00	14.20	na	na	9.25	11.75	15.00
Unlimited	5.07	14.40	na	na	9.38	11.91	15.21
SMALL GROUP				**$45 Copay**			
20	4.07	11.56	na	na	7.53	9.56	12.21
30	4.41	12.52	na	na	8.16	10.36	13.23
40	4.62	13.12	na	na	8.55	10.86	13.86
60	4.85	13.77	na	na	8.97	11.40	14.55
Unlimited	4.89	13.89	na	na	9.05	11.49	14.67
SMALL GROUP				**$50 Copay**			
20	3.95	11.22	na	na	7.31	9.28	11.85
30	4.27	12.13	na	na	7.90	10.03	12.81

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	5.23	14.85	na	na	9.68	12.29	15.69
Unlimited	5.26	14.94	na	na	9.73	12.36	15.78
SMALL GROUP				**$50 Copay**			
20	3.64	10.34	na	na	6.73	8.55	10.92
30	4.28	12.16	na	na	7.92	10.06	12.84
40	4.67	13.26	na	na	8.64	10.97	14.01
60	5.06	14.37	na	na	9.36	11.89	15.18
Unlimited	5.12	14.54	na	na	9.47	12.03	15.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.01	19.91	na	na	12.97	16.47	21.03
30	7.62	21.64	na	na	14.10	17.91	22.86
40	7.97	22.63	na	na	14.74	18.73	23.91
60	8.37	23.77	na	na	15.48	19.67	25.11
Unlimited	8.46	24.03	na	na	15.65	19.88	25.38
SMALL GROUP				**$5 Copay**			
20	6.59	18.72	na	na	12.19	15.49	19.77
30	7.16	20.33	na	na	13.25	16.83	21.48
40	7.50	21.30	na	na	13.88	17.63	22.50
60	7.87	22.35	na	na	14.56	18.49	23.61
Unlimited	7.96	22.61	na	na	14.73	18.71	23.88
SMALL GROUP				**$10 Copay**			
20	6.16	17.49	na	na	11.40	14.48	18.48
30	6.67	18.94	na	na	12.34	15.67	20.01
40	7.00	19.88	na	na	12.95	16.45	21.00
60	7.35	20.87	na	na	13.60	17.27	22.05
Unlimited	7.42	21.07	na	na	13.73	17.44	22.26
SMALL GROUP				**$15 Copay**			
20	5.78	16.42	na	na	10.69	13.58	17.34
30	6.26	17.78	na	na	11.58	14.71	18.78
40	6.56	18.63	na	na	12.14	15.42	19.68
60	6.88	19.54	na	na	12.73	16.17	20.64
Unlimited	6.97	19.79	na	na	12.89	16.38	20.91
SMALL GROUP				**$20 Copay**			
20	5.43	15.42	na	na	10.05	12.76	16.29
30	5.88	16.70	na	na	10.88	13.82	17.64
40	6.17	17.52	na	na	11.41	14.50	18.51
60	6.48	18.40	na	na	11.99	15.23	19.44
Unlimited	6.55	18.60	na	na	12.12	15.39	19.65
SMALL GROUP				**$25 Copay**			
20	5.04	14.31	na	na	9.32	11.84	15.12
30	5.46	15.51	na	na	10.10	12.83	16.38
40	5.75	16.33	na	na	10.64	13.51	17.25
60	6.03	17.13	na	na	11.16	14.17	18.09
Unlimited	6.09	17.30	na	na	11.27	14.31	18.27
SMALL GROUP				**$30 Copay**			
20	4.88	13.86	na	na	9.03	11.47	14.64
30	5.27	14.97	na	na	9.75	12.38	15.81
40	5.56	15.79	na	na	10.29	13.07	16.68
60	5.82	16.53	na	na	10.77	13.68	17.46
Unlimited	5.87	16.67	na	na	10.86	13.79	17.61
SMALL GROUP				**$35 Copay**			
20	4.72	13.40	na	na	8.73	11.09	14.16
30	5.14	14.60	na	na	9.51	12.08	15.42
40	5.37	15.25	na	na	9.93	12.62	16.11
60	5.63	15.99	na	na	10.42	13.23	16.89
Unlimited	5.69	16.16	na	na	10.53	13.37	17.07
SMALL GROUP				**$40 Copay**			
20	4.59	13.04	na	na	8.49	10.79	13.77
30	4.99	14.17	na	na	9.23	11.73	14.97
40	5.21	14.80	na	na	9.64	12.24	15.63
60	5.46	15.51	na	na	10.10	12.83	16.38
Unlimited	5.54	15.73	na	na	10.25	13.02	16.62
SMALL GROUP				**$45 Copay**			
20	4.45	12.64	na	na	8.23	10.46	13.35
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.05	14.34	na	na	9.34	11.87	15.15
60	5.30	15.05	na	na	9.81	12.46	15.90
Unlimited	5.35	15.19	na	na	9.90	12.57	16.05
SMALL GROUP				**$50 Copay**			
20	4.32	12.27	na	na	7.99	10.15	12.96
30	4.67	13.26	na	na	8.64	10.97	14.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	0.44	1.25	na	na	0.82	1.03	1.32
Unlimited	0.44	1.25	na	na	0.81	1.03	1.32
SMALL GROUP				**$50 Copay**			
20	0.31	0.88	na	na	0.57	0.72	0.93
30	0.36	1.03	na	na	0.67	0.85	1.08
40	0.40	1.13	na	na	0.74	0.94	1.20
60	0.43	1.22	na	na	0.79	1.01	1.29
Unlimited	0.43	1.22	na	na	0.79	1.01	1.29
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	0.59	1.68	na	na	1.09	1.38	1.77
30	0.65	1.85	na	na	1.21	1.53	1.95
40	0.68	1.93	na	na	1.25	1.60	2.04
60	0.71	2.02	na	na	1.31	1.67	2.13
Unlimited	0.72	2.05	na	na	1.33	1.69	2.16
SMALL GROUP				**$5 Copay**			
20	0.56	1.59	na	na	1.03	1.32	1.68
30	0.61	1.73	na	na	1.13	1.44	1.83
40	0.64	1.82	na	na	1.19	1.51	1.92
60	0.67	1.90	na	na	1.24	1.57	2.01
Unlimited	0.68	1.93	na	na	1.26	1.60	2.04
SMALL GROUP				**$10 Copay**			
20	0.52	1.47	na	na	0.97	1.23	1.56
30	0.56	1.59	na	na	1.04	1.31	1.68
40	0.59	1.68	na	na	1.09	1.39	1.77
60	0.62	1.76	na	na	1.15	1.45	1.86
Unlimited	0.63	1.79	na	na	1.17	1.48	1.89
SMALL GROUP				**$15 Copay**			
20	0.49	1.40	na	na	0.90	1.15	1.47
30	0.53	1.51	na	na	0.98	1.24	1.59
40	0.56	1.59	na	na	1.04	1.32	1.68
60	0.58	1.65	na	na	1.07	1.36	1.74
Unlimited	0.59	1.67	na	na	1.09	1.39	1.77
SMALL GROUP				**$20 Copay**			
20	0.46	1.31	na	na	0.86	1.08	1.38
30	0.50	1.42	na	na	0.93	1.18	1.50
40	0.52	1.47	na	na	0.96	1.22	1.56
60	0.55	1.56	na	na	1.02	1.29	1.65
Unlimited	0.56	1.59	na	na	1.04	1.31	1.68
SMALL GROUP				**$25 Copay**			
20	0.43	1.22	na	na	0.79	1.01	1.29
30	0.46	1.31	na	na	0.85	1.08	1.38
40	0.49	1.39	na	na	0.91	1.15	1.47
60	0.52	1.48	na	na	0.97	1.22	1.56
Unlimited	0.52	1.48	na	na	0.97	1.22	1.56
SMALL GROUP				**$30 Copay**			
20	0.41	1.17	na	na	0.76	0.97	1.23
30	0.44	1.25	na	na	0.81	1.03	1.32
40	0.47	1.33	na	na	0.87	1.11	1.41
60	0.49	1.39	na	na	0.91	1.15	1.47
Unlimited	0.50	1.42	na	na	0.93	1.17	1.50
SMALL GROUP				**$35 Copay**			
20	0.40	1.13	na	na	0.74	0.94	1.20
30	0.44	1.25	na	na	0.81	1.03	1.32
40	0.46	1.31	na	na	0.85	1.08	1.38
60	0.47	1.34	na	na	0.87	1.10	1.41
Unlimited	0.49	1.39	na	na	0.91	1.15	1.47
SMALL GROUP				**$40 Copay**			
20	0.39	1.11	na	na	0.72	0.92	1.17
30	0.43	1.22	na	na	0.79	1.01	1.29
40	0.44	1.25	na	na	0.82	1.03	1.32
60	0.46	1.31	na	na	0.85	1.08	1.38
Unlimited	0.47	1.33	na	na	0.87	1.11	1.41
SMALL GROUP				**$45 Copay**			
20	0.38	1.08	na	na	0.70	0.90	1.14
30	0.41	1.17	na	na	0.76	0.97	1.23
40	0.43	1.22	na	na	0.79	1.01	1.29
60	0.45	1.28	na	na	0.84	1.06	1.35
Unlimited	0.46	1.30	na	na	0.85	1.08	1.38
SMALL GROUP				**$50 Copay**			
20	0.37	1.05	na	na	0.68	0.87	1.11
30	0.40	1.13	na	na	0.74	0.94	1.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	9.2%	9.2%	n/a	n/a	9.3%	9.1%	9.2%
Unlimited	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
SMALL GROUP				**$50 Copay**			
20	9.3%	9.3%	n/a	n/a	9.3%	9.2%	9.3%
30	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
40	9.4%	9.3%	n/a	n/a	9.4%	9.4%	9.4%
60	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
Unlimited	9.2%	9.2%	n/a	n/a	9.1%	9.2%	9.2%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	9.2%	9.2%	n/a	n/a	9.2%	9.1%	9.2%
30	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
40	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
SMALL GROUP				**$5 Copay**			
20	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
30	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
40	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
60	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
SMALL GROUP				**$10 Copay**			
20	9.2%	9.2%	n/a	n/a	9.3%	9.3%	9.2%
30	9.2%	9.2%	n/a	n/a	9.2%	9.1%	9.2%
40	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
SMALL GROUP				**$15 Copay**			
20	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
30	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
40	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.2%	9.2%	n/a	n/a	9.2%	9.3%	9.2%
SMALL GROUP				**$20 Copay**			
20	9.3%	9.3%	n/a	n/a	9.4%	9.2%	9.3%
30	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
40	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
60	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
SMALL GROUP				**$25 Copay**			
20	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
30	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
40	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
60	9.4%	9.5%	n/a	n/a	9.5%	9.4%	9.4%
Unlimited	9.3%	9.4%	n/a	n/a	9.4%	9.3%	9.3%
SMALL GROUP				**$30 Copay**			
20	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
30	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
40	9.2%	9.2%	n/a	n/a	9.2%	9.3%	9.2%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
SMALL GROUP				**$35 Copay**			
20	9.3%	9.2%	n/a	n/a	9.3%	9.3%	9.3%
30	9.4%	9.4%	n/a	n/a	9.3%	9.3%	9.4%
40	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
60	9.1%	9.1%	n/a	n/a	9.1%	9.1%	9.1%
Unlimited	9.4%	9.4%	n/a	n/a	9.5%	9.4%	9.4%
SMALL GROUP				**$40 Copay**			
20	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
30	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
40	9.2%	9.2%	n/a	n/a	9.3%	9.2%	9.2%
60	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
Unlimited	9.3%	9.2%	n/a	n/a	9.3%	9.3%	9.3%
SMALL GROUP				**$45 Copay**			
20	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
30	9.3%	9.3%	n/a	n/a	9.3%	9.4%	9.3%
40	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
60	9.3%	9.3%	n/a	n/a	9.4%	9.3%	9.3%
Unlimited	9.4%	9.4%	n/a	n/a	9.4%	9.4%	9.4%
SMALL GROUP				**$50 Copay**			
20	9.4%	9.4%	n/a	n/a	9.3%	9.4%	9.4%
30	9.4%	9.3%	n/a	n/a	9.4%	9.4%	9.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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**
40	4.49	12.75	na	na	8.31	10.55	13.47
60	4.72	13.40	na	na	8.73	11.09	14.16
Unlimited	4.75	13.49	na	na	8.79	11.16	14.25
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
40	4.90	13.92	na	na	9.07	11.52	14.70
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.19	14.74	na	na	9.60	12.20	15.57
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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**
40	0.41	1.17	na	na	0.76	0.97	1.23
60	0.44	1.25	na	na	0.82	1.04	1.32
Unlimited	0.44	1.25	na	na	0.81	1.04	1.32
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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**
40	9.1%	9.2%	n/a	n/a	9.1%	9.2%	9.1%
60	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
Unlimited	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
4TH QUARTER 2010 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	13.49	na	na	8.79	11.16	14.25
$0/Max $5000	4.49	12.75	na	na	8.31	10.55	13.47
$0/Max $2500	4.21	11.96	na	na	7.79	9.89	12.63
$25	4.49	12.75	na	na	8.31	10.55	13.47
$50	4.21	11.96	na	na	7.79	9.89	12.63
$100	3.87	10.99	na	na	7.16	9.09	11.61
$500	1.86	5.28	na	na	3.44	4.37	5.58
$5,000	0.30	0.85	na	na	0.56	0.71	0.90
Coinsurance							
20%	3.80	10.79	na	na	7.03	8.93	11.40
25%	3.57	10.14	na	na	6.60	8.39	10.71
30%	3.32	9.43	na	na	6.14	7.80	9.96
Deductible			**Orthotics Riders**				
$0	0.82	2.33	na	na	1.52	1.93	2.46
$0/Max $5000	0.77	2.19	na	na	1.42	1.81	2.31
$0/Max $2500	0.73	2.07	na	na	1.35	1.72	2.19
$25	0.77	2.19	na	na	1.42	1.81	2.31
$50	0.73	2.07	na	na	1.35	1.72	2.19
$100	0.66	1.87	na	na	1.22	1.55	1.98
$500	0.34	0.97	na	na	0.63	0.80	1.02
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.66	1.87	na	na	1.22	1.55	1.98
25%	0.63	1.79	na	na	1.17	1.48	1.89
30%	0.59	1.68	na	na	1.09	1.39	1.77
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.57	4.46	na	na	2.90	3.69	4.71
12 Months	2.51	7.13	na	na	4.64	5.90	7.53
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.46	6.99	na	na	4.55	5.78	7.38
12 Months	3.92	11.13	na	na	7.25	9.21	11.76
			Private Duty Nursing Riders				
In Full	0.63	1.79	na	na	1.17	1.48	1.89
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.17	0.48	na	na	0.31	0.40	0.51
			Dental Network Access				
	0.48	1.36	na	na	0.89	1.13	1.44
Limit			**Infertility Rider**				
2 IVF	10.02	28.46	na	na	18.54	23.55	30.06
3 IVF	12.12	34.42	na	na	22.42	28.48	36.36
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.14	11.76	na	na	7.66	9.73	12.42
			Health Club Reimbursement				
$200 per year	1.18	3.35	na	na	2.18	2.77	3.54
			Wellness Rider				
Inclusion	0.97	2.75	na	na	1.79	2.28	2.91
			Nurse Advice Line Rider				
	0.30	0.81	na	na	0.56	0.71	0.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
4TH QUARTER 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	5.19	14.74	na	na	9.60	12.20	15.57
$0/Max $5000	4.90	13.92	na	na	9.07	11.52	14.70
$0/Max $2500	4.60	13.06	na	na	8.51	10.81	13.80
$25	4.90	13.92	na	na	9.07	11.52	14.70
$50	4.60	13.06	na	na	8.51	10.81	13.80
$100	4.23	12.01	na	na	7.83	9.94	12.69
$500	2.04	5.79	na	na	3.77	4.79	6.12
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.15	11.79	na	na	7.68	9.75	12.45
25%	3.90	11.08	na	na	7.22	9.17	11.70
30%	3.63	10.31	na	na	6.72	8.53	10.89
Deductible			**Orthotics Riders**				
$0	0.90	2.56	na	na	1.67	2.12	2.70
$0/Max $5000	0.83	2.36	na	na	1.54	1.95	2.49
$0/Max $2500	0.79	2.24	na	na	1.46	1.86	2.37
$25	0.83	2.36	na	na	1.54	1.95	2.49
$50	0.79	2.24	na	na	1.46	1.86	2.37
$100	0.72	2.04	na	na	1.33	1.69	2.16
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.72	2.04	na	na	1.33	1.69	2.16
25%	0.69	1.96	na	na	1.28	1.62	2.07
30%	0.65	1.85	na	na	1.20	1.53	1.95
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.72	4.88	na	na	3.18	4.04	5.16
12 Months	2.75	7.81	na	na	5.09	6.46	8.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.69	7.64	na	na	4.98	6.32	8.07
12 Months	4.28	12.16	na	na	7.92	10.06	12.84
			Private Duty Nursing Riders				
In Full	0.69	1.96	na	na	1.28	1.62	2.07
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.52	1.48	na	na	0.96	1.22	1.56
Limit			**Infertility Rider**				
2 IVF	10.95	31.10	na	na	20.26	25.73	32.85
3 IVF	13.24	37.60	na	na	24.49	31.11	39.72
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.52	12.84	na	na	8.36	10.62	13.56
			Health Club Reimbursement				
$200 per year	1.30	3.69	na	na	2.41	3.06	3.90
			Wellness Rider				
Inclusion	1.06	3.01	na	na	1.96	2.49	3.18
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	0.44	1.25	na	na	0.81	1.04	1.32
$0/Max $5000	0.41	1.17	na	na	0.76	0.97	1.23
$0/Max $2500	0.39	1.10	na	na	0.72	0.92	1.17
$25	0.41	1.17	na	na	0.76	0.97	1.23
$50	0.39	1.10	na	na	0.72	0.92	1.17
$100	0.36	1.02	na	na	0.67	0.85	1.08
$500	0.18	0.51	na	na	0.33	0.42	0.54
$5,000	0.03	0.09	na	na	0.05	0.07	0.09
Coinsurance							
20%	0.35	1.00	na	na	0.65	0.82	1.05
25%	0.33	0.94	na	na	0.62	0.78	0.99
30%	0.31	0.88	na	na	0.58	0.73	0.93
Deductible			**Orthotics Riders**				
$0	0.08	0.23	na	na	0.15	0.19	0.24
$0/Max $5000	0.06	0.17	na	na	0.12	0.14	0.18
$0/Max $2500	0.06	0.17	na	na	0.11	0.14	0.18
$25	0.06	0.17	na	na	0.12	0.14	0.18
$50	0.06	0.17	na	na	0.11	0.14	0.18
$100	0.06	0.17	na	na	0.11	0.14	0.18
$500	0.03	0.08	na	na	0.05	0.07	0.09
$5,000	-	-	na	na	-	-	-
Coinsurance							
20%	0.06	0.17	na	na	0.11	0.14	0.18
25%	0.06	0.17	na	na	0.11	0.14	0.18
30%	0.06	0.17	na	na	0.11	0.14	0.18
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.15	0.42	na	na	0.28	0.35	0.45
12 Months	0.24	0.68	na	na	0.45	0.56	0.72
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.23	0.65	na	na	0.43	0.54	0.69
12 Months	0.36	1.03	na	na	0.67	0.85	1.08
			Private Duty Nursing Riders				
In Full	0.06	0.17	na	na	0.11	0.14	0.18
80% hrs 73-504	-	-	na	na	-	-	-
100% hrs 73-504	0.03	0.09	na	na	0.06	0.07	0.09
			Dental Network Access				
	0.04	0.12	na	na	0.07	0.09	0.12
Limit			**Infertility Rider**				
2 IVF	0.93	2.64	na	na	1.72	2.18	2.79
3 IVF	1.12	3.18	na	na	2.07	2.63	3.36
			Complementary Alternative Medicine (CAM)				
$20 Copay	0.38	1.08	na	na	0.70	0.89	1.14
			Health Club Reimbursement				
$200 per year	0.12	0.34	na	na	0.23	0.29	0.36
			Wellness Rider				
Inclusion	0.09	0.26	na	na	0.17	0.21	0.27
			Nurse Advice Line Rider				
	0.03	0.08	na	na	0.05	0.07	0.09

HEALTH INSURANCE PLAN OF GREATER NEW YORK
1st Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	9.3%	9.3%	n/a	n/a	9.2%	9.3%	9.3%
$0/Max $5000	9.1%	9.2%	n/a	n/a	9.1%	9.2%	9.1%
$0/Max $2500	9.3%	9.2%	n/a	n/a	9.2%	9.3%	9.3%
$25	9.1%	9.2%	n/a	n/a	9.1%	9.2%	9.1%
$50	9.3%	9.2%	n/a	n/a	9.2%	9.3%	9.3%
$100	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
$500	9.7%	9.7%	n/a	n/a	9.6%	9.6%	9.7%
$5,000	10.0%	10.6%	n/a	n/a	8.9%	9.9%	10.0%
Coinsurance							
20%	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
25%	9.2%	9.3%	n/a	n/a	9.4%	9.3%	9.2%
30%	9.3%	9.3%	n/a	n/a	9.4%	9.4%	9.3%
Deductible			**Orthotics Riders**				
$0	9.8%	9.9%	n/a	n/a	9.9%	9.8%	9.8%
$0/Max $5000	7.8%	7.8%	n/a	n/a	8.5%	7.7%	7.8%
$0/Max $2500	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
$25	7.8%	7.8%	n/a	n/a	8.5%	7.7%	7.8%
$50	8.2%	8.2%	n/a	n/a	8.1%	8.1%	8.2%
$100	9.1%	9.1%	n/a	n/a	9.0%	9.0%	9.1%
$500	8.8%	8.2%	n/a	n/a	7.9%	8.7%	8.8%
$5,000	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Coinsurance							
20%	9.1%	9.1%	n/a	n/a	9.0%	9.0%	9.1%
25%	9.5%	9.5%	n/a	n/a	9.4%	9.5%	9.5%
30%	10.2%	10.1%	n/a	n/a	10.1%	10.1%	10.2%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	9.6%	9.4%	n/a	n/a	9.7%	9.5%	9.6%
12 Months	9.6%	9.5%	n/a	n/a	9.7%	9.5%	9.6%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	9.3%	9.3%	n/a	n/a	9.5%	9.3%	9.3%
12 Months	9.2%	9.3%	n/a	n/a	9.2%	9.2%	9.2%
			Private Duty Nursing Riders				
In Full	9.5%	9.5%	n/a	n/a	9.4%	9.5%	9.5%
80% hrs 73-504	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
100% hrs 73-504	17.6%	18.8%	n/a	n/a	19.4%	17.5%	17.6%
			Dental Network Access				
	8.3%	8.8%	n/a	n/a	7.9%	8.0%	8.3%
Limit			**Infertility Rider**				
2 IVF	9.3%	9.3%	n/a	n/a	9.3%	9.3%	9.3%
3 IVF	9.2%	9.2%	n/a	n/a	9.2%	9.2%	9.2%
			Complementary Alternative Medicine (CAM)				
$20 Copay	9.2%	9.2%	n/a	n/a	9.1%	9.1%	9.2%
			Health Club Reimbursement				
$200 per year	10.2%	10.1%	n/a	n/a	10.6%	10.5%	10.2%
			Wellness Rider				
Inclusion	9.3%	9.5%	n/a	n/a	9.5%	9.2%	9.3%
			Nurse Advice Line Rider				
	10.0%	9.9%	n/a	n/a	8.9%	9.9%	10.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 SMALL 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

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2011 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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
January 01, 2013 - March 31, 2013 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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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	-	-	-
$750 *	-	-	-
$1,000	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
Unlimited	-	-	-

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	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group 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	0.012	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 Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	2.50%
1Q2010-1Q2011	2.50%
2Q2011	4.10%
3Q2011-4Q2011	3.00%
1Q12	3.00%

Table 5: Tier Conversion Factors

	HIP	**Emblem Coordinated Care Plans**
	Small Group	**Small Group**
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

$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 Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	0.0%
1Q2010-1Q2011	2.5%
2Q2011	4.1%
3Q2011-4Q2011	3.0%
1Q2012	3.0%
2Q 2012 - 4Q 2012	3.0%
1Q2013 HMO/POS	-6.3%
1Q2013 CH	0.0%

Table 5: Tier Conversion Factors

	HIP	**Emblem Coordinated Care Plans**
	Small Group	**Small Group**
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.22	1.21
EE + Child(ren	2.25	2.24
EE + Spouse	2.86	2.85
Family	3.65	3.63

$0	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	**% Adjustment To Above Rates**
[a] Exclude Contraceptives	-
[b] Annual Maximum to also include Generic Drugs:	-
$1,000 (Brand & Generic)	-
$2,000 (Brand & Generic)	-
$2,500 (Brand & Generic)	-
$3,000 (Brand & Generic)	-
$4,000 (Brand & Generic)	-
$5,000 (Brand & Generic)	-
[c] Non Formulary Coverage, Generic Only Plans	-
[d] PICA Adjustm Applies only to New York City account	-
[e] IC Adjustmer Applies only to New York City account	-
[f] Product Facto HMO, Access I, and EPO	-
POS, Access II, and PPO	-
[g] Trend per Quarter	
1Q2010-1Q2011	-
2Q2011	-
3Q2011-4Q2011	-
1Q2012	-
2Q 2012 - 4Q 2012	0.030
1Q2013 HMO/POS	(0.063)
1Q2013 CH	-
	-

Table 5: Tier Conversion Factors

	HIP	**Emblem Coordinated Care Plans**
	Small Group	**Small Group**
Two Tier		
Individual EE	-	-
Family	-	-
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	-	-
EE + Child(ren	-	-
EE + Spouse	-	-
Family	-	-

$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	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 Adjustmer Applies only to New York City account	0.0%
[f] Product Facto HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
1Q2010-1Q2011	0.0%
2Q2011	0.0%
3Q2011-4Q2011	0.0%
1Q2012	0.0%
2Q 2012 - 4Q 2012	#DIV/0!
1Q2013 HMO/POS	#DIV/0!
1Q2013 CH	#DIV/0!
$0	#DIV/0!

Table 5: Tier Conversion Factors

	HIP	**Emblem Coordinated Care Plans**
	Small Group	**Small Group**
Two Tier		
Individual EE	0.0%	0.0%
Family	0.0%	0.0%
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	0.0%	0.0%
EE + Child(ren	0.0%	0.0%
EE + Spouse	0.0%	0.0%
Family	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st QUARTER 2012 SMALL GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JANUARY 1, 2012 - MARCH 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not availa**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2012
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
January 01, 2013 - March 31, 2013 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not availa**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	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	-	-
Upstate[2]			
	HMO, HIP*access* I	-	
	POS	-	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	-
Access I Groups	-
POS Groups	-
Access II Groups	-

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
1st Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**0.0%**	**0.0%**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**0.0%**	**0.0%**
Upstate[2]			
	HMO, HIP*access* I	**0.0%**	
	POS	**0.0%**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**0.0%**
Access I Groups	**0.0%**
POS Groups	**0.0%**
Access II Groups	**0.0%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small 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

Small Groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Inpatient Mental Health Subsidy
+	Outpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Outpatient Mental Health Subsidy
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor
x	Sole Proprientor Factor

Example: Small Group HMO Individual Employee Rate Example

=	688.94	2nd Quarter	(Base Rate
+	(5.65)	$10 Specialist visit copay	Optional Base Benefit Variables (excluding Mental Health)
+	7.17	30 Days	Inpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	30 Days	Small Group Inpatient Mental Health Subsidy
+	6.21	$10 copay, 20 visits	Outpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	$10 copay, 20 visits	Small Group Outpatient Mental Health Subsidy
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.00	Standard Coverage	Optional Dependent Care Coverage
x	1.00	Standard Coverage	Network Area Factor
x	1.00	> 1 Employee Group	Sole Proprientor Factor
	696.67		Individual Employee Rate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2nd Quarter Small Group RATE MANUAL

HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS

April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Effective 04/01/2013 - 06/30/2013 (With WH & Autism)				
Small Group*	688.94	1,860.14	na	na	1,274.54	1,446.77	2,066.82
Classic*	491.71	1,327.62	na	na	909.66	1,032.59	1,475.13
			Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)				
Small Group*	682.12	1,841.72	na	na	1,261.92	1,432.45	2,046.36
Classic*	486.84	1,314.47	na	na	900.65	1,022.36	1,460.52

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$5	(3.87)	(10.45)	na	na	(7.16)	(8.13)	(11.61)
$10	(8.13)	(21.95)	na	na	(15.04)	(17.07)	(24.39)
$15	(13.50)	(36.45)	na	na	(24.98)	(28.35)	(40.50)
$20	(20.84)	(56.27)	na	na	(38.55)	(43.76)	(62.52)
$25	(27.47)	(74.17)	na	na	(50.82)	(57.69)	(82.41)
$30	(34.72)	(93.74)	na	na	(64.23)	(72.91)	(104.16)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.21)	(5.97)	na	na	(4.09)	(4.64)	(6.63)
$10	(4.65)	(12.56)	na	na	(8.60)	(9.77)	(13.95)
$15	(7.74)	(20.90)	na	na	(14.32)	(16.25)	(23.22)
$20	(11.94)	(32.24)	na	na	(22.09)	(25.07)	(35.82)
$25	(15.73)	(42.47)	na	na	(29.10)	(33.03)	(47.19)
$30	(19.90)	(53.73)	na	na	(36.82)	(41.79)	(59.70)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.73)	(7.37)	na	na	(5.05)	(5.73)	(8.19)
$10	(5.65)	(15.26)	na	na	(10.45)	(11.87)	(16.95)
$15	(8.85)	(23.90)	na	na	(16.37)	(18.59)	(26.55)
$20	(12.48)	(33.70)	na	na	(23.09)	(26.21)	(37.44)
$25	(16.47)	(44.47)	na	na	(30.47)	(34.59)	(49.41)
$30	(20.97)	(56.62)	na	na	(38.79)	(44.04)	(62.91)
$35	(25.21)	(68.07)	na	na	(46.64)	(52.94)	(75.63)
$40	(34.05)	(91.94)	na	na	(62.99)	(71.51)	(102.15)
$45	(34.22)	(92.39)	na	na	(63.31)	(71.86)	(102.66)
$50	(39.07)	(105.49)	na	na	(72.28)	(82.05)	(117.21)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$5	(2.31)	(6.24)	na	na	(4.27)	(4.85)	(6.93)
$10	(4.78)	(12.91)	na	na	(8.84)	(10.04)	(14.34)
$15	(7.49)	(20.22)	na	na	(13.86)	(15.73)	(22.47)
$20	(10.56)	(28.51)	na	na	(19.54)	(22.18)	(31.68)
$25	(13.92)	(37.58)	na	na	(25.75)	(29.23)	(41.76)
$30	(17.74)	(47.90)	na	na	(32.82)	(37.25)	(53.22)
$35	(21.31)	(57.54)	na	na	(39.42)	(44.75)	(63.93)
$40	(28.79)	(77.73)	na	na	(53.26)	(60.46)	(86.37)
$45	(28.93)	(78.11)	na	na	(53.52)	(60.75)	(86.79)
$50	(33.03)	(89.18)	na	na	(61.11)	(69.36)	(99.09)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.08)	(5.62)	na	na	(3.85)	(4.37)	(6.24)
$150	(3.43)	(9.26)	na	na	(6.35)	(7.20)	(10.29)
$200	(4.89)	(13.20)	na	na	(9.05)	(10.27)	(14.67)
$250	(7.00)	(18.90)	na	na	(12.95)	(14.70)	(21.00)
$500	(16.79)	(45.33)	na	na	(31.06)	(35.26)	(50.37)
$750	(28.86)	(77.92)	na	na	(53.39)	(60.61)	(86.58)
$1,000	(43.40)	(117.18)	na	na	(80.29)	(91.14)	(130.20)
Copay/Day							
$50 w/3 Day Max	(2.52)	(6.80)	na	na	(4.66)	(5.29)	(7.56)
$50 w/5 Day Max	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)
$100 w/3 Day Max	(6.30)	(17.01)	na	na	(11.66)	(13.23)	(18.90)
$100 w/5 Day Max	(9.09)	(24.54)	na	na	(16.82)	(19.09)	(27.27)
$250 w/3 Day Max	(20.91)	(56.46)	na	na	(38.68)	(43.91)	(62.73)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.14)	(3.08)	na	na	(2.11)	(2.39)	(3.42)
$75	(1.85)	(5.00)	na	na	(3.42)	(3.89)	(5.55)
$100	(2.65)	(7.16)	na	na	(4.90)	(5.57)	(7.95)
$125	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)
$150	(4.34)	(11.72)	na	na	(8.03)	(9.11)	(13.02)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$15	(0.40)	(1.08)	na	na	(0.74)	(0.84)	(1.20)
$25	(0.73)	(1.97)	na	na	(1.35)	(1.53)	(2.19)
$35	(1.21)	(3.27)	na	na	(2.24)	(2.54)	(3.63)
$50	(2.07)	(5.59)	na	na	(3.83)	(4.35)	(6.21)
$60	(2.63)	(7.10)	na	na	(4.87)	(5.52)	(7.89)
$75	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)
$100	(4.91)	(13.26)	na	na	(9.08)	(10.31)	(14.73)
$125	(6.05)	(16.34)	na	na	(11.19)	(12.71)	(18.15)
$150	(7.23)	(19.52)	na	na	(13.38)	(15.18)	(21.69)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.62	1.67	na	na	1.15	1.30	1.86
60	1.16	3.13	na	na	2.15	2.44	3.48
90	1.76	4.75	na	na	3.26	3.70	5.28
120	2.07	5.59	na	na	3.83	4.35	6.21
Unlimited	2.66	7.18	na	na	4.92	5.59	7.98
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
40/$10 copay	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
40/$15 copay	(0.46)	(1.24)	na	na	(0.85)	(0.97)	(1.38)
40/$20 copay	(0.67)	(1.81)	na	na	(1.24)	(1.41)	(2.01)
40/$25 copay	(0.87)	(2.35)	na	na	(1.61)	(1.83)	(2.61)
60	0.32	0.86	na	na	0.59	0.67	0.96
100	0.77	2.08	na	na	1.42	1.62	2.31
200	2.07	5.59	na	na	3.83	4.35	6.21
	** 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)	(3.32)	na	na	(2.28)	(2.58)	(3.69)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.80	2.16	na	na	1.48	1.68	2.40
90	1.70	4.59	na	na	3.15	3.57	5.10
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.72	1.94	na	na	1.33	1.51	2.16
90	1.34	3.62	na	na	2.48	2.81	4.02
120	2.14	5.78	na	na	3.96	4.49	6.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.03)	(2.78)	na	na	(1.91)	(2.16)	(3.09)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.31	0.84	na	na	0.57	0.65	0.93
30	0.47	1.27	na	na	0.87	0.99	1.41
Unlimited	0.72	1.94	na	na	1.33	1.51	2.16
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.64	9.83	na	na	6.73	7.64	10.92
60	4.25	11.48	na	na	7.86	8.93	12.75
90	5.09	13.74	na	na	9.42	10.69	15.27
Unlimited	5.16	13.93	na	na	9.55	10.84	15.48
	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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
60/$10 copay	(0.29)	(0.78)	na	na	(0.54)	(0.61)	(0.87)
60/$15 copay	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
60/$20 copay	(0.63)	(1.70)	na	na	(1.17)	(1.32)	(1.89)
60/$25 copay	(0.74)	(2.00)	na	na	(1.37)	(1.55)	(2.22)
120/$0 copay	0.65	1.76	na	na	1.20	1.37	1.95
120/$5 copay	0.47	1.27	na	na	0.87	0.99	1.41
120/$10 copay	0.29	0.78	na	na	0.54	0.61	0.87
120/$15 copay	0.02	0.05	na	na	0.04	0.04	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
120/$25 copay	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
Unlimited/$0 copay	0.73	1.97	na	na	1.35	1.53	2.19
Unlimited/$5 copay	0.58	1.57	na	na	1.07	1.22	1.74
Unlimited/$10 copay	0.36	0.97	na	na	0.67	0.76	1.08
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.15	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
Unlimited/$25 copay	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	0.22	0.59	na	na	0.41	0.46	0.66
$5	0.07	0.19	na	na	0.13	0.15	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$20	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$25	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
$10	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
$15	(0.47)	(1.27)	na	na	(0.87)	(0.99)	(1.41)
$20	(0.69)	(1.86)	na	na	(1.28)	(1.45)	(2.07)
$25	(0.91)	(2.46)	na	na	(1.68)	(1.91)	(2.73)
$30	(1.09)	(2.94)	na	na	(2.02)	(2.29)	(3.27)
$35	(1.30)	(3.51)	na	na	(2.41)	(2.73)	(3.90)
$40	(1.49)	(4.02)	na	na	(2.76)	(3.13)	(4.47)
$45	(1.71)	(4.62)	na	na	(3.16)	(3.59)	(5.13)
$50	(1.90)	(5.13)	na	na	(3.52)	(3.99)	(5.70)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$10	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
$15	(0.53)	(1.43)	na	na	(0.98)	(1.11)	(1.59)
$20	(0.77)	(2.08)	na	na	(1.42)	(1.62)	(2.31)
$25	(1.05)	(2.84)	na	na	(1.94)	(2.21)	(3.15)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$35	(0.24)	(0.65)	na	na	(0.44)	(0.50)	(0.72)
$50	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
$60	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
$75	(0.60)	(1.62)	na	na	(1.11)	(1.26)	(1.80)
$100	(0.77)	(2.08)	na	na	(1.42)	(1.62)	(2.31)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$50	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
$60	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
$75	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
$100	(0.53)	(1.43)	na	na	(0.98)	(1.11)	(1.59)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.29)	(8.88)	na	na	(6.09)	(6.91)	(9.87)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.08)	(13.72)	na	na	(9.40)	(10.67)	(15.24)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.42)	(1.13)	na	na	(0.78)	(0.88)	(1.26)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.03	10.88	na	na	7.46	8.46	12.09
60	5.69	15.36	na	na	10.53	11.95	17.07
90	6.75	18.23	na	na	12.49	14.18	20.25
Unlimited	6.83	18.44	na	na	12.64	14.34	20.49
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.17	19.36	na	na	13.26	15.06	21.51
60	7.58	20.47	na	na	14.02	15.92	22.74
90	7.86	21.22	na	na	14.54	16.51	23.58
Unlimited	7.93	21.41	na	na	14.67	16.65	23.79
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.47	14.77	na	na	10.12	11.49	16.41
30	6.50	17.55	na	na	12.03	13.65	19.50
40	7.16	19.33	na	na	13.25	15.04	21.48
60	7.83	21.14	na	na	14.49	16.44	23.49
Unlimited	7.89	21.30	na	na	14.60	16.57	23.67
SMALL GROUP	**$5 Copay**						
20	5.15	13.91	na	na	9.53	10.82	15.45
30	6.11	16.50	na	na	11.30	12.83	18.33
40	6.74	18.20	na	na	12.47	14.15	20.22
60	7.36	19.87	na	na	13.62	15.46	22.08
Unlimited	7.44	20.09	na	na	13.76	15.62	22.32

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$10 Copay**			
20	4.79	12.93	na	na	8.86	10.06	14.37
30	5.70	15.39	na	na	10.55	11.97	17.10
40	6.27	16.93	na	na	11.60	13.17	18.81
60	6.86	18.52	na	na	12.69	14.41	20.58
Unlimited	6.93	18.71	na	na	12.82	14.55	20.79
SMALL GROUP				**$15 Copay**			
20	4.51	12.18	na	na	8.34	9.47	13.53
30	5.36	14.47	na	na	9.92	11.26	16.08
40	5.90	15.93	na	na	10.92	12.39	17.70
60	6.44	17.39	na	na	11.91	13.52	19.32
Unlimited	6.51	17.58	na	na	12.04	13.67	19.53
SMALL GROUP				**$20 Copay**			
20	4.22	11.39	na	na	7.81	8.86	12.66
30	5.02	13.55	na	na	9.29	10.54	15.06
40	5.53	14.93	na	na	10.23	11.61	16.59
60	6.05	16.34	na	na	11.19	12.71	18.15
Unlimited	6.09	16.44	na	na	11.27	12.79	18.27
SMALL GROUP				**$25 Copay**			
20	3.94	10.64	na	na	7.29	8.27	11.82
30	4.68	12.64	na	na	8.66	9.83	14.04
40	5.16	13.93	na	na	9.55	10.84	15.48
60	5.63	15.20	na	na	10.42	11.82	16.89
Unlimited	5.70	15.39	na	na	10.55	11.97	17.10
SMALL GROUP				**$30 Copay**			
20	3.78	10.21	na	na	6.99	7.94	11.34
30	4.52	12.20	na	na	8.36	9.49	13.56
40	4.97	13.42	na	na	9.19	10.44	14.91
60	5.44	14.69	na	na	10.06	11.42	16.32
Unlimited	5.49	14.82	na	na	10.16	11.53	16.47

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$35 Copay**			
20	3.68	9.94	na	na	6.81	7.73	11.04
30	4.37	11.80	na	na	8.08	9.18	13.11
40	4.83	13.04	na	na	8.94	10.14	14.49
60	5.28	14.26	na	na	9.77	11.09	15.84
Unlimited	5.33	14.39	na	na	9.86	11.19	15.99
SMALL GROUP				**$40 Copay**			
20	3.59	9.69	na	na	6.64	7.54	10.77
30	4.24	11.45	na	na	7.84	8.90	12.72
40	4.68	12.64	na	na	8.66	9.83	14.04
60	5.13	13.85	na	na	9.49	10.77	15.39
Unlimited	5.17	13.96	na	na	9.56	10.86	15.51
SMALL GROUP				**$45 Copay**			
20	3.46	9.34	na	na	6.40	7.27	10.38
30	4.12	11.12	na	na	7.62	8.65	12.36
40	4.54	12.26	na	na	8.40	9.53	13.62
60	4.96	13.39	na	na	9.18	10.42	14.88
Unlimited	5.00	13.50	na	na	9.25	10.50	15.00
SMALL GROUP				**$50 Copay**			
20	3.37	9.10	na	na	6.23	7.08	10.11
30	4.00	10.80	na	na	7.40	8.40	12.00
40	4.40	11.88	na	na	8.14	9.24	13.20
60	4.82	13.01	na	na	8.92	10.12	14.46
Unlimited	4.84	13.07	na	na	8.95	10.16	14.52

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.09	19.14	na	na	13.12	14.89	21.27
30	7.80	21.06	na	na	14.43	16.38	23.40
40	8.24	22.25	na	na	15.24	17.30	24.72
60	8.70	23.49	na	na	16.10	18.27	26.10
Unlimited	8.80	23.76	na	na	16.28	18.48	26.40
SMALL GROUP				**$5 Copay**			
20	6.66	17.98	na	na	12.32	13.99	19.98
30	7.34	19.82	na	na	13.58	15.41	22.02
40	7.75	20.93	na	na	14.34	16.28	23.25
60	8.20	22.14	na	na	15.17	17.22	24.60
Unlimited	8.27	22.33	na	na	15.30	17.37	24.81
SMALL GROUP				**$10 Copay**			
20	6.21	16.77	na	na	11.49	13.04	18.63
30	6.83	18.44	na	na	12.64	14.34	20.49
40	7.22	19.49	na	na	13.36	15.16	21.66
60	7.62	20.57	na	na	14.10	16.00	22.86
Unlimited	7.70	20.79	na	na	14.25	16.17	23.10
SMALL GROUP				**$15 Copay**			
20	5.85	15.80	na	na	10.82	12.29	17.55
30	6.43	17.36	na	na	11.90	13.50	19.29
40	6.78	18.31	na	na	12.54	14.24	20.34
60	7.16	19.33	na	na	13.25	15.04	21.48
Unlimited	7.23	19.52	na	na	13.38	15.18	21.69

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.49	14.82	na	na	10.16	11.53	16.47
30	6.03	16.28	na	na	11.16	12.66	18.09
40	6.37	17.20	na	na	11.78	13.38	19.11
60	6.73	18.17	na	na	12.45	14.13	20.19
Unlimited	6.78	18.31	na	na	12.54	14.24	20.34
SMALL GROUP				**$25 Copay**			
20	5.11	13.80	na	na	9.45	10.73	15.33
30	5.61	15.15	na	na	10.38	11.78	16.83
40	5.93	16.01	na	na	10.97	12.45	17.79
60	6.26	16.90	na	na	11.58	13.15	18.78
Unlimited	6.32	17.06	na	na	11.69	13.27	18.96
SMALL GROUP				**$30 Copay**			
20	4.92	13.28	na	na	9.10	10.33	14.76
30	5.42	14.63	na	na	10.03	11.38	16.26
40	5.73	15.47	na	na	10.60	12.03	17.19
60	6.05	16.34	na	na	11.19	12.71	18.15
Unlimited	6.08	16.42	na	na	11.25	12.77	18.24
SMALL GROUP				**$35 Copay**			
20	4.78	12.91	na	na	8.84	10.04	14.34
30	5.27	14.23	na	na	9.75	11.07	15.81
40	5.55	14.99	na	na	10.27	11.66	16.65
60	5.88	15.88	na	na	10.88	12.35	17.64
Unlimited	5.91	15.96	na	na	10.93	12.41	17.73
SMALL GROUP				**$40 Copay**			
20	4.64	12.53	na	na	8.58	9.74	13.92
30	5.11	13.80	na	na	9.45	10.73	15.33
40	5.38	14.53	na	na	9.95	11.30	16.14
60	5.70	15.39	na	na	10.55	11.97	17.10
Unlimited	5.74	15.50	na	na	10.62	12.05	17.22

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	4.51	12.18	na	na	8.34	9.47	13.53
30	4.93	13.31	na	na	9.12	10.35	14.79
40	5.22	14.09	na	na	9.66	10.96	15.66
60	5.52	14.90	na	na	10.21	11.59	16.56
Unlimited	5.56	15.01	na	na	10.29	11.68	16.68
SMALL GROUP				**$50 Copay**			
20	4.36	11.77	na	na	8.07	9.16	13.08
30	4.79	12.93	na	na	8.86	10.06	14.37
40	5.08	13.72	na	na	9.40	10.67	15.24
60	5.35	14.45	na	na	9.90	11.24	16.05
Unlimited	5.38	14.53	na	na	9.95	11.30	16.14
SMALL GROUP		**Small Group Premium Credit - Outpatient Mental Health**					
Specialist Copay		****[above rates must be reduced by premium credit]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2nd Quarter Small Group RATE MANUAL

HIP HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 01, 2013 - June 30, 2013 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

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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

Full-time Students

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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%

Class II Dependents

	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
April 01, 2013 - June 30, 2013 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	4.71	12.72	na	na	8.71	9.89	14.13
$0/Max $5000	4.48	12.10	na	na	8.29	9.41	13.44
$0/Max $2500	4.19	11.31	na	na	7.75	8.80	12.57
$25	4.48	12.10	na	na	8.29	9.41	13.44
$50	4.19	11.31	na	na	7.75	8.80	12.57
$100	3.83	10.34	na	na	7.09	8.04	11.49
$500	1.83	4.94	na	na	3.39	3.84	5.49
$5,000	0.31	0.84	na	na	0.57	0.65	0.93
Coinsurance							
80%	3.76	10.15	na	na	6.96	7.90	11.28
75%	3.53	9.53	na	na	6.53	7.41	10.59
70%	3.31	8.94	na	na	6.12	6.95	9.93
Deductible			**Orthotics Riders**				
$0	0.79	2.13	na	na	1.46	1.66	2.37
$0/Max $5000	0.76	2.05	na	na	1.41	1.60	2.28
$0/Max $2500	0.72	1.94	na	na	1.33	1.51	2.16
$25	0.76	2.05	na	na	1.41	1.60	2.28
$50	0.72	1.94	na	na	1.33	1.51	2.16
$100	0.66	1.78	na	na	1.22	1.39	1.98
$500	0.33	0.89	na	na	0.61	0.69	0.99
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
Coinsurance							
80%	0.66	1.78	na	na	1.22	1.39	1.98
75%	0.63	1.70	na	na	1.17	1.32	1.89
70%	0.60	1.62	na	na	1.11	1.26	1.80

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.52	4.10	na	na	2.81	3.19	4.56
12 Months	2.46	6.64	na	na	4.55	5.17	7.38
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.39	6.45	na	na	4.42	5.02	7.17
12 Months	3.82	10.31	na	na	7.07	8.02	11.46
			Private Duty Nursing Riders				
In Full	0.58	1.57	na	na	1.07	1.22	1.74
80% hrs 73-504	0.07	0.19	na	na	0.13	0.15	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.29	0.42
			Dental Network Access				
	0.46	1.24	na	na	0.85	0.97	1.38
Limit			**Infertility Rider**				
2 IVF	9.96	26.89	na	na	18.43	20.92	29.88
3 IVF	12.02	32.45	na	na	22.24	25.24	36.06
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.58	12.37	na	na	8.47	9.62	13.74
Health Club Reimbursement							
$200 per year	1.18	3.19	na	na	2.18	2.48	3.54
			Nurse Advice Line Rider				
	0.31	0.84	na	na	0.57	0.65	0.93
Subject to			**Wellness Rider**				
DFS approval	0.78	2.11	na	na	1.44	1.64	2.34

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS

April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
	Effective 04/01/2013 - 06/30/2013 (With WH & Autism)						
Small Group *	495.44	1,337.69	na	na	916.56	1,040.42	1,486.32
	Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)						
Small Group *	490.54	1,324.46	na	na	907.50	1,030.13	1,471.62

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$5	(4.32)	(11.66)	na	na	(7.99)	(9.07)	(12.96)
$10	(9.06)	(24.46)	na	na	(16.76)	(19.03)	(27.18)
$15	(14.02)	(37.85)	na	na	(25.94)	(29.44)	(42.06)
$20	(20.19)	(54.51)	na	na	(37.35)	(42.40)	(60.57)
$25	(37.47)	(101.17)	na	na	(69.32)	(78.69)	(112.41)
$30	(59.52)	(160.70)	na	na	(110.11)	(124.99)	(178.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.47)	(6.67)	na	na	(4.57)	(5.19)	(7.41)
$10	(5.20)	(14.04)	na	na	(9.62)	(10.92)	(15.60)
$15	(8.03)	(21.68)	na	na	(14.86)	(16.86)	(24.09)
$20	(11.58)	(31.27)	na	na	(21.42)	(24.32)	(34.74)
$25	(21.47)	(57.97)	na	na	(39.72)	(45.09)	(64.41)
$30	(34.13)	(92.15)	na	na	(63.14)	(71.67)	(102.39)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.06)	(8.26)	na	na	(5.66)	(6.43)	(9.18)
$10	(6.27)	(16.93)	na	na	(11.60)	(13.17)	(18.81)
$15	(9.52)	(25.70)	na	na	(17.61)	(19.99)	(28.56)
$20	(12.95)	(34.97)	na	na	(23.96)	(27.20)	(38.85)
$25	(19.23)	(51.92)	na	na	(35.58)	(40.38)	(57.69)
$30	(27.15)	(73.31)	na	na	(50.23)	(57.02)	(81.45)
$35	(35.51)	(95.88)	na	na	(65.69)	(74.57)	(106.53)
$40	(44.91)	(121.26)	na	na	(83.08)	(94.31)	(134.73)
$45	(55.41)	(149.61)	na	na	(102.51)	(116.36)	(166.23)
$50	(67.02)	(180.95)	na	na	(123.99)	(140.74)	(201.06)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.56)	(6.91)	na	na	(4.74)	(5.38)	(7.68)
$10	(5.30)	(14.31)	na	na	(9.81)	(11.13)	(15.90)
$15	(8.04)	(21.71)	na	na	(14.87)	(16.88)	(24.12)
$20	(10.95)	(29.57)	na	na	(20.26)	(23.00)	(32.85)
$25	(16.26)	(43.90)	na	na	(30.08)	(34.15)	(48.78)
$30	(22.93)	(61.91)	na	na	(42.42)	(48.15)	(68.79)
$35	(30.01)	(81.03)	na	na	(55.52)	(63.02)	(90.03)
$40	(37.99)	(102.57)	na	na	(70.28)	(79.78)	(113.97)
$45	(46.84)	(126.47)	na	na	(86.65)	(98.36)	(140.52)
$50	(56.67)	(153.01)	na	na	(104.84)	(119.01)	(170.01)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

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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	na	na	0.00	0.00	0.00
$100	(2.44)	(6.59)	na	na	(4.51)	(5.12)	(7.32)
$150	(4.08)	(11.02)	na	na	(7.55)	(8.57)	(12.24)
$200	(5.88)	(15.88)	na	na	(10.88)	(12.35)	(17.64)
$250	(8.49)	(22.92)	na	na	(15.71)	(17.83)	(25.47)
$500	(20.87)	(56.35)	na	na	(38.61)	(43.83)	(62.61)
$750	(36.54)	(98.66)	na	na	(67.60)	(76.73)	(109.62)
$1,000	(55.81)	(150.69)	na	na	(103.25)	(117.20)	(167.43)
Copay/Day							
$50 w/3 Day Max	(3.51)	(9.48)	na	na	(6.49)	(7.37)	(10.53)
$50 w/5 Day Max	(4.76)	(12.85)	na	na	(8.81)	(10.00)	(14.28)
$100 w/3 Day Max	(7.50)	(20.25)	na	na	(13.88)	(15.75)	(22.50)
$100 w/5 Day Max	(12.77)	(34.48)	na	na	(23.62)	(26.82)	(38.31)
$250 w/3 Day Max	(24.78)	(66.91)	na	na	(45.84)	(52.04)	(74.34)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.37)	(3.70)	na	na	(2.53)	(2.88)	(4.11)
$75	(2.39)	(6.45)	na	na	(4.42)	(5.02)	(7.17)
$100	(3.59)	(9.69)	na	na	(6.64)	(7.54)	(10.77)
$125	(4.99)	(13.47)	na	na	(9.23)	(10.48)	(14.97)
$150	(6.61)	(17.85)	na	na	(12.23)	(13.88)	(19.83)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.30)	na	na	(0.89)	(1.01)	(1.44)
$25	(0.88)	(2.38)	na	na	(1.63)	(1.85)	(2.64)
$35	(1.48)	(4.00)	na	na	(2.74)	(3.11)	(4.44)
$50	(2.45)	(6.62)	na	na	(4.53)	(5.15)	(7.35)
$60	(3.11)	(8.40)	na	na	(5.75)	(6.53)	(9.33)
$75	(4.01)	(10.83)	na	na	(7.42)	(8.42)	(12.03)
$100	(5.62)	(15.17)	na	na	(10.40)	(11.80)	(16.86)
$125	(7.37)	(19.90)	na	na	(13.63)	(15.48)	(22.11)
$150	(9.29)	(25.08)	na	na	(17.19)	(19.51)	(27.87)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.67	1.81	na	na	1.24	1.41	2.01
60	1.30	3.51	na	na	2.41	2.73	3.90
90	1.94	5.24	na	na	3.59	4.07	5.82
120	2.27	6.13	na	na	4.20	4.77	6.81
Unlimited	2.90	7.83	na	na	5.37	6.09	8.70

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
40/$10 copay	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
40/$15 copay	(0.52)	(1.40)	na	na	(0.96)	(1.09)	(1.56)
40/$20 copay	(0.73)	(1.97)	na	na	(1.35)	(1.53)	(2.19)
40/$25 copay	(0.95)	(2.57)	na	na	(1.76)	(2.00)	(2.85)
60	0.35	0.95	na	na	0.65	0.74	1.05
100	0.84	2.27	na	na	1.55	1.76	2.52
200	2.28	6.16	na	na	4.22	4.79	6.84
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.35)	(3.65)	na	na	(2.50)	(2.84)	(4.05)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.90	2.43	na	na	1.67	1.89	2.70
90	1.87	5.05	na	na	3.46	3.93	5.61
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.13	na	na	1.46	1.66	2.37
90	1.47	3.97	na	na	2.72	3.09	4.41
120	2.35	6.35	na	na	4.35	4.94	7.05
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.13)	(3.05)	na	na	(2.09)	(2.37)	(3.39)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.89	na	na	0.61	0.69	0.99
30	0.54	1.46	na	na	1.00	1.13	1.62
Unlimited	0.79	2.13	na	na	1.46	1.66	2.37
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.01	10.83	na	na	7.42	8.42	12.03
60	4.70	12.69	na	na	8.70	9.87	14.10
90	5.60	15.12	na	na	10.36	11.76	16.80
Unlimited	5.68	15.34	na	na	10.51	11.93	17.04

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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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
60/$10 copay	(0.28)	(0.76)	na	na	(0.52)	(0.59)	(0.84)
60/$15 copay	(0.44)	(1.19)	na	na	(0.81)	(0.92)	(1.32)
60/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.37)	(1.95)
60/$25 copay	(0.75)	(2.03)	na	na	(1.39)	(1.58)	(2.25)
120/$0 copay	0.71	1.92	na	na	1.31	1.49	2.13
120/$5 copay	0.56	1.51	na	na	1.04	1.18	1.68
120/$10 copay	0.35	0.95	na	na	0.65	0.74	1.05
120/$15 copay	0.07	0.19	na	na	0.13	0.15	0.21
120/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
120/$25 copay	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
Unlimited/$0 copay	0.81	2.19	na	na	1.50	1.70	2.43
Unlimited/$5 copay	0.66	1.78	na	na	1.22	1.39	1.98
Unlimited/$10 copay	0.42	1.13	na	na	0.78	0.88	1.26
Unlimited/$15 copay	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited/$20 copay	(0.03)	(0.08)	na	na	(0.06)	(0.06)	(0.09)
Unlimited/$25 copay	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.54	na	na	0.37	0.42	0.60
$5	0.07	0.19	na	na	0.13	0.15	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$20	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$25	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
$10	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.03)	(1.47)
$20	(0.71)	(1.92)	na	na	(1.31)	(1.49)	(2.13)
$25	(0.90)	(2.43)	na	na	(1.67)	(1.89)	(2.70)
$30	(1.13)	(3.05)	na	na	(2.09)	(2.37)	(3.39)
$35	(1.32)	(3.56)	na	na	(2.44)	(2.77)	(3.96)
$40	(1.51)	(4.08)	na	na	(2.79)	(3.17)	(4.53)
$45	(1.73)	(4.67)	na	na	(3.20)	(3.63)	(5.19)
$50	(1.93)	(5.21)	na	na	(3.57)	(4.05)	(5.79)

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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	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$10	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
$15	(0.54)	(1.46)	na	na	(1.00)	(1.13)	(1.62)
$20	(0.79)	(2.13)	na	na	(1.46)	(1.66)	(2.37)
$25	(1.07)	(2.89)	na	na	(1.98)	(2.25)	(3.21)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$35	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$50	(0.37)	(1.00)	na	na	(0.68)	(0.78)	(1.11)
$60	(0.44)	(1.19)	na	na	(0.81)	(0.92)	(1.32)
$75	(0.61)	(1.65)	na	na	(1.13)	(1.28)	(1.83)
$100	(0.79)	(2.13)	na	na	(1.46)	(1.66)	(2.37)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$50	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
$60	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$75	(0.39)	(1.05)	na	na	(0.72)	(0.82)	(1.17)
$100	(0.54)	(1.46)	na	na	(1.00)	(1.13)	(1.62)

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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]							
	(3.31)	(8.94)	na	na	(6.12)	(6.95)	(9.93)
Diagnostic and Therapeutic Radiology [std: $0]							
Copay per procedure of minimum (20%, $100); $500 annual maximum							
	(5.17)	(13.96)	na	na	(9.56)	(10.86)	(15.51)
Diagnostic Testing [std: $0]							
Copay per procedure minimum of [20%, $100], $500 annual maximum							
	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)

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**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.36	11.77	na	na	8.07	9.16	13.08
60	5.21	14.07	na	na	9.64	10.94	15.63
90	5.77	15.58	na	na	10.67	12.12	17.31
Unlimited	5.85	15.80	na	na	10.82	12.29	17.55
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.07	19.09	na	na	13.08	14.85	21.21
60	7.46	20.14	na	na	13.80	15.67	22.38
90	7.75	20.93	na	na	14.34	16.28	23.25
Unlimited	7.84	21.17	na	na	14.50	16.46	23.52
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.91	15.96	na	na	10.93	12.41	17.73
30	6.94	18.74	na	na	12.84	14.57	20.82
40	7.61	20.55	na	na	14.08	15.98	22.83
60	8.26	22.30	na	na	15.28	17.35	24.78
Unlimited	8.35	22.55	na	na	15.45	17.54	25.05
SMALL GROUP	**$5 Copay**						
20	5.57	15.04	na	na	10.30	11.70	16.71
30	6.52	17.60	na	na	12.06	13.69	19.56
40	7.15	19.31	na	na	13.23	15.02	21.45
60	7.76	20.95	na	na	14.36	16.30	23.28
Unlimited	7.84	21.17	na	na	14.50	16.46	23.52
SMALL GROUP	**$10 Copay**						
20	5.19	14.01	na	na	9.60	10.90	15.57
30	6.08	16.42	na	na	11.25	12.77	18.24
40	6.66	17.98	na	na	12.32	13.99	19.98
60	7.23	19.52	na	na	13.38	15.18	21.69
Unlimited	7.33	19.79	na	na	13.56	15.39	21.99

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$15 Copay**			
20	4.87	13.15	na	na	9.01	10.23	14.61
30	5.70	15.39	na	na	10.55	11.97	17.10
40	6.25	16.88	na	na	11.56	13.13	18.75
60	6.80	18.36	na	na	12.58	14.28	20.40
Unlimited	6.86	18.52	na	na	12.69	14.41	20.58
SMALL GROUP				**$20 Copay**			
20	4.58	12.37	na	na	8.47	9.62	13.74
30	5.37	14.50	na	na	9.93	11.28	16.11
40	5.88	15.88	na	na	10.88	12.35	17.64
60	6.40	17.28	na	na	11.84	13.44	19.20
Unlimited	6.46	17.44	na	na	11.95	13.57	19.38
SMALL GROUP				**$25 Copay**			
20	4.27	11.53	na	na	7.90	8.97	12.81
30	5.00	13.50	na	na	9.25	10.50	15.00
40	5.45	14.72	na	na	10.08	11.45	16.35
60	5.93	16.01	na	na	10.97	12.45	17.79
Unlimited	5.99	16.17	na	na	11.08	12.58	17.97
SMALL GROUP				**$30 Copay**			
20	4.10	11.07	na	na	7.59	8.61	12.30
30	4.82	13.01	na	na	8.92	10.12	14.46
40	5.26	14.20	na	na	9.73	11.05	15.78
60	5.76	15.55	na	na	10.66	12.10	17.28
Unlimited	5.80	15.66	na	na	10.73	12.18	17.40
SMALL GROUP				**$35 Copay**			
20	3.99	10.77	na	na	7.38	8.38	11.97
30	4.67	12.61	na	na	8.64	9.81	14.01
40	5.14	13.88	na	na	9.51	10.79	15.42
60	5.57	15.04	na	na	10.30	11.70	16.71
Unlimited	5.61	15.15	na	na	10.38	11.78	16.83
SMALL GROUP				**$40 Copay**			
20	3.88	10.48	na	na	7.18	8.15	11.64
30	4.54	12.26	na	na	8.40	9.53	13.62
40	4.97	13.42	na	na	9.19	10.44	14.91
60	5.39	14.55	na	na	9.97	11.32	16.17
Unlimited	5.44	14.69	na	na	10.06	11.42	16.32

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	3.76	10.15	na	na	6.96	7.90	11.28
30	4.40	11.88	na	na	8.14	9.24	13.20
40	4.81	12.99	na	na	8.90	10.10	14.43
60	5.23	14.12	na	na	9.68	10.98	15.69
Unlimited	5.26	14.20	na	na	9.73	11.05	15.78
SMALL GROUP				**$50 Copay**			
20	3.64	9.83	na	na	6.73	7.64	10.92
30	4.28	11.56	na	na	7.92	8.99	12.84
40	4.67	12.61	na	na	8.64	9.81	14.01
60	5.06	13.66	na	na	9.36	10.63	15.18
Unlimited	5.12	13.82	na	na	9.47	10.75	15.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.01	18.93	na	na	12.97	14.72	21.03
30	7.62	20.57	na	na	14.10	16.00	22.86
40	7.97	21.52	na	na	14.74	16.74	23.91
60	8.37	22.60	na	na	15.48	17.58	25.11
Unlimited	8.46	22.84	na	na	15.65	17.77	25.38
SMALL GROUP				**$5 Copay**			
20	6.59	17.79	na	na	12.19	13.84	19.77
30	7.16	19.33	na	na	13.25	15.04	21.48
40	7.50	20.25	na	na	13.88	15.75	22.50
60	7.87	21.25	na	na	14.56	16.53	23.61
Unlimited	7.96	21.49	na	na	14.73	16.72	23.88
SMALL GROUP				**$10 Copay**			
20	6.16	16.63	na	na	11.40	12.94	18.48
30	6.67	18.01	na	na	12.34	14.01	20.01
40	7.00	18.90	na	na	12.95	14.70	21.00
60	7.35	19.85	na	na	13.60	15.44	22.05
Unlimited	7.42	20.03	na	na	13.73	15.58	22.26
SMALL GROUP				**$15 Copay**			
20	5.78	15.61	na	na	10.69	12.14	17.34
30	6.26	16.90	na	na	11.58	13.15	18.78
40	6.56	17.71	na	na	12.14	13.78	19.68
60	6.88	18.58	na	na	12.73	14.45	20.64
Unlimited	6.97	18.82	na	na	12.89	14.64	20.91

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.43	14.66	na	na	10.05	11.40	16.29
30	5.88	15.88	na	na	10.88	12.35	17.64
40	6.17	16.66	na	na	11.41	12.96	18.51
60	6.48	17.50	na	na	11.99	13.61	19.44
Unlimited	6.55	17.69	na	na	12.12	13.76	19.65
SMALL GROUP				**$25 Copay**			
20	5.04	13.61	na	na	9.32	10.58	15.12
30	5.46	14.74	na	na	10.10	11.47	16.38
40	5.75	15.53	na	na	10.64	12.08	17.25
60	6.03	16.28	na	na	11.16	12.66	18.09
Unlimited	6.09	16.44	na	na	11.27	12.79	18.27
SMALL GROUP				**$30 Copay**			
20	4.88	13.18	na	na	9.03	10.25	14.64
30	5.27	14.23	na	na	9.75	11.07	15.81
40	5.56	15.01	na	na	10.29	11.68	16.68
60	5.82	15.71	na	na	10.77	12.22	17.46
Unlimited	5.87	15.85	na	na	10.86	12.33	17.61
SMALL GROUP				**$35 Copay**			
20	4.72	12.74	na	na	8.73	9.91	14.16
30	5.14	13.88	na	na	9.51	10.79	15.42
40	5.37	14.50	na	na	9.93	11.28	16.11
60	5.63	15.20	na	na	10.42	11.82	16.89
Unlimited	5.69	15.36	na	na	10.53	11.95	17.07
SMALL GROUP				**$40 Copay**			
20	4.59	12.39	na	na	8.49	9.64	13.77
30	4.99	13.47	na	na	9.23	10.48	14.97
40	5.21	14.07	na	na	9.64	10.94	15.63
60	5.46	14.74	na	na	10.10	11.47	16.38
Unlimited	5.54	14.96	na	na	10.25	11.63	16.62
SMALL GROUP				**$45 Copay**			
20	4.45	12.02	na	na	8.23	9.35	13.35
30	4.82	13.01	na	na	8.92	10.12	14.46
40	5.05	13.64	na	na	9.34	10.61	15.15
60	5.30	14.31	na	na	9.81	11.13	15.90
Unlimited	5.35	14.45	na	na	9.90	11.24	16.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$50 Copay**			
20	4.32	11.66	na	na	7.99	9.07	12.96
30	4.67	12.61	na	na	8.64	9.81	14.01
40	4.90	13.23	na	na	9.07	10.29	14.70
60	5.16	13.93	na	na	9.55	10.84	15.48
Unlimited	5.19	14.01	na	na	9.60	10.90	15.57
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2nd Quarter Small Group RATE MANUAL

HIP COMPREHEALTH HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 01, 2013 - June 30, 2013 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				
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
			Full-time Students				
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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
April 01, 2013 - June 30, 2013 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	5.19	14.01	na	na	9.60	10.90	15.57
$0/Max $5000	4.90	13.23	na	na	9.07	10.29	14.70
$0/Max $2500	4.60	12.42	na	na	8.51	9.66	13.80
$25	4.90	13.23	na	na	9.07	10.29	14.70
$50	4.60	12.42	na	na	8.51	9.66	13.80
$100	4.23	11.42	na	na	7.83	8.88	12.69
$500	2.04	5.51	na	na	3.77	4.28	6.12
$5,000	0.33	0.89	na	na	0.61	0.69	0.99
Coinsurance							
20%	4.15	11.21	na	na	7.68	8.72	12.45
25%	3.90	10.53	na	na	7.22	8.19	11.70
30%	3.63	9.80	na	na	6.72	7.62	10.89
Deductible			**Orthotics Riders**				
$0	0.90	2.43	na	na	1.67	1.89	2.70
$0/Max $5000	0.83	2.24	na	na	1.54	1.74	2.49
$0/Max $2500	0.79	2.13	na	na	1.46	1.66	2.37
$25	0.83	2.24	na	na	1.54	1.74	2.49
$50	0.79	2.13	na	na	1.46	1.66	2.37
$100	0.72	1.94	na	na	1.33	1.51	2.16
$500	0.37	1.00	na	na	0.68	0.78	1.11
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
20%	0.72	1.94	na	na	1.33	1.51	2.16
25%	0.69	1.86	na	na	1.28	1.45	2.07
30%	0.65	1.76	na	na	1.20	1.37	1.95
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.72	4.64	na	na	3.18	3.61	5.16
12 Months	2.75	7.43	na	na	5.09	5.78	8.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.69	7.26	na	na	4.98	5.65	8.07
12 Months	4.28	11.56	na	na	7.92	8.99	12.84

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Private Duty Nursing Riders				
In Full	0.69	1.86	na	na	1.28	1.45	2.07
80% hrs 73-504	0.09	0.24	na	na	0.17	0.19	0.27
100% hrs 73-504	0.20	0.54	na	na	0.37	0.42	0.60
			Dental Network Access				
	0.52	1.40	na	na	0.96	1.09	1.56
Limit			**Infertility Rider**				
2 IVF	10.95	29.57	na	na	20.26	23.00	32.85
3 IVF	13.24	35.75	na	na	24.49	27.80	39.72
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.52	12.20	na	na	8.36	9.49	13.56
			Health Club Reimbursement				
$200 per year	1.30	3.51	na	na	2.41	2.73	3.90
			Wellness Rider				
Inclusion	1.06	2.86	na	na	1.96	2.23	3.18
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.69	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HMO Factors
April 01, 2013 - June 30, 2013

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island		1.000	1.074
New York City, Westchester, Rockland and Orange Counties		1.000	1.028
Upstate[2]		1.000	not available

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	115%

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.
(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
April 01, 2013 - June 30, 2013 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[g]
+ applicable pmpm for Women's Preventive Services Table 4 [h]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS

MONTHLY PREMIUMS EFFECTIVE 2011 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*

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 Adjustmer Applies only to New York City account	-2.0%	
[f] Product Factc HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
	HMO	CompreHealth HMO
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
[h] Mandatory Women's Preventive Services	$0.58	$0.60

Table 5: Tier Conversion Factors

	HIP	Emblem Coordinated Care Plans
	Small Group	**Small Group**
Two Tier		
Individual EE	1.2179	1.2179
Family	3.2883	3.2883
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2179
EE + Child(ren	2.2531	2.2531
EE + Spouse	2.5576	2.5576
Family	3.6537	3.6537

Health Insurance Plan of Greater New York
and HIP Insurance Company of New York

Rating Region Definitions

County	Region
Bronx	Downstate
Kings	Downstate
Nassau	Downstate
New York	Downstate
Orange	Downstate
Queens	Downstate
Richmond	Downstate
Rockland	Downstate
Suffolk	Downstate
Westchester	Downstate

Commissions Schedule

Please see SERFF filing # HPHP-127874918

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
APRIL 1, 2012 - JUNE 30, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group*	666.20	1,798.74	na	na	1,232.47	1,399.02	1,998.60
Classic*	475.49	1,283.82	na	na	879.66	998.53	1,426.47
Small Group*	666.20	1,798.74	na	na	1,232.47	1,399.02	1,998.60
Classic*	475.49	1,283.82	na	na	879.66	998.53	1,426.47

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 04/01/2013 - 06/30/2013 (With WH & Autism)							
Small Group*	688.94	1,860.14	na	na	1,274.54	1,446.77	2,066.82
Classic*	491.71	1,327.62	na	na	909.66	1,032.59	1,475.13
Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)							
Small Group*	682.12	1,841.72	na	na	1,261.92	1,432.45	2,046.36
Classic*	486.84	1,314.47	na	na	900.65	1,022.36	1,460.52

* Base rates exclude premium component for mandatory mental health coverage

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 04/01/2013 - 06/30/2013 (With WH & Autism)							
Small Gro	22.74	61.40	na	na	42.07	47.75	68.22
Classic*	16.22	43.80	na	na	30.00	34.06	48.66
Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)							
Small Gro	15.92	42.98	na	na	29.45	33.43	47.76
Classic*	11.35	30.65	na	na	20.99	23.83	34.05

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee Child(ren)	Employee & Spouse	Family
Effective 04/01/2013 - 06/30/2013 (With WH & Autism)							
Small Gro	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Classic*	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)							
Small Gro	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	na	na	0.00	0.00	0.00
$5	(3.78)	(10.21)	na	na	(6.99)	(7.94)	(11.34)
$10	(7.93)	(21.41)	na	na	(14.67)	(16.65)	(23.79)
$15	(13.18)	(35.59)	na	na	(24.38)	(27.68)	(39.54)
$20	(20.35)	(54.95)	na	na	(37.65)	(42.74)	(61.05)
$25	(26.83)	(72.44)	na	na	(49.64)	(56.34)	(80.49)
$30	(33.91)	(91.56)	na	na	(62.73)	(71.21)	(101.73)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.16)	(5.83)	na	na	(4.00)	(4.54)	(6.48)
$10	(4.53)	(12.23)	na	na	(8.38)	(9.51)	(13.59)
$15	(7.55)	(20.39)	na	na	(13.97)	(15.86)	(22.65)
$20	(11.66)	(31.48)	na	na	(21.57)	(24.49)	(34.98)
$25	(15.37)	(41.50)	na	na	(28.43)	(32.28)	(46.11)
$30	(19.44)	(52.49)	na	na	(35.96)	(40.82)	(58.32)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.67)	(7.21)	na	na	(4.94)	(5.61)	(8.01)
$10	(5.52)	(14.90)	na	na	(10.21)	(11.59)	(16.56)
$15	(8.64)	(23.33)	na	na	(15.98)	(18.14)	(25.92)
$20	(12.18)	(32.89)	na	na	(22.53)	(25.58)	(36.54)
$25	(16.08)	(43.42)	na	na	(29.75)	(33.77)	(48.24)
$30	(20.49)	(55.32)	na	na	(37.91)	(43.03)	(61.47)
$35	(24.63)	(66.50)	na	na	(45.57)	(51.72)	(73.89)
$40	(33.25)	(89.78)	na	na	(61.51)	(69.83)	(99.75)
$45	(33.42)	(90.23)	na	na	(61.83)	(70.18)	(100.26)
$50	(38.16)	(103.03)	na	na	(70.60)	(80.14)	(114.48)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.25)	(6.08)	na	na	(4.16)	(4.73)	(6.75)
$10	(4.67)	(12.61)	na	na	(8.64)	(9.81)	(14.01)
$15	(7.31)	(19.74)	na	na	(13.52)	(15.35)	(21.93)
$20	(10.31)	(27.84)	na	na	(19.07)	(21.65)	(30.93)
$25	(13.59)	(36.69)	na	na	(25.14)	(28.54)	(40.77)
$30	(17.32)	(46.76)	na	na	(32.04)	(36.37)	(51.96)
$35	(20.82)	(56.21)	na	na	(38.52)	(43.72)	(62.46)
$40	(28.12)	(75.92)	na	na	(52.02)	(59.05)	(84.36)
$45	(28.26)	(76.30)	na	na	(52.28)	(59.35)	(84.78)
$50	(32.26)	(87.10)	na	na	(59.68)	(67.75)	(96.78)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.04)	(5.51)	na	na	(3.77)	(4.28)	(6.12)
$150	(3.35)	(9.05)	na	na	(6.20)	(7.04)	(10.05)
$200	(4.78)	(12.91)	na	na	(8.84)	(10.04)	(14.34)
$250	(6.84)	(18.47)	na	na	(12.65)	(14.36)	(20.52)
$500	(16.40)	(44.28)	na	na	(30.34)	(34.44)	(49.20)
$750	(28.18)	(76.09)	na	na	(52.13)	(59.18)	(84.54)
$1,000	(42.39)	(114.45)	na	na	(78.42)	(89.02)	(127.17)
Copay/Day							
$50 w/3 Day Max	(2.46)	(6.64)	na	na	(4.55)	(5.17)	(7.38)
$50 w/5 Day Max	(3.39)	(9.15)	na	na	(6.27)	(7.12)	(10.17)
$100 w/3 Day Max	(6.16)	(16.63)	na	na	(11.40)	(12.94)	(18.48)
$100 w/5 Day Max	(8.88)	(23.98)	na	na	(16.43)	(18.65)	(26.64)
$250 w/3 Day Max	(20.42)	(55.13)	na	na	(37.78)	(42.88)	(61.26)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.12)	(3.02)	na	na	(2.07)	(2.35)	(3.36)
$75	(1.81)	(4.89)	na	na	(3.35)	(3.80)	(5.43)
$100	(2.58)	(6.97)	na	na	(4.77)	(5.42)	(7.74)
$125	(3.39)	(9.15)	na	na	(6.27)	(7.12)	(10.17)
$150	(4.23)	(11.42)	na	na	(7.83)	(8.88)	(12.69)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.40)	(1.08)	na	na	(0.74)	(0.84)	(1.20)
$25	(0.72)	(1.94)	na	na	(1.33)	(1.51)	(2.16)
$35	(1.17)	(3.16)	na	na	(2.16)	(2.46)	(3.51)
$50	(2.02)	(5.45)	na	na	(3.74)	(4.24)	(6.06)
$60	(2.56)	(6.91)	na	na	(4.74)	(5.38)	(7.68)
$75	(3.39)	(9.15)	na	na	(6.27)	(7.12)	(10.17)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$5	(3.87)	(10.45)	na	na	(7.16)	(8.13)	(11.61)
$10	(8.13)	(21.95)	na	na	(15.04)	(17.07)	(24.39)
$15	(13.50)	(36.45)	na	na	(24.98)	(28.35)	(40.50)
$20	(20.84)	(56.27)	na	na	(38.55)	(43.76)	(62.52)
$25	(27.47)	(74.17)	na	na	(50.82)	(57.69)	(82.41)
$30	(34.72)	(93.74)	na	na	(64.23)	(72.91)	(104.16)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.21)	(5.97)	na	na	(4.09)	(4.64)	(6.63)
$10	(4.65)	(12.56)	na	na	(8.60)	(9.77)	(13.95)
$15	(7.74)	(20.90)	na	na	(14.32)	(16.25)	(23.22)
$20	(11.94)	(32.24)	na	na	(22.09)	(25.07)	(35.82)
$25	(15.73)	(42.47)	na	na	(29.10)	(33.03)	(47.19)
$30	(19.90)	(53.73)	na	na	(36.82)	(41.79)	(59.70)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.73)	(7.37)	na	na	(5.05)	(5.73)	(8.19)
$10	(5.65)	(15.26)	na	na	(10.45)	(11.87)	(16.95)
$15	(8.85)	(23.90)	na	na	(16.37)	(18.59)	(26.55)
$20	(12.48)	(33.70)	na	na	(23.09)	(26.21)	(37.44)
$25	(16.47)	(44.47)	na	na	(30.47)	(34.59)	(49.41)
$30	(20.97)	(56.62)	na	na	(38.79)	(44.04)	(62.91)
$35	(25.21)	(68.07)	na	na	(46.64)	(52.94)	(75.63)
$40	(34.05)	(91.94)	na	na	(62.99)	(71.51)	(102.15)
$45	(34.22)	(92.39)	na	na	(63.31)	(71.86)	(102.66)
$50	(39.07)	(105.49)	na	na	(72.28)	(82.05)	(117.21)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.31)	(6.24)	na	na	(4.27)	(4.85)	(6.93)
$10	(4.78)	(12.91)	na	na	(8.84)	(10.04)	(14.34)
$15	(7.49)	(20.22)	na	na	(13.86)	(15.73)	(22.47)
$20	(10.56)	(28.51)	na	na	(19.54)	(22.18)	(31.68)
$25	(13.92)	(37.58)	na	na	(25.75)	(29.23)	(41.76)
$30	(17.74)	(47.90)	na	na	(32.82)	(37.25)	(53.22)
$35	(21.31)	(57.54)	na	na	(39.42)	(44.75)	(63.93)
$40	(28.79)	(77.73)	na	na	(53.26)	(60.46)	(86.37)
$45	(28.93)	(78.11)	na	na	(53.52)	(60.75)	(86.79)
$50	(33.03)	(89.18)	na	na	(61.11)	(69.36)	(99.09)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.08)	(5.62)	na	na	(3.85)	(4.37)	(6.24)
$150	(3.43)	(9.26)	na	na	(6.35)	(7.20)	(10.29)
$200	(4.89)	(13.20)	na	na	(9.05)	(10.27)	(14.67)
$250	(7.00)	(18.90)	na	na	(12.95)	(14.70)	(21.00)
$500	(16.79)	(45.33)	na	na	(31.06)	(35.26)	(50.37)
$750	(28.86)	(77.92)	na	na	(53.39)	(60.61)	(86.58)
$1,000	(43.40)	(117.18)	na	na	(80.29)	(91.14)	(130.20)
Copay/Day							
$50 w/3 Day Max	(2.52)	(6.80)	na	na	(4.66)	(5.29)	(7.56)
$50 w/5 Day Max	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)
$100 w/3 Day Max	(6.30)	(17.01)	na	na	(11.66)	(13.23)	(18.90)
$100 w/5 Day Max	(9.09)	(24.54)	na	na	(16.82)	(19.09)	(27.27)
$250 w/3 Day Max	(20.91)	(56.46)	na	na	(38.68)	(43.91)	(62.73)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.14)	(3.08)	na	na	(2.11)	(2.39)	(3.42)
$75	(1.85)	(5.00)	na	na	(3.42)	(3.89)	(5.55)
$100	(2.65)	(7.16)	na	na	(4.90)	(5.57)	(7.95)
$125	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)
$150	(4.34)	(11.72)	na	na	(8.03)	(9.11)	(13.02)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.40)	(1.08)	na	na	(0.74)	(0.84)	(1.20)
$25	(0.73)	(1.97)	na	na	(1.35)	(1.53)	(2.19)
$35	(1.21)	(3.27)	na	na	(2.24)	(2.54)	(3.63)
$50	(2.07)	(5.59)	na	na	(3.83)	(4.35)	(6.21)
$60	(2.63)	(7.10)	na	na	(4.87)	(5.52)	(7.89)
$75	(3.46)	(9.34)	na	na	(6.40)	(7.27)	(10.38)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	-	-	na	na	-	-	-
$0	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$0	(0.20)	(0.54)	na	na	(0.37)	(0.42)	(0.60)
$0	(0.32)	(0.86)	na	na	(0.60)	(0.67)	(0.96)
$0	(0.49)	(1.32)	na	na	(0.90)	(1.02)	(1.47)
$0	(0.64)	(1.73)	na	na	(1.18)	(1.35)	(1.92)
$0	(0.81)	(2.18)	na	na	(1.50)	(1.70)	(2.43)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.05)	(0.14)	na	na	(0.09)	(0.10)	(0.15)
$0	(0.12)	(0.33)	na	na	(0.22)	(0.26)	(0.36)
$0	(0.19)	(0.51)	na	na	(0.35)	(0.39)	(0.57)
$0	(0.28)	(0.76)	na	na	(0.52)	(0.58)	(0.84)
$0	(0.36)	(0.97)	na	na	(0.67)	(0.75)	(1.08)
$0	(0.46)	(1.24)	na	na	(0.86)	(0.97)	(1.38)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.16)	na	na	(0.11)	(0.12)	(0.18)
$0	(0.13)	(0.36)	na	na	(0.24)	(0.28)	(0.39)
$0	(0.21)	(0.57)	na	na	(0.39)	(0.45)	(0.63)
$0	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$0	(0.39)	(1.05)	na	na	(0.72)	(0.82)	(1.17)
$0	(0.48)	(1.30)	na	na	(0.88)	(1.01)	(1.44)
$0	(0.58)	(1.57)	na	na	(1.07)	(1.22)	(1.74)
$0	(0.80)	(2.16)	na	na	(1.48)	(1.68)	(2.40)
$0	(0.80)	(2.16)	na	na	(1.48)	(1.68)	(2.40)
$0	(0.91)	(2.46)	na	na	(1.68)	(1.91)	(2.73)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.16)	na	na	(0.11)	(0.12)	(0.18)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
$0	(0.18)	(0.48)	na	na	(0.34)	(0.38)	(0.54)
$0	(0.25)	(0.67)	na	na	(0.47)	(0.53)	(0.75)
$0	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
$0	(0.42)	(1.14)	na	na	(0.78)	(0.88)	(1.26)
$0	(0.49)	(1.33)	na	na	(0.90)	(1.03)	(1.47)
$0	(0.67)	(1.81)	na	na	(1.24)	(1.41)	(2.01)
$0	(0.67)	(1.81)	na	na	(1.24)	(1.40)	(2.01)
$0	(0.77)	(2.08)	na	na	(1.43)	(1.61)	(2.31)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
$0	(0.08)	(0.21)	na	na	(0.15)	(0.16)	(0.24)
$0	(0.11)	(0.29)	na	na	(0.21)	(0.23)	(0.33)
$0	(0.16)	(0.43)	na	na	(0.30)	(0.34)	(0.48)
$0	(0.39)	(1.05)	na	na	(0.72)	(0.82)	(1.17)
$0	(0.68)	(1.83)	na	na	(1.26)	(1.43)	(2.04)
$0	(1.01)	(2.73)	na	na	(1.87)	(2.12)	(3.03)
Copay/Day							
$0	(0.06)	(0.16)	na	na	(0.11)	(0.12)	(0.18)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$0	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$0	(0.21)	(0.56)	na	na	(0.39)	(0.44)	(0.63)
$0	(0.49)	(1.33)	na	na	(0.90)	(1.03)	(1.47)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.04)	(0.11)	na	na	(0.08)	(0.08)	(0.12)
$0	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.14)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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%	na	na	0.0%	0.0%	0.0%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.3%	2.4%	na	na	2.3%	2.2%	2.3%
$0	2.6%	2.7%	na	na	2.6%	2.7%	2.6%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.2%	2.2%	na	na	2.2%	2.1%	2.2%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.7%	2.6%	na	na	2.6%	2.5%	2.7%
$0	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
$0	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.0%	2.0%	na	na	2.1%	2.1%	2.0%
$0	2.4%	2.3%	na	na	2.4%	2.3%	2.4%
$0	2.3%	2.2%	na	na	2.4%	2.3%	2.3%
$0	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Day							
$0	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
$0	2.1%	2.1%	na	na	2.1%	2.1%	2.1%
$0	2.3%	2.3%	na	na	2.3%	2.2%	2.3%
$0	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.8%	2.0%	na	na	1.9%	1.7%	1.8%
$0	2.2%	2.2%	na	na	2.1%	2.4%	2.2%
$0	2.7%	2.7%	na	na	2.7%	2.8%	2.7%
$0	2.1%	2.1%	na	na	2.1%	2.1%	2.1%
$0	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.5%	na	na	1.5%	1.3%	1.4%
$0	3.4%	3.5%	na	na	3.7%	3.3%	3.4%
$0	2.5%	2.6%	na	na	2.4%	2.6%	2.5%
$0	2.7%	2.7%	na	na	2.7%	2.6%	2.7%
$0	2.1%	2.1%	na	na	2.1%	2.1%	2.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(4.80)	(12.96)	na	na	(8.88)	(10.08)	(14.40)
$125	(5.91)	(15.96)	na	na	(10.93)	(12.41)	(17.73)
$150	(7.06)	(19.06)	na	na	(13.06)	(14.83)	(21.18)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.60	1.62	na	na	1.11	1.26	1.80
60	1.14	3.08	na	na	2.11	2.39	3.42
90	1.73	4.67	na	na	3.20	3.63	5.19
120	2.02	5.45	na	na	3.74	4.24	6.06
Unlimited	2.59	6.99	na	na	4.79	5.44	7.77
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
40/$10 copay	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)
40/$15 copay	(0.46)	(1.24)	na	na	(0.85)	(0.97)	(1.38)
40/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.37)	(1.95)
40/$25 copay	(0.84)	(2.27)	na	na	(1.55)	(1.76)	(2.52)
60	0.31	0.84	na	na	0.57	0.65	0.93
100	0.76	2.05	na	na	1.41	1.60	2.28
200	2.02	5.45	na	na	3.74	4.24	6.06
	** 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)	(3.21)	na	na	(2.20)	(2.50)	(3.57)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.13	na	na	1.46	1.66	2.37
90	1.66	4.48	na	na	3.07	3.49	4.98
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.71	1.92	na	na	1.31	1.49	2.13
90	1.31	3.54	na	na	2.42	2.75	3.93
120	2.10	5.67	na	na	3.89	4.41	6.30
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.01)	(2.73)	na	na	(1.87)	(2.12)	(3.03)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.30	0.81	na	na	0.56	0.63	0.90
30	0.47	1.27	na	na	0.87	0.99	1.41
Unlimited	0.71	1.92	na	na	1.31	1.49	2.13
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.55	9.59	na	na	6.57	7.46	10.65
60	4.16	11.23	na	na	7.70	8.74	12.48
90	4.97	13.42	na	na	9.19	10.44	14.91
Unlimited	5.04	13.61	na	na	9.32	10.58	15.12
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)
60/$10 copay	(0.28)	(0.76)	na	na	(0.52)	(0.59)	(0.84)
60/$15 copay	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
60/$20 copay	(0.61)	(1.65)	na	na	(1.13)	(1.28)	(1.83)
60/$25 copay	(0.73)	(1.97)	na	na	(1.35)	(1.53)	(2.19)
120/$0 copay	0.63	1.70	na	na	1.17	1.32	1.89
120/$5 copay	0.47	1.27	na	na	0.87	0.99	1.41
120/$10 copay	0.28	0.76	na	na	0.52	0.59	0.84
120/$15 copay	0.02	0.05	na	na	0.04	0.04	0.06
120/$20 copay	(0.16)	(0.43)	na	na	(0.30)	(0.34)	(0.48)
120/$25 copay	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
Unlimited/$0 copay	0.72	1.94	na	na	1.33	1.51	2.16
Unlimited/$5 copay	0.56	1.51	na	na	1.04	1.18	1.68
Unlimited/$10 copay	0.35	0.95	na	na	0.65	0.74	1.05
Unlimited/$15 copay	0.08	0.22	na	na	0.15	0.17	0.24
Unlimited/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
Unlimited/$25 copay	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.20	0.54	na	na	0.37	0.42	0.60
$5	0.08	0.22	na	na	0.15	0.17	0.24
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(4.91)	(13.26)	na	na	(9.08)	(10.31)	(14.73)
$125	(6.05)	(16.34)	na	na	(11.19)	(12.71)	(18.15)
$150	(7.23)	(19.52)	na	na	(13.38)	(15.18)	(21.69)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.62	1.67	na	na	1.15	1.30	1.86
$60	1.16	3.13	na	na	2.15	2.44	3.48
$90	1.76	4.75	na	na	3.26	3.70	5.28
$120	2.07	5.59	na	na	3.83	4.35	6.21
Unlimited	2.66	7.18	na	na	4.92	5.59	7.98
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
40/$10 copay	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
40/$15 copay	(0.46)	(1.24)	na	na	(0.85)	(0.97)	(1.38)
40/$20 copay	(0.67)	(1.81)	na	na	(1.24)	(1.41)	(2.01)
40/$25 copay	(0.87)	(2.35)	na	na	(1.61)	(1.83)	(2.61)
$60	0.32	0.86	na	na	0.59	0.67	0.96
$100	0.77	2.08	na	na	1.42	1.62	2.31
$200	2.07	5.59	na	na	3.83	4.35	6.21
	** 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)	(3.32)	na	na	(2.28)	(2.58)	(3.69)
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.80	2.16	na	na	1.48	1.68	2.40
$90	1.70	4.59	na	na	3.15	3.57	5.10
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.72	1.94	na	na	1.33	1.51	2.16
$90	1.34	3.62	na	na	2.48	2.81	4.02
$120	2.14	5.78	na	na	3.96	4.49	6.42
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(1.03)	(2.78)	na	na	(1.91)	(2.16)	(3.09)
$7	0.00	0.00	na	na	0.00	0.00	0.00
$21	0.31	0.84	na	na	0.57	0.65	0.93
$30	0.47	1.27	na	na	0.87	0.99	1.41
Unlimited	0.72	1.94	na	na	1.33	1.51	2.16
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$30	3.64	9.83	na	na	6.73	7.64	10.92
$60	4.25	11.48	na	na	7.86	8.93	12.75
$90	5.09	13.74	na	na	9.42	10.69	15.27
Unlimited	5.16	13.93	na	na	9.55	10.84	15.48
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
60/$10 copay	(0.29)	(0.78)	na	na	(0.54)	(0.61)	(0.87)
60/$15 copay	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
60/$20 copay	(0.63)	(1.70)	na	na	(1.17)	(1.32)	(1.89)
60/$25 copay	(0.74)	(2.00)	na	na	(1.37)	(1.55)	(2.22)
120/$0 copay	0.65	1.76	na	na	1.20	1.37	1.95
120/$5 copay	0.47	1.27	na	na	0.87	0.99	1.41
120/$10 copay	0.29	0.78	na	na	0.54	0.61	0.87
120/$15 copay	0.02	0.05	na	na	0.04	0.04	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
120/$25 copay	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
Unlimited/$0 copay	0.73	1.97	na	na	1.35	1.53	2.19
Unlimited/$5 copay	0.58	1.57	na	na	1.07	1.22	1.74
Unlimited/$10 copay	0.36	0.97	na	na	0.67	0.76	1.08
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.15	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
Unlimited/$25 copay	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.22	0.59	na	na	0.41	0.46	0.66
$5	0.07	0.19	na	na	0.13	0.15	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
$0	(0.14)	(0.38)	na	na	(0.26)	(0.30)	(0.42)
$0	(0.17)	(0.46)	na	na	(0.32)	(0.35)	(0.51)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	-	-	na	na	-	-	-
$0	0.02	0.05	na	na	0.04	0.04	0.06
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.03	0.08	na	na	0.06	0.07	0.09
$0	0.05	0.14	na	na	0.09	0.11	0.15
$0	0.07	0.19	na	na	0.13	0.15	0.21
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.05	0.14	na	na	0.09	0.11	0.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	(0.04)	(0.11)	na	na	(0.08)	(0.08)	(0.12)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.04	0.11	na	na	0.08	0.08	0.12
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.03	0.08	na	na	0.06	0.06	0.09
$0	0.04	0.11	na	na	0.07	0.08	0.12
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	-	-	na	na	-	-	-
$0	0.09	0.24	na	na	0.16	0.18	0.27
$0	0.09	0.25	na	na	0.16	0.19	0.27
$0	0.12	0.32	na	na	0.23	0.25	0.36
$0	0.12	0.32	na	na	0.23	0.26	0.36
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	0.02	0.06	na	na	0.03	0.05	0.06
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.02	0.06	na	na	0.03	0.04	0.06
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	0.01	0.03	na	na	0.02	0.02	0.03
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.02	0.05	na	na	0.04	0.04	0.06
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.3%	3.1%	na	na	3.6%	3.2%	3.3%
$0	1.8%	1.6%	na	na	1.9%	2.1%	1.8%
$0	1.7%	1.7%	na	na	1.9%	1.9%	1.7%
$0	2.5%	2.6%	na	na	2.4%	2.6%	2.5%
$0	2.7%	2.7%	na	na	2.7%	2.8%	2.7%
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.9%	-7.1%
$0	3.2%	2.4%	na	na	3.5%	3.1%	3.2%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.1%	2.8%	na	na	3.3%	2.9%	3.1%
$0	3.6%	3.5%	na	na	3.9%	4.0%	3.6%
$0	3.2%	2.4%	na	na	3.5%	3.1%	3.2%
$0	1.3%	1.5%	na	na	0.7%	1.3%	1.3%
$0	2.5%	2.6%	na	na	2.4%	2.6%	2.5%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	3.4%	3.4%	na	na	3.6%	3.2%	3.4%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.3%	1.4%	na	na	1.4%	1.2%	1.3%
$0	2.4%	2.5%	na	na	2.6%	2.3%	2.4%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.0%	na	na	1.5%	1.3%	1.4%
$0	2.3%	2.3%	na	na	2.5%	2.2%	2.3%
$0	1.9%	1.9%	na	na	1.8%	1.8%	1.9%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	2.0%	1.8%	na	na	2.1%	1.9%	2.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.3%	3.7%	na	na	1.8%	3.2%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.0%	na	na	1.5%	1.3%	1.4%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
$0	2.2%	2.2%	na	na	2.1%	2.2%	2.2%
$0	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-9.5%	-10.0%
$0	3.6%	2.6%	na	na	3.8%	3.4%	3.6%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.3%	3.0%	na	na	3.5%	3.1%	3.3%
$0	1.4%	1.5%	na	na	1.5%	1.3%	1.4%
$0	3.2%	3.5%	na	na	2.6%	3.8%	3.2%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.6%	2.6%	na	na	3.8%	3.4%	3.6%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.3%	-4.7%	na	na	-6.7%	-5.9%	-6.2%
$0	2.9%	2.1%	na	na	3.1%	2.7%	2.9%
$0	1.4%	1.5%	na	na	1.5%	1.3%	1.4%
$0	3.6%	4.0%	na	na	2.9%	3.4%	3.6%
$0	2.9%	2.1%	na	na	3.1%	2.7%	2.9%
$0	-12.5%	-13.6%	na	na	-13.3%	-11.8%	-12.5%
$0	-11.1%	-8.3%	na	na	-11.8%	-10.5%	-11.1%
$0	3.3%	3.7%	na	na	1.8%	3.2%	3.3%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	10.0%	9.3%	na	na	10.8%	9.5%	10.0%
$0	-12.5%	-13.6%	na	na	-13.3%	-11.8%	-12.5%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-9.5%	-10.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(0.24)	(0.65)	na	na	(0.44)	(0.50)	(0.72)
$25	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$10	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)
$15	(0.47)	(1.27)	na	na	(0.87)	(0.99)	(1.41)
$20	(0.68)	(1.84)	na	na	(1.26)	(1.43)	(2.04)
$25	(0.88)	(2.38)	na	na	(1.63)	(1.85)	(2.64)
$30	(1.07)	(2.89)	na	na	(1.98)	(2.25)	(3.21)
$35	(1.27)	(3.43)	na	na	(2.35)	(2.67)	(3.81)
$40	(1.46)	(3.94)	na	na	(2.70)	(3.07)	(4.38)
$45	(1.67)	(4.51)	na	na	(3.09)	(3.51)	(5.01)
$50	(1.84)	(4.97)	na	na	(3.40)	(3.86)	(5.52)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$10	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
$15	(0.50)	(1.35)	na	na	(0.93)	(1.05)	(1.50)
$20	(0.76)	(2.05)	na	na	(1.41)	(1.60)	(2.28)
$25	(1.03)	(2.78)	na	na	(1.91)	(2.16)	(3.09)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$35	(0.23)	(0.62)	na	na	(0.43)	(0.48)	(0.69)
$50	(0.34)	(0.92)	na	na	(0.63)	(0.71)	(1.02)
$60	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
$75	(0.58)	(1.57)	na	na	(1.07)	(1.22)	(1.74)
$100	(0.76)	(2.05)	na	na	(1.41)	(1.60)	(2.28)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$50	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$60	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)
$75	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
$100	(0.50)	(1.35)	na	na	(0.93)	(1.05)	(1.50)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.20)	(8.64)	na	na	(5.92)	(6.72)	(9.60)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(4.96)	(13.39)	na	na	(9.18)	(10.42)	(14.88)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.42)	(1.13)	na	na	(0.78)	(0.88)	(1.26)
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$10/15/20	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$25	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
$10	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
$15	(0.47)	(1.27)	na	na	(0.87)	(0.99)	(1.41)
$20	(0.69)	(1.86)	na	na	(1.28)	(1.45)	(2.07)
$25	(0.91)	(2.46)	na	na	(1.68)	(1.91)	(2.73)
$30	(1.09)	(2.94)	na	na	(2.02)	(2.29)	(3.27)
$35	(1.30)	(3.51)	na	na	(2.41)	(2.73)	(3.90)
$40	(1.49)	(4.02)	na	na	(2.76)	(3.13)	(4.47)
$45	(1.71)	(4.62)	na	na	(3.16)	(3.59)	(5.13)
$50	(1.90)	(5.13)	na	na	(3.52)	(3.99)	(5.70)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$10	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
$15	(0.53)	(1.43)	na	na	(0.98)	(1.11)	(1.59)
$20	(0.77)	(2.08)	na	na	(1.42)	(1.62)	(2.31)
$25	(1.05)	(2.84)	na	na	(1.94)	(2.21)	(3.15)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$35	(0.24)	(0.65)	na	na	(0.44)	(0.50)	(0.72)
$50	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
$60	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
$75	(0.60)	(1.62)	na	na	(1.11)	(1.26)	(1.80)
$100	(0.77)	(2.08)	na	na	(1.42)	(1.62)	(2.31)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.21)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)
$50	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
$60	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)
$75	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
$100	(0.53)	(1.43)	na	na	(0.98)	(1.11)	(1.59)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	(3.29)	(8.88)	na	na	(6.09)	(6.91)	(9.87)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	(5.08)	(13.72)	na	na	(9.40)	(10.67)	(15.24)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	(0.42)	(1.13)	na	na	(0.78)	(0.88)	(1.26)
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.29)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.06)	(0.09)
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.06)	(0.09)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.06)	(0.09)
$0	(0.04)	(0.11)	na	na	(0.07)	(0.08)	(0.12)
$0	(0.06)	(0.16)	na	na	(0.12)	(0.13)	(0.18)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.06)	(0.09)
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.01	0.02	0.03
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.03)	(0.08)	na	na	(0.05)	(0.06)	(0.09)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	(0.12)	(0.33)	na	na	(0.22)	(0.25)	(0.36)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	-	-	na	na	-	-	-
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$0	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	4.2%	4.6%	na	na	4.5%	6.0%	4.2%
$0	3.1%	3.5%	na	na	3.4%	3.0%	3.1%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.9%	-7.1%
$0	3.2%	2.4%	na	na	3.5%	3.1%	3.2%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.5%	1.1%	na	na	1.6%	1.4%	1.5%
$0	3.4%	3.4%	na	na	3.1%	3.2%	3.4%
$0	1.9%	1.7%	na	na	2.0%	1.8%	1.9%
$0	2.4%	2.3%	na	na	2.6%	2.2%	2.4%
$0	2.1%	2.0%	na	na	2.2%	2.0%	2.1%
$0	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
$0	3.3%	3.2%	na	na	3.5%	3.4%	3.3%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.7%	-7.3%	na	na	-7.1%	-9.4%	-6.7%
$0	2.9%	2.1%	na	na	3.1%	2.7%	2.9%
$0	6.0%	5.9%	na	na	5.4%	5.7%	6.0%
$0	1.3%	1.5%	na	na	0.7%	1.3%	1.3%
$0	1.9%	2.2%	na	na	1.6%	2.3%	1.9%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-12.5%	-13.6%	na	na	-13.3%	-11.8%	-12.5%
$0	-9.1%	-10.0%	na	na	-5.0%	-8.7%	-9.1%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-11.1%	-8.3%	na	na	-11.8%	-10.5%	-11.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-9.4%	-6.7%
$0	4.3%	4.8%	na	na	2.3%	4.2%	4.3%
$0	2.9%	3.3%	na	na	3.2%	4.2%	2.9%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.4%	3.2%	na	na	3.7%	3.3%	3.4%
$0	1.3%	1.5%	na	na	0.7%	1.3%	1.3%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-9.1%	-10.0%	na	na	-5.0%	-8.7%	-9.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-9.4%	-6.7%
$0	4.0%	2.9%	na	na	4.3%	3.8%	4.0%
$0	3.2%	2.4%	na	na	3.5%	3.1%	3.2%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	6.0%	5.9%	na	na	5.4%	5.7%	6.0%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	2.8%	2.8%	na	na	2.9%	2.8%	2.8%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$0	-6.7%	-7.3%	na	na	-7.1%	-9.4%	-6.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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							
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
April 01, 2013 - June 30, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	3.93	10.61	na	na	7.27	8.25	11.79
60	5.55	14.99	na	na	10.27	11.66	16.65
90	6.59	17.79	na	na	12.19	13.84	19.77
Unlimited	6.67	18.01	na	na	12.34	14.01	20.01
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.00	18.90	na	na	12.95	14.70	21.00
60	7.40	19.98	na	na	13.69	15.54	22.20
90	7.67	20.71	na	na	14.19	16.11	23.01
Unlimited	7.75	20.93	na	na	14.34	16.28	23.25
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
npatient Mental Hlt	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.34	14.42	na	na	9.88	11.21	16.02
30	6.34	17.12	na	na	11.73	13.31	19.02
40	6.99	18.87	na	na	12.93	14.68	20.97
60	7.64	20.63	na	na	14.13	16.04	22.92
Unlimited	7.71	20.82	na	na	14.26	16.19	23.13
SMALL GROUP	**$5 Copay**						
20	5.03	13.58	na	na	9.31	10.56	15.09
30	5.97	16.12	na	na	11.04	12.54	17.91
40	6.58	17.77	na	na	12.17	13.82	19.74
60	7.19	19.41	na	na	13.30	15.10	21.57
Unlimited	7.27	19.63	na	na	13.45	15.27	21.81
SMALL GROUP	**$10 Copay**						
20	4.68	12.64	na	na	8.66	9.83	14.04
30	5.56	15.01	na	na	10.29	11.68	16.68
40	6.13	16.55	na	na	11.34	12.87	18.39
60	6.70	18.09	na	na	12.40	14.07	20.10
Unlimited	6.77	18.28	na	na	12.52	14.22	20.31
SMALL GROUP	**$15 Copay**						
20	4.40	11.88	na	na	8.14	9.24	13.20
30	5.23	14.12	na	na	9.68	10.98	15.69
40	5.76	15.55	na	na	10.66	12.10	17.28
60	6.29	16.98	na	na	11.64	13.21	18.87
Unlimited	6.36	17.17	na	na	11.77	13.36	19.08
SMALL GROUP	**$20 Copay**						
20	4.13	11.15	na	na	7.64	8.67	12.39
30	4.90	13.23	na	na	9.07	10.29	14.70
40	5.40	14.58	na	na	9.99	11.34	16.20
60	5.90	15.93	na	na	10.92	12.39	17.70
Unlimited	5.95	16.07	na	na	11.01	12.50	17.85
SMALL GROUP	**$25 Copay**						
20	3.85	10.40	na	na	7.12	8.09	11.55
30	4.57	12.34	na	na	8.45	9.60	13.71
40	5.04	13.61	na	na	9.32	10.58	15.12
60	5.50	14.85	na	na	10.18	11.55	16.50
Unlimited	5.56	15.01	na	na	10.29	11.68	16.68
SMALL GROUP	**$30 Copay**						
20	3.70	9.99	na	na	6.85	7.77	11.10
30	4.41	11.91	na	na	8.16	9.26	13.23
40	4.86	13.12	na	na	8.99	10.21	14.58
60	5.31	14.34	na	na	9.82	11.15	15.93
Unlimited	5.36	14.47	na	na	9.92	11.26	16.08
SMALL GROUP	**$35 Copay**						
20	3.59	9.69	na	na	6.64	7.54	10.77
30	4.27	11.53	na	na	7.90	8.97	12.81
40	4.71	12.72	na	na	8.71	9.89	14.13
60	5.16	13.93	na	na	9.55	10.84	15.48
Unlimited	5.20	14.04	na	na	9.62	10.92	15.60
SMALL GROUP	**$40 Copay**						
20	3.50	9.45	na	na	6.48	7.35	10.50

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.03	10.88	na	na	7.46	8.46	12.09
60	5.69	15.36	na	na	10.53	11.95	17.07
90	6.75	18.23	na	na	12.49	14.18	20.25
Unlimited	6.83	18.44	na	na	12.64	14.34	20.49
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.17	19.36	na	na	13.26	15.06	21.51
60	7.58	20.47	na	na	14.02	15.92	22.74
90	7.86	21.22	na	na	14.54	16.51	23.58
Unlimited	7.93	21.41	na	na	14.67	16.65	23.79
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.47	14.77	na	na	10.12	11.49	16.41
30	6.50	17.55	na	na	12.03	13.65	19.50
40	7.16	19.33	na	na	13.25	15.04	21.48
60	7.83	21.14	na	na	14.49	16.44	23.49
Unlimited	7.89	21.30	na	na	14.60	16.57	23.67
SMALL GROUP	**$5 Copay**						
20	5.15	13.91	na	na	9.53	10.82	15.45
30	6.11	16.50	na	na	11.30	12.83	18.33
40	6.74	18.20	na	na	12.47	14.15	20.22
60	7.36	19.87	na	na	13.62	15.46	22.08
Unlimited	7.44	20.09	na	na	13.76	15.62	22.32
SMALL GROUP	**$10 Copay**						
20	4.79	12.93	na	na	8.86	10.06	14.37
30	5.70	15.39	na	na	10.55	11.97	17.10
40	6.27	16.93	na	na	11.60	13.17	18.81
60	6.86	18.52	na	na	12.69	14.41	20.58
Unlimited	6.93	18.71	na	na	12.82	14.55	20.79
SMALL GROUP	**$15 Copay**						
20	4.51	12.18	na	na	8.34	9.47	13.53
30	5.36	14.47	na	na	9.92	11.26	16.08
40	5.90	15.93	na	na	10.92	12.39	17.70
60	6.44	17.39	na	na	11.91	13.52	19.32
Unlimited	6.51	17.58	na	na	12.04	13.67	19.53
SMALL GROUP	**$20 Copay**						
20	4.22	11.39	na	na	7.81	8.86	12.66
30	5.02	13.55	na	na	9.29	10.54	15.06
40	5.53	14.93	na	na	10.23	11.61	16.59
60	6.05	16.34	na	na	11.19	12.71	18.15
Unlimited	6.09	16.44	na	na	11.27	12.79	18.27
SMALL GROUP	**$25 Copay**						
20	3.94	10.64	na	na	7.29	8.27	11.82
30	4.68	12.64	na	na	8.66	9.83	14.04
40	5.16	13.93	na	na	9.55	10.84	15.48
60	5.63	15.20	na	na	10.42	11.82	16.89
Unlimited	5.70	15.39	na	na	10.55	11.97	17.10
SMALL GROUP	**$30 Copay**						
20	3.78	10.21	na	na	6.99	7.94	11.34
30	4.52	12.20	na	na	8.36	9.49	13.56
40	4.97	13.42	na	na	9.19	10.44	14.91
60	5.44	14.69	na	na	10.06	11.42	16.32
Unlimited	5.49	14.82	na	na	10.16	11.53	16.47
SMALL GROUP	**$35 Copay**						
20	3.68	9.94	na	na	6.81	7.73	11.04
30	4.37	11.80	na	na	8.08	9.18	13.11
40	4.83	13.04	na	na	8.94	10.14	14.49
60	5.28	14.26	na	na	9.77	11.09	15.84
Unlimited	5.33	14.39	na	na	9.86	11.19	15.99
SMALL GROUP	**$40 Copay**						
20	3.59	9.69	na	na	6.64	7.54	10.77

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.10	0.27	na	na	0.19	0.21	0.30
60	0.14	0.37	na	na	0.26	0.29	0.42
90	0.16	0.44	na	na	0.30	0.34	0.48
Unlimited	0.16	0.43	na	na	0.30	0.33	0.48
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.17	0.46	na	na	0.31	0.36	0.51
60	0.18	0.49	na	na	0.33	0.38	0.54
90	0.19	0.51	na	na	0.35	0.40	0.57
Unlimited	0.18	0.48	na	na	0.33	0.37	0.54
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.13	0.35	na	na	0.24	0.28	0.39
30	0.16	0.43	na	na	0.30	0.34	0.48
40	0.17	0.46	na	na	0.32	0.36	0.51
60	0.19	0.51	na	na	0.36	0.40	0.57
Unlimited	0.18	0.48	na	na	0.34	0.38	0.54
SMALL GROUP	**$5 Copay**						
20	0.12	0.33	na	na	0.22	0.26	0.36
30	0.14	0.38	na	na	0.26	0.29	0.42
40	0.16	0.43	na	na	0.30	0.33	0.48
60	0.17	0.46	na	na	0.32	0.36	0.51
Unlimited	0.17	0.46	na	na	0.31	0.35	0.51
SMALL GROUP	**$10 Copay**						
20	0.11	0.29	na	na	0.20	0.23	0.33
30	0.14	0.38	na	na	0.26	0.29	0.42
40	0.14	0.38	na	na	0.26	0.30	0.42
60	0.16	0.43	na	na	0.29	0.34	0.48
Unlimited	0.16	0.43	na	na	0.30	0.33	0.48
SMALL GROUP	**$15 Copay**						
20	0.11	0.30	na	na	0.20	0.23	0.33
30	0.13	0.35	na	na	0.24	0.28	0.39
40	0.14	0.38	na	na	0.26	0.29	0.42
60	0.15	0.41	na	na	0.27	0.31	0.45
Unlimited	0.15	0.41	na	na	0.27	0.31	0.45
SMALL GROUP	**$20 Copay**						
20	0.09	0.24	na	na	0.17	0.19	0.27
30	0.12	0.32	na	na	0.22	0.25	0.36
40	0.13	0.35	na	na	0.24	0.27	0.39
60	0.15	0.41	na	na	0.27	0.32	0.45
Unlimited	0.14	0.37	na	na	0.26	0.29	0.42
SMALL GROUP	**$25 Copay**						
20	0.09	0.24	na	na	0.17	0.18	0.27
30	0.11	0.30	na	na	0.21	0.23	0.33
40	0.12	0.32	na	na	0.23	0.26	0.36
60	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited	0.14	0.38	na	na	0.26	0.29	0.42
SMALL GROUP	**$30 Copay**						
20	0.08	0.22	na	na	0.14	0.17	0.24
30	0.11	0.29	na	na	0.20	0.23	0.33
40	0.11	0.30	na	na	0.20	0.23	0.33
60	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited	0.13	0.35	na	na	0.24	0.27	0.39
SMALL GROUP	**$35 Copay**						
20	0.09	0.25	na	na	0.17	0.19	0.27
30	0.10	0.27	na	na	0.18	0.21	0.30
40	0.12	0.32	na	na	0.23	0.25	0.36
60	0.12	0.33	na	na	0.22	0.25	0.36
Unlimited	0.13	0.35	na	na	0.24	0.27	0.39
SMALL GROUP	**$40 Copay**						
20	0.09	0.24	na	na	0.16	0.19	0.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
90	2.4%	2.5%	na	na	2.5%	2.5%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
90	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
30	2.5%	2.5%	na	na	2.6%	2.6%	2.5%
40	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
SMALL GROUP	**$5 Copay**						
20	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
30	2.3%	2.4%	na	na	2.4%	2.3%	2.3%
40	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP	**$10 Copay**						
20	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
SMALL GROUP	**$15 Copay**						
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.5%	2.5%	na	na	2.5%	2.6%	2.5%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
Unlimited	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
SMALL GROUP	**$20 Copay**						
20	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.6%	na	na	2.5%	2.6%	2.5%
Unlimited	2.4%	2.3%	na	na	2.4%	2.3%	2.4%
SMALL GROUP	**$25 Copay**						
20	2.3%	2.3%	na	na	2.4%	2.2%	2.3%
30	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP	**$30 Copay**						
20	2.2%	2.2%	na	na	2.0%	2.2%	2.2%
30	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**$35 Copay**						
20	2.5%	2.6%	na	na	2.6%	2.5%	2.5%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
60	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP	**$40 Copay**						
20	2.6%	2.5%	na	na	2.5%	2.6%	2.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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	4.15	11.21	na	na	7.68	8.72	12.45
40	4.57	12.34	na	na	8.45	9.60	13.71
60	5.01	13.53	na	na	9.27	10.52	15.03
Unlimited	5.05	13.64	na	na	9.34	10.61	15.15
SMALL GROUP				**$45 Copay**			
20	3.39	9.15	na	na	6.27	7.12	10.17
30	4.03	10.88	na	na	7.46	8.46	12.09
40	4.44	11.99	na	na	8.21	9.32	13.32
60	4.84	13.07	na	na	8.95	10.16	14.52
Unlimited	4.88	13.18	na	na	9.03	10.25	14.64
SMALL GROUP				**$50 Copay**			
20	3.29	8.88	na	na	6.09	6.91	9.87
30	3.90	10.53	na	na	7.22	8.19	11.70
40	4.30	11.61	na	na	7.96	9.03	12.90
60	4.70	12.69	na	na	8.70	9.87	14.10
Unlimited	4.73	12.77	na	na	8.75	9.93	14.19
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	6.92	18.68	na	na	12.80	14.53	20.76
30	7.61	20.55	na	na	14.08	15.98	22.83
40	8.05	21.74	na	na	14.89	16.91	24.15
60	8.50	22.95	na	na	15.73	17.85	25.50
Unlimited	8.58	23.17	na	na	15.87	18.02	25.74
SMALL GROUP				**$5 Copay**			
20	6.50	17.55	na	na	12.03	13.65	19.50
30	7.17	19.36	na	na	13.26	15.06	21.51
40	7.57	20.44	na	na	14.00	15.90	22.71
60	8.01	21.63	na	na	14.82	16.82	24.03
Unlimited	8.08	21.82	na	na	14.95	16.97	24.24
SMALL GROUP				**$10 Copay**			
20	6.07	16.39	na	na	11.23	12.75	18.21
30	6.67	18.01	na	na	12.34	14.01	20.01
40	7.05	19.04	na	na	13.04	14.81	21.15
60	7.45	20.12	na	na	13.78	15.65	22.35
Unlimited	7.52	20.30	na	na	13.91	15.79	22.56
SMALL GROUP				**$15 Copay**			
20	5.71	15.42	na	na	10.56	11.99	17.13
30	6.28	16.96	na	na	11.62	13.19	18.84
40	6.62	17.87	na	na	12.25	13.90	19.86
60	6.99	18.87	na	na	12.93	14.68	20.97
Unlimited	7.06	19.06	na	na	13.06	14.83	21.18
SMALL GROUP				**$20 Copay**			
20	5.36	14.47	na	na	9.92	11.26	16.08
30	5.88	15.88	na	na	10.88	12.35	17.64
40	6.22	16.79	na	na	11.51	13.06	18.66
60	6.57	17.74	na	na	12.15	13.80	19.71
Unlimited	6.62	17.87	na	na	12.25	13.90	19.86
SMALL GROUP				**$25 Copay**			
20	4.99	13.47	na	na	9.23	10.48	14.97
30	5.49	14.82	na	na	10.16	11.53	16.47
40	5.80	15.66	na	na	10.73	12.18	17.40
60	6.12	16.52	na	na	11.32	12.85	18.36
Unlimited	6.17	16.66	na	na	11.41	12.96	18.51
SMALL GROUP				**$30 Copay**			
20	4.81	12.99	na	na	8.90	10.10	14.43
30	5.29	14.28	na	na	9.79	11.11	15.87
40	5.59	15.09	na	na	10.34	11.74	16.77
60	5.90	15.93	na	na	10.92	12.39	17.70
Unlimited	5.94	16.04	na	na	10.99	12.47	17.82
SMALL GROUP				**$35 Copay**			
20	4.67	12.61	na	na	8.64	9.81	14.01
30	5.15	13.91	na	na	9.53	10.82	15.45
40	5.42	14.63	na	na	10.03	11.38	16.26
60	5.74	15.50	na	na	10.62	12.05	17.22
Unlimited	5.78	15.61	na	na	10.69	12.14	17.34

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	4.24	11.45	na	na	7.84	8.90	12.72
40	4.68	12.64	na	na	8.66	9.83	14.04
60	5.13	13.85	na	na	9.49	10.77	15.39
Unlimited	5.17	13.96	na	na	9.56	10.86	15.51
SMALL GROUP				**$45 Copay**			
20	3.46	9.34	na	na	6.40	7.27	10.38
30	4.12	11.12	na	na	7.62	8.65	12.36
40	4.54	12.26	na	na	8.40	9.53	13.62
60	4.96	13.39	na	na	9.18	10.42	14.88
Unlimited	5.00	13.50	na	na	9.25	10.50	15.00
SMALL GROUP				**$50 Copay**			
20	3.37	9.10	na	na	6.23	7.08	10.11
30	4.00	10.80	na	na	7.40	8.40	12.00
40	4.40	11.88	na	na	8.14	9.24	13.20
60	4.82	13.01	na	na	8.92	10.12	14.46
Unlimited	4.84	13.07	na	na	8.95	10.16	14.52
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.09	19.14	na	na	13.12	14.89	21.27
30	7.80	21.06	na	na	14.43	16.38	23.40
40	8.24	22.25	na	na	15.24	17.30	24.72
60	8.70	23.49	na	na	16.10	18.27	26.10
Unlimited	8.80	23.76	na	na	16.28	18.48	26.40
SMALL GROUP				**$5 Copay**			
20	6.66	17.98	na	na	12.32	13.99	19.98
30	7.34	19.82	na	na	13.58	15.41	22.02
40	7.75	20.93	na	na	14.34	16.28	23.25
60	8.20	22.14	na	na	15.17	17.22	24.60
Unlimited	8.27	22.33	na	na	15.30	17.37	24.81
SMALL GROUP				**$10 Copay**			
20	6.21	16.77	na	na	11.49	13.04	18.63
30	6.83	18.44	na	na	12.64	14.34	20.49
40	7.22	19.49	na	na	13.36	15.16	21.66
60	7.62	20.57	na	na	14.10	16.00	22.86
Unlimited	7.70	20.79	na	na	14.25	16.17	23.10
SMALL GROUP				**$15 Copay**			
20	5.85	15.80	na	na	10.82	12.29	17.55
30	6.43	17.36	na	na	11.90	13.50	19.29
40	6.78	18.31	na	na	12.54	14.24	20.34
60	7.16	19.33	na	na	13.25	15.04	21.48
Unlimited	7.23	19.52	na	na	13.38	15.18	21.69
SMALL GROUP				**$20 Copay**			
20	5.49	14.82	na	na	10.16	11.53	16.47
30	6.03	16.28	na	na	11.16	12.66	18.09
40	6.37	17.20	na	na	11.78	13.38	19.11
60	6.73	18.17	na	na	12.45	14.13	20.19
Unlimited	6.78	18.31	na	na	12.54	14.24	20.34
SMALL GROUP				**$25 Copay**			
20	5.11	13.80	na	na	9.45	10.73	15.33
30	5.61	15.15	na	na	10.38	11.78	16.83
40	5.93	16.01	na	na	10.97	12.45	17.79
60	6.26	16.90	na	na	11.58	13.15	18.78
Unlimited	6.32	17.06	na	na	11.69	13.27	18.96
SMALL GROUP				**$30 Copay**			
20	4.92	13.28	na	na	9.10	10.33	14.76
30	5.42	14.63	na	na	10.03	11.38	16.26
40	5.73	15.47	na	na	10.60	12.03	17.19
60	6.05	16.34	na	na	11.19	12.71	18.15
Unlimited	6.08	16.42	na	na	11.25	12.77	18.24
SMALL GROUP				**$35 Copay**			
20	4.78	12.91	na	na	8.84	10.04	14.34
30	5.27	14.23	na	na	9.75	11.07	15.81
40	5.55	14.99	na	na	10.27	11.66	16.65
60	5.88	15.88	na	na	10.88	12.35	17.64
Unlimited	5.91	15.96	na	na	10.93	12.41	17.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	0.09	0.24	na	na	0.16	0.18	0.27
40	0.11	0.30	na	na	0.21	0.23	0.33
60	0.12	0.32	na	na	0.22	0.25	0.36
Unlimited	0.12	0.32	na	na	0.22	0.25	0.36
SMALL GROUP				**$45 Copay**			
20	0.07	0.19	na	na	0.13	0.15	0.21
30	0.09	0.24	na	na	0.16	0.19	0.27
40	0.10	0.27	na	na	0.19	0.21	0.30
60	0.12	0.32	na	na	0.23	0.26	0.36
Unlimited	0.12	0.32	na	na	0.22	0.25	0.36
SMALL GROUP				**$50 Copay**			
20	0.08	0.22	na	na	0.14	0.17	0.24
30	0.10	0.27	na	na	0.18	0.21	0.30
40	0.10	0.27	na	na	0.18	0.21	0.30
60	0.12	0.32	na	na	0.22	0.25	0.36
Unlimited	0.11	0.30	na	na	0.20	0.23	0.33
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	0.17	0.46	na	na	0.32	0.36	0.51
30	0.19	0.51	na	na	0.35	0.40	0.57
40	0.19	0.51	na	na	0.35	0.39	0.57
60	0.20	0.54	na	na	0.37	0.42	0.60
Unlimited	0.22	0.59	na	na	0.41	0.46	0.66
SMALL GROUP				**$5 Copay**			
20	0.16	0.43	na	na	0.29	0.34	0.48
30	0.17	0.46	na	na	0.32	0.35	0.51
40	0.18	0.49	na	na	0.34	0.38	0.54
60	0.19	0.51	na	na	0.35	0.40	0.57
Unlimited	0.19	0.51	na	na	0.35	0.40	0.57
SMALL GROUP				**$10 Copay**			
20	0.14	0.38	na	na	0.26	0.29	0.42
30	0.16	0.43	na	na	0.30	0.33	0.48
40	0.17	0.45	na	na	0.32	0.35	0.51
60	0.17	0.45	na	na	0.32	0.35	0.51
Unlimited	0.18	0.49	na	na	0.34	0.38	0.54
SMALL GROUP				**$15 Copay**			
20	0.14	0.38	na	na	0.26	0.30	0.42
30	0.15	0.40	na	na	0.28	0.31	0.45
40	0.16	0.44	na	na	0.29	0.34	0.48
60	0.17	0.46	na	na	0.32	0.36	0.51
Unlimited	0.17	0.46	na	na	0.32	0.35	0.51
SMALL GROUP				**$20 Copay**			
20	0.13	0.35	na	na	0.24	0.27	0.39
30	0.15	0.40	na	na	0.28	0.31	0.45
40	0.15	0.41	na	na	0.27	0.32	0.45
60	0.16	0.43	na	na	0.30	0.33	0.48
Unlimited	0.16	0.44	na	na	0.29	0.34	0.48
SMALL GROUP				**$25 Copay**			
20	0.12	0.33	na	na	0.22	0.25	0.36
30	0.12	0.33	na	na	0.22	0.25	0.36
40	0.13	0.35	na	na	0.24	0.27	0.39
60	0.14	0.38	na	na	0.26	0.30	0.42
Unlimited	0.15	0.40	na	na	0.28	0.31	0.45
SMALL GROUP				**$30 Copay**			
20	0.11	0.29	na	na	0.20	0.23	0.33
30	0.13	0.35	na	na	0.24	0.27	0.39
40	0.14	0.38	na	na	0.26	0.29	0.42
60	0.15	0.41	na	na	0.27	0.32	0.45
Unlimited	0.14	0.38	na	na	0.26	0.30	0.42
SMALL GROUP				**$35 Copay**			
20	0.11	0.30	na	na	0.20	0.23	0.33
30	0.12	0.32	na	na	0.22	0.25	0.36
40	0.13	0.36	na	na	0.24	0.28	0.39
60	0.14	0.38	na	na	0.26	0.30	0.42
Unlimited	0.13	0.35	na	na	0.24	0.27	0.39

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	2.2%	2.1%	na	na	2.1%	2.1%	2.2%
40	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$45 Copay**			
20	2.1%	2.1%	na	na	2.1%	2.1%	2.1%
30	2.2%	2.2%	na	na	2.1%	2.2%	2.2%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.5%	2.4%	na	na	2.6%	2.6%	2.5%
Unlimited	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
SMALL GROUP				**$50 Copay**			
20	2.4%	2.5%	na	na	2.3%	2.5%	2.4%
30	2.6%	2.6%	na	na	2.5%	2.6%	2.6%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.6%	2.5%	na	na	2.5%	2.5%	2.6%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.4%	2.3%	na	na	2.4%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.6%	2.5%	na	na	2.6%	2.6%	2.6%
SMALL GROUP				**$5 Copay**			
20	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
30	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
SMALL GROUP				**$10 Copay**			
20	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
60	2.3%	2.2%	na	na	2.3%	2.2%	2.3%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$15 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
SMALL GROUP				**$20 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.6%	2.5%	na	na	2.6%	2.5%	2.6%
40	2.4%	2.4%	na	na	2.3%	2.5%	2.4%
60	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Unlimited	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$25 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
40	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
SMALL GROUP				**$30 Copay**			
20	2.3%	2.2%	na	na	2.2%	2.3%	2.3%
30	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.6%	na	na	2.5%	2.6%	2.5%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$35 Copay**			
20	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.4%	2.5%	na	na	2.4%	2.5%	2.4%
60	2.4%	2.5%	na	na	2.4%	2.5%	2.4%
Unlimited	2.2%	2.2%	na	na	2.2%	2.2%	2.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	4.52	12.20	na	na	8.36	9.49	13.56
30	4.99	13.47	na	na	9.23	10.48	14.97
40	5.25	14.18	na	na	9.71	11.03	15.75
60	5.56	15.01	na	na	10.29	11.68	16.68
Unlimited	5.60	15.12	na	na	10.36	11.76	16.80
SMALL GROUP				**$45 Copay**			
20	4.40	11.88	na	na	8.14	9.24	13.20
30	4.82	13.01	na	na	8.92	10.12	14.46
40	5.10	13.77	na	na	9.44	10.71	15.30
60	5.39	14.55	na	na	9.97	11.32	16.17
Unlimited	5.43	14.66	na	na	10.05	11.40	16.29
SMALL GROUP				**$50 Copay**			
20	4.25	11.48	na	na	7.86	8.93	12.75
30	4.68	12.64	na	na	8.66	9.83	14.04
40	4.96	13.39	na	na	9.18	10.42	14.88
60	5.22	14.09	na	na	9.66	10.96	15.66
Unlimited	5.25	14.18	na	na	9.71	11.03	15.75
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$40 Copay**			
20	4.64	12.53	na	na	8.58	9.74	13.92
30	5.11	13.80	na	na	9.45	10.73	15.33
40	5.38	14.53	na	na	9.95	11.30	16.14
60	5.70	15.39	na	na	10.55	11.97	17.10
Unlimited	5.74	15.50	na	na	10.62	12.05	17.22
SMALL GROUP				**$45 Copay**			
20	4.51	12.18	na	na	8.34	9.47	13.53
30	4.93	13.31	na	na	9.12	10.35	14.79
40	5.22	14.09	na	na	9.66	10.96	15.66
60	5.52	14.90	na	na	10.21	11.59	16.56
Unlimited	5.56	15.01	na	na	10.29	11.68	16.68
SMALL GROUP				**$50 Copay**			
20	4.36	11.77	na	na	8.07	9.16	13.08
30	4.79	12.93	na	na	8.86	10.06	14.37
40	5.08	13.72	na	na	9.40	10.67	15.24
60	5.35	14.45	na	na	9.90	11.24	16.05
Unlimited	5.38	14.53	na	na	9.95	11.30	16.14
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
5	0.00	0.00	na	na	0.00	0.00	0.00
10	0.00	0.00	na	na	0.00	0.00	0.00
15	0.00	0.00	na	na	0.00	0.00	0.00
20	0.00	0.00	na	na	0.00	0.00	0.00
25	0.00	0.00	na	na	0.00	0.00	0.00
30	0.00	0.00	na	na	0.00	0.00	0.00
35	0.00	0.00	na	na	0.00	0.00	0.00
40	0.00	0.00	na	na	0.00	0.00	0.00
45	0.00	0.00	na	na	0.00	0.00	0.00
50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	0.12	0.33	na	na	0.22	0.25	0.36
30	0.12	0.33	na	na	0.22	0.25	0.36
40	0.13	0.35	na	na	0.24	0.27	0.39
60	0.14	0.38	na	na	0.26	0.29	0.42
Unlimited	0.14	0.38	na	na	0.26	0.29	0.42
SMALL GROUP				**$45 Copay**			
20	0.11	0.30	na	na	0.20	0.23	0.33
30	0.11	0.30	na	na	0.20	0.23	0.33
40	0.12	0.32	na	na	0.22	0.25	0.36
60	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited	0.13	0.35	na	na	0.24	0.28	0.39
SMALL GROUP				**$50 Copay**			
20	0.11	0.29	na	na	0.21	0.23	0.33
30	0.11	0.29	na	na	0.20	0.23	0.33
40	0.12	0.33	na	na	0.22	0.25	0.36
60	0.13	0.36	na	na	0.24	0.28	0.39
Unlimited	0.13	0.35	na	na	0.24	0.27	0.39
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	2.7%	2.7%	na	na	2.6%	2.6%	2.7%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$45 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
40	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
SMALL GROUP				**$50 Copay**			
20	2.6%	2.5%	na	na	2.7%	2.6%	2.6%
30	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
40	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.6%	na	na	2.5%	2.6%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
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
Deductible			**Durable Medical Equipment Riders**				
$0	4.60	12.42	na	na	8.51	9.66	13.80
$0/Max $5000	4.37	11.80	na	na	8.08	9.18	13.11
$0/Max $2500	4.09	11.04	na	na	7.57	8.59	12.27
$25	4.37	11.80	na	na	8.08	9.18	13.11
$50	4.09	11.04	na	na	7.57	8.59	12.27
$100	3.74	10.10	na	na	6.92	7.85	11.22
$500	1.79	4.83	na	na	3.31	3.76	5.37
$5,000	0.30	0.81	na	na	0.56	0.63	0.90
Coinsurance							
80%	3.68	9.94	na	na	6.81	7.73	11.04
75%	3.45	9.32	na	na	6.38	7.25	10.35
70%	3.23	8.72	na	na	5.98	6.78	9.69
Deductible			**Orthotics Riders**				
$0	0.78	2.11	na	na	1.44	1.64	2.34
$0/Max $5000	0.75	2.03	na	na	1.39	1.58	2.25
$0/Max $2500	0.71	1.92	na	na	1.31	1.49	2.13
$25	0.75	2.03	na	na	1.39	1.58	2.25
$50	0.71	1.92	na	na	1.31	1.49	2.13
$100	0.64	1.73	na	na	1.18	1.34	1.92
$500	0.32	0.86	na	na	0.59	0.67	0.96
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
Coinsurance							
80%	0.64	1.73	na	na	1.18	1.34	1.92
75%	0.61	1.65	na	na	1.13	1.28	1.83
70%	0.58	1.57	na	na	1.07	1.22	1.74
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.49	4.02	na	na	2.76	3.13	4.47
12 Months	2.41	6.51	na	na	4.46	5.06	7.23
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.34	6.32	na	na	4.33	4.91	7.02
12 Months	3.73	10.07	na	na	6.90	7.83	11.19
			Private Duty Nursing Riders				
In Full	0.56	1.51	na	na	1.04	1.18	1.68
80% hrs 73-504	0.08	0.22	na	na	0.15	0.17	0.24
100% hrs 73-504	0.15	0.41	na	na	0.28	0.32	0.45
			Dental Network Access				
	0.46	1.24	na	na	0.85	0.97	1.38
Limit			**Infertility Rider**				
2 IVF	9.73	26.27	na	na	18.00	20.43	29.19
3 IVF	11.74	31.70	na	na	21.72	24.65	35.22
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.48	12.10	na	na	8.29	9.41	13.44
Health Club Reimbursement							
$200 per year	1.16	3.13	na	na	2.15	2.44	3.48
			Nurse Advice Line Rider				
	0.30	0.81	na	na	0.56	0.63	0.90

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
April 01, 2013 - June 30, 2013 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	4.71	12.72	na	na	8.71	9.89	14.13
$0/Max $5000	4.48	12.10	na	na	8.29	9.41	13.44
$0/Max $2500	4.19	11.31	na	na	7.75	8.80	12.57
$25	4.48	12.10	na	na	8.29	9.41	13.44
$50	4.19	11.31	na	na	7.75	8.80	12.57
$100	3.83	10.34	na	na	7.09	8.04	11.49
$500	1.83	4.94	na	na	3.39	3.84	5.49
$5,000	0.31	0.84	na	na	0.57	0.65	0.93
Coinsurance							
80%	3.76	10.15	na	na	6.96	7.90	11.28
75%	3.53	9.53	na	na	6.53	7.41	10.59
70%	3.31	8.94	na	na	6.12	6.95	9.93
Deductible			**Orthotics Riders**				
$0	0.79	2.13	na	na	1.46	1.66	2.37
$0/Max $5000	0.76	2.05	na	na	1.41	1.60	2.28
$0/Max $2500	0.72	1.94	na	na	1.33	1.51	2.16
$25	0.76	2.05	na	na	1.41	1.60	2.28
$50	0.72	1.94	na	na	1.33	1.51	2.16
$100	0.66	1.78	na	na	1.22	1.39	1.98
$500	0.33	0.89	na	na	0.61	0.69	0.99
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
Coinsurance							
80%	0.66	1.78	na	na	1.22	1.39	1.98
75%	0.63	1.70	na	na	1.17	1.32	1.89
70%	0.60	1.62	na	na	1.11	1.26	1.80
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.52	4.10	na	na	2.81	3.19	4.56
12 Months	2.46	6.64	na	na	4.55	5.17	7.38
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.39	6.45	na	na	4.42	5.02	7.17
12 Months	3.82	10.31	na	na	7.07	8.02	11.46
			Private Duty Nursing Riders				
In Full	0.58	1.57	na	na	1.07	1.22	1.74
80% hrs 73-504	0.07	0.19	na	na	0.13	0.15	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.29	0.42
			Dental Network Access				
	0.46	1.24	na	na	0.85	0.97	1.38
Limit			**Infertility Rider**				
2 IVF	9.96	26.89	na	na	18.43	20.92	29.88
3 IVF	12.02	32.45	na	na	22.24	25.24	36.06
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.58	12.37	na	na	8.47	9.62	13.74
Health Club Reimbursement							
$200 per year	1.18	3.19	na	na	2.18	2.48	3.54
			Nurse Advice Line Rider				
	0.31	0.84	na	na	0.57	0.65	0.93

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO 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	0.11	0.30	na	na	0.20	0.23	0.33
$0/Max $5000	0.11	0.30	na	na	0.21	0.23	0.33
$0/Max $2500	0.10	0.27	na	na	0.18	0.21	0.30
$25	0.11	0.30	na	na	0.21	0.23	0.33
$50	0.10	0.27	na	na	0.18	0.21	0.30
$100	0.09	0.24	na	na	0.17	0.19	0.27
$500	0.04	0.11	na	na	0.08	0.08	0.12
$5,000	0.01	0.03	na	na	0.01	0.02	0.03
Coinsurance							
80%	0.08	0.21	na	na	0.15	0.17	0.24
75%	0.08	0.21	na	na	0.15	0.16	0.24
70%	0.08	0.22	na	na	0.14	0.17	0.24
Deductible			**Orthotics Riders**				
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0/Max $5000	0.01	0.02	na	na	0.02	0.02	0.03
$0/Max $2500	0.01	0.02	na	na	0.02	0.02	0.03
$25	0.01	0.02	na	na	0.02	0.02	0.03
$50	0.01	0.02	na	na	0.02	0.02	0.03
$100	0.02	0.05	na	na	0.04	0.05	0.06
$500	0.01	0.03	na	na	0.02	0.02	0.03
$5,000	-	-	na	na	-	-	-
Coinsurance							
80%	0.02	0.05	na	na	0.04	0.05	0.06
75%	0.02	0.05	na	na	0.04	0.04	0.06
70%	0.02	0.05	na	na	0.04	0.04	0.06
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.03	0.08	na	na	0.05	0.06	0.09
12 Months	0.05	0.13	na	na	0.09	0.11	0.15
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.05	0.13	na	na	0.09	0.11	0.15
12 Months	0.09	0.24	na	na	0.17	0.19	0.27
			Private Duty Nursing Riders				
In Full	0.02	0.06	na	na	0.03	0.04	0.06
80% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
100% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
			Dental Network Access				
	-	-	na	na	-	-	-
Limit			**Infertility Rider**				
2 IVF	0.23	0.62	na	na	0.43	0.49	0.69
3 IVF	0.28	0.75	na	na	0.52	0.59	0.84
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	0.10	0.27	na	na	0.18	0.21	0.30
Health Club Reimbursement							
$200 per year	0.02	0.06	na	na	0.03	0.04	0.06
			Nurse Advice Line Rider				
	0.01	0.03	na	na	0.01	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
HIP HMO 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	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0/Max $5000	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
$0/Max $2500	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$25	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
$50	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$100	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
$500	2.2%	2.3%	na	na	2.4%	2.1%	2.2%
$5,000	3.3%	3.7%	na	na	1.8%	3.2%	3.3%
Coinsurance							
80%	2.2%	2.1%	na	na	2.2%	2.2%	2.2%
75%	2.3%	2.3%	na	na	2.4%	2.2%	2.3%
70%	2.5%	2.5%	na	na	2.3%	2.5%	2.5%
Deductible			**Orthotics Riders**				
$0	1.3%	0.9%	na	na	1.4%	1.2%	1.3%
$0/Max $5000	1.3%	1.0%	na	na	1.4%	1.3%	1.3%
$0/Max $2500	1.4%	1.0%	na	na	1.5%	1.3%	1.4%
$25	1.3%	1.0%	na	na	1.4%	1.3%	1.3%
$50	1.4%	1.0%	na	na	1.5%	1.3%	1.4%
$100	3.1%	2.9%	na	na	3.4%	3.7%	3.1%
$500	3.1%	3.5%	na	na	3.4%	3.0%	3.1%
$5,000	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Coinsurance							
80%	3.1%	2.9%	na	na	3.4%	3.7%	3.1%
75%	3.3%	3.0%	na	na	3.5%	3.1%	3.3%
70%	3.4%	3.2%	na	na	3.7%	3.3%	3.4%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	2.0%	2.0%	na	na	1.8%	1.9%	2.0%
12 Months	2.1%	2.0%	na	na	2.0%	2.2%	2.1%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.1%	2.1%	na	na	2.1%	2.2%	2.1%
12 Months	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
			Private Duty Nursing Riders				
In Full	3.6%	4.0%	na	na	2.9%	3.4%	3.6%
80% hrs 73-504	-12.5%	-13.6%	na	na	-13.3%	-11.8%	-12.5%
100% hrs 73-504	-6.7%	-7.3%	na	na	-7.1%	-9.4%	-6.7%
			Dental Network Access				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Limit			**Infertility Rider**				
2 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
3 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
Health Club Reimbursement							
$200 per year	1.7%	1.9%	na	na	1.4%	1.6%	1.7%
			Nurse Advice Line Rider				
24 Months	3.3%	3.7%	na	na	1.8%	3.2%	3.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
APRIL 1, 2012 - JUNE 30, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group *	462.38	1,248.43	na	na	855.40	971.00	1,387.14
Small Group *	462.38	1,248.43	na	na	855.40	971.00	1,387.14

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 04/01/2013 - 06/30/2013 (With WH & Autism)				
Small Group *	495.44	1,337.69	na	na	916.56	1,040.42	1,486.32
			Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)				
	490.54	1,324.46	na	na	907.50	1,030.13	1,471.62

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 04/01/2013 - 06/30/2013 (With WH & Autism)				
Small Group *	33.06	89.26	na	na	61.16	69.42	99.18
			Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)				
Small Group *	28.16	76.03	na	na	52.10	59.13	84.48

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 04/01/2013 - 06/30/2013 (With WH & Autism)				
Small Group *	7.1%	7.1%	n/a	n/a	7.1%	7.1%	7.1%
			Effective 04/01/2013 - 06/30/2013 (Without WH & Autism)				
Small Group *	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	na	na	0.00	0.00	0.00
$5	(4.07)	(10.99)	na	na	(7.53)	(8.55)	(12.21)
$10	(8.54)	(23.06)	na	na	(15.80)	(17.93)	(25.62)
$15	(13.21)	(35.67)	na	na	(24.44)	(27.74)	(39.63)
$20	(19.03)	(51.38)	na	na	(35.21)	(39.96)	(57.09)
$25	(35.32)	(95.36)	na	na	(65.34)	(74.17)	(105.96)
$30	(56.11)	(151.50)	na	na	(103.80)	(117.83)	(168.33)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.33)	(6.29)	na	na	(4.31)	(4.89)	(6.99)
$10	(4.90)	(13.23)	na	na	(9.07)	(10.29)	(14.70)
$15	(7.57)	(20.44)	na	na	(14.00)	(15.90)	(22.71)
$20	(10.91)	(29.46)	na	na	(20.18)	(22.91)	(32.73)
$25	(20.23)	(54.62)	na	na	(37.43)	(42.48)	(60.69)
$30	(32.17)	(86.86)	na	na	(59.51)	(67.56)	(96.51)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.88)	(7.78)	na	na	(5.33)	(6.05)	(8.64)
$10	(5.91)	(15.96)	na	na	(10.93)	(12.41)	(17.73)
$15	(8.97)	(24.22)	na	na	(16.59)	(18.84)	(26.91)
$20	(12.20)	(32.94)	na	na	(22.57)	(25.62)	(36.60)
$25	(18.13)	(48.95)	na	na	(33.54)	(38.07)	(54.39)
$30	(25.59)	(69.09)	na	na	(47.34)	(53.74)	(76.77)
$35	(33.48)	(90.40)	na	na	(61.94)	(70.31)	(100.44)
$40	(42.33)	(114.29)	na	na	(78.31)	(88.89)	(126.99)
$45	(52.23)	(141.02)	na	na	(96.63)	(109.68)	(156.69)
$50	(63.17)	(170.56)	na	na	(116.86)	(132.66)	(189.51)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.42)	(6.53)	na	na	(4.48)	(5.08)	(7.26)
$10	(5.00)	(13.50)	na	na	(9.25)	(10.50)	(15.00)
$15	(7.58)	(20.47)	na	na	(14.02)	(15.92)	(22.74)
$20	(10.32)	(27.86)	na	na	(19.09)	(21.67)	(30.96)
$25	(15.33)	(41.39)	na	na	(28.36)	(32.19)	(45.99)
$30	(21.61)	(58.35)	na	na	(39.98)	(45.38)	(64.83)
$35	(28.29)	(76.38)	na	na	(52.34)	(59.41)	(84.87)
$40	(35.81)	(96.69)	na	na	(66.25)	(75.20)	(107.43)
$45	(44.16)	(119.23)	na	na	(81.70)	(92.74)	(132.48)
$50	(53.42)	(144.23)	na	na	(98.83)	(112.18)	(160.26)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	Inpatient Facility Copay [std: $0]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.30)	(6.21)	na	na	(4.26)	(4.83)	(6.90)
$150	(3.84)	(10.37)	na	na	(7.10)	(8.06)	(11.52)
$200	(5.54)	(14.96)	na	na	(10.25)	(11.63)	(16.62)
$250	(8.00)	(21.60)	na	na	(14.80)	(16.80)	(24.00)
$500	(19.67)	(53.11)	na	na	(36.39)	(41.31)	(59.01)
$750	(34.45)	(93.02)	na	na	(63.73)	(72.35)	(103.35)
$1,000	(52.60)	(142.02)	na	na	(97.31)	(110.46)	(157.80)
Copay/Day							
$50 w/3 Day Max	(3.31)	(8.94)	na	na	(6.12)	(6.95)	(9.93)
$50 w/5 Day Max	(4.49)	(12.12)	na	na	(8.31)	(9.43)	(13.47)
$100 w/3 Day Max	(7.07)	(19.09)	na	na	(13.08)	(14.85)	(21.21)
$100 w/5 Day Max	(12.04)	(32.51)	na	na	(22.27)	(25.28)	(36.12)
$250 w/3 Day Max	(23.36)	(63.07)	na	na	(43.22)	(49.06)	(70.08)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.29)	(3.48)	na	na	(2.39)	(2.71)	(3.87)
$75	(2.25)	(6.08)	na	na	(4.16)	(4.73)	(6.75)
$100	(3.39)	(9.15)	na	na	(6.27)	(7.12)	(10.17)
$125	(4.70)	(12.69)	na	na	(8.70)	(9.87)	(14.10)
$150	(6.23)	(16.82)	na	na	(11.53)	(13.08)	(18.69)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.46)	(1.24)	na	na	(0.85)	(0.97)	(1.38)
$25	(0.83)	(2.24)	na	na	(1.54)	(1.74)	(2.49)
$35	(1.40)	(3.78)	na	na	(2.59)	(2.94)	(4.20)
$50	(2.31)	(6.24)	na	na	(4.27)	(4.85)	(6.93)
$60	(2.93)	(7.91)	na	na	(5.42)	(6.15)	(8.79)
$75	(3.78)	(10.21)	na	na	(6.99)	(7.94)	(11.34)
$100	(5.30)	(14.31)	na	na	(9.81)	(11.13)	(15.90)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 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	na	na	0.00	0.00	0.00
$5	(4.32)	(11.66)	na	na	(7.99)	(9.07)	(12.96)
$10	(9.06)	(24.46)	na	na	(16.76)	(19.03)	(27.18)
$15	(14.02)	(37.85)	na	na	(25.94)	(29.44)	(42.06)
$20	(20.19)	(54.51)	na	na	(37.35)	(42.40)	(60.57)
$25	(37.47)	(101.17)	na	na	(69.32)	(78.69)	(112.41)
$30	(59.52)	(160.70)	na	na	(110.11)	(124.99)	(178.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.47)	(6.67)	na	na	(4.57)	(5.19)	(7.41)
$10	(5.20)	(14.04)	na	na	(9.62)	(10.92)	(15.60)
$15	(8.03)	(21.68)	na	na	(14.86)	(16.86)	(24.09)
$20	(11.58)	(31.27)	na	na	(21.42)	(24.32)	(34.74)
$25	(21.47)	(57.97)	na	na	(39.72)	(45.09)	(64.41)
$30	(34.13)	(92.15)	na	na	(63.14)	(71.67)	(102.39)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.06)	(8.26)	na	na	(5.66)	(6.43)	(9.18)
$10	(6.27)	(16.93)	na	na	(11.60)	(13.17)	(18.81)
$15	(9.52)	(25.70)	na	na	(17.61)	(19.99)	(28.56)
$20	(12.95)	(34.97)	na	na	(23.96)	(27.20)	(38.85)
$25	(19.23)	(51.92)	na	na	(35.58)	(40.38)	(57.69)
$30	(27.15)	(73.31)	na	na	(50.23)	(57.02)	(81.45)
$35	(35.51)	(95.88)	na	na	(65.69)	(74.57)	(106.53)
$40	(44.91)	(121.26)	na	na	(83.08)	(94.31)	(134.73)
$45	(55.41)	(149.61)	na	na	(102.51)	(116.36)	(166.23)
$50	(67.02)	(180.95)	na	na	(123.99)	(140.74)	(201.06)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.56)	(6.91)	na	na	(4.74)	(5.38)	(7.68)
$10	(5.30)	(14.31)	na	na	(9.81)	(11.13)	(15.90)
$15	(8.04)	(21.71)	na	na	(14.87)	(16.88)	(24.12)
$20	(10.95)	(29.57)	na	na	(20.26)	(23.00)	(32.85)
$25	(16.26)	(43.90)	na	na	(30.08)	(34.15)	(48.78)
$30	(22.93)	(61.91)	na	na	(42.42)	(48.15)	(68.79)
$35	(30.01)	(81.03)	na	na	(55.52)	(63.02)	(90.03)
$40	(37.99)	(102.57)	na	na	(70.28)	(79.78)	(113.97)
$45	(46.84)	(126.47)	na	na	(86.65)	(98.36)	(140.52)
$50	(56.67)	(153.01)	na	na	(104.84)	(119.01)	(170.01)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	Inpatient Facility Copay [std: $0]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.44)	(6.59)	na	na	(4.51)	(5.12)	(7.32)
$150	(4.08)	(11.02)	na	na	(7.55)	(8.57)	(12.24)
$200	(5.88)	(15.88)	na	na	(10.88)	(12.35)	(17.64)
$250	(8.49)	(22.92)	na	na	(15.71)	(17.83)	(25.47)
$500	(20.87)	(56.35)	na	na	(38.61)	(43.83)	(62.61)
$750	(36.54)	(98.66)	na	na	(67.60)	(76.73)	(109.62)
$1,000	(55.81)	(150.69)	na	na	(103.25)	(117.20)	(167.43)
Copay/Day							
$50 w/3 Day Max	(3.51)	(9.48)	na	na	(6.49)	(7.37)	(10.53)
$50 w/5 Day Max	(4.76)	(12.85)	na	na	(8.81)	(10.00)	(14.28)
$100 w/3 Day Max	(7.50)	(20.25)	na	na	(13.88)	(15.75)	(22.50)
$100 w/5 Day Max	(12.77)	(34.48)	na	na	(23.62)	(26.82)	(38.31)
$250 w/3 Day Max	(24.78)	(66.91)	na	na	(45.84)	(52.04)	(74.34)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.37)	(3.70)	na	na	(2.53)	(2.88)	(4.11)
$75	(2.39)	(6.45)	na	na	(4.42)	(5.02)	(7.17)
$100	(3.59)	(9.69)	na	na	(6.64)	(7.54)	(10.77)
$125	(4.99)	(13.47)	na	na	(9.23)	(10.48)	(14.97)
$150	(6.61)	(17.85)	na	na	(12.23)	(13.88)	(19.83)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.30)	na	na	(0.89)	(1.01)	(1.44)
$25	(0.88)	(2.38)	na	na	(1.63)	(1.85)	(2.64)
$35	(1.48)	(4.00)	na	na	(2.74)	(3.11)	(4.44)
$50	(2.45)	(6.62)	na	na	(4.53)	(5.15)	(7.35)
$60	(3.11)	(8.40)	na	na	(5.75)	(6.53)	(9.33)
$75	(4.01)	(10.83)	na	na	(7.42)	(8.42)	(12.03)
$100	(5.62)	(15.17)	na	na	(10.40)	(11.80)	(16.86)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	-	-	na	na	-	-	-
$5	(0.25)	(0.67)	na	na	(0.46)	(0.52)	(0.75)
$10	(0.52)	(1.40)	na	na	(0.96)	(1.10)	(1.56)
$15	(0.81)	(2.18)	na	na	(1.50)	(1.70)	(2.43)
$20	(1.16)	(3.13)	na	na	(2.14)	(2.44)	(3.48)
$25	(2.15)	(5.81)	na	na	(3.98)	(4.52)	(6.45)
$30	(3.41)	(9.20)	na	na	(6.31)	(7.16)	(10.23)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.14)	(0.38)	na	na	(0.26)	(0.30)	(0.42)
$10	(0.30)	(0.81)	na	na	(0.55)	(0.63)	(0.90)
$15	(0.46)	(1.24)	na	na	(0.86)	(0.96)	(1.38)
$20	(0.67)	(1.81)	na	na	(1.24)	(1.41)	(2.01)
$25	(1.24)	(3.35)	na	na	(2.29)	(2.61)	(3.72)
$30	(1.96)	(5.29)	na	na	(3.63)	(4.11)	(5.88)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.18)	(0.48)	na	na	(0.33)	(0.38)	(0.54)
$10	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
$15	(0.55)	(1.48)	na	na	(1.02)	(1.15)	(1.65)
$20	(0.75)	(2.03)	na	na	(1.39)	(1.58)	(2.25)
$25	(1.10)	(2.97)	na	na	(2.04)	(2.31)	(3.30)
$30	(1.56)	(4.22)	na	na	(2.89)	(3.28)	(4.68)
$35	(2.03)	(5.48)	na	na	(3.75)	(4.26)	(6.09)
$40	(2.58)	(6.97)	na	na	(4.77)	(5.42)	(7.74)
$45	(3.18)	(8.59)	na	na	(5.88)	(6.68)	(9.54)
$50	(3.85)	(10.39)	na	na	(7.13)	(8.08)	(11.55)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.14)	(0.38)	na	na	(0.26)	(0.30)	(0.42)
$10	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$15	(0.46)	(1.24)	na	na	(0.85)	(0.96)	(1.38)
$20	(0.63)	(1.71)	na	na	(1.17)	(1.33)	(1.89)
$25	(0.93)	(2.51)	na	na	(1.72)	(1.96)	(2.79)
$30	(1.32)	(3.56)	na	na	(2.44)	(2.77)	(3.96)
$35	(1.72)	(4.65)	na	na	(3.18)	(3.61)	(5.16)
$40	(2.18)	(5.88)	na	na	(4.03)	(4.58)	(6.54)
$45	(2.68)	(7.24)	na	na	(4.95)	(5.62)	(8.04)
$50	(3.25)	(8.78)	na	na	(6.01)	(6.83)	(9.75)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	Inpatient Facility Copay [std: $0]						
$0	-	-	na	na	-	-	-
$100	(0.14)	(0.38)	na	na	(0.25)	(0.29)	(0.42)
$150	(0.24)	(0.65)	na	na	(0.45)	(0.51)	(0.72)
$200	(0.34)	(0.92)	na	na	(0.63)	(0.72)	(1.02)
$250	(0.49)	(1.32)	na	na	(0.91)	(1.03)	(1.47)
$500	(1.20)	(3.24)	na	na	(2.22)	(2.52)	(3.60)
$750	(2.09)	(5.64)	na	na	(3.87)	(4.38)	(6.27)
$1,000	(3.21)	(8.67)	na	na	(5.94)	(6.74)	(9.63)
Copay/Day							
$50 w/3 Day Max	(0.20)	(0.54)	na	na	(0.37)	(0.42)	(0.60)
$50 w/5 Day Max	(0.27)	(0.73)	na	na	(0.50)	(0.57)	(0.81)
$100 w/3 Day Max	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)
$100 w/5 Day Max	(0.73)	(1.97)	na	na	(1.35)	(1.54)	(2.19)
$250 w/3 Day Max	(1.42)	(3.84)	na	na	(2.62)	(2.98)	(4.26)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$50	(0.08)	(0.22)	na	na	(0.14)	(0.17)	(0.24)
$75	(0.14)	(0.37)	na	na	(0.26)	(0.29)	(0.42)
$100	(0.20)	(0.54)	na	na	(0.37)	(0.42)	(0.60)
$125	(0.29)	(0.78)	na	na	(0.53)	(0.61)	(0.87)
$150	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$15	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$25	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
$35	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$50	(0.14)	(0.38)	na	na	(0.26)	(0.30)	(0.42)
$60	(0.18)	(0.49)	na	na	(0.33)	(0.38)	(0.54)
$75	(0.23)	(0.62)	na	na	(0.43)	(0.48)	(0.69)
$100	(0.32)	(0.86)	na	na	(0.59)	(0.67)	(0.96)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$10	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$15	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$25	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	6.0%	6.0%	n/a	n/a	6.0%	6.1%	6.0%
$10	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$15	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
$20	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
$25	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	6.3%	6.2%	n/a	n/a	6.2%	6.3%	6.3%
$10	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$15	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$20	6.1%	6.2%	n/a	n/a	6.2%	6.2%	6.1%
$25	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$35	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$45	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$50	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	5.8%	5.8%	n/a	n/a	5.8%	5.9%	5.8%
$10	6.0%	6.0%	n/a	n/a	6.1%	6.0%	6.0%
$15	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
$20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$25	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$35	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$45	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$50	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	Inpatient Facility Copay [std: $0]						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$100	6.1%	6.1%	n/a	n/a	5.9%	6.0%	6.1%
$150	6.3%	6.3%	n/a	n/a	6.3%	6.3%	6.3%
$200	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
$250	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$500	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$750	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$1,000	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay/Day							
$50 w/3 Day Max	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
$50 w/5 Day Max	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
$100 w/3 Day Max	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$100 w/5 Day Max	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$250 w/3 Day Max	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	6.2%	6.3%	n/a	n/a	5.9%	6.3%	6.2%
$75	6.2%	6.1%	n/a	n/a	6.3%	6.1%	6.2%
$100	5.9%	5.9%	n/a	n/a	5.9%	5.9%	5.9%
$125	6.2%	6.1%	n/a	n/a	6.1%	6.2%	6.2%
$150	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	4.3%	4.8%	n/a	n/a	4.7%	4.1%	4.3%
$25	6.0%	6.2%	n/a	n/a	5.8%	6.3%	6.0%
$35	5.7%	5.8%	n/a	n/a	5.8%	5.8%	5.7%
$50	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
$60	6.1%	6.2%	n/a	n/a	6.1%	6.2%	6.1%
$75	6.1%	6.1%	n/a	n/a	6.2%	6.0%	6.1%
$100	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(6.95)	(18.77)	na	na	(12.86)	(14.60)	(20.85)
$150	(8.76)	(23.65)	na	na	(16.21)	(18.40)	(26.28)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.63	1.70	na	na	1.17	1.32	1.89
60	1.22	3.29	na	na	2.26	2.56	3.66
90	1.83	4.94	na	na	3.39	3.84	5.49
120	2.14	5.78	na	na	3.96	4.49	6.42
Unlimited	2.74	7.40	na	na	5.07	5.75	8.22
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
40/$10 copay	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
40/$15 copay	(0.49)	(1.32)	na	na	(0.91)	(1.03)	(1.47)
40/$20 copay	(0.69)	(1.86)	na	na	(1.28)	(1.45)	(2.07)
40/$25 copay	(0.89)	(2.40)	na	na	(1.65)	(1.87)	(2.67)
60	0.33	0.89	na	na	0.61	0.69	0.99
100	0.80	2.16	na	na	1.48	1.68	2.40
200	2.15	5.81	na	na	3.98	4.52	6.45
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.27)	(3.43)	na	na	(2.35)	(2.67)	(3.81)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.84	2.27	na	na	1.55	1.76	2.52
90	1.77	4.78	na	na	3.27	3.72	5.31
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.75	2.03	na	na	1.39	1.58	2.25
90	1.39	3.75	na	na	2.57	2.92	4.17
120	2.21	5.97	na	na	4.09	4.64	6.63
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.07)	(2.89)	na	na	(1.98)	(2.25)	(3.21)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.31	0.84	na	na	0.57	0.65	0.93
30	0.50	1.35	na	na	0.93	1.05	1.50
Unlimited	0.75	2.03	na	na	1.39	1.58	2.25
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.78	10.21	na	na	6.99	7.94	11.34
60	4.43	11.96	na	na	8.20	9.30	13.29
90	5.28	14.26	na	na	9.77	11.09	15.84
Unlimited	5.35	14.45	na	na	9.90	11.24	16.05
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
60/$10 copay	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
60/$15 copay	(0.42)	(1.13)	na	na	(0.78)	(0.88)	(1.26)
60/$20 copay	(0.61)	(1.65)	na	na	(1.13)	(1.28)	(1.83)
60/$25 copay	(0.71)	(1.92)	na	na	(1.31)	(1.49)	(2.13)
120/$0 copay	0.67	1.81	na	na	1.24	1.41	2.01
120/$5 copay	0.52	1.40	na	na	0.96	1.09	1.56
120/$10 copay	0.33	0.89	na	na	0.61	0.69	0.99
120/$15 copay	0.07	0.19	na	na	0.13	0.15	0.21
120/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
120/$25 copay	(0.31)	(0.84)	na	na	(0.57)	(0.65)	(0.93)
Unlimited/$0 copay	0.77	2.08	na	na	1.42	1.62	2.31
Unlimited/$5 copay	0.62	1.67	na	na	1.15	1.30	1.86
Unlimited/$10 copay	0.40	1.08	na	na	0.74	0.84	1.20
Unlimited/$15 copay	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited/$20 copay	(0.03)	(0.08)	na	na	(0.06)	(0.06)	(0.09)
Unlimited/$25 copay	(0.24)	(0.65)	na	na	(0.44)	(0.50)	(0.72)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.18	0.49	na	na	0.33	0.38	0.54
$5	0.07	0.19	na	na	0.13	0.15	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$125	(7.37)	(19.90)	na	na	(13.63)	(15.48)	(22.11)
$150	(9.29)	(25.08)	na	na	(17.19)	(19.51)	(27.87)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.67	1.81	na	na	1.24	1.41	2.01
60	1.30	3.51	na	na	2.41	2.73	3.90
90	1.94	5.24	na	na	3.59	4.07	5.82
120	2.27	6.13	na	na	4.20	4.77	6.81
Unlimited	2.90	7.83	na	na	5.37	6.09	8.70
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
40/$10 copay	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
40/$15 copay	(0.52)	(1.40)	na	na	(0.96)	(1.09)	(1.56)
40/$20 copay	(0.73)	(1.97)	na	na	(1.35)	(1.53)	(2.19)
40/$25 copay	(0.95)	(2.57)	na	na	(1.76)	(2.00)	(2.85)
60	0.35	0.95	na	na	0.65	0.74	1.05
100	0.84	2.27	na	na	1.55	1.76	2.52
200	2.28	6.16	na	na	4.22	4.79	6.84
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.35)	(3.65)	na	na	(2.50)	(2.84)	(4.05)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.90	2.43	na	na	1.67	1.89	2.70
90	1.87	5.05	na	na	3.46	3.93	5.61
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.13	na	na	1.46	1.66	2.37
90	1.47	3.97	na	na	2.72	3.09	4.41
120	2.35	6.35	na	na	4.35	4.94	7.05
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.13)	(3.05)	na	na	(2.09)	(2.37)	(3.39)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.89	na	na	0.61	0.69	0.99
30	0.54	1.46	na	na	1.00	1.13	1.62
Unlimited	0.79	2.13	na	na	1.46	1.66	2.37
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.01	10.83	na	na	7.42	8.42	12.03
60	4.70	12.69	na	na	8.70	9.87	14.10
90	5.60	15.12	na	na	10.36	11.76	16.80
Unlimited	5.68	15.34	na	na	10.51	11.93	17.04
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
60/$10 copay	(0.28)	(0.76)	na	na	(0.52)	(0.59)	(0.84)
60/$15 copay	(0.44)	(1.19)	na	na	(0.81)	(0.92)	(1.32)
60/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.37)	(1.95)
60/$25 copay	(0.75)	(2.03)	na	na	(1.39)	(1.58)	(2.25)
120/$0 copay	0.71	1.92	na	na	1.31	1.49	2.13
120/$5 copay	0.56	1.51	na	na	1.04	1.18	1.68
120/$10 copay	0.35	0.95	na	na	0.65	0.74	1.05
120/$15 copay	0.07	0.19	na	na	0.13	0.15	0.21
120/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
120/$25 copay	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
Unlimited/$0 copay	0.81	2.19	na	na	1.50	1.70	2.43
Unlimited/$5 copay	0.66	1.78	na	na	1.22	1.39	1.98
Unlimited/$10 copay	0.42	1.13	na	na	0.78	0.88	1.26
Unlimited/$15 copay	0.13	0.35	na	na	0.24	0.27	0.39
Unlimited/$20 copay	(0.03)	(0.08)	na	na	(0.06)	(0.06)	(0.09)
Unlimited/$25 copay	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.20	0.54	na	na	0.37	0.42	0.60
$5	0.07	0.19	na	na	0.13	0.15	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(0.42)	(1.13)	na	na	(0.77)	(0.88)	(1.26)
$150	(0.53)	(1.43)	na	na	(0.98)	(1.11)	(1.59)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	-	-	na	na	-	-	-
45	0.04	0.11	na	na	0.07	0.09	0.12
60	0.08	0.22	na	na	0.15	0.17	0.24
90	0.11	0.30	na	na	0.20	0.23	0.33
120	0.13	0.35	na	na	0.24	0.28	0.39
Unlimited	0.16	0.43	na	na	0.30	0.34	0.48
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	-	-	na	na	-	-	-
40/$5 copay	-	-	na	na	-	-	-
40/$10 copay	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
40/$15 copay	(0.03)	(0.08)	na	na	(0.05)	(0.06)	(0.09)
40/$20 copay	(0.04)	(0.11)	na	na	(0.07)	(0.08)	(0.12)
40/$25 copay	(0.06)	(0.17)	na	na	(0.11)	(0.13)	(0.18)
60	0.02	0.06	na	na	0.04	0.05	0.06
100	0.04	0.11	na	na	0.07	0.08	0.12
200	0.13	0.35	na	na	0.24	0.27	0.39
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
30	-	-	na	na	-	-	-
60	0.06	0.16	na	na	0.12	0.13	0.18
90	0.10	0.27	na	na	0.19	0.21	0.30
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	-	-	na	na	-	-	-
60	0.04	0.10	na	na	0.07	0.08	0.12
90	0.08	0.22	na	na	0.15	0.17	0.24
120	0.14	0.38	na	na	0.26	0.30	0.42
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(0.06)	(0.16)	na	na	(0.11)	(0.12)	(0.18)
7	-	-	na	na	-	-	-
21	0.02	0.05	na	na	0.04	0.04	0.06
30	0.04	0.11	na	na	0.07	0.08	0.12
Unlimited	0.04	0.10	na	na	0.07	0.08	0.12
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	-	-	na	na	-	-	-
30	0.23	0.62	na	na	0.43	0.48	0.69
60	0.27	0.73	na	na	0.50	0.57	0.81
90	0.32	0.86	na	na	0.59	0.67	0.96
Unlimited	0.33	0.89	na	na	0.61	0.69	0.99
# 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	-	-	na	na	-	-	-
60/$5 copay	-	-	na	na	-	-	-
60/$10 copay	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
60/$15 copay	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
60/$20 copay	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
60/$25 copay	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
120/$0 copay	0.04	0.11	na	na	0.07	0.08	0.12
120/$5 copay	0.04	0.11	na	na	0.08	0.09	0.12
120/$10 copay	0.02	0.06	na	na	0.04	0.05	0.06
120/$15 copay	-	-	na	na	-	-	-
120/$20 copay	-	-	na	na	-	-	-
120/$25 copay	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
Unlimited/$0 copay	0.04	0.11	na	na	0.08	0.08	0.12
Unlimited/$5 copay	0.04	0.11	na	na	0.07	0.09	0.12
Unlimited/$10 copay	0.02	0.05	na	na	0.04	0.04	0.06
Unlimited/$15 copay	-	-	na	na	-	-	-
Unlimited/$20 copay	-	-	na	na	-	-	-
Unlimited/$25 copay	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.02	0.05	na	na	0.04	0.04	0.06
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
$150	6.1%	6.0%	n/a	n/a	6.0%	6.0%	6.1%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
45	6.3%	6.5%	n/a	n/a	6.0%	6.8%	6.3%
60	6.6%	6.7%	n/a	n/a	6.6%	6.6%	6.6%
90	6.0%	6.1%	n/a	n/a	5.9%	6.0%	6.0%
120	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
Unlimited	5.8%	5.8%	n/a	n/a	5.9%	5.9%	5.8%
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
40/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
40/$10 copay	6.1%	6.7%	n/a	n/a	6.6%	7.2%	6.1%
40/$15 copay	6.1%	6.1%	n/a	n/a	5.5%	5.8%	6.1%
40/$20 copay	5.8%	5.9%	n/a	n/a	5.5%	5.5%	5.8%
40/$25 copay	6.7%	7.1%	n/a	n/a	6.7%	7.0%	6.7%
60	6.1%	6.7%	n/a	n/a	6.6%	7.2%	6.1%
100	5.0%	5.1%	n/a	n/a	4.7%	4.8%	5.0%
200	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	6.3%	6.4%	n/a	n/a	6.4%	6.4%	6.3%
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	7.1%	7.0%	n/a	n/a	7.7%	7.4%	7.1%
90	5.6%	5.6%	n/a	n/a	5.8%	5.6%	5.6%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
90	5.8%	5.9%	n/a	n/a	5.8%	5.8%	5.8%
120	6.3%	6.4%	n/a	n/a	6.4%	6.5%	6.3%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	5.6%	5.5%	n/a	n/a	5.6%	5.3%	5.6%
7	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
21	6.5%	6.0%	n/a	n/a	7.0%	6.2%	6.5%
30	8.0%	8.1%	n/a	n/a	7.5%	7.6%	8.0%
Unlimited	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
30	6.1%	6.1%	n/a	n/a	6.2%	6.0%	6.1%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
90	6.1%	6.0%	n/a	n/a	6.0%	6.0%	6.1%
Unlimited	6.2%	6.2%	n/a	n/a	6.2%	6.1%	6.2%
# 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$10 copay	7.7%	8.6%	n/a	n/a	8.3%	7.3%	7.7%
60/$15 copay	4.8%	5.3%	n/a	n/a	3.8%	4.5%	4.8%
60/$20 copay	6.6%	6.7%	n/a	n/a	6.2%	7.0%	6.6%
60/$25 copay	5.6%	5.7%	n/a	n/a	6.1%	6.0%	5.6%
120/$0 copay	6.0%	6.1%	n/a	n/a	5.6%	5.7%	6.0%
120/$5 copay	7.7%	7.9%	n/a	n/a	8.3%	8.3%	7.7%
120/$10 copay	6.1%	6.7%	n/a	n/a	6.6%	7.2%	6.1%
120/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$25 copay	6.5%	6.0%	n/a	n/a	7.0%	6.2%	6.5%
Unlimited/$0 copay	5.2%	5.3%	n/a	n/a	5.6%	4.9%	5.2%
Unlimited/$5 copay	6.5%	6.6%	n/a	n/a	6.1%	6.9%	6.5%
Unlimited/$10 copay	5.0%	4.6%	n/a	n/a	5.4%	4.8%	5.0%
Unlimited/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$25 copay	8.3%	7.7%	n/a	n/a	9.1%	10.0%	8.3%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	11.1%	10.2%	n/a	n/a	12.1%	10.5%	11.1%
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	(0.23)	(0.62)	na	na	(0.43)	(0.48)	(0.69)
$25	(0.33)	(0.89)	na	na	(0.61)	(0.69)	(0.99)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
$10	(0.28)	(0.76)	na	na	(0.52)	(0.59)	(0.84)
$15	(0.47)	(1.27)	na	na	(0.87)	(0.99)	(1.41)
$20	(0.67)	(1.81)	na	na	(1.24)	(1.41)	(2.01)
$25	(0.84)	(2.27)	na	na	(1.55)	(1.76)	(2.52)
$30	(1.07)	(2.89)	na	na	(1.98)	(2.25)	(3.21)
$35	(1.24)	(3.35)	na	na	(2.29)	(2.60)	(3.72)
$40	(1.43)	(3.86)	na	na	(2.65)	(3.00)	(4.29)
$45	(1.63)	(4.40)	na	na	(3.02)	(3.42)	(4.89)
$50	(1.82)	(4.91)	na	na	(3.37)	(3.82)	(5.46)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$10	(0.36)	(0.97)	na	na	(0.67)	(0.76)	(1.08)
$15	(0.50)	(1.35)	na	na	(0.93)	(1.05)	(1.50)
$20	(0.75)	(2.03)	na	na	(1.39)	(1.58)	(2.25)
$25	(1.01)	(2.73)	na	na	(1.87)	(2.12)	(3.03)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$35	(0.23)	(0.62)	na	na	(0.43)	(0.48)	(0.69)
$50	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
$60	(0.42)	(1.13)	na	na	(0.78)	(0.88)	(1.26)
$75	(0.57)	(1.54)	na	na	(1.05)	(1.20)	(1.71)
$100	(0.75)	(2.03)	na	na	(1.39)	(1.58)	(2.25)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$50	(0.24)	(0.65)	na	na	(0.44)	(0.50)	(0.72)
$60	(0.28)	(0.76)	na	na	(0.52)	(0.59)	(0.84)
$75	(0.37)	(1.00)	na	na	(0.68)	(0.78)	(1.11)
$100	(0.50)	(1.35)	na	na	(0.93)	(1.05)	(1.50)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.12)	(8.42)	na	na	(5.77)	(6.55)	(9.36)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(4.87)	(13.15)	na	na	(9.01)	(10.23)	(14.61)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.41)	(1.11)	na	na	(0.76)	(0.86)	(1.23)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$25	(0.35)	(0.95)	na	na	(0.65)	(0.74)	(1.05)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.27)	(0.39)
$10	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.03)	(1.47)
$20	(0.71)	(1.92)	na	na	(1.31)	(1.49)	(2.13)
$25	(0.90)	(2.43)	na	na	(1.67)	(1.89)	(2.70)
$30	(1.13)	(3.05)	na	na	(2.09)	(2.37)	(3.39)
$35	(1.32)	(3.56)	na	na	(2.44)	(2.77)	(3.96)
$40	(1.51)	(4.08)	na	na	(2.79)	(3.17)	(4.53)
$45	(1.73)	(4.67)	na	na	(3.20)	(3.63)	(5.19)
$50	(1.93)	(5.21)	na	na	(3.57)	(4.05)	(5.79)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$10	(0.38)	(1.03)	na	na	(0.70)	(0.80)	(1.14)
$15	(0.54)	(1.46)	na	na	(1.00)	(1.13)	(1.62)
$20	(0.79)	(2.13)	na	na	(1.46)	(1.66)	(2.37)
$25	(1.07)	(2.89)	na	na	(1.98)	(2.25)	(3.21)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.15)	(0.21)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.17)	(0.24)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$35	(0.25)	(0.68)	na	na	(0.46)	(0.53)	(0.75)
$50	(0.37)	(1.00)	na	na	(0.68)	(0.78)	(1.11)
$60	(0.44)	(1.19)	na	na	(0.81)	(0.92)	(1.32)
$75	(0.61)	(1.65)	na	na	(1.13)	(1.28)	(1.83)
$100	(0.79)	(2.13)	na	na	(1.46)	(1.66)	(2.37)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
$25	(0.09)	(0.24)	na	na	(0.17)	(0.19)	(0.27)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.32)	(0.45)
$50	(0.26)	(0.70)	na	na	(0.48)	(0.55)	(0.78)
$60	(0.30)	(0.81)	na	na	(0.56)	(0.63)	(0.90)
$75	(0.39)	(1.05)	na	na	(0.72)	(0.82)	(1.17)
$100	(0.54)	(1.46)	na	na	(1.00)	(1.13)	(1.62)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.31)	(8.94)	na	na	(6.12)	(6.95)	(9.93)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(5.17)	(13.96)	na	na	(9.56)	(10.86)	(15.51)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.43)	(1.16)	na	na	(0.80)	(0.90)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$25	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$15	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$20	(0.04)	(0.11)	na	na	(0.07)	(0.08)	(0.12)
$25	(0.06)	(0.16)	na	na	(0.12)	(0.13)	(0.18)
$30	(0.06)	(0.16)	na	na	(0.11)	(0.12)	(0.18)
$35	(0.08)	(0.21)	na	na	(0.15)	(0.17)	(0.24)
$40	(0.08)	(0.22)	na	na	(0.14)	(0.17)	(0.24)
$45	(0.10)	(0.27)	na	na	(0.18)	(0.21)	(0.30)
$50	(0.11)	(0.30)	na	na	(0.20)	(0.23)	(0.33)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
$15	(0.04)	(0.11)	na	na	(0.07)	(0.08)	(0.12)
$20	(0.04)	(0.10)	na	na	(0.07)	(0.08)	(0.12)
$25	(0.06)	(0.16)	na	na	(0.11)	(0.13)	(0.18)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$50	(0.02)	(0.05)	na	na	(0.03)	(0.04)	(0.06)
$60	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
$75	(0.04)	(0.11)	na	na	(0.08)	(0.08)	(0.12)
$100	(0.04)	(0.10)	na	na	(0.07)	(0.08)	(0.12)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$50	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$60	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$75	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$100	(0.04)	(0.11)	na	na	(0.07)	(0.08)	(0.12)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(0.19)	(0.52)	na	na	(0.35)	(0.40)	(0.57)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(0.30)	(0.81)	na	na	(0.55)	(0.63)	(0.90)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	8.7%	9.7%	n/a	n/a	7.0%	10.4%	8.7%
$25	6.1%	6.7%	n/a	n/a	6.6%	7.2%	6.1%
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	7.1%	6.6%	n/a	n/a	7.7%	6.8%	7.1%
$15	4.3%	3.9%	n/a	n/a	4.6%	4.0%	4.3%
$20	6.0%	6.1%	n/a	n/a	5.6%	5.7%	6.0%
$25	7.1%	7.0%	n/a	n/a	7.7%	7.4%	7.1%
$30	5.6%	5.5%	n/a	n/a	5.6%	5.3%	5.6%
$35	6.5%	6.3%	n/a	n/a	6.6%	6.5%	6.5%
$40	5.6%	5.7%	n/a	n/a	5.3%	5.7%	5.6%
$45	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
$50	6.0%	6.1%	n/a	n/a	5.9%	6.0%	6.0%
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	5.6%	6.2%	n/a	n/a	4.5%	5.3%	5.6%
$15	8.0%	8.1%	n/a	n/a	7.5%	7.6%	8.0%
$20	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
$25	5.9%	5.9%	n/a	n/a	5.9%	6.1%	5.9%
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	8.7%	9.7%	n/a	n/a	7.0%	10.4%	8.7%
$50	5.7%	5.3%	n/a	n/a	4.6%	5.4%	5.7%
$60	4.8%	5.3%	n/a	n/a	3.8%	4.5%	4.8%
$75	7.0%	7.1%	n/a	n/a	7.6%	6.7%	7.0%
$100	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$50	8.3%	7.7%	n/a	n/a	9.1%	10.0%	8.3%
$60	7.1%	6.6%	n/a	n/a	7.7%	6.8%	7.1%
$75	5.4%	5.0%	n/a	n/a	5.9%	5.1%	5.4%
$100	8.0%	8.1%	n/a	n/a	7.5%	7.6%	8.0%
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	6.1%	6.2%	n/a	n/a	6.1%	6.1%	6.1%
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	6.2%	6.2%	n/a	n/a	6.1%	6.2%	6.2%
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	4.9%	4.5%	n/a	n/a	5.3%	4.7%	4.9%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
21	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
22	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
23	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
24	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
26	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			End of Year				
19	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
21	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
22	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
23	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
24	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
26	0.0%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
24	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
26	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			End of Month				
23	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
24	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
26	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
			Grandchildren				
	0.0%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
April 01, 2013 - June 30, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
30	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			Class II Dependents				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.11	11.10	na	na	7.60	8.63	12.33
60	4.91	13.26	na	na	9.08	10.31	14.73
90	5.44	14.69	na	na	10.06	11.42	16.32
Unlimited	5.51	14.88	na	na	10.19	11.57	16.53
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	6.66	17.98	na	na	12.32	13.99	19.98
60	7.03	18.98	na	na	13.01	14.76	21.09
90	7.30	19.71	na	na	13.51	15.33	21.90
Unlimited	7.39	19.95	na	na	13.67	15.52	22.17
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.57	15.04	na	na	10.30	11.70	16.71
30	6.54	17.66	na	na	12.10	13.73	19.62
40	7.17	19.36	na	na	13.26	15.06	21.51
60	7.79	21.03	na	na	14.41	16.36	23.37
Unlimited	7.87	21.25	na	na	14.56	16.53	23.61
SMALL GROUP	**$5 Copay**						
20	5.25	14.18	na	na	9.71	11.03	15.75
30	6.15	16.61	na	na	11.38	12.92	18.45
40	6.74	18.20	na	na	12.47	14.15	20.22
60	7.31	19.74	na	na	13.52	15.35	21.93
Unlimited	7.39	19.95	na	na	13.67	15.52	22.17
SMALL GROUP	**$10 Copay**						
20	4.89	13.20	na	na	9.05	10.27	14.67
30	5.73	15.47	na	na	10.60	12.03	17.19
40	6.28	16.96	na	na	11.62	13.19	18.84
60	6.82	18.41	na	na	12.62	14.32	20.46
Unlimited	6.91	18.66	na	na	12.78	14.51	20.73
SMALL GROUP	**$15 Copay**						
20	4.59	12.39	na	na	8.49	9.64	13.77
30	5.37	14.50	na	na	9.93	11.28	16.11
40	5.89	15.90	na	na	10.90	12.37	17.67
60	6.41	17.31	na	na	11.86	13.46	19.23
Unlimited	6.47	17.47	na	na	11.97	13.59	19.41
SMALL GROUP	**$20 Copay**						
20	4.32	11.66	na	na	7.99	9.07	12.96
30	5.06	13.66	na	na	9.36	10.63	15.18
40	5.54	14.96	na	na	10.25	11.63	16.62
60	6.03	16.28	na	na	11.16	12.66	18.09
Unlimited	6.09	16.44	na	na	11.27	12.79	18.27
SMALL GROUP	**$25 Copay**						
20	4.03	10.88	na	na	7.46	8.46	12.09
30	4.71	12.72	na	na	8.71	9.89	14.13
40	5.14	13.88	na	na	9.51	10.79	15.42
60	5.59	15.09	na	na	10.34	11.74	16.77
Unlimited	5.65	15.26	na	na	10.45	11.87	16.95
SMALL GROUP	**$30 Copay**						
20	3.86	10.42	na	na	7.14	8.11	11.58
30	4.54	12.26	na	na	8.40	9.53	13.62
40	4.96	13.39	na	na	9.18	10.42	14.88
60	5.43	14.66	na	na	10.05	11.40	16.29
Unlimited	5.47	14.77	na	na	10.12	11.49	16.41
SMALL GROUP	**$35 Copay**						
20	3.76	10.15	na	na	6.96	7.90	11.28
30	4.40	11.88	na	na	8.14	9.24	13.20
40	4.84	13.07	na	na	8.95	10.16	14.52
60	5.25	14.18	na	na	9.71	11.03	15.75
Unlimited	5.29	14.28	na	na	9.79	11.11	15.87
SMALL GROUP	**$40 Copay**						
20	3.66	9.88	na	na	6.77	7.69	10.98
30	4.28	11.56	na	na	7.92	8.99	12.84
40	4.69	12.66	na	na	8.68	9.85	14.07
60	5.08	13.72	na	na	9.40	10.67	15.24
Unlimited	5.13	13.85	na	na	9.49	10.77	15.39
SMALL GROUP	**$45 Copay**						
20	3.54	9.56	na	na	6.55	7.43	10.62
30	4.15	11.21	na	na	7.68	8.72	12.45
40	4.53	12.23	na	na	8.38	9.51	13.59

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.36	11.77	na	na	8.07	9.16	13.08
60	5.21	14.07	na	na	9.64	10.94	15.63
90	5.77	15.58	na	na	10.67	12.12	17.31
Unlimited	5.85	15.80	na	na	10.82	12.29	17.55
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.07	19.09	na	na	13.08	14.85	21.21
60	7.46	20.14	na	na	13.80	15.67	22.38
90	7.75	20.93	na	na	14.34	16.28	23.25
Unlimited	7.84	21.17	na	na	14.50	16.46	23.52
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.91	15.96	na	na	10.93	12.41	17.73
30	6.94	18.74	na	na	12.84	14.57	20.82
40	7.61	20.55	na	na	14.08	15.98	22.83
60	8.26	22.30	na	na	15.28	17.35	24.78
Unlimited	8.35	22.55	na	na	15.45	17.54	25.05
SMALL GROUP	**$5 Copay**						
20	5.57	15.04	na	na	10.30	11.70	16.71
30	6.52	17.60	na	na	12.06	13.69	19.56
40	7.15	19.31	na	na	13.23	15.02	21.45
60	7.76	20.95	na	na	14.36	16.30	23.28
Unlimited	7.84	21.17	na	na	14.50	16.46	23.52
SMALL GROUP	**$10 Copay**						
20	5.19	14.01	na	na	9.60	10.90	15.57
30	6.08	16.42	na	na	11.25	12.77	18.24
40	6.66	17.98	na	na	12.32	13.99	19.98
60	7.23	19.52	na	na	13.38	15.18	21.69
Unlimited	7.33	19.79	na	na	13.56	15.39	21.99
SMALL GROUP	**$15 Copay**						
20	4.87	13.15	na	na	9.01	10.23	14.61
30	5.70	15.39	na	na	10.55	11.97	17.10
40	6.25	16.88	na	na	11.56	13.13	18.75
60	6.80	18.36	na	na	12.58	14.28	20.40
Unlimited	6.86	18.52	na	na	12.69	14.41	20.58
SMALL GROUP	**$20 Copay**						
20	4.58	12.37	na	na	8.47	9.62	13.74
30	5.37	14.50	na	na	9.93	11.28	16.11
40	5.88	15.88	na	na	10.88	12.35	17.64
60	6.40	17.28	na	na	11.84	13.44	19.20
Unlimited	6.46	17.44	na	na	11.95	13.57	19.38
SMALL GROUP	**$25 Copay**						
20	4.27	11.53	na	na	7.90	8.97	12.81
30	5.00	13.50	na	na	9.25	10.50	15.00
40	5.45	14.72	na	na	10.08	11.45	16.35
60	5.93	16.01	na	na	10.97	12.45	17.79
Unlimited	5.99	16.17	na	na	11.08	12.58	17.97
SMALL GROUP	**$30 Copay**						
20	4.10	11.07	na	na	7.59	8.61	12.30
30	4.82	13.01	na	na	8.92	10.12	14.46
40	5.26	14.20	na	na	9.73	11.05	15.78
60	5.76	15.55	na	na	10.66	12.10	17.28
Unlimited	5.80	15.66	na	na	10.73	12.18	17.40
SMALL GROUP	**$35 Copay**						
20	3.99	10.77	na	na	7.38	8.38	11.97
30	4.67	12.61	na	na	8.64	9.81	14.01
40	5.14	13.88	na	na	9.51	10.79	15.42
60	5.57	15.04	na	na	10.30	11.70	16.71
Unlimited	5.61	15.15	na	na	10.38	11.78	16.83
SMALL GROUP	**$40 Copay**						
20	3.88	10.48	na	na	7.18	8.15	11.64
30	4.54	12.26	na	na	8.40	9.53	13.62
40	4.97	13.42	na	na	9.19	10.44	14.91
60	5.39	14.55	na	na	9.97	11.32	16.17
Unlimited	5.44	14.69	na	na	10.06	11.42	16.32
SMALL GROUP	**$45 Copay**						
20	3.76	10.15	na	na	6.96	7.90	11.28
30	4.40	11.88	na	na	8.14	9.24	13.20
40	4.81	12.99	na	na	8.90	10.10	14.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.25	0.67	na	na	0.47	0.53	0.75
60	0.30	0.81	na	na	0.56	0.63	0.90
90	0.33	0.89	na	na	0.61	0.70	0.99
Unlimited	0.34	0.92	na	na	0.63	0.72	1.02
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.41	1.11	na	na	0.76	0.86	1.23
60	0.43	1.16	na	na	0.79	0.91	1.29
90	0.45	1.22	na	na	0.83	0.95	1.35
Unlimited	0.45	1.22	na	na	0.83	0.94	1.35
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.34	0.92	na	na	0.63	0.71	1.02
30	0.40	1.08	na	na	0.74	0.84	1.20
40	0.44	1.19	na	na	0.82	0.92	1.32
60	0.47	1.27	na	na	0.87	0.99	1.41
Unlimited	0.48	1.30	na	na	0.89	1.01	1.44
SMALL GROUP	**$5 Copay**						
20	0.32	0.86	na	na	0.59	0.67	0.96
30	0.37	0.99	na	na	0.68	0.77	1.11
40	0.41	1.11	na	na	0.76	0.87	1.23
60	0.45	1.21	na	na	0.84	0.95	1.35
Unlimited	0.45	1.22	na	na	0.83	0.94	1.35
SMALL GROUP	**$10 Copay**						
20	0.30	0.81	na	na	0.55	0.63	0.90
30	0.35	0.95	na	na	0.65	0.74	1.05
40	0.38	1.02	na	na	0.70	0.80	1.14
60	0.41	1.11	na	na	0.76	0.86	1.23
Unlimited	0.42	1.13	na	na	0.78	0.88	1.26
SMALL GROUP	**$15 Copay**						
20	0.28	0.76	na	na	0.52	0.59	0.84
30	0.33	0.89	na	na	0.62	0.69	0.99
40	0.36	0.98	na	na	0.66	0.76	1.08
60	0.39	1.05	na	na	0.72	0.82	1.17
Unlimited	0.39	1.05	na	na	0.72	0.82	1.17
SMALL GROUP	**$20 Copay**						
20	0.26	0.71	na	na	0.48	0.55	0.78
30	0.31	0.84	na	na	0.57	0.65	0.93
40	0.34	0.92	na	na	0.63	0.72	1.02
60	0.37	1.00	na	na	0.68	0.78	1.11
Unlimited	0.37	1.00	na	na	0.68	0.78	1.11
SMALL GROUP	**$25 Copay**						
20	0.24	0.65	na	na	0.44	0.51	0.72
30	0.29	0.78	na	na	0.54	0.61	0.87
40	0.31	0.84	na	na	0.57	0.66	0.93
60	0.34	0.92	na	na	0.63	0.71	1.02
Unlimited	0.34	0.91	na	na	0.63	0.71	1.02
SMALL GROUP	**$30 Copay**						
20	0.24	0.65	na	na	0.45	0.50	0.72
30	0.28	0.75	na	na	0.52	0.59	0.84
40	0.30	0.81	na	na	0.55	0.63	0.90
60	0.33	0.89	na	na	0.61	0.70	0.99
Unlimited	0.33	0.89	na	na	0.61	0.69	0.99
SMALL GROUP	**$35 Copay**						
20	0.23	0.62	na	na	0.42	0.48	0.69
30	0.27	0.73	na	na	0.50	0.57	0.81
40	0.30	0.81	na	na	0.56	0.63	0.90
60	0.32	0.86	na	na	0.59	0.67	0.96
Unlimited	0.32	0.87	na	na	0.59	0.67	0.96
SMALL GROUP	**$40 Copay**						
20	0.22	0.60	na	na	0.41	0.46	0.66
30	0.26	0.70	na	na	0.48	0.54	0.78
40	0.28	0.76	na	na	0.51	0.59	0.84
60	0.31	0.83	na	na	0.57	0.65	0.93
Unlimited	0.31	0.84	na	na	0.57	0.65	0.93
SMALL GROUP	**$45 Copay**						
20	0.22	0.59	na	na	0.41	0.47	0.66
30	0.25	0.67	na	na	0.46	0.52	0.75
40	0.28	0.76	na	na	0.52	0.59	0.84

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	6.1%	6.0%	n/a	n/a	6.2%	6.1%	6.1%
60	6.1%	6.1%	n/a	n/a	6.2%	6.1%	6.1%
90	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.2%	6.2%	n/a	n/a	6.2%	6.2%	6.2%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	6.2%	6.2%	n/a	n/a	6.2%	6.1%	6.2%
60	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
90	6.2%	6.2%	n/a	n/a	6.1%	6.2%	6.2%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
40	6.1%	6.1%	n/a	n/a	6.2%	6.1%	6.1%
60	6.0%	6.0%	n/a	n/a	6.0%	6.1%	6.0%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP	**$5 Copay**						
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
60	6.2%	6.1%	n/a	n/a	6.2%	6.2%	6.2%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP	**$10 Copay**						
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
40	6.1%	6.0%	n/a	n/a	6.0%	6.1%	6.1%
60	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP	**$15 Copay**						
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.2%	6.1%	6.1%
40	6.1%	6.2%	n/a	n/a	6.1%	6.1%	6.1%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP	**$20 Copay**						
20	6.0%	6.1%	n/a	n/a	6.0%	6.1%	6.0%
30	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
40	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
60	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
Unlimited	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
SMALL GROUP	**$25 Copay**						
20	6.0%	6.0%	n/a	n/a	5.9%	6.0%	6.0%
30	6.2%	6.1%	n/a	n/a	6.2%	6.2%	6.2%
40	6.0%	6.1%	n/a	n/a	6.0%	6.1%	6.0%
60	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
Unlimited	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP	**$30 Copay**						
20	6.2%	6.2%	n/a	n/a	6.3%	6.2%	6.2%
30	6.2%	6.1%	n/a	n/a	6.2%	6.2%	6.2%
40	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP	**$35 Copay**						
20	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
40	6.2%	6.2%	n/a	n/a	6.3%	6.2%	6.2%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.1%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP	**$40 Copay**						
20	6.0%	6.1%	n/a	n/a	6.1%	6.0%	6.0%
30	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
40	6.0%	6.0%	n/a	n/a	5.9%	6.0%	6.0%
60	6.1%	6.0%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.1%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP	**$45 Copay**						
20	6.2%	6.2%	n/a	n/a	6.3%	6.3%	6.2%
30	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
40	6.2%	6.2%	n/a	n/a	6.2%	6.2%	6.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	4.93	13.31	na	na	9.12	10.35	14.79
Unlimited	4.96	13.39	na	na	9.18	10.42	14.88
SMALL GROUP				**$50 Copay**			
20	3.43	9.26	na	na	6.35	7.20	10.29
30	4.04	10.91	na	na	7.47	8.48	12.12
40	4.40	11.88	na	na	8.14	9.24	13.20
60	4.77	12.88	na	na	8.82	10.02	14.31
Unlimited	4.83	13.04	na	na	8.94	10.14	14.49
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	6.61	17.85	na	na	12.23	13.88	19.83
30	7.18	19.39	na	na	13.28	15.08	21.54
40	7.51	20.28	na	na	13.89	15.77	22.53
60	7.89	21.30	na	na	14.60	16.57	23.67
Unlimited	7.97	21.52	na	na	14.74	16.74	23.91
SMALL GROUP				**$5 Copay**			
20	6.21	16.77	na	na	11.49	13.04	18.63
30	6.75	18.23	na	na	12.49	14.18	20.25
40	7.07	19.09	na	na	13.08	14.85	21.21
60	7.42	20.03	na	na	13.73	15.58	22.26
Unlimited	7.50	20.25	na	na	13.88	15.75	22.50
SMALL GROUP				**$10 Copay**			
20	5.81	15.69	na	na	10.75	12.20	17.43
30	6.29	16.98	na	na	11.64	13.21	18.87
40	6.60	17.82	na	na	12.21	13.86	19.80
60	6.93	18.71	na	na	12.82	14.55	20.79
Unlimited	6.99	18.87	na	na	12.93	14.68	20.97
SMALL GROUP				**$15 Copay**			
20	5.45	14.72	na	na	10.08	11.45	16.35
30	5.90	15.93	na	na	10.92	12.39	17.70
40	6.18	16.69	na	na	11.43	12.98	18.54
60	6.49	17.52	na	na	12.01	13.63	19.47
Unlimited	6.57	17.74	na	na	12.15	13.80	19.71
SMALL GROUP				**$20 Copay**			
20	5.12	13.82	na	na	9.47	10.75	15.36
30	5.54	14.96	na	na	10.25	11.63	16.62
40	5.82	15.71	na	na	10.77	12.22	17.46
60	6.11	16.50	na	na	11.30	12.83	18.33
Unlimited	6.17	16.66	na	na	11.41	12.96	18.51
SMALL GROUP				**$25 Copay**			
20	4.75	12.83	na	na	8.79	9.98	14.25
30	5.15	13.91	na	na	9.53	10.82	15.45
40	5.42	14.63	na	na	10.03	11.38	16.26
60	5.68	15.34	na	na	10.51	11.93	17.04
Unlimited	5.74	15.50	na	na	10.62	12.05	17.22
SMALL GROUP				**$30 Copay**			
20	4.60	12.42	na	na	8.51	9.66	13.80
30	4.97	13.42	na	na	9.19	10.44	14.91
40	5.24	14.15	na	na	9.69	11.00	15.72
60	5.49	14.82	na	na	10.16	11.53	16.47
Unlimited	5.53	14.93	na	na	10.23	11.61	16.59
SMALL GROUP				**$35 Copay**			
20	4.45	12.02	na	na	8.23	9.35	13.35
30	4.84	13.07	na	na	8.95	10.16	14.52
40	5.06	13.66	na	na	9.36	10.63	15.18
60	5.31	14.34	na	na	9.82	11.15	15.93
Unlimited	5.36	14.47	na	na	9.92	11.26	16.08
SMALL GROUP				**$40 Copay**			
20	4.33	11.69	na	na	8.01	9.09	12.99
30	4.70	12.69	na	na	8.70	9.87	14.10
40	4.91	13.26	na	na	9.08	10.31	14.73
60	5.15	13.91	na	na	9.53	10.82	15.45
Unlimited	5.22	14.09	na	na	9.66	10.96	15.66
SMALL GROUP				**$45 Copay**			
20	4.19	11.31	na	na	7.75	8.80	12.57
30	4.54	12.26	na	na	8.40	9.53	13.62
40	4.76	12.85	na	na	8.81	10.00	14.28
60	5.00	13.50	na	na	9.25	10.50	15.00
Unlimited	5.04	13.61	na	na	9.32	10.58	15.12
SMALL GROUP				**$50 Copay**			
20	4.07	10.99	na	na	7.53	8.55	12.21
30	4.40	11.88	na	na	8.14	9.24	13.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	5.23	14.12	na	na	9.68	10.98	15.69
Unlimited	5.26	14.20	na	na	9.73	11.05	15.78
SMALL GROUP				**$50 Copay**			
20	3.64	9.83	na	na	6.73	7.64	10.92
30	4.28	11.56	na	na	7.92	8.99	12.84
40	4.67	12.61	na	na	8.64	9.81	14.01
60	5.06	13.66	na	na	9.36	10.63	15.18
Unlimited	5.12	13.82	na	na	9.47	10.75	15.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.01	18.93	na	na	12.97	14.72	21.03
30	7.62	20.57	na	na	14.10	16.00	22.86
40	7.97	21.52	na	na	14.74	16.74	23.91
60	8.37	22.60	na	na	15.48	17.58	25.11
Unlimited	8.46	22.84	na	na	15.65	17.77	25.38
SMALL GROUP				**$5 Copay**			
20	6.59	17.79	na	na	12.19	13.84	19.77
30	7.16	19.33	na	na	13.25	15.04	21.48
40	7.50	20.25	na	na	13.88	15.75	22.50
60	7.87	21.25	na	na	14.56	16.53	23.61
Unlimited	7.96	21.49	na	na	14.73	16.72	23.88
SMALL GROUP				**$10 Copay**			
20	6.16	16.63	na	na	11.40	12.94	18.48
30	6.67	18.01	na	na	12.34	14.01	20.01
40	7.00	18.90	na	na	12.95	14.70	21.00
60	7.35	19.85	na	na	13.60	15.44	22.05
Unlimited	7.42	20.03	na	na	13.73	15.58	22.26
SMALL GROUP				**$15 Copay**			
20	5.78	15.61	na	na	10.69	12.14	17.34
30	6.26	16.90	na	na	11.58	13.15	18.78
40	6.56	17.71	na	na	12.14	13.78	19.68
60	6.88	18.58	na	na	12.73	14.45	20.64
Unlimited	6.97	18.82	na	na	12.89	14.64	20.91
SMALL GROUP				**$20 Copay**			
20	5.43	14.66	na	na	10.05	11.40	16.29
30	5.88	15.88	na	na	10.88	12.35	17.64
40	6.17	16.66	na	na	11.41	12.96	18.51
60	6.48	17.50	na	na	11.99	13.61	19.44
Unlimited	6.55	17.69	na	na	12.12	13.76	19.65
SMALL GROUP				**$25 Copay**			
20	5.04	13.61	na	na	9.32	10.58	15.12
30	5.46	14.74	na	na	10.10	11.47	16.38
40	5.75	15.53	na	na	10.64	12.08	17.25
60	6.03	16.28	na	na	11.16	12.66	18.09
Unlimited	6.09	16.44	na	na	11.27	12.79	18.27
SMALL GROUP				**$30 Copay**			
20	4.88	13.18	na	na	9.03	10.25	14.64
30	5.27	14.23	na	na	9.75	11.07	15.81
40	5.56	15.01	na	na	10.29	11.68	16.68
60	5.82	15.71	na	na	10.77	12.22	17.46
Unlimited	5.87	15.85	na	na	10.86	12.33	17.61
SMALL GROUP				**$35 Copay**			
20	4.72	12.74	na	na	8.73	9.91	14.16
30	5.14	13.88	na	na	9.51	10.79	15.42
40	5.37	14.50	na	na	9.93	11.28	16.11
60	5.63	15.20	na	na	10.42	11.82	16.89
Unlimited	5.69	15.36	na	na	10.53	11.95	17.07
SMALL GROUP				**$40 Copay**			
20	4.59	12.39	na	na	8.49	9.64	13.77
30	4.99	13.47	na	na	9.23	10.48	14.97
40	5.21	14.07	na	na	9.64	10.94	15.63
60	5.46	14.74	na	na	10.10	11.47	16.38
Unlimited	5.54	14.96	na	na	10.25	11.63	16.62
SMALL GROUP				**$45 Copay**			
20	4.45	12.02	na	na	8.23	9.35	13.35
30	4.82	13.01	na	na	8.92	10.12	14.46
40	5.05	13.64	na	na	9.34	10.61	15.15
60	5.30	14.31	na	na	9.81	11.13	15.90
Unlimited	5.35	14.45	na	na	9.90	11.24	16.05
SMALL GROUP				**$50 Copay**			
20	4.32	11.66	na	na	7.99	9.07	12.96
30	4.67	12.61	na	na	8.64	9.81	14.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	0.30	0.81	na	na	0.56	0.63	0.90
Unlimited	0.30	0.81	na	na	0.55	0.63	0.90
SMALL GROUP				**$50 Copay**			
20	0.21	0.57	na	na	0.38	0.44	0.63
30	0.24	0.65	na	na	0.45	0.51	0.72
40	0.27	0.73	na	na	0.50	0.57	0.81
60	0.29	0.78	na	na	0.54	0.61	0.87
Unlimited	0.29	0.78	na	na	0.53	0.61	0.87
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	0.40	1.08	na	na	0.74	0.84	1.20
30	0.44	1.18	na	na	0.82	0.92	1.32
40	0.46	1.24	na	na	0.85	0.97	1.38
60	0.48	1.30	na	na	0.88	1.01	1.44
Unlimited	0.49	1.32	na	na	0.91	1.03	1.47
SMALL GROUP				**$5 Copay**			
20	0.38	1.02	na	na	0.70	0.80	1.14
30	0.41	1.10	na	na	0.76	0.86	1.23
40	0.43	1.16	na	na	0.80	0.90	1.29
60	0.45	1.22	na	na	0.83	0.95	1.35
Unlimited	0.46	1.24	na	na	0.85	0.97	1.38
SMALL GROUP				**$10 Copay**			
20	0.35	0.94	na	na	0.65	0.74	1.05
30	0.38	1.03	na	na	0.70	0.80	1.14
40	0.40	1.08	na	na	0.74	0.84	1.20
60	0.42	1.14	na	na	0.78	0.89	1.26
Unlimited	0.43	1.16	na	na	0.80	0.90	1.29
SMALL GROUP				**$15 Copay**			
20	0.33	0.89	na	na	0.61	0.69	0.99
30	0.36	0.97	na	na	0.66	0.76	1.08
40	0.38	1.02	na	na	0.71	0.80	1.14
60	0.39	1.06	na	na	0.72	0.82	1.17
Unlimited	0.40	1.08	na	na	0.74	0.84	1.20
SMALL GROUP				**$20 Copay**			
20	0.31	0.84	na	na	0.58	0.65	0.93
30	0.34	0.92	na	na	0.63	0.72	1.02
40	0.35	0.95	na	na	0.64	0.74	1.05
60	0.37	1.00	na	na	0.69	0.78	1.11
Unlimited	0.38	1.03	na	na	0.71	0.80	1.14
SMALL GROUP				**$25 Copay**			
20	0.29	0.78	na	na	0.53	0.60	0.87
30	0.31	0.83	na	na	0.57	0.65	0.93
40	0.33	0.90	na	na	0.61	0.70	0.99
60	0.35	0.94	na	na	0.65	0.73	1.05
Unlimited	0.35	0.94	na	na	0.65	0.74	1.05
SMALL GROUP				**$30 Copay**			
20	0.28	0.76	na	na	0.52	0.59	0.84
30	0.30	0.81	na	na	0.56	0.63	0.90
40	0.32	0.86	na	na	0.60	0.68	0.96
60	0.33	0.89	na	na	0.61	0.69	0.99
Unlimited	0.34	0.92	na	na	0.63	0.72	1.02
SMALL GROUP				**$35 Copay**			
20	0.27	0.72	na	na	0.50	0.56	0.81
30	0.30	0.81	na	na	0.56	0.63	0.90
40	0.31	0.84	na	na	0.57	0.65	0.93
60	0.32	0.86	na	na	0.60	0.67	0.96
Unlimited	0.33	0.89	na	na	0.61	0.69	0.99
SMALL GROUP				**$40 Copay**			
20	0.26	0.70	na	na	0.48	0.55	0.78
30	0.29	0.78	na	na	0.53	0.61	0.87
40	0.30	0.81	na	na	0.56	0.63	0.90
60	0.31	0.83	na	na	0.57	0.65	0.93
Unlimited	0.32	0.87	na	na	0.59	0.67	0.96
SMALL GROUP				**$45 Copay**			
20	0.26	0.71	na	na	0.48	0.55	0.78
30	0.28	0.75	na	na	0.52	0.59	0.84
40	0.29	0.79	na	na	0.53	0.61	0.87
60	0.30	0.81	na	na	0.56	0.63	0.90
Unlimited	0.31	0.84	na	na	0.58	0.66	0.93
SMALL GROUP				**$50 Copay**			
20	0.25	0.67	na	na	0.46	0.52	0.75
30	0.27	0.73	na	na	0.50	0.57	0.81

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
SMALL GROUP				**$50 Copay**			
20	6.1%	6.2%	n/a	n/a	6.0%	6.1%	6.1%
30	5.9%	6.0%	n/a	n/a	6.0%	6.0%	5.9%
40	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.0%	6.0%	n/a	n/a	5.9%	6.0%	6.0%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.2%	6.1%	6.1%
40	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
60	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
Unlimited	6.1%	6.1%	n/a	n/a	6.2%	6.2%	6.1%
SMALL GROUP				**$5 Copay**			
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.0%	n/a	n/a	6.1%	6.1%	6.1%
40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
60	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
SMALL GROUP				**$10 Copay**			
20	6.0%	6.0%	n/a	n/a	6.0%	6.1%	6.0%
30	6.0%	6.1%	n/a	n/a	6.0%	6.1%	6.0%
40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.2%	6.1%	n/a	n/a	6.2%	6.1%	6.2%
SMALL GROUP				**$15 Copay**			
20	6.1%	6.0%	n/a	n/a	6.1%	6.0%	6.1%
30	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
40	6.1%	6.1%	n/a	n/a	6.2%	6.2%	6.1%
60	6.0%	6.1%	n/a	n/a	6.0%	6.0%	6.0%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP				**$20 Copay**			
20	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
30	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%
40	6.0%	6.0%	n/a	n/a	5.9%	6.1%	6.0%
60	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
Unlimited	6.2%	6.2%	n/a	n/a	6.2%	6.2%	6.2%
SMALL GROUP				**$25 Copay**			
20	6.1%	6.1%	n/a	n/a	6.0%	6.0%	6.1%
30	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
40	6.1%	6.2%	n/a	n/a	6.1%	6.2%	6.1%
60	6.2%	6.1%	n/a	n/a	6.2%	6.1%	6.2%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP				**$30 Copay**			
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.0%	6.0%	n/a	n/a	6.1%	6.0%	6.0%
40	6.1%	6.1%	n/a	n/a	6.2%	6.2%	6.1%
60	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
Unlimited	6.1%	6.2%	n/a	n/a	6.2%	6.2%	6.1%
SMALL GROUP				**$35 Copay**			
20	6.1%	6.0%	n/a	n/a	6.1%	6.0%	6.1%
30	6.2%	6.2%	n/a	n/a	6.3%	6.2%	6.2%
40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
60	6.0%	6.0%	n/a	n/a	6.1%	6.0%	6.0%
Unlimited	6.2%	6.2%	n/a	n/a	6.1%	6.1%	6.2%
SMALL GROUP				**$40 Copay**			
20	6.0%	6.0%	n/a	n/a	6.0%	6.1%	6.0%
30	6.2%	6.1%	n/a	n/a	6.1%	6.2%	6.2%
40	6.1%	6.1%	n/a	n/a	6.2%	6.1%	6.1%
60	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
Unlimited	6.1%	6.2%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP				**$45 Copay**			
20	6.2%	6.3%	n/a	n/a	6.2%	6.2%	6.2%
30	6.2%	6.1%	n/a	n/a	6.2%	6.2%	6.2%
40	6.1%	6.1%	n/a	n/a	6.0%	6.1%	6.1%
60	6.0%	6.0%	n/a	n/a	6.1%	6.0%	6.0%
Unlimited	6.2%	6.2%	n/a	n/a	6.2%	6.2%	6.2%
SMALL GROUP				**$50 Copay**			
20	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
30	6.1%	6.1%	n/a	n/a	6.1%	6.2%	6.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	4.62	12.47	na	na	8.55	9.70	13.86
60	4.86	13.12	na	na	8.99	10.21	14.58
Unlimited	4.89	13.20	na	na	9.05	10.27	14.67
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40	4.90	13.23	na	na	9.07	10.29	14.70
60	5.16	13.93	na	na	9.55	10.84	15.48
Unlimited	5.19	14.01	na	na	9.60	10.90	15.57
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	0.28	0.76	na	na	0.52	0.59	0.84
60	0.30	0.81	na	na	0.56	0.63	0.90
Unlimited	0.30	0.81	na	na	0.55	0.63	0.90
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
60	6.2%	6.2%	n/a	n/a	6.2%	6.2%	6.2%
Unlimited	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	4.89	13.20	na	na	9.05	10.27	14.67
$0/Max $5000	4.62	12.47	na	na	8.55	9.70	13.86
$0/Max $2500	4.34	11.72	na	na	8.03	9.11	13.02
$25	4.62	12.47	na	na	8.55	9.70	13.86
$50	4.34	11.72	na	na	8.03	9.11	13.02
$100	3.99	10.77	na	na	7.38	8.38	11.97
$500	1.92	5.18	na	na	3.55	4.03	5.76
$5,000	0.31	0.84	na	na	0.57	0.65	0.93
Coinsurance							
20%	3.91	10.56	na	na	7.23	8.21	11.73
25%	3.68	9.94	na	na	6.81	7.73	11.04
30%	3.42	9.23	na	na	6.33	7.18	10.26
Deductible			**Orthotics Riders**				
$0	0.84	2.27	na	na	1.55	1.76	2.52
$0/Max $5000	0.79	2.13	na	na	1.46	1.66	2.37
$0/Max $2500	0.75	2.03	na	na	1.39	1.58	2.25
$25	0.79	2.13	na	na	1.46	1.66	2.37
$50	0.75	2.03	na	na	1.39	1.58	2.25
$100	0.68	1.84	na	na	1.26	1.43	2.04
$500	0.35	0.95	na	na	0.65	0.74	1.05
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
Coinsurance							
20%	0.68	1.84	na	na	1.26	1.43	2.04
25%	0.65	1.76	na	na	1.20	1.37	1.95
30%	0.61	1.65	na	na	1.13	1.28	1.83
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.62	4.37	na	na	3.00	3.40	4.86
12 Months	2.59	6.99	na	na	4.79	5.44	7.77
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.53	6.83	na	na	4.68	5.31	7.59
12 Months	4.04	10.91	na	na	7.47	8.48	12.12
			Private Duty Nursing Riders				
In Full	0.65	1.76	na	na	1.20	1.37	1.95
80% hrs 73-504	0.09	0.24	na	na	0.17	0.19	0.27
100% hrs 73-504	0.18	0.49	na	na	0.33	0.38	0.54
			Dental Network Access				
	0.49	1.32	na	na	0.91	1.03	1.47
Limit			**Infertility Rider**				
2 IVF	10.32	27.86	na	na	19.09	21.67	30.96
3 IVF	12.48	33.70	na	na	23.09	26.21	37.44
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.26	11.50	na	na	7.88	8.95	12.78
			Health Club Reimbursement				
$200 per year	1.22	3.29	na	na	2.26	2.56	3.66
			Wellness Rider				
Inclusion	1.00	2.70	na	na	1.85	2.10	3.00
			Nurse Advice Line Rider				
	0.31	0.84	na	na	0.57	0.65	0.93

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
April 01, 2013 - June 30, 2013 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	5.19	14.01	na	na	9.60	10.90	15.57
$0/Max $5000	4.90	13.23	na	na	9.07	10.29	14.70
$0/Max $2500	4.60	12.42	na	na	8.51	9.66	13.80
$25	4.90	13.23	na	na	9.07	10.29	14.70
$50	4.60	12.42	na	na	8.51	9.66	13.80
$100	4.23	11.42	na	na	7.83	8.88	12.69
$500	2.04	5.51	na	na	3.77	4.28	6.12
$5,000	0.33	0.89	na	na	0.61	0.69	0.99
Coinsurance							
20%	4.15	11.21	na	na	7.68	8.72	12.45
25%	3.90	10.53	na	na	7.22	8.19	11.70
30%	3.63	9.80	na	na	6.72	7.62	10.89
Deductible			**Orthotics Riders**				
$0	0.90	2.43	na	na	1.67	1.89	2.70
$0/Max $5000	0.83	2.24	na	na	1.54	1.74	2.49
$0/Max $2500	0.79	2.13	na	na	1.46	1.66	2.37
$25	0.83	2.24	na	na	1.54	1.74	2.49
$50	0.79	2.13	na	na	1.46	1.66	2.37
$100	0.72	1.94	na	na	1.33	1.51	2.16
$500	0.37	1.00	na	na	0.68	0.78	1.11
$5,000	0.03	0.08	na	na	0.06	0.06	0.09
Coinsurance							
20%	0.72	1.94	na	na	1.33	1.51	2.16
25%	0.69	1.86	na	na	1.28	1.45	2.07
30%	0.65	1.76	na	na	1.20	1.37	1.95
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.72	4.64	na	na	3.18	3.61	5.16
12 Months	2.75	7.43	na	na	5.09	5.78	8.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.69	7.26	na	na	4.98	5.65	8.07
12 Months	4.28	11.56	na	na	7.92	8.99	12.84
			Private Duty Nursing Riders				
In Full	0.69	1.86	na	na	1.28	1.45	2.07
80% hrs 73-504	0.09	0.24	na	na	0.17	0.19	0.27
100% hrs 73-504	0.20	0.54	na	na	0.37	0.42	0.60
			Dental Network Access				
	0.52	1.40	na	na	0.96	1.09	1.56
Limit			**Infertility Rider**				
2 IVF	10.95	29.57	na	na	20.26	23.00	32.85
3 IVF	13.24	35.75	na	na	24.49	27.80	39.72
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.52	12.20	na	na	8.36	9.49	13.56
			Health Club Reimbursement				
$200 per year	1.30	3.51	na	na	2.41	2.73	3.90
			Wellness Rider				
Inclusion	1.06	2.86	na	na	1.96	2.23	3.18
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.69	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	0.30	0.81	na	na	0.55	0.63	0.90
$0/Max $5000	0.28	0.76	na	na	0.52	0.59	0.84
$0/Max $2500	0.26	0.70	na	na	0.48	0.55	0.78
$25	0.28	0.76	na	na	0.52	0.59	0.84
$50	0.26	0.70	na	na	0.48	0.55	0.78
$100	0.24	0.65	na	na	0.45	0.50	0.72
$500	0.12	0.33	na	na	0.22	0.25	0.36
$5,000	0.02	0.05	na	na	0.04	0.04	0.06
Coinsurance							
20%	0.24	0.65	na	na	0.45	0.51	0.72
25%	0.22	0.59	na	na	0.41	0.46	0.66
30%	0.21	0.57	na	na	0.39	0.44	0.63
Deductible			**Orthotics Riders**				
$0	0.06	0.16	na	na	0.12	0.13	0.18
$0/Max $5000	0.04	0.11	na	na	0.08	0.08	0.12
$0/Max $2500	0.04	0.10	na	na	0.07	0.08	0.12
$25	0.04	0.11	na	na	0.08	0.08	0.12
$50	0.04	0.10	na	na	0.07	0.08	0.12
$100	0.04	0.10	na	na	0.07	0.08	0.12
$500	0.02	0.05	na	na	0.03	0.04	0.06
$5,000	-	-	na	na	-	-	-
Coinsurance							
20%	0.04	0.10	na	na	0.07	0.08	0.12
25%	0.04	0.10	na	na	0.08	0.08	0.12
30%	0.04	0.11	na	na	0.07	0.09	0.12
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.10	0.27	na	na	0.18	0.21	0.30
12 Months	0.16	0.44	na	na	0.30	0.34	0.48
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.16	0.43	na	na	0.30	0.34	0.48
12 Months	0.24	0.65	na	na	0.45	0.51	0.72
			Private Duty Nursing Riders				
In Full	0.04	0.10	na	na	0.08	0.08	0.12
80% hrs 73-504	-	-	na	na	-	-	-
100% hrs 73-504	0.02	0.05	na	na	0.04	0.04	0.06
			Dental Network Access				
	0.03	0.08	na	na	0.05	0.06	0.09
Limit			**Infertility Rider**				
2 IVF	0.63	1.71	na	na	1.17	1.33	1.89
3 IVF	0.76	2.05	na	na	1.40	1.59	2.28
			Complementary Alternative Medicine (CAM)				
$20 Copay	0.26	0.70	na	na	0.48	0.54	0.78
			Health Club Reimbursement				
$200 per year	0.08	0.22	na	na	0.15	0.17	0.24
			Wellness Rider				
Inclusion	0.06	0.16	na	na	0.11	0.13	0.18
			Nurse Advice Line Rider				
	0.02	0.05	na	na	0.04	0.04	0.06

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2nd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$0/Max $5000	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$0/Max $2500	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
$25	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
$50	6.0%	6.0%	n/a	n/a	6.0%	6.0%	6.0%
$100	6.0%	6.0%	n/a	n/a	6.1%	6.0%	6.0%
$500	6.3%	6.4%	n/a	n/a	6.2%	6.2%	6.3%
$5,000	6.5%	6.0%	n/a	n/a	7.0%	6.2%	6.5%
Coinsurance							
20%	6.1%	6.2%	n/a	n/a	6.2%	6.2%	6.1%
25%	6.0%	5.9%	n/a	n/a	6.0%	6.0%	6.0%
30%	6.1%	6.2%	n/a	n/a	6.2%	6.1%	6.1%
Deductible			**Orthotics Riders**				
$0	7.1%	7.0%	n/a	n/a	7.7%	7.4%	7.1%
$0/Max $5000	5.1%	5.2%	n/a	n/a	5.5%	4.8%	5.1%
$0/Max $2500	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
$25	5.1%	5.2%	n/a	n/a	5.5%	4.8%	5.1%
$50	5.3%	4.9%	n/a	n/a	5.0%	5.1%	5.3%
$100	5.9%	5.4%	n/a	n/a	5.6%	5.6%	5.9%
$500	5.7%	5.3%	n/a	n/a	4.6%	5.4%	5.7%
$5,000	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Coinsurance							
20%	5.9%	5.4%	n/a	n/a	5.6%	5.6%	5.9%
25%	6.2%	5.7%	n/a	n/a	6.7%	5.8%	6.2%
30%	6.6%	6.7%	n/a	n/a	6.2%	7.0%	6.6%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	6.2%	6.2%	n/a	n/a	6.0%	6.2%	6.2%
12 Months	6.2%	6.3%	n/a	n/a	6.3%	6.3%	6.2%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	6.3%	6.3%	n/a	n/a	6.4%	6.4%	6.3%
12 Months	5.9%	6.0%	n/a	n/a	6.0%	6.0%	5.9%
			Private Duty Nursing Riders				
In Full	6.2%	5.7%	n/a	n/a	6.7%	5.8%	6.2%
80% hrs 73-504	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
100% hrs 73-504	11.1%	10.2%	n/a	n/a	12.1%	10.5%	11.1%
			Dental Network Access				
	6.1%	6.1%	n/a	n/a	5.5%	5.8%	6.1%
Limit			**Infertility Rider**				
2 IVF	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
3 IVF	6.1%	6.1%	n/a	n/a	6.1%	6.1%	6.1%
			Complementary Alternative Medicine (CAM)				
$20 Copay	6.1%	6.1%	n/a	n/a	6.1%	6.0%	6.1%
			Health Club Reimbursement				
$200 per year	6.6%	6.7%	n/a	n/a	6.6%	6.6%	6.6%
			Wellness Rider				
Inclusion	6.0%	5.9%	n/a	n/a	5.9%	6.2%	6.0%
			Nurse Advice Line Rider				
	6.5%	6.0%	n/a	n/a	7.0%	6.2%	6.5%

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

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not availa**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2012
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
April 01, 2013 - June 30, 2013 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO,	**1.000**	**1.074**
New York City, Westchester, Rockland and Orange Counties			
Upstate[2]			
	HMO,	**1.000**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**-**	**-**
	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)**
Upstate[2]			
	HMO, HIP*access* I	**-**	
	POS	**(1.000)**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**-**
Access I Groups	**(1.150)**
POS Groups	**(1.150)**
Access II Groups	**(1.150)**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**-100.0%**	**-100.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
Upstate[2]			
	HMO, HIP*access* I	**0.0%**	
	POS	**-100.0%**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**0.0%**
Access I Groups	**-100.0%**
POS Groups	**-100.0%**
Access II Groups	**-100.0%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd QUARTER 2012 SMALL GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
APRIL 1, 2012 - JUNE 30, 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

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2011 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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
April 01, 2013 - June 30, 2013 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

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$2,500	27.61	53.20	6.20
$3,000	27.61	57.90	7.00
$4,000	27.61	65.00	8.20
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$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
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$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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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

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+ 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	-	-	-
$750 *	-	-	-
$1,000	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
Unlimited	-	-	-

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	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
2nd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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.

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+ Base Generic PMPM Value (Table 1a)
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+ Base Non-Formulary Brand PMPM Value (Table 1c)
- Generic Copay x Generic Copay PMPM Value (Table 2a)
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- 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	0.012	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 Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	2.50%
1Q2010-1Q2011	2.50%
2Q2011	4.10%
3Q2011-4Q2011	3.00%
1Q2012	3.00%
2Q2012	3.00%

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.2692
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.5576	2.5427
Family	3.6537	3.6324

$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 Adjustm Applies only to New York City account	-10.0%	
[e] IC Adjustmer Applies only to New York City account	-2.0%	
[f] Product Facto HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
$0	HMO	CompreHealth HMO
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
	0.0%	0.0%
[h] Mandatory Women's Preventive Services HMO/POS	0.58	0.60

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2179
Family	3.2883	3.2883
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2179
EE + Child(ren	2.2531	2.2531
EE + Spouse	2.5576	2.5576
Family	3.6537	3.6537

$0	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates	
[a] Exclude Contraceptives	-	
[b] Annual Maximum to also include Generic Drugs:	-	
$1,000 (Brand & Generic)	-	
$2,000 (Brand & Generic)	-	
$2,500 (Brand & Generic)	-	
$3,000 (Brand & Generic)	-	
$4,000 (Brand & Generic)	-	
$5,000 (Brand & Generic)	-	
[c] Non Formulary Coverage, Generic Only Plans	-	
[d] PICA Adjustm Applies only to New York City account	-	
[e] IC Adjustmer Applies only to New York City account	-	
[f] Product Facto HMO, Access I, and EPO	-	
POS, Access II, and PPO	-	
[g] Trend per Quarter		
1Q2010-1Q2011	-	
2Q2011	-	
3Q2011-4Q2011	-	-
1Q2012	-	-
2Q 2012 - 4Q 2012	-	-
1Q2013	(0.063)	-
2Q2013	0.030	-
	-	-
[h] Mandatory W $0	0.580	0.600

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	-	0.007
Family	-	0.019
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	-	0.007
EE + Child(ren	-	0.013
EE + Spouse	-	0.015
Family	-	0.021

$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	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 Adjustmer Applies only to New York City account	0.0%
[f] Product Facto HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
1Q2010-1Q2011	0.0%
2Q2011	0.0%
3Q2011-4Q2011	0.0%
1Q2012	0.0%
2Q 2012 - 4Q 2012	0.0%
$0	#VALUE!
1Q2013	#DIV/0!
$0	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	0.0%	0.6%
Family	0.0%	0.6%
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	0.0%	0.6%
EE + Child(ren	0.0%	0.6%
EE + Spouse	0.0%	0.6%
Family	0.0%	0.6%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small 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

Small Groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Inpatient Mental Health Subsidy
+	Outpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Outpatient Mental Health Subsidy
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor
x	Sole Proprientor Factor

Example: Small Group HMO Individual Employee Rate Example

=	709.61	3rd Quarter	(Base Rate
+	(5.82)	$10 Specialist visit copay	Optional Base Benefit Variables (excluding Mental Health)
+	7.39	30 Days	Inpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	30 Days	Small Group Inpatient Mental Health Subsidy
+	6.40	$10 copay, 20 visits	Outpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	$10 copay, 20 visits	Small Group Outpatient Mental Health Subsidy
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.00	Standard Coverage	Optional Dependent Care Coverage
x	1.00	Standard Coverage	Network Area Factor
x	1.00	> 1 Employee Group	Sole Proprientor Factor
	717.58		Individual Employee Rate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

3rd Quarter Small Group RATE MANUAL

HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS

July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Effective 07/01/2013 - 09/30/2013 (With WH & Autism)				
Small Group*	709.61	1,915.95	na	na	1,312.78	1,667.58	2,128.83
Classic*	506.46	1,367.44	na	na	936.95	1,190.18	1,519.38
			Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)				
Small Group*	702.58	1,896.97	na	na	1,299.77	1,651.06	2,107.74
Classic*	501.45	1,353.92	na	na	927.68	1,178.41	1,504.35

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK

3rd Quarter Small Group RATE MANUAL

HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES

July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$5	(3.99)	(10.77)	na	na	(7.38)	(9.38)	(11.97)
$10	(8.37)	(22.60)	na	na	(15.48)	(19.67)	(25.11)
$15	(13.91)	(37.56)	na	na	(25.73)	(32.69)	(41.73)
$20	(21.47)	(57.97)	na	na	(39.72)	(50.45)	(64.41)
$25	(28.29)	(76.38)	na	na	(52.34)	(66.48)	(84.87)
$30	(35.76)	(96.55)	na	na	(66.16)	(84.04)	(107.28)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.28)	(6.16)	na	na	(4.22)	(5.36)	(6.84)
$10	(4.79)	(12.93)	na	na	(8.86)	(11.26)	(14.37)
$15	(7.97)	(21.52)	na	na	(14.74)	(18.73)	(23.91)
$20	(12.30)	(33.21)	na	na	(22.76)	(28.91)	(36.90)
$25	(16.20)	(43.74)	na	na	(29.97)	(38.07)	(48.60)
$30	(20.50)	(55.35)	na	na	(37.93)	(48.18)	(61.50)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.81)	(7.59)	na	na	(5.20)	(6.60)	(8.43)
$10	(5.82)	(15.71)	na	na	(10.77)	(13.68)	(17.46)
$15	(9.12)	(24.62)	na	na	(16.87)	(21.43)	(27.36)
$20	(12.85)	(34.70)	na	na	(23.77)	(30.20)	(38.55)
$25	(16.96)	(45.79)	na	na	(31.38)	(39.86)	(50.88)
$30	(21.60)	(58.32)	na	na	(39.96)	(50.76)	(64.80)
$35	(25.97)	(70.12)	na	na	(48.04)	(61.03)	(77.91)
$40	(35.07)	(94.69)	na	na	(64.88)	(82.41)	(105.21)
$45	(35.25)	(95.18)	na	na	(65.21)	(82.84)	(105.75)
$50	(40.24)	(108.65)	na	na	(74.44)	(94.56)	(120.72)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$5	(2.38)	(6.43)	na	na	(4.40)	(5.59)	(7.14)
$10	(4.92)	(13.28)	na	na	(9.10)	(11.56)	(14.76)
$15	(7.71)	(20.82)	na	na	(14.26)	(18.12)	(23.13)
$20	(10.88)	(29.38)	na	na	(20.13)	(25.57)	(32.64)
$25	(14.34)	(38.72)	na	na	(26.53)	(33.70)	(43.02)
$30	(18.27)	(49.33)	na	na	(33.80)	(42.93)	(54.81)
$35	(21.95)	(59.27)	na	na	(40.61)	(51.58)	(65.85)
$40	(29.65)	(80.06)	na	na	(54.85)	(69.68)	(88.95)
$45	(29.80)	(80.46)	na	na	(55.13)	(70.03)	(89.40)
$50	(34.02)	(91.85)	na	na	(62.94)	(79.95)	(102.06)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.14)	(5.78)	na	na	(3.96)	(5.03)	(6.42)
$150	(3.53)	(9.53)	na	na	(6.53)	(8.30)	(10.59)
$200	(5.04)	(13.61)	na	na	(9.32)	(11.84)	(15.12)
$250	(7.21)	(19.47)	na	na	(13.34)	(16.94)	(21.63)
$500	(17.29)	(46.68)	na	na	(31.99)	(40.63)	(51.87)
$750	(29.73)	(80.27)	na	na	(55.00)	(69.87)	(89.19)
$1,000	(44.70)	(120.69)	na	na	(82.70)	(105.05)	(134.10)
Copay/Day							
$50 w/3 Day Max	(2.60)	(7.02)	na	na	(4.81)	(6.11)	(7.80)
$50 w/5 Day Max	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)
$100 w/3 Day Max	(6.49)	(17.52)	na	na	(12.01)	(15.25)	(19.47)
$100 w/5 Day Max	(9.36)	(25.27)	na	na	(17.32)	(22.00)	(28.08)
$250 w/3 Day Max	(21.54)	(58.16)	na	na	(39.85)	(50.62)	(64.62)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.17)	(3.16)	na	na	(2.16)	(2.75)	(3.51)
$75	(1.91)	(5.16)	na	na	(3.53)	(4.49)	(5.73)
$100	(2.73)	(7.37)	na	na	(5.05)	(6.42)	(8.19)
$125	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)
$150	(4.47)	(12.07)	na	na	(8.27)	(10.50)	(13.41)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$15	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
$25	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
$35	(1.25)	(3.38)	na	na	(2.31)	(2.94)	(3.75)
$50	(2.13)	(5.75)	na	na	(3.94)	(5.01)	(6.39)
$60	(2.71)	(7.32)	na	na	(5.01)	(6.37)	(8.13)
$75	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)
$100	(5.06)	(13.66)	na	na	(9.36)	(11.89)	(15.18)
$125	(6.23)	(16.82)	na	na	(11.53)	(14.64)	(18.69)
$150	(7.45)	(20.12)	na	na	(13.78)	(17.51)	(22.35)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.64	1.73	na	na	1.18	1.50	1.92
60	1.19	3.21	na	na	2.20	2.80	3.57
90	1.81	4.89	na	na	3.35	4.25	5.43
120	2.13	5.75	na	na	3.94	5.01	6.39
Unlimited	2.74	7.40	na	na	5.07	6.44	8.22
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
40/$15 copay	(0.47)	(1.27)	na	na	(0.87)	(1.10)	(1.41)
40/$20 copay	(0.69)	(1.86)	na	na	(1.28)	(1.62)	(2.07)
40/$25 copay	(0.90)	(2.43)	na	na	(1.67)	(2.12)	(2.70)
60	0.33	0.89	na	na	0.61	0.78	0.99
100	0.79	2.13	na	na	1.46	1.86	2.37
200	2.13	5.75	na	na	3.94	5.01	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	(1.27)	(3.43)	na	na	(2.35)	(2.98)	(3.81)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.82	2.21	na	na	1.52	1.93	2.46
90	1.75	4.73	na	na	3.24	4.11	5.25
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.74	2.00	na	na	1.37	1.74	2.22
90	1.38	3.73	na	na	2.55	3.24	4.14
120	2.20	5.94	na	na	4.07	5.17	6.60

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.06)	(2.86)	na	na	(1.96)	(2.49)	(3.18)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.32	0.86	na	na	0.59	0.75	0.96
30	0.48	1.30	na	na	0.89	1.13	1.44
Unlimited	0.74	2.00	na	na	1.37	1.74	2.22
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.75	10.13	na	na	6.94	8.81	11.25
60	4.38	11.83	na	na	8.10	10.29	13.14
90	5.24	14.15	na	na	9.69	12.31	15.72
Unlimited	5.31	14.34	na	na	9.82	12.48	15.93
	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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
60/$15 copay	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.76)	(2.05)	na	na	(1.41)	(1.79)	(2.28)
120/$0 copay	0.67	1.81	na	na	1.24	1.57	2.01
120/$5 copay	0.48	1.30	na	na	0.89	1.13	1.44
120/$10 copay	0.30	0.81	na	na	0.56	0.71	0.90
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
Unlimited/$0 copay	0.75	2.03	na	na	1.39	1.76	2.25
Unlimited/$5 copay	0.60	1.62	na	na	1.11	1.41	1.80
Unlimited/$10 copay	0.37	1.00	na	na	0.68	0.87	1.11
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	0.23	0.62	na	na	0.43	0.54	0.69
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$25	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$15	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
$20	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
$25	(0.94)	(2.54)	na	na	(1.74)	(2.21)	(2.82)
$30	(1.12)	(3.02)	na	na	(2.07)	(2.63)	(3.36)
$35	(1.34)	(3.62)	na	na	(2.48)	(3.15)	(4.02)
$40	(1.53)	(4.13)	na	na	(2.83)	(3.60)	(4.59)
$45	(1.76)	(4.75)	na	na	(3.26)	(4.14)	(5.28)
$50	(1.96)	(5.29)	na	na	(3.63)	(4.61)	(5.88)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$15	(0.55)	(1.49)	na	na	(1.02)	(1.29)	(1.65)
$20	(0.79)	(2.13)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.08)	(2.92)	na	na	(2.00)	(2.54)	(3.24)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.36)	(0.97)	na	na	(0.67)	(0.85)	(1.08)
$60	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.62)	(1.67)	na	na	(1.15)	(1.46)	(1.86)
$100	(0.79)	(2.13)	na	na	(1.46)	(1.86)	(2.37)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$60	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$75	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.55)	(1.49)	na	na	(1.02)	(1.29)	(1.65)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.39)	(9.15)	na	na	(6.27)	(7.97)	(10.17)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.23)	(14.12)	na	na	(9.68)	(12.29)	(15.69)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.43)	(1.16)	na	na	(0.80)	(1.01)	(1.29)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.15	11.21	na	na	7.68	9.75	12.45
60	5.86	15.82	na	na	10.84	13.77	17.58
90	6.95	18.77	na	na	12.86	16.33	20.85
Unlimited	7.03	18.98	na	na	13.01	16.52	21.09
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.39	19.95	na	na	13.67	17.37	22.17
60	7.81	21.09	na	na	14.45	18.35	23.43
90	8.10	21.87	na	na	14.99	19.04	24.30
Unlimited	8.17	22.06	na	na	15.11	19.20	24.51
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	5.63	15.20	na	na	10.42	13.23	16.89
30	6.70	18.09	na	na	12.40	15.75	20.10
40	7.37	19.90	na	na	13.63	17.32	22.11
60	8.06	21.76	na	na	14.91	18.94	24.18
Unlimited	8.13	21.95	na	na	15.04	19.11	24.39
SMALL GROUP				**$5 Copay**			
20	5.30	14.31	na	na	9.81	12.46	15.90
30	6.29	16.98	na	na	11.64	14.78	18.87
40	6.94	18.74	na	na	12.84	16.31	20.82
60	7.58	20.47	na	na	14.02	17.81	22.74
Unlimited	7.66	20.68	na	na	14.17	18.00	22.98

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$10 Copay**			
20	4.93	13.31	na	na	9.12	11.59	14.79
30	5.87	15.85	na	na	10.86	13.79	17.61
40	6.46	17.44	na	na	11.95	15.18	19.38
60	7.07	19.09	na	na	13.08	16.61	21.21
Unlimited	7.14	19.28	na	na	13.21	16.78	21.42
SMALL GROUP				**$15 Copay**			
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.52	14.90	na	na	10.21	12.97	16.56
40	6.08	16.42	na	na	11.25	14.29	18.24
60	6.63	17.90	na	na	12.27	15.58	19.89
Unlimited	6.71	18.12	na	na	12.41	15.77	20.13
SMALL GROUP				**$20 Copay**			
20	4.35	11.75	na	na	8.05	10.22	13.05
30	5.17	13.96	na	na	9.56	12.15	15.51
40	5.70	15.39	na	na	10.55	13.40	17.10
60	6.23	16.82	na	na	11.53	14.64	18.69
Unlimited	6.27	16.93	na	na	11.60	14.73	18.81
SMALL GROUP				**$25 Copay**			
20	4.06	10.96	na	na	7.51	9.54	12.18
30	4.82	13.01	na	na	8.92	11.33	14.46
40	5.31	14.34	na	na	9.82	12.48	15.93
60	5.80	15.66	na	na	10.73	13.63	17.40
Unlimited	5.87	15.85	na	na	10.86	13.79	17.61
SMALL GROUP				**$30 Copay**			
20	3.89	10.50	na	na	7.20	9.14	11.67
30	4.66	12.58	na	na	8.62	10.95	13.98
40	5.12	13.82	na	na	9.47	12.03	15.36
60	5.60	15.12	na	na	10.36	13.16	16.80
Unlimited	5.65	15.26	na	na	10.45	13.28	16.95

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$35 Copay**			
20	3.79	10.23	na	na	7.01	8.91	11.37
30	4.50	12.15	na	na	8.33	10.58	13.50
40	4.97	13.42	na	na	9.19	11.68	14.91
60	5.44	14.69	na	na	10.06	12.78	16.32
Unlimited	5.49	14.82	na	na	10.16	12.90	16.47
SMALL GROUP				**$40 Copay**			
20	3.70	9.99	na	na	6.85	8.70	11.10
30	4.37	11.80	na	na	8.08	10.27	13.11
40	4.82	13.01	na	na	8.92	11.33	14.46
60	5.28	14.26	na	na	9.77	12.41	15.84
Unlimited	5.33	14.39	na	na	9.86	12.53	15.99
SMALL GROUP				**$45 Copay**			
20	3.56	9.61	na	na	6.59	8.37	10.68
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.68	12.64	na	na	8.66	11.00	14.04
60	5.11	13.80	na	na	9.45	12.01	15.33
Unlimited	5.15	13.91	na	na	9.53	12.10	15.45
SMALL GROUP				**$50 Copay**			
20	3.47	9.37	na	na	6.42	8.15	10.41
30	4.12	11.12	na	na	7.62	9.68	12.36
40	4.53	12.23	na	na	8.38	10.65	13.59
60	4.96	13.39	na	na	9.18	11.66	14.88
Unlimited	4.99	13.47	na	na	9.23	11.73	14.97

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.30	19.71	na	na	13.51	17.16	21.90
30	8.03	21.68	na	na	14.86	18.87	24.09
40	8.49	22.92	na	na	15.71	19.95	25.47
60	8.96	24.19	na	na	16.58	21.06	26.88
Unlimited	9.06	24.46	na	na	16.76	21.29	27.18
SMALL GROUP				**$5 Copay**			
20	6.86	18.52	na	na	12.69	16.12	20.58
30	7.56	20.41	na	na	13.99	17.77	22.68
40	7.98	21.55	na	na	14.76	18.75	23.94
60	8.45	22.82	na	na	15.63	19.86	25.35
Unlimited	8.52	23.00	na	na	15.76	20.02	25.56
SMALL GROUP				**$10 Copay**			
20	6.40	17.28	na	na	11.84	15.04	19.20
30	7.03	18.98	na	na	13.01	16.52	21.09
40	7.44	20.09	na	na	13.76	17.48	22.32
60	7.85	21.20	na	na	14.52	18.45	23.55
Unlimited	7.93	21.41	na	na	14.67	18.64	23.79
SMALL GROUP				**$15 Copay**			
20	6.03	16.28	na	na	11.16	14.17	18.09
30	6.62	17.87	na	na	12.25	15.56	19.86
40	6.98	18.85	na	na	12.91	16.40	20.94
60	7.37	19.90	na	na	13.63	17.32	22.11
Unlimited	7.45	20.12	na	na	13.78	17.51	22.35

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.65	15.26	na	na	10.45	13.28	16.95
30	6.21	16.77	na	na	11.49	14.59	18.63
40	6.56	17.71	na	na	12.14	15.42	19.68
60	6.93	18.71	na	na	12.82	16.29	20.79
Unlimited	6.98	18.85	na	na	12.91	16.40	20.94
SMALL GROUP				**$25 Copay**			
20	5.26	14.20	na	na	9.73	12.36	15.78
30	5.78	15.61	na	na	10.69	13.58	17.34
40	6.11	16.50	na	na	11.30	14.36	18.33
60	6.45	17.42	na	na	11.93	15.16	19.35
Unlimited	6.51	17.58	na	na	12.04	15.30	19.53
SMALL GROUP				**$30 Copay**			
20	5.07	13.69	na	na	9.38	11.91	15.21
30	5.58	15.07	na	na	10.32	13.11	16.74
40	5.90	15.93	na	na	10.92	13.87	17.70
60	6.23	16.82	na	na	11.53	14.64	18.69
Unlimited	6.26	16.90	na	na	11.58	14.71	18.78
SMALL GROUP				**$35 Copay**			
20	4.92	13.28	na	na	9.10	11.56	14.76
30	5.43	14.66	na	na	10.05	12.76	16.29
40	5.72	15.44	na	na	10.58	13.44	17.16
60	6.06	16.36	na	na	11.21	14.24	18.18
Unlimited	6.09	16.44	na	na	11.27	14.31	18.27
SMALL GROUP				**$40 Copay**			
20	4.78	12.91	na	na	8.84	11.23	14.34
30	5.26	14.20	na	na	9.73	12.36	15.78
40	5.54	14.96	na	na	10.25	13.02	16.62
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.91	15.96	na	na	10.93	13.89	17.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.08	13.72	na	na	9.40	11.94	15.24
40	5.38	14.53	na	na	9.95	12.64	16.14
60	5.69	15.36	na	na	10.53	13.37	17.07
Unlimited	5.73	15.47	na	na	10.60	13.47	17.19
SMALL GROUP				**$50 Copay**			
20	4.49	12.12	na	na	8.31	10.55	13.47
30	4.93	13.31	na	na	9.12	11.59	14.79
40	5.23	14.12	na	na	9.68	12.29	15.69
60	5.51	14.88	na	na	10.19	12.95	16.53
Unlimited	5.54	14.96	na	na	10.25	13.02	16.62
SMALL GROUP		**Small Group Premium Credit - Outpatient Mental Health**					
Specialist Copay		****[above rates must be reduced by premium credit]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

3rd Quarter Small Group RATE MANUAL

HIP HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 01, 2013 - September 30, 2013 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

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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

Full-time Students

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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%

Class II Dependents

	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
July 01, 2013 - September 30, 2013 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	4.85	13.10	na	na	8.97	11.40	14.55
$0/Max $5000	4.61	12.45	na	na	8.53	10.83	13.83
$0/Max $2500	4.32	11.66	na	na	7.99	10.15	12.96
$25	4.61	12.45	na	na	8.53	10.83	13.83
$50	4.32	11.66	na	na	7.99	10.15	12.96
$100	3.94	10.64	na	na	7.29	9.26	11.82
$500	1.88	5.08	na	na	3.48	4.42	5.64
$5,000	0.32	0.86	na	na	0.59	0.75	0.96
Coinsurance							
80%	3.87	10.45	na	na	7.16	9.09	11.61
75%	3.64	9.83	na	na	6.73	8.55	10.92
70%	3.41	9.21	na	na	6.31	8.01	10.23
Deductible			**Orthotics Riders**				
$0	0.81	2.19	na	na	1.50	1.90	2.43
$0/Max $5000	0.78	2.11	na	na	1.44	1.83	2.34
$0/Max $2500	0.74	2.00	na	na	1.37	1.74	2.22
$25	0.78	2.11	na	na	1.44	1.83	2.34
$50	0.74	2.00	na	na	1.37	1.74	2.22
$100	0.68	1.84	na	na	1.26	1.60	2.04
$500	0.34	0.92	na	na	0.63	0.80	1.02
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.68	1.84	na	na	1.26	1.60	2.04
75%	0.65	1.76	na	na	1.20	1.53	1.95
70%	0.62	1.67	na	na	1.15	1.46	1.86

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.57	4.24	na	na	2.90	3.69	4.71
12 Months	2.53	6.83	na	na	4.68	5.95	7.59
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.46	6.64	na	na	4.55	5.78	7.38
12 Months	3.93	10.61	na	na	7.27	9.24	11.79
			Private Duty Nursing Riders				
In Full	0.60	1.62	na	na	1.11	1.41	1.80
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
			Dental Network Access				
	0.47	1.27	na	na	0.87	1.10	1.41
Limit			**Infertility Rider**				
2 IVF	10.26	27.70	na	na	18.98	24.11	30.78
3 IVF	12.38	33.43	na	na	22.90	29.09	37.14
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.72	12.74	na	na	8.73	11.09	14.16
Health Club Reimbursement							
$200 per year	1.22	3.29	na	na	2.26	2.87	3.66
			Nurse Advice Line Rider				
	0.32	0.86	na	na	0.59	0.75	0.96
Subject to			**Wellness Rider**				
DFS approval	0.80	2.16	na	na	1.48	1.88	2.40

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 07/01/2013 - 09/30/2013 (With WH & Autism)				
Small Group *	500.39	1,421.11	na	na	925.72	1,175.92	1,501.17
			Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)				
Small Group *	495.45	1,407.08	na	na	916.58	1,164.31	1,486.35

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$5	(4.36)	(12.38)	na	na	(8.07)	(10.25)	(13.08)
$10	(9.15)	(25.99)	na	na	(16.93)	(21.50)	(27.45)
$15	(14.16)	(40.21)	na	na	(26.20)	(33.28)	(42.48)
$20	(20.39)	(57.91)	na	na	(37.72)	(47.92)	(61.17)
$25	(37.84)	(107.47)	na	na	(70.00)	(88.92)	(113.52)
$30	(60.12)	(170.74)	na	na	(111.22)	(141.28)	(180.36)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.49)	(7.07)	na	na	(4.61)	(5.85)	(7.47)
$10	(5.25)	(14.91)	na	na	(9.71)	(12.34)	(15.75)
$15	(8.11)	(23.03)	na	na	(15.00)	(19.06)	(24.33)
$20	(11.70)	(33.23)	na	na	(21.65)	(27.50)	(35.10)
$25	(21.68)	(61.57)	na	na	(40.11)	(50.95)	(65.04)
$30	(34.47)	(97.89)	na	na	(63.77)	(81.00)	(103.41)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.09)	(8.78)	na	na	(5.72)	(7.26)	(9.27)
$10	(6.33)	(17.98)	na	na	(11.71)	(14.88)	(18.99)
$15	(9.62)	(27.32)	na	na	(17.80)	(22.61)	(28.86)
$20	(13.08)	(37.15)	na	na	(24.20)	(30.74)	(39.24)
$25	(19.42)	(55.15)	na	na	(35.93)	(45.64)	(58.26)
$30	(27.42)	(77.87)	na	na	(50.73)	(64.44)	(82.26)
$35	(35.87)	(101.87)	na	na	(66.36)	(84.29)	(107.61)
$40	(45.36)	(128.82)	na	na	(83.92)	(106.60)	(136.08)
$45	(55.96)	(158.93)	na	na	(103.53)	(131.51)	(167.88)
$50	(67.69)	(192.24)	na	na	(125.23)	(159.07)	(203.07)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.59)	(7.36)	na	na	(4.79)	(6.09)	(7.77)
$10	(5.35)	(15.19)	na	na	(9.90)	(12.57)	(16.05)
$15	(8.12)	(23.06)	na	na	(15.02)	(19.08)	(24.36)
$20	(11.06)	(31.41)	na	na	(20.46)	(25.99)	(33.18)
$25	(16.42)	(46.63)	na	na	(30.38)	(38.59)	(49.26)
$30	(23.16)	(65.77)	na	na	(42.85)	(54.43)	(69.48)
$35	(30.31)	(86.08)	na	na	(56.07)	(71.23)	(90.93)
$40	(38.37)	(108.97)	na	na	(70.98)	(90.17)	(115.11)
$45	(47.31)	(134.36)	na	na	(87.52)	(111.18)	(141.93)
$50	(57.24)	(162.56)	na	na	(105.89)	(134.51)	(171.72)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

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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	na	na	0.00	0.00	0.00
$100	(2.46)	(6.99)	na	na	(4.55)	(5.78)	(7.38)
$150	(4.12)	(11.70)	na	na	(7.62)	(9.68)	(12.36)
$200	(5.94)	(16.87)	na	na	(10.99)	(13.96)	(17.82)
$250	(8.57)	(24.34)	na	na	(15.85)	(20.14)	(25.71)
$500	(21.08)	(59.87)	na	na	(39.00)	(49.54)	(63.24)
$750	(36.91)	(104.82)	na	na	(68.28)	(86.74)	(110.73)
$1,000	(56.37)	(160.09)	na	na	(104.28)	(132.47)	(169.11)
Copay/Day							
$50 w/3 Day Max	(3.55)	(10.08)	na	na	(6.57)	(8.34)	(10.65)
$50 w/5 Day Max	(4.81)	(13.66)	na	na	(8.90)	(11.30)	(14.43)
$100 w/3 Day Max	(7.58)	(21.53)	na	na	(14.02)	(17.81)	(22.74)
$100 w/5 Day Max	(12.90)	(36.64)	na	na	(23.87)	(30.32)	(38.70)
$250 w/3 Day Max	(25.03)	(71.09)	na	na	(46.31)	(58.82)	(75.09)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.38)	(3.92)	na	na	(2.55)	(3.24)	(4.14)
$75	(2.41)	(6.84)	na	na	(4.46)	(5.66)	(7.23)
$100	(3.63)	(10.31)	na	na	(6.72)	(8.53)	(10.89)
$125	(5.04)	(14.31)	na	na	(9.32)	(11.84)	(15.12)
$150	(6.68)	(18.97)	na	na	(12.36)	(15.70)	(20.04)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.89)	(2.53)	na	na	(1.65)	(2.09)	(2.67)
$35	(1.49)	(4.23)	na	na	(2.76)	(3.50)	(4.47)
$50	(2.47)	(7.01)	na	na	(4.57)	(5.80)	(7.41)
$60	(3.14)	(8.92)	na	na	(5.81)	(7.38)	(9.42)
$75	(4.05)	(11.50)	na	na	(7.49)	(9.52)	(12.15)
$100	(5.68)	(16.13)	na	na	(10.51)	(13.35)	(17.04)
$125	(7.44)	(21.13)	na	na	(13.76)	(17.48)	(22.32)
$150	(9.38)	(26.64)	na	na	(17.35)	(22.04)	(28.14)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.68	1.93	na	na	1.26	1.60	2.04
60	1.31	3.72	na	na	2.42	3.08	3.93
90	1.96	5.57	na	na	3.63	4.61	5.88
120	2.29	6.50	na	na	4.24	5.38	6.87
Unlimited	2.93	8.32	na	na	5.42	6.89	8.79

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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	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.53)	(1.51)	na	na	(0.98)	(1.25)	(1.59)
40/$20 copay	(0.74)	(2.10)	na	na	(1.37)	(1.74)	(2.22)
40/$25 copay	(0.96)	(2.73)	na	na	(1.78)	(2.26)	(2.88)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.85	2.41	na	na	1.57	2.00	2.55
200	2.30	6.53	na	na	4.26	5.41	6.90
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.36)	(3.86)	na	na	(2.52)	(3.20)	(4.08)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.91	2.58	na	na	1.68	2.14	2.73
90	1.89	5.37	na	na	3.50	4.44	5.67
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.80	2.27	na	na	1.48	1.88	2.40
90	1.48	4.20	na	na	2.74	3.48	4.44
120	2.37	6.73	na	na	4.38	5.57	7.11
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.14)	(3.24)	na	na	(2.11)	(2.68)	(3.42)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.55	1.56	na	na	1.02	1.29	1.65
Unlimited	0.80	2.27	na	na	1.48	1.88	2.40
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.05	11.50	na	na	7.49	9.52	12.15
60	4.75	13.49	na	na	8.79	11.16	14.25
90	5.66	16.07	na	na	10.47	13.30	16.98
Unlimited	5.74	16.30	na	na	10.62	13.49	17.22

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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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.66)	(1.87)	na	na	(1.22)	(1.55)	(1.98)
60/$25 copay	(0.76)	(2.16)	na	na	(1.41)	(1.79)	(2.28)
120/$0 copay	0.72	2.04	na	na	1.33	1.69	2.16
120/$5 copay	0.57	1.62	na	na	1.05	1.34	1.71
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.82	2.33	na	na	1.52	1.93	2.46
Unlimited/$5 copay	0.67	1.90	na	na	1.24	1.57	2.01
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.72)	(2.04)	na	na	(1.33)	(1.69)	(2.16)
$25	(0.91)	(2.58)	na	na	(1.68)	(2.14)	(2.73)
$30	(1.14)	(3.24)	na	na	(2.11)	(2.68)	(3.42)
$35	(1.33)	(3.78)	na	na	(2.46)	(3.13)	(3.99)
$40	(1.53)	(4.35)	na	na	(2.83)	(3.60)	(4.59)
$45	(1.75)	(4.97)	na	na	(3.24)	(4.11)	(5.25)
$50	(1.95)	(5.54)	na	na	(3.61)	(4.58)	(5.85)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.55)	(1.56)	na	na	(1.02)	(1.29)	(1.65)
$20	(0.80)	(2.27)	na	na	(1.48)	(1.88)	(2.40)
$25	(1.08)	(3.07)	na	na	(2.00)	(2.54)	(3.24)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.62)	(1.76)	na	na	(1.15)	(1.46)	(1.86)
$100	(0.80)	(2.27)	na	na	(1.48)	(1.88)	(2.40)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.55)	(1.56)	na	na	(1.02)	(1.29)	(1.65)

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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]							
	(3.34)	(9.49)	na	na	(6.18)	(7.85)	(10.02)
Diagnostic and Therapeutic Radiology [std: $0]							
Copay per procedure of minimum (20%, $100); $500 annual maximum							
	(5.22)	(14.82)	na	na	(9.66)	(12.27)	(15.66)
Diagnostic Testing [std: $0]							
Copay per procedure minimum of [20%, $100], $500 annual maximum							
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.40	12.50	na	na	8.14	10.34	13.20
60	5.26	14.94	na	na	9.73	12.36	15.78
90	5.83	16.56	na	na	10.79	13.70	17.49
Unlimited	5.91	16.78	na	na	10.93	13.89	17.73
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.14	20.28	na	na	13.21	16.78	21.42
60	7.53	21.39	na	na	13.93	17.70	22.59
90	7.83	22.24	na	na	14.49	18.40	23.49
Unlimited	7.92	22.49	na	na	14.65	18.61	23.76
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.97	16.95	na	na	11.04	14.03	17.91
30	7.01	19.91	na	na	12.97	16.47	21.03
40	7.69	21.84	na	na	14.23	18.07	23.07
60	8.34	23.69	na	na	15.43	19.60	25.02
Unlimited	8.43	23.94	na	na	15.60	19.81	25.29
SMALL GROUP	**$5 Copay**						
20	5.63	15.99	na	na	10.42	13.23	16.89
30	6.59	18.72	na	na	12.19	15.49	19.77
40	7.22	20.50	na	na	13.36	16.97	21.66
60	7.84	22.27	na	na	14.50	18.42	23.52
Unlimited	7.92	22.49	na	na	14.65	18.61	23.76
SMALL GROUP	**$10 Copay**						
20	5.24	14.88	na	na	9.69	12.31	15.72
30	6.14	17.44	na	na	11.36	14.43	18.42
40	6.73	19.11	na	na	12.45	15.82	20.19
60	7.30	20.73	na	na	13.51	17.16	21.90
Unlimited	7.40	21.02	na	na	13.69	17.39	22.20

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	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$15 Copay**			
20	4.92	13.97	na	na	9.10	11.56	14.76
30	5.76	16.36	na	na	10.66	13.54	17.28
40	6.31	17.92	na	na	11.67	14.83	18.93
60	6.87	19.51	na	na	12.71	16.14	20.61
Unlimited	6.93	19.68	na	na	12.82	16.29	20.79
SMALL GROUP				**$20 Copay**			
20	4.63	13.15	na	na	8.57	10.88	13.89
30	5.42	15.39	na	na	10.03	12.74	16.26
40	5.94	16.87	na	na	10.99	13.96	17.82
60	6.46	18.35	na	na	11.95	15.18	19.38
Unlimited	6.52	18.52	na	na	12.06	15.32	19.56
SMALL GROUP				**$25 Copay**			
20	4.31	12.24	na	na	7.97	10.13	12.93
30	5.05	14.34	na	na	9.34	11.87	15.15
40	5.50	15.62	na	na	10.18	12.93	16.50
60	5.99	17.01	na	na	11.08	14.08	17.97
Unlimited	6.05	17.18	na	na	11.19	14.22	18.15
SMALL GROUP				**$30 Copay**			
20	4.14	11.76	na	na	7.66	9.73	12.42
30	4.87	13.83	na	na	9.01	11.44	14.61
40	5.31	15.08	na	na	9.82	12.48	15.93
60	5.82	16.53	na	na	10.77	13.68	17.46
Unlimited	5.86	16.64	na	na	10.84	13.77	17.58
SMALL GROUP				**$35 Copay**			
20	4.03	11.45	na	na	7.46	9.47	12.09
30	4.72	13.40	na	na	8.73	11.09	14.16
40	5.19	14.74	na	na	9.60	12.20	15.57
60	5.63	15.99	na	na	10.42	13.23	16.89
Unlimited	5.67	16.10	na	na	10.49	13.32	17.01
SMALL GROUP				**$40 Copay**			
20	3.92	11.13	na	na	7.25	9.21	11.76
30	4.59	13.04	na	na	8.49	10.79	13.77
40	5.02	14.26	na	na	9.29	11.80	15.06
60	5.44	15.45	na	na	10.06	12.78	16.32
Unlimited	5.49	15.59	na	na	10.16	12.90	16.47

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	3.80	10.79	na	na	7.03	8.93	11.40
30	4.44	12.61	na	na	8.21	10.43	13.32
40	4.86	13.80	na	na	8.99	11.42	14.58
60	5.28	15.00	na	na	9.77	12.41	15.84
Unlimited	5.31	15.08	na	na	9.82	12.48	15.93
SMALL GROUP				**$50 Copay**			
20	3.68	10.45	na	na	6.81	8.65	11.04
30	4.32	12.27	na	na	7.99	10.15	12.96
40	4.72	13.40	na	na	8.73	11.09	14.16
60	5.11	14.51	na	na	9.45	12.01	15.33
Unlimited	5.17	14.68	na	na	9.56	12.15	15.51
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.08	20.11	na	na	13.10	16.64	21.24
30	7.70	21.87	na	na	14.25	18.10	23.10
40	8.05	22.86	na	na	14.89	18.92	24.15
60	8.45	24.00	na	na	15.63	19.86	25.35
Unlimited	8.54	24.25	na	na	15.80	20.07	25.62
SMALL GROUP				**$5 Copay**			
20	6.66	18.91	na	na	12.32	15.65	19.98
30	7.23	20.53	na	na	13.38	16.99	21.69
40	7.58	21.53	na	na	14.02	17.81	22.74
60	7.95	22.58	na	na	14.71	18.68	23.85
Unlimited	8.04	22.83	na	na	14.87	18.89	24.12
SMALL GROUP				**$10 Copay**			
20	6.22	17.66	na	na	11.51	14.62	18.66
30	6.74	19.14	na	na	12.47	15.84	20.22
40	7.07	20.08	na	na	13.08	16.61	21.21
60	7.42	21.07	na	na	13.73	17.44	22.26
Unlimited	7.49	21.27	na	na	13.86	17.60	22.47
SMALL GROUP				**$15 Copay**			
20	5.84	16.59	na	na	10.80	13.72	17.52
30	6.32	17.95	na	na	11.69	14.85	18.96
40	6.63	18.83	na	na	12.27	15.58	19.89
60	6.95	19.74	na	na	12.86	16.33	20.85
Unlimited	7.04	19.99	na	na	13.02	16.54	21.12

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.48	15.56	na	na	10.14	12.88	16.44
30	5.94	16.87	na	na	10.99	13.96	17.82
40	6.23	17.69	na	na	11.53	14.64	18.69
60	6.54	18.57	na	na	12.10	15.37	19.62
Unlimited	6.62	18.80	na	na	12.25	15.56	19.86
SMALL GROUP				**$25 Copay**			
20	5.09	14.46	na	na	9.42	11.96	15.27
30	5.51	15.65	na	na	10.19	12.95	16.53
40	5.81	16.50	na	na	10.75	13.65	17.43
60	6.09	17.30	na	na	11.27	14.31	18.27
Unlimited	6.15	17.47	na	na	11.38	14.45	18.45
SMALL GROUP				**$30 Copay**			
20	4.93	14.00	na	na	9.12	11.59	14.79
30	5.32	15.11	na	na	9.84	12.50	15.96
40	5.62	15.96	na	na	10.40	13.21	16.86
60	5.88	16.70	na	na	10.88	13.82	17.64
Unlimited	5.93	16.84	na	na	10.97	13.94	17.79
SMALL GROUP				**$35 Copay**			
20	4.77	13.55	na	na	8.82	11.21	14.31
30	5.19	14.74	na	na	9.60	12.20	15.57
40	5.42	15.39	na	na	10.03	12.74	16.26
60	5.69	16.16	na	na	10.53	13.37	17.07
Unlimited	5.75	16.33	na	na	10.64	13.51	17.25
SMALL GROUP				**$40 Copay**			
20	4.64	13.18	na	na	8.58	10.90	13.92
30	5.04	14.31	na	na	9.32	11.84	15.12
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.51	15.65	na	na	10.19	12.95	16.53
Unlimited	5.60	15.90	na	na	10.36	13.16	16.80
SMALL GROUP				**$45 Copay**			
20	4.49	12.75	na	na	8.31	10.55	13.47
30	4.87	13.83	na	na	9.01	11.44	14.61
40	5.10	14.48	na	na	9.44	11.99	15.30
60	5.35	15.19	na	na	9.90	12.57	16.05
Unlimited	5.40	15.34	na	na	9.99	12.69	16.20

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$50 Copay**			
20	4.36	12.38	na	na	8.07	10.25	13.08
30	4.72	13.40	na	na	8.73	11.09	14.16
40	4.95	14.06	na	na	9.16	11.63	14.85
60	5.21	14.80	na	na	9.64	12.24	15.63
Unlimited	5.24	14.88	na	na	9.69	12.31	15.72
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

3rd Quarter Small Group RATE MANUAL

HIP COMPREHEALTH HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 01, 2013 - September 30, 2013 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				
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
			Full-time Students				
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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
July 01, 2013 - September 30, 2013 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	5.24	14.88	na	na	9.69	12.31	15.72
$0/Max $5000	4.95	14.06	na	na	9.16	11.63	14.85
$0/Max $2500	4.65	13.21	na	na	8.60	10.93	13.95
$25	4.95	14.06	na	na	9.16	11.63	14.85
$50	4.65	13.21	na	na	8.60	10.93	13.95
$100	4.27	12.13	na	na	7.90	10.03	12.81
$500	2.06	5.85	na	na	3.81	4.84	6.18
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.19	11.90	na	na	7.75	9.85	12.57
25%	3.94	11.19	na	na	7.29	9.26	11.82
30%	3.67	10.42	na	na	6.79	8.62	11.01
Deductible			**Orthotics Riders**				
$0	0.91	2.58	na	na	1.68	2.14	2.73
$0/Max $5000	0.84	2.39	na	na	1.55	1.97	2.52
$0/Max $2500	0.80	2.27	na	na	1.48	1.88	2.40
$25	0.84	2.39	na	na	1.55	1.97	2.52
$50	0.80	2.27	na	na	1.48	1.88	2.40
$100	0.73	2.07	na	na	1.35	1.72	2.19
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
20%	0.73	2.07	na	na	1.35	1.72	2.19
25%	0.70	1.99	na	na	1.30	1.65	2.10
30%	0.66	1.87	na	na	1.22	1.55	1.98
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.74	4.94	na	na	3.22	4.09	5.22
12 Months	2.78	7.90	na	na	5.14	6.53	8.34
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.72	7.72	na	na	5.03	6.39	8.16
12 Months	4.32	12.27	na	na	7.99	10.15	12.96

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Private Duty Nursing Riders				
In Full	0.70	1.99	na	na	1.30	1.65	2.10
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.53	1.51	na	na	0.98	1.25	1.59
Limit			**Infertility Rider**				
2 IVF	11.06	31.41	na	na	20.46	25.99	33.18
3 IVF	13.37	37.97	na	na	24.73	31.42	40.11
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.57	12.98	na	na	8.45	10.74	13.71
			Health Club Reimbursement				
$200 per year	1.31	3.72	na	na	2.42	3.08	3.93
			Wellness Rider				
Inclusion	1.07	3.04	na	na	1.98	2.51	3.21
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HMO Factors
July 01, 2013 - September 30, 2013

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO	1.000	1.074
New York City, Westchester, Rockland and Orange Counties			
	HMO	1.000	1.028
Upstate[2]			
	HMO	1.000	not available

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	115%

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.
(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
July 01, 2013 - September 30, 2013 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[g]
+ applicable pmpm for Women's Preventive Services Table 4 [h]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS

MONTHLY PREMIUMS EFFECTIVE 2011 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*

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 Adjustmer Applies only to New York City account	-2.0%	
[f] Product Factc HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
	HMO	CompreHealth HMO
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
3Q2013	3.0%	1.0%
[h] Mandatory Women's Preventive Services	$0.60	$0.61

Table 5: Tier Conversion Factors

	HIP	Emblem Coordinated Care Plans
	Small Group	Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

Health Insurance Plan of Greater New York
and HIP Insurance Company of New York

Rating Region Definitions

County	Region
Bronx	Downstate
Kings	Downstate
Nassau	Downstate
New York	Downstate
Orange	Downstate
Queens	Downstate
Richmond	Downstate
Rockland	Downstate
Suffolk	Downstate
Westchester	Downstate

Commissions Schedule

Please see SERFF filing # HPHP-127874918

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group*	686.19	1,852.71	na	na	1,269.45	1,612.55	2,058.57
Classic*	489.75	1,322.33	na	na	906.04	1,150.91	1,469.25
Small Group*	686.19	1,852.71	na	na	1,269.45	1,612.55	2,058.57
Classic*	489.75	1,322.33	na	na	906.04	1,150.91	1,469.25

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 07/01/2013 - 09/30/2013 (With WH & Autism)							
Small Group*	709.61	1,915.95	na	na	1,312.78	1,667.58	2,128.83
Classic*	506.46	1,367.44	na	na	936.95	1,190.18	1,519.38
Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)							
Small Group*	702.58	1,896.97	na	na	1,299.77	1,651.06	2,107.74
Classic*	501.45	1,353.92	na	na	927.68	1,178.41	1,504.35

* Base rates exclude premium component for mandatory mental health coverage

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 07/01/2013 - 09/30/2013 (With WH & Autism)							
Small Gro	23.42	63.24	na	na	43.33	55.03	70.26
Classic*	16.71	45.11	na	na	30.91	39.27	50.13
Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)							
Small Gro	16.39	44.26	na	na	30.32	38.51	49.17
Classic*	11.70	31.59	na	na	21.64	27.50	35.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 07/01/2013 - 09/30/2013 (With WH & Autism)							
Small Gro	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Classic*	3.4%	3.4%	na	na	3.4%	3.4%	3.4%
Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)							
Small Gro	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 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	na	na	0.00	0.00	0.00
$5	(3.89)	(10.50)	na	na	(7.20)	(9.14)	(11.67)
$10	(8.17)	(22.06)	na	na	(15.11)	(19.20)	(24.51)
$15	(13.58)	(36.67)	na	na	(25.12)	(31.91)	(40.74)
$20	(20.96)	(56.59)	na	na	(38.78)	(49.26)	(62.88)
$25	(27.63)	(74.60)	na	na	(51.12)	(64.93)	(82.89)
$30	(34.93)	(94.31)	na	na	(64.62)	(82.09)	(104.79)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.22)	(5.99)	na	na	(4.11)	(5.22)	(6.66)
$10	(4.67)	(12.61)	na	na	(8.64)	(10.97)	(14.01)
$15	(7.78)	(21.01)	na	na	(14.39)	(18.28)	(23.34)
$20	(12.01)	(32.43)	na	na	(22.22)	(28.22)	(36.03)
$25	(15.83)	(42.74)	na	na	(29.29)	(37.20)	(47.49)
$30	(20.02)	(54.05)	na	na	(37.04)	(47.05)	(60.06)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.75)	(7.43)	na	na	(5.09)	(6.46)	(8.25)
$10	(5.69)	(15.36)	na	na	(10.53)	(13.37)	(17.07)
$15	(8.90)	(24.03)	na	na	(16.47)	(20.92)	(26.70)
$20	(12.55)	(33.89)	na	na	(23.22)	(29.49)	(37.65)
$25	(16.56)	(44.71)	na	na	(30.64)	(38.92)	(49.68)
$30	(21.10)	(56.97)	na	na	(39.04)	(49.59)	(63.30)
$35	(25.37)	(68.50)	na	na	(46.93)	(59.62)	(76.11)
$40	(34.25)	(92.48)	na	na	(63.36)	(80.49)	(102.75)
$45	(34.42)	(92.93)	na	na	(63.68)	(80.89)	(103.26)
$50	(39.30)	(106.11)	na	na	(72.71)	(92.36)	(117.90)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.32)	(6.26)	na	na	(4.29)	(5.45)	(6.96)
$10	(4.81)	(12.99)	na	na	(8.90)	(11.30)	(14.43)
$15	(7.53)	(20.33)	na	na	(13.93)	(17.70)	(22.59)
$20	(10.62)	(28.67)	na	na	(19.65)	(24.96)	(31.86)
$25	(14.00)	(37.80)	na	na	(25.90)	(32.90)	(42.00)
$30	(17.84)	(48.17)	na	na	(33.00)	(41.92)	(53.52)
$35	(21.44)	(57.89)	na	na	(39.66)	(50.38)	(64.32)
$40	(28.96)	(78.19)	na	na	(53.58)	(68.06)	(86.88)
$45	(29.11)	(78.60)	na	na	(53.85)	(68.41)	(87.33)
$50	(33.23)	(89.72)	na	na	(61.48)	(78.09)	(99.69)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.10)	(5.67)	na	na	(3.89)	(4.94)	(6.30)
$150	(3.45)	(9.32)	na	na	(6.38)	(8.11)	(10.35)
$200	(4.92)	(13.28)	na	na	(9.10)	(11.56)	(14.76)
$250	(7.05)	(19.04)	na	na	(13.04)	(16.57)	(21.15)
$500	(16.89)	(45.60)	na	na	(31.25)	(39.69)	(50.67)
$750	(29.03)	(78.38)	na	na	(53.71)	(68.22)	(87.09)
$1,000	(43.66)	(117.88)	na	na	(80.77)	(102.60)	(130.98)
Copay/Day							
$50 w/3 Day Max	(2.53)	(6.83)	na	na	(4.68)	(5.95)	(7.59)
$50 w/5 Day Max	(3.49)	(9.42)	na	na	(6.46)	(8.20)	(10.47)
$100 w/3 Day Max	(6.34)	(17.12)	na	na	(11.73)	(14.90)	(19.02)
$100 w/5 Day Max	(9.15)	(24.71)	na	na	(16.93)	(21.50)	(27.45)
$250 w/3 Day Max	(21.03)	(56.78)	na	na	(38.91)	(49.42)	(63.09)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.15)	(3.11)	na	na	(2.13)	(2.70)	(3.45)
$75	(1.86)	(5.02)	na	na	(3.44)	(4.37)	(5.58)
$100	(2.66)	(7.18)	na	na	(4.92)	(6.25)	(7.98)
$125	(3.49)	(9.42)	na	na	(6.46)	(8.20)	(10.47)
$150	(4.36)	(11.77)	na	na	(8.07)	(10.25)	(13.08)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
$25	(0.74)	(2.00)	na	na	(1.37)	(1.74)	(2.22)
$35	(1.21)	(3.27)	na	na	(2.24)	(2.84)	(3.63)
$50	(2.08)	(5.62)	na	na	(3.85)	(4.89)	(6.24)
$60	(2.64)	(7.13)	na	na	(4.88)	(6.20)	(7.92)
$75	(3.49)	(9.42)	na	na	(6.46)	(8.20)	(10.47)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$5	(3.99)	(10.77)	na	na	(7.38)	(9.38)	(11.97)
$10	(8.37)	(22.60)	na	na	(15.48)	(19.67)	(25.11)
$15	(13.91)	(37.56)	na	na	(25.73)	(32.69)	(41.73)
$20	(21.47)	(57.97)	na	na	(39.72)	(50.45)	(64.41)
$25	(28.29)	(76.38)	na	na	(52.34)	(66.48)	(84.87)
$30	(35.76)	(96.55)	na	na	(66.16)	(84.04)	(107.28)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.28)	(6.16)	na	na	(4.22)	(5.36)	(6.84)
$10	(4.79)	(12.93)	na	na	(8.86)	(11.26)	(14.37)
$15	(7.97)	(21.52)	na	na	(14.74)	(18.73)	(23.91)
$20	(12.30)	(33.21)	na	na	(22.76)	(28.91)	(36.90)
$25	(16.20)	(43.74)	na	na	(29.97)	(38.07)	(48.60)
$30	(20.50)	(55.35)	na	na	(37.93)	(48.18)	(61.50)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.81)	(7.59)	na	na	(5.20)	(6.60)	(8.43)
$10	(5.82)	(15.71)	na	na	(10.77)	(13.68)	(17.46)
$15	(9.12)	(24.62)	na	na	(16.87)	(21.43)	(27.36)
$20	(12.85)	(34.70)	na	na	(23.77)	(30.20)	(38.55)
$25	(16.96)	(45.79)	na	na	(31.38)	(39.86)	(50.88)
$30	(21.60)	(58.32)	na	na	(39.96)	(50.76)	(64.80)
$35	(25.97)	(70.12)	na	na	(48.04)	(61.03)	(77.91)
$40	(35.07)	(94.69)	na	na	(64.88)	(82.41)	(105.21)
$45	(35.25)	(95.18)	na	na	(65.21)	(82.84)	(105.75)
$50	(40.24)	(108.65)	na	na	(74.44)	(94.56)	(120.72)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.38)	(6.43)	na	na	(4.40)	(5.59)	(7.14)
$10	(4.92)	(13.28)	na	na	(9.10)	(11.56)	(14.76)
$15	(7.71)	(20.82)	na	na	(14.26)	(18.12)	(23.13)
$20	(10.88)	(29.38)	na	na	(20.13)	(25.57)	(32.64)
$25	(14.34)	(38.72)	na	na	(26.53)	(33.70)	(43.02)
$30	(18.27)	(49.33)	na	na	(33.80)	(42.93)	(54.81)
$35	(21.95)	(59.27)	na	na	(40.61)	(51.58)	(65.85)
$40	(29.65)	(80.06)	na	na	(54.85)	(69.68)	(88.95)
$45	(29.80)	(80.46)	na	na	(55.13)	(70.03)	(89.40)
$50	(34.02)	(91.85)	na	na	(62.94)	(79.95)	(102.06)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.14)	(5.78)	na	na	(3.96)	(5.03)	(6.42)
$150	(3.53)	(9.53)	na	na	(6.53)	(8.30)	(10.59)
$200	(5.04)	(13.61)	na	na	(9.32)	(11.84)	(15.12)
$250	(7.21)	(19.47)	na	na	(13.34)	(16.94)	(21.63)
$500	(17.29)	(46.68)	na	na	(31.99)	(40.63)	(51.87)
$750	(29.73)	(80.27)	na	na	(55.00)	(69.87)	(89.19)
$1,000	(44.70)	(120.69)	na	na	(82.70)	(105.05)	(134.10)
Copay/Day							
$50 w/3 Day Max	(2.60)	(7.02)	na	na	(4.81)	(6.11)	(7.80)
$50 w/5 Day Max	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)
$100 w/3 Day Max	(6.49)	(17.52)	na	na	(12.01)	(15.25)	(19.47)
$100 w/5 Day Max	(9.36)	(25.27)	na	na	(17.32)	(22.00)	(28.08)
$250 w/3 Day Max	(21.54)	(58.16)	na	na	(39.85)	(50.62)	(64.62)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.17)	(3.16)	na	na	(2.16)	(2.75)	(3.51)
$75	(1.91)	(5.16)	na	na	(3.53)	(4.49)	(5.73)
$100	(2.73)	(7.37)	na	na	(5.05)	(6.42)	(8.19)
$125	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)
$150	(4.47)	(12.07)	na	na	(8.27)	(10.50)	(13.41)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
$25	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
$35	(1.25)	(3.38)	na	na	(2.31)	(2.94)	(3.75)
$50	(2.13)	(5.75)	na	na	(3.94)	(5.01)	(6.39)
$60	(2.71)	(7.32)	na	na	(5.01)	(6.37)	(8.13)
$75	(3.56)	(9.61)	na	na	(6.59)	(8.37)	(10.68)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	-	-	na	na	-	-	-
$0	(0.10)	(0.27)	na	na	(0.18)	(0.24)	(0.30)
$0	(0.20)	(0.54)	na	na	(0.37)	(0.47)	(0.60)
$0	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$0	(0.51)	(1.38)	na	na	(0.94)	(1.19)	(1.53)
$0	(0.66)	(1.78)	na	na	(1.22)	(1.55)	(1.98)
$0	(0.83)	(2.24)	na	na	(1.54)	(1.95)	(2.49)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.12)	(0.32)	na	na	(0.22)	(0.29)	(0.36)
$0	(0.19)	(0.51)	na	na	(0.35)	(0.45)	(0.57)
$0	(0.29)	(0.78)	na	na	(0.54)	(0.69)	(0.87)
$0	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$0	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$0	(0.22)	(0.59)	na	na	(0.40)	(0.51)	(0.66)
$0	(0.30)	(0.81)	na	na	(0.55)	(0.71)	(0.90)
$0	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$0	(0.50)	(1.35)	na	na	(0.92)	(1.17)	(1.50)
$0	(0.60)	(1.62)	na	na	(1.11)	(1.41)	(1.80)
$0	(0.82)	(2.21)	na	na	(1.52)	(1.92)	(2.46)
$0	(0.83)	(2.25)	na	na	(1.53)	(1.95)	(2.49)
$0	(0.94)	(2.54)	na	na	(1.73)	(2.20)	(2.82)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.11)	(0.29)	na	na	(0.20)	(0.26)	(0.33)
$0	(0.18)	(0.49)	na	na	(0.33)	(0.42)	(0.54)
$0	(0.26)	(0.71)	na	na	(0.48)	(0.61)	(0.78)
$0	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$0	(0.43)	(1.16)	na	na	(0.80)	(1.01)	(1.29)
$0	(0.51)	(1.38)	na	na	(0.95)	(1.20)	(1.53)
$0	(0.69)	(1.87)	na	na	(1.27)	(1.62)	(2.07)
$0	(0.69)	(1.86)	na	na	(1.28)	(1.62)	(2.07)
$0	(0.79)	(2.13)	na	na	(1.46)	(1.86)	(2.37)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	(0.08)	(0.21)	na	na	(0.15)	(0.19)	(0.24)
$0	(0.12)	(0.33)	na	na	(0.22)	(0.28)	(0.36)
$0	(0.16)	(0.43)	na	na	(0.30)	(0.37)	(0.48)
$0	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$0	(0.70)	(1.89)	na	na	(1.29)	(1.65)	(2.10)
$0	(1.04)	(2.81)	na	na	(1.93)	(2.45)	(3.12)
Copay/Day							
$0	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.15)	(0.40)	na	na	(0.28)	(0.35)	(0.45)
$0	(0.21)	(0.56)	na	na	(0.39)	(0.50)	(0.63)
$0	(0.51)	(1.38)	na	na	(0.94)	(1.20)	(1.53)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.05)	(0.14)	na	na	(0.09)	(0.12)	(0.15)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.25)	(0.33)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.04)	(0.11)	na	na	(0.07)	(0.10)	(0.12)
$0	(0.05)	(0.13)	na	na	(0.09)	(0.12)	(0.15)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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%	na	na	0.0%	0.0%	0.0%
$0	2.6%	2.6%	na	na	2.5%	2.6%	2.6%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.7%	2.8%	na	na	2.7%	2.7%	2.7%
$0	2.6%	2.5%	na	na	2.5%	2.6%	2.6%
$0	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.6%	2.7%	na	na	2.6%	2.6%	2.6%
$0	2.3%	2.2%	na	na	2.2%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.9%	1.9%	na	na	1.8%	1.8%	1.9%
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$0	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.2%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Day							
$0	2.8%	2.8%	na	na	2.8%	2.7%	2.8%
$0	2.0%	2.0%	na	na	2.0%	2.1%	2.0%
$0	2.4%	2.3%	na	na	2.4%	2.3%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.7%	1.6%	na	na	1.4%	1.9%	1.7%
$0	2.7%	2.8%	na	na	2.6%	2.7%	2.7%
$0	2.6%	2.6%	na	na	2.6%	2.7%	2.6%
$0	2.0%	2.0%	na	na	2.0%	2.1%	2.0%
$0	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.5%	na	na	1.5%	1.1%	1.4%
$0	3.3%	3.4%	na	na	3.1%	3.5%	3.3%
$0	2.4%	2.3%	na	na	2.3%	2.5%	2.4%
$0	2.7%	2.7%	na	na	2.7%	2.7%	2.7%
$0	2.0%	2.0%	na	na	2.0%	2.1%	2.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 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	(4.94)	(13.34)	na	na	(9.14)	(11.61)	(14.82)
$125	(6.09)	(16.44)	na	na	(11.27)	(14.31)	(18.27)
$150	(7.27)	(19.63)	na	na	(13.45)	(17.08)	(21.81)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.62	1.67	na	na	1.15	1.46	1.86
60	1.17	3.16	na	na	2.16	2.75	3.51
90	1.78	4.81	na	na	3.29	4.18	5.34
120	2.08	5.62	na	na	3.85	4.89	6.24
Unlimited	2.67	7.21	na	na	4.94	6.27	8.01
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
40/$10 copay	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
40/$15 copay	(0.47)	(1.27)	na	na	(0.87)	(1.10)	(1.41)
40/$20 copay	(0.67)	(1.81)	na	na	(1.24)	(1.57)	(2.01)
40/$25 copay	(0.87)	(2.35)	na	na	(1.61)	(2.04)	(2.61)
60	0.32	0.86	na	na	0.59	0.75	0.96
100	0.78	2.11	na	na	1.44	1.83	2.34
200	2.08	5.62	na	na	3.85	4.89	6.24
	** 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)	(3.32)	na	na	(2.28)	(2.89)	(3.69)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.81	2.19	na	na	1.50	1.90	2.43
90	1.71	4.62	na	na	3.16	4.02	5.13
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.73	1.97	na	na	1.35	1.72	2.19
90	1.35	3.65	na	na	2.50	3.17	4.05
120	2.16	5.83	na	na	4.00	5.08	6.48
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.04)	(2.81)	na	na	(1.92)	(2.44)	(3.12)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.31	0.84	na	na	0.57	0.73	0.93
30	0.48	1.30	na	na	0.89	1.13	1.44
Unlimited	0.73	1.97	na	na	1.35	1.72	2.19
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.66	9.88	na	na	6.77	8.60	10.98
60	4.28	11.56	na	na	7.92	10.06	12.84
90	5.12	13.82	na	na	9.47	12.03	15.36
Unlimited	5.19	14.01	na	na	9.60	12.20	15.57
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
60/$10 copay	(0.29)	(0.78)	na	na	(0.54)	(0.68)	(0.87)
60/$15 copay	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.63)	(1.70)	na	na	(1.17)	(1.48)	(1.89)
60/$25 copay	(0.75)	(2.03)	na	na	(1.39)	(1.76)	(2.25)
120/$0 copay	0.65	1.76	na	na	1.20	1.53	1.95
120/$5 copay	0.48	1.30	na	na	0.89	1.13	1.44
120/$10 copay	0.29	0.78	na	na	0.54	0.68	0.87
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.16)	(0.43)	na	na	(0.30)	(0.38)	(0.48)
120/$25 copay	(0.36)	(0.97)	na	na	(0.67)	(0.85)	(1.08)
Unlimited/$0 copay	0.74	2.00	na	na	1.37	1.74	2.22
Unlimited/$5 copay	0.58	1.57	na	na	1.07	1.36	1.74
Unlimited/$10 copay	0.36	0.97	na	na	0.67	0.85	1.08
Unlimited/$15 copay	0.08	0.22	na	na	0.15	0.19	0.24
Unlimited/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
Unlimited/$25 copay	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.21	0.57	na	na	0.39	0.49	0.63
$5	0.08	0.22	na	na	0.15	0.19	0.24
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(5.06)	(13.66)	na	na	(9.36)	(11.89)	(15.18)
$125	(6.23)	(16.82)	na	na	(11.53)	(14.64)	(18.69)
$150	(7.45)	(20.12)	na	na	(13.78)	(17.51)	(22.35)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.64	1.73	na	na	1.18	1.50	1.92
$60	1.19	3.21	na	na	2.20	2.80	3.57
$90	1.81	4.89	na	na	3.35	4.25	5.43
$120	2.13	5.75	na	na	3.94	5.01	6.39
Unlimited	2.74	7.40	na	na	5.07	6.44	8.22
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
40/$15 copay	(0.47)	(1.27)	na	na	(0.87)	(1.10)	(1.41)
40/$20 copay	(0.69)	(1.86)	na	na	(1.28)	(1.62)	(2.07)
40/$25 copay	(0.90)	(2.43)	na	na	(1.67)	(2.12)	(2.70)
60	0.33	0.89	na	na	0.61	0.78	0.99
100	0.79	2.13	na	na	1.46	1.86	2.37
200	2.13	5.75	na	na	3.94	5.01	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	(1.27)	(3.43)	na	na	(2.35)	(2.98)	(3.81)
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.82	2.21	na	na	1.52	1.93	2.46
$90	1.75	4.73	na	na	3.24	4.11	5.25
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.74	2.00	na	na	1.37	1.74	2.22
$90	1.38	3.73	na	na	2.55	3.24	4.14
$120	2.20	5.94	na	na	4.07	5.17	6.60
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(1.06)	(2.86)	na	na	(1.96)	(2.49)	(3.18)
$7	0.00	0.00	na	na	0.00	0.00	0.00
$21	0.32	0.86	na	na	0.59	0.75	0.96
$30	0.48	1.30	na	na	0.89	1.13	1.44
Unlimited	0.74	2.00	na	na	1.37	1.74	2.22
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$30	3.75	10.13	na	na	6.94	8.81	11.25
$60	4.38	11.83	na	na	8.10	10.29	13.14
$90	5.24	14.15	na	na	9.69	12.31	15.72
Unlimited	5.31	14.34	na	na	9.82	12.48	15.93
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
60/$15 copay	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.76)	(2.05)	na	na	(1.41)	(1.79)	(2.28)
120/$0 copay	0.67	1.81	na	na	1.24	1.57	2.01
120/$5 copay	0.48	1.30	na	na	0.89	1.13	1.44
120/$10 copay	0.30	0.81	na	na	0.56	0.71	0.90
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
Unlimited/$0 copay	0.75	2.03	na	na	1.39	1.76	2.25
Unlimited/$5 copay	0.60	1.62	na	na	1.11	1.41	1.80
Unlimited/$10 copay	0.37	1.00	na	na	0.68	0.87	1.11
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.23	0.62	na	na	0.43	0.54	0.69
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.12)	(0.32)	na	na	(0.22)	(0.28)	(0.36)
$0	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$0	(0.18)	(0.49)	na	na	(0.33)	(0.43)	(0.54)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	-	-	na	na	-	-	-
$0	0.02	0.06	na	na	0.03	0.04	0.06
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.03	0.08	na	na	0.06	0.07	0.09
$0	0.05	0.13	na	na	0.09	0.12	0.15
$0	0.07	0.19	na	na	0.13	0.17	0.21
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.08)	(0.09)
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	0.05	0.13	na	na	0.09	0.12	0.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	0.04	0.11	na	na	0.08	0.09	0.12
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.03	0.08	na	na	0.05	0.07	0.09
$0	0.04	0.11	na	na	0.07	0.09	0.12
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	-	-	na	na	-	-	-
$0	0.09	0.25	na	na	0.17	0.21	0.27
$0	0.10	0.27	na	na	0.18	0.23	0.30
$0	0.12	0.33	na	na	0.22	0.28	0.36
$0	0.12	0.33	na	na	0.22	0.28	0.36
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.03)	(0.03)
$0	0.02	0.05	na	na	0.04	0.04	0.06
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.2%	3.6%	na	na	2.6%	2.7%	3.2%
$0	1.7%	1.6%	na	na	1.9%	1.8%	1.7%
$0	1.7%	1.7%	na	na	1.8%	1.7%	1.7%
$0	2.4%	2.3%	na	na	2.3%	2.5%	2.4%
$0	2.6%	2.6%	na	na	2.6%	2.7%	2.6%
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.0%	2.8%	na	na	3.2%	3.2%	3.0%
$0	3.4%	3.4%	na	na	3.7%	3.9%	3.4%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
$0	1.3%	0.9%	na	na	1.4%	1.6%	1.3%
$0	2.4%	2.3%	na	na	2.3%	2.5%	2.4%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	3.3%	3.3%	na	na	3.1%	3.1%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.2%	0.9%	na	na	1.3%	1.6%	1.2%
$0	2.3%	2.4%	na	na	2.5%	2.2%	2.3%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
$0	2.2%	2.2%	na	na	2.0%	2.2%	2.2%
$0	1.9%	1.9%	na	na	1.8%	1.8%	1.9%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	1.9%	1.8%	na	na	2.1%	2.0%	1.9%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.2%	2.4%	na	na	3.5%	2.7%	3.2%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
$0	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%
$0	3.4%	3.8%	na	na	3.7%	4.4%	3.4%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.2%	3.5%	na	na	2.6%	3.4%	3.2%
$0	1.3%	1.0%	na	na	1.4%	1.7%	1.3%
$0	3.1%	2.8%	na	na	3.3%	2.6%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.4%	3.8%	na	na	3.7%	4.4%	3.4%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.3%	-4.7%	na	na	-6.7%	-7.9%	-6.2%
$0	2.8%	3.1%	na	na	1.5%	2.4%	2.8%
$0	1.4%	1.5%	na	na	1.5%	1.1%	1.4%
$0	3.4%	3.2%	na	na	3.7%	3.7%	3.4%
$0	2.8%	3.1%	na	na	1.5%	2.4%	2.8%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	3.2%	2.4%	na	na	3.5%	2.7%	3.2%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	9.5%	8.8%	na	na	10.3%	10.2%	9.5%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 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	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
$15	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
$20	(0.70)	(1.89)	na	na	(1.30)	(1.65)	(2.10)
$25	(0.91)	(2.46)	na	na	(1.68)	(2.14)	(2.73)
$30	(1.10)	(2.97)	na	na	(2.04)	(2.59)	(3.30)
$35	(1.31)	(3.54)	na	na	(2.42)	(3.08)	(3.93)
$40	(1.50)	(4.05)	na	na	(2.78)	(3.53)	(4.50)
$45	(1.72)	(4.64)	na	na	(3.18)	(4.04)	(5.16)
$50	(1.90)	(5.13)	na	na	(3.52)	(4.47)	(5.70)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.36)	(0.97)	na	na	(0.67)	(0.85)	(1.08)
$15	(0.52)	(1.40)	na	na	(0.96)	(1.22)	(1.56)
$20	(0.78)	(2.11)	na	na	(1.44)	(1.83)	(2.34)
$25	(1.06)	(2.86)	na	na	(1.96)	(2.49)	(3.18)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.24)	(0.65)	na	na	(0.44)	(0.56)	(0.72)
$50	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
$60	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.60)	(1.62)	na	na	(1.11)	(1.41)	(1.80)
$100	(0.78)	(2.11)	na	na	(1.44)	(1.83)	(2.34)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
$75	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.52)	(1.40)	na	na	(0.96)	(1.22)	(1.56)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
	(3.30)	(8.91)	na	na	(6.11)	(7.76)	(9.90)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
	(5.11)	(13.80)	na	na	(9.45)	(12.01)	(15.33)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
	(0.43)	(1.16)	na	na	(0.80)	(1.01)	(1.29)
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$10/15/20	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$25	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$15	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
$20	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
$25	(0.94)	(2.54)	na	na	(1.74)	(2.21)	(2.82)
$30	(1.12)	(3.02)	na	na	(2.07)	(2.63)	(3.36)
$35	(1.34)	(3.62)	na	na	(2.48)	(3.15)	(4.02)
$40	(1.53)	(4.13)	na	na	(2.83)	(3.60)	(4.59)
$45	(1.76)	(4.75)	na	na	(3.26)	(4.14)	(5.28)
$50	(1.96)	(5.29)	na	na	(3.63)	(4.61)	(5.88)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$15	(0.55)	(1.49)	na	na	(1.02)	(1.29)	(1.65)
$20	(0.79)	(2.13)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.08)	(2.92)	na	na	(2.00)	(2.54)	(3.24)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.36)	(0.97)	na	na	(0.67)	(0.85)	(1.08)
$60	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.62)	(1.67)	na	na	(1.15)	(1.46)	(1.86)
$100	(0.79)	(2.13)	na	na	(1.46)	(1.86)	(2.37)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$60	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$75	(0.39)	(1.05)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.55)	(1.49)	na	na	(1.02)	(1.29)	(1.65)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	(3.39)	(9.15)	na	na	(6.27)	(7.97)	(10.17)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	(5.23)	(14.12)	na	na	(9.68)	(12.29)	(15.69)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	(0.43)	(1.16)	na	na	(0.80)	(1.01)	(1.29)
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$0	(0.02)	(0.05)	na	na	(0.03)	(0.04)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.04)	(0.11)	na	na	(0.08)	(0.10)	(0.12)
$0	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	0.01	0.03	na	na	0.01	0.02	0.03
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	(0.01)	(0.02)	na	na	(0.02)	(0.03)	(0.03)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	(0.09)	(0.24)	na	na	(0.16)	(0.21)	(0.27)
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	(0.12)	(0.32)	na	na	(0.23)	(0.28)	(0.36)
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	-	-	na	na	-	-	-
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$0	0.01	0.03	na	na	0.02	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	4.0%	2.9%	na	na	4.3%	3.4%	4.0%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.6%	na	na	0.8%	1.2%	1.4%
$0	3.3%	3.3%	na	na	3.6%	3.3%	3.3%
$0	1.8%	1.7%	na	na	1.5%	1.5%	1.8%
$0	2.3%	2.3%	na	na	2.5%	2.3%	2.3%
$0	2.0%	2.0%	na	na	1.8%	2.0%	2.0%
$0	2.3%	2.4%	na	na	2.5%	2.5%	2.3%
$0	3.2%	3.1%	na	na	3.1%	3.1%	3.2%
Copay	**Diabetic Supplies Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	2.8%	3.1%	na	na	1.5%	2.4%	2.8%
$0	5.8%	6.4%	na	na	6.3%	5.7%	5.8%
$0	1.3%	0.9%	na	na	1.4%	1.6%	1.3%
$0	1.9%	2.1%	na	na	2.0%	2.0%	1.9%
	Chemotherapy [std: $0]						
Copay	**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	4.2%	4.6%	na	na	4.5%	5.4%	4.2%
$0	2.9%	2.1%	na	na	3.1%	3.7%	2.9%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.3%	3.1%	na	na	3.6%	3.5%	3.3%
$0	1.3%	0.9%	na	na	1.4%	1.6%	1.3%
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	3.8%	4.3%	na	na	4.2%	3.3%	3.8%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	5.8%	6.4%	na	na	6.3%	5.7%	5.8%
	Surgery [std: $0 copay]						
	Copay per procedure of minimum of [20%, $300]						
$0	2.7%	2.7%	na	na	2.6%	2.7%	2.7%
	Diagnostic and Therapeutic Radiology [std: $0]						
	Copay per procedure of minimum (20%, $100); $500 annual maximum						
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
	Diagnostic Testing [std: $0]						
	Copay per procedure minimum of [20%, $100], $500 annual maximum						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Copay	**Mammogram Copay [std: $0] (HealthPass]**						
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
JULY 1, 2012 - SEPTEMBER 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
July 01, 2013 - September 30, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.05	10.94	na	na	7.49	9.52	12.15
60	5.72	15.44	na	na	10.58	13.44	17.16
90	6.79	18.33	na	na	12.56	15.96	20.37
Unlimited	6.87	18.55	na	na	12.71	16.14	20.61
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.21	19.47	na	na	13.34	16.94	21.63
60	7.62	20.57	na	na	14.10	17.91	22.86
90	7.90	21.33	na	na	14.62	18.57	23.70
Unlimited	7.98	21.55	na	na	14.76	18.75	23.94
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
npatient Mental Hlt	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.50	14.85	na	na	10.18	12.93	16.50
30	6.53	17.63	na	na	12.08	15.35	19.59
40	7.20	19.44	na	na	13.32	16.92	21.60
60	7.87	21.25	na	na	14.56	18.49	23.61
Unlimited	7.94	21.44	na	na	14.69	18.66	23.82
SMALL GROUP	**$5 Copay**						
20	5.18	13.99	na	na	9.58	12.17	15.54
30	6.15	16.61	na	na	11.38	14.45	18.45
40	6.78	18.31	na	na	12.54	15.93	20.34
60	7.41	20.01	na	na	13.71	17.41	22.23
Unlimited	7.49	20.22	na	na	13.86	17.60	22.47
SMALL GROUP	**$10 Copay**						
20	4.82	13.01	na	na	8.92	11.33	14.46
30	5.73	15.47	na	na	10.60	13.47	17.19
40	6.31	17.04	na	na	11.67	14.83	18.93
60	6.90	18.63	na	na	12.77	16.22	20.70
Unlimited	6.97	18.82	na	na	12.89	16.38	20.91
SMALL GROUP	**$15 Copay**						
20	4.53	12.23	na	na	8.38	10.65	13.59
30	5.39	14.55	na	na	9.97	12.67	16.17
40	5.93	16.01	na	na	10.97	13.94	17.79
60	6.48	17.50	na	na	11.99	15.23	19.44
Unlimited	6.55	17.69	na	na	12.12	15.39	19.65
SMALL GROUP	**$20 Copay**						
20	4.25	11.48	na	na	7.86	9.99	12.75
30	5.05	13.64	na	na	9.34	11.87	15.15
40	5.56	15.01	na	na	10.29	13.07	16.68
60	6.08	16.42	na	na	11.25	14.29	18.24
Unlimited	6.13	16.55	na	na	11.34	14.41	18.39
SMALL GROUP	**$25 Copay**						
20	3.97	10.72	na	na	7.34	9.33	11.91
30	4.71	12.72	na	na	8.71	11.07	14.13
40	5.19	14.01	na	na	9.60	12.20	15.57
60	5.67	15.31	na	na	10.49	13.32	17.01
Unlimited	5.73	15.47	na	na	10.60	13.47	17.19
SMALL GROUP	**$30 Copay**						
20	3.81	10.29	na	na	7.05	8.95	11.43
30	4.54	12.26	na	na	8.40	10.67	13.62
40	5.01	13.53	na	na	9.27	11.77	15.03
60	5.47	14.77	na	na	10.12	12.85	16.41
Unlimited	5.52	14.90	na	na	10.21	12.97	16.56
SMALL GROUP	**$35 Copay**						
20	3.70	9.99	na	na	6.85	8.70	11.10
30	4.40	11.88	na	na	8.14	10.34	13.20
40	4.85	13.10	na	na	8.97	11.40	14.55
60	5.31	14.34	na	na	9.82	12.48	15.93
Unlimited	5.36	14.47	na	na	9.92	12.60	16.08
SMALL GROUP	**$40 Copay**						
20	3.61	9.75	na	na	6.68	8.48	10.83

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.15	11.21	na	na	7.68	9.75	12.45
60	5.86	15.82	na	na	10.84	13.77	17.58
90	6.95	18.77	na	na	12.86	16.33	20.85
Unlimited	7.03	18.98	na	na	13.01	16.52	21.09
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.39	19.95	na	na	13.67	17.37	22.17
60	7.81	21.09	na	na	14.45	18.35	23.43
90	8.10	21.87	na	na	14.99	19.04	24.30
Unlimited	8.17	22.06	na	na	15.11	19.20	24.51
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.63	15.20	na	na	10.42	13.23	16.89
30	6.70	18.09	na	na	12.40	15.75	20.10
40	7.37	19.90	na	na	13.63	17.32	22.11
60	8.06	21.76	na	na	14.91	18.94	24.18
Unlimited	8.13	21.95	na	na	15.04	19.11	24.39
SMALL GROUP	**$5 Copay**						
20	5.30	14.31	na	na	9.81	12.46	15.90
30	6.29	16.98	na	na	11.64	14.78	18.87
40	6.94	18.74	na	na	12.84	16.31	20.82
60	7.58	20.47	na	na	14.02	17.81	22.74
Unlimited	7.66	20.68	na	na	14.17	18.00	22.98
SMALL GROUP	**$10 Copay**						
20	4.93	13.31	na	na	9.12	11.59	14.79
30	5.87	15.85	na	na	10.86	13.79	17.61
40	6.46	17.44	na	na	11.95	15.18	19.38
60	7.07	19.09	na	na	13.08	16.61	21.21
Unlimited	7.14	19.28	na	na	13.21	16.78	21.42
SMALL GROUP	**$15 Copay**						
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.52	14.90	na	na	10.21	12.97	16.56
40	6.08	16.42	na	na	11.25	14.29	18.24
60	6.63	17.90	na	na	12.27	15.58	19.89
Unlimited	6.71	18.12	na	na	12.41	15.77	20.13
SMALL GROUP	**$20 Copay**						
20	4.35	11.75	na	na	8.05	10.22	13.05
30	5.17	13.96	na	na	9.56	12.15	15.51
40	5.70	15.39	na	na	10.55	13.40	17.10
60	6.23	16.82	na	na	11.53	14.64	18.69
Unlimited	6.27	16.93	na	na	11.60	14.73	18.81
SMALL GROUP	**$25 Copay**						
20	4.06	10.96	na	na	7.51	9.54	12.18
30	4.82	13.01	na	na	8.92	11.33	14.46
40	5.31	14.34	na	na	9.82	12.48	15.93
60	5.80	15.66	na	na	10.73	13.63	17.40
Unlimited	5.87	15.85	na	na	10.86	13.79	17.61
SMALL GROUP	**$30 Copay**						
20	3.89	10.50	na	na	7.20	9.14	11.67
30	4.66	12.58	na	na	8.62	10.95	13.98
40	5.12	13.82	na	na	9.47	12.03	15.36
60	5.60	15.12	na	na	10.36	13.16	16.80
Unlimited	5.65	15.26	na	na	10.45	13.28	16.95
SMALL GROUP	**$35 Copay**						
20	3.79	10.23	na	na	7.01	8.91	11.37
30	4.50	12.15	na	na	8.33	10.58	13.50
40	4.97	13.42	na	na	9.19	11.68	14.91
60	5.44	14.69	na	na	10.06	12.78	16.32
Unlimited	5.49	14.82	na	na	10.16	12.90	16.47
SMALL GROUP	**$40 Copay**						
20	3.70	9.99	na	na	6.85	8.70	11.10

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.10	0.27	na	na	0.19	0.23	0.30
60	0.14	0.38	na	na	0.26	0.33	0.42
90	0.16	0.44	na	na	0.30	0.37	0.48
Unlimited	0.16	0.43	na	na	0.30	0.38	0.48
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.18	0.48	na	na	0.33	0.43	0.54
60	0.19	0.52	na	na	0.35	0.44	0.57
90	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.19	0.51	na	na	0.35	0.45	0.57
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.13	0.35	na	na	0.24	0.30	0.39
30	0.17	0.46	na	na	0.32	0.40	0.51
40	0.17	0.46	na	na	0.31	0.40	0.51
60	0.19	0.51	na	na	0.35	0.45	0.57
Unlimited	0.19	0.51	na	na	0.35	0.45	0.57
SMALL GROUP	**$5 Copay**						
20	0.12	0.32	na	na	0.23	0.29	0.36
30	0.14	0.37	na	na	0.26	0.33	0.42
40	0.16	0.43	na	na	0.30	0.38	0.48
60	0.17	0.46	na	na	0.31	0.40	0.51
Unlimited	0.17	0.46	na	na	0.31	0.40	0.51
SMALL GROUP	**$10 Copay**						
20	0.11	0.30	na	na	0.20	0.26	0.33
30	0.14	0.38	na	na	0.26	0.32	0.42
40	0.15	0.40	na	na	0.28	0.35	0.45
60	0.17	0.46	na	na	0.31	0.39	0.51
Unlimited	0.17	0.46	na	na	0.32	0.40	0.51
SMALL GROUP	**$15 Copay**						
20	0.12	0.33	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.30	0.39
40	0.15	0.41	na	na	0.28	0.35	0.45
60	0.15	0.40	na	na	0.28	0.35	0.45
Unlimited	0.16	0.43	na	na	0.29	0.38	0.48
SMALL GROUP	**$20 Copay**						
20	0.10	0.27	na	na	0.19	0.23	0.30
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.15	0.40	na	na	0.28	0.35	0.45
Unlimited	0.14	0.38	na	na	0.26	0.32	0.42
SMALL GROUP	**$25 Copay**						
20	0.09	0.24	na	na	0.17	0.21	0.27
30	0.11	0.29	na	na	0.21	0.26	0.33
40	0.12	0.33	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.14	0.38	na	na	0.26	0.32	0.42
SMALL GROUP	**$30 Copay**						
20	0.08	0.21	na	na	0.15	0.19	0.24
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.11	0.29	na	na	0.20	0.26	0.33
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.13	0.36	na	na	0.24	0.31	0.39
SMALL GROUP	**$35 Copay**						
20	0.09	0.24	na	na	0.16	0.21	0.27
30	0.10	0.27	na	na	0.19	0.24	0.30
40	0.12	0.32	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.30	0.39
Unlimited	0.13	0.35	na	na	0.24	0.30	0.39
SMALL GROUP	**$40 Copay**						
20	0.09	0.24	na	na	0.17	0.22	0.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
60	2.4%	2.5%	na	na	2.5%	2.5%	2.4%
90	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
Unlimited	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
90	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
30	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
40	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**$5 Copay**						
20	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
30	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
40	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
SMALL GROUP	**$10 Copay**						
20	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
30	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
40	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
Unlimited	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
SMALL GROUP	**$15 Copay**						
20	2.6%	2.7%	na	na	2.6%	2.6%	2.6%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.6%	na	na	2.6%	2.5%	2.5%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
SMALL GROUP	**$20 Copay**						
20	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
30	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.4%	na	na	2.5%	2.4%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.2%	2.3%
SMALL GROUP	**$25 Copay**						
20	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
30	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
40	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
SMALL GROUP	**$30 Copay**						
20	2.1%	2.0%	na	na	2.1%	2.1%	2.1%
30	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
40	2.2%	2.1%	na	na	2.2%	2.2%	2.2%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**$35 Copay**						
20	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.5%	2.4%	na	na	2.5%	2.5%	2.5%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**$40 Copay**						
20	2.5%	2.5%	na	na	2.5%	2.6%	2.5%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 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	4.27	11.53	na	na	7.90	10.03	12.81
40	4.71	12.72	na	na	8.71	11.07	14.13
60	5.16	13.93	na	na	9.55	12.13	15.48
Unlimited	5.20	14.04	na	na	9.62	12.22	15.60
SMALL GROUP				**$45 Copay**			
20	3.49	9.42	na	na	6.46	8.20	10.47
30	4.15	11.21	na	na	7.68	9.75	12.45
40	4.57	12.34	na	na	8.45	10.74	13.71
60	4.99	13.47	na	na	9.23	11.73	14.97
Unlimited	5.03	13.58	na	na	9.31	11.82	15.09
SMALL GROUP				**$50 Copay**			
20	3.39	9.15	na	na	6.27	7.97	10.17
30	4.02	10.85	na	na	7.44	9.45	12.06
40	4.43	11.96	na	na	8.20	10.41	13.29
60	4.84	13.07	na	na	8.95	11.37	14.52
Unlimited	4.87	13.15	na	na	9.01	11.44	14.61
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.13	19.25	na	na	13.19	16.76	21.39
30	7.84	21.17	na	na	14.50	18.42	23.52
40	8.29	22.38	na	na	15.34	19.48	24.87
60	8.76	23.65	na	na	16.21	20.59	26.28
Unlimited	8.84	23.87	na	na	16.35	20.77	26.52
SMALL GROUP				**$5 Copay**			
20	6.70	18.09	na	na	12.40	15.75	20.10
30	7.39	19.95	na	na	13.67	17.37	22.17
40	7.80	21.06	na	na	14.43	18.33	23.40
60	8.25	22.28	na	na	15.26	19.39	24.75
Unlimited	8.32	22.46	na	na	15.39	19.55	24.96
SMALL GROUP				**$10 Copay**			
20	6.25	16.88	na	na	11.56	14.69	18.75
30	6.87	18.55	na	na	12.71	16.14	20.61
40	7.26	19.60	na	na	13.43	17.06	21.78
60	7.67	20.71	na	na	14.19	18.02	23.01
Unlimited	7.75	20.93	na	na	14.34	18.21	23.25
SMALL GROUP				**$15 Copay**			
20	5.88	15.88	na	na	10.88	13.82	17.64
30	6.47	17.47	na	na	11.97	15.20	19.41
40	6.82	18.41	na	na	12.62	16.03	20.46
60	7.20	19.44	na	na	13.32	16.92	21.60
Unlimited	7.27	19.63	na	na	13.45	17.08	21.81
SMALL GROUP				**$20 Copay**			
20	5.52	14.90	na	na	10.21	12.97	16.56
30	6.06	16.36	na	na	11.21	14.24	18.18
40	6.41	17.31	na	na	11.86	15.06	19.23
60	6.77	18.28	na	na	12.52	15.91	20.31
Unlimited	6.82	18.41	na	na	12.62	16.03	20.46
SMALL GROUP				**$25 Copay**			
20	5.14	13.88	na	na	9.51	12.08	15.42
30	5.65	15.26	na	na	10.45	13.28	16.95
40	5.97	16.12	na	na	11.04	14.03	17.91
60	6.30	17.01	na	na	11.66	14.81	18.90
Unlimited	6.36	17.17	na	na	11.77	14.95	19.08
SMALL GROUP				**$30 Copay**			
20	4.95	13.37	na	na	9.16	11.63	14.85
30	5.45	14.72	na	na	10.08	12.81	16.35
40	5.76	15.55	na	na	10.66	13.54	17.28
60	6.08	16.42	na	na	11.25	14.29	18.24
Unlimited	6.12	16.52	na	na	11.32	14.38	18.36
SMALL GROUP				**$35 Copay**			
20	4.81	12.99	na	na	8.90	11.30	14.43
30	5.30	14.31	na	na	9.81	12.46	15.90
40	5.58	15.07	na	na	10.32	13.11	16.74
60	5.91	15.96	na	na	10.93	13.89	17.73
Unlimited	5.95	16.07	na	na	11.01	13.98	17.85

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	4.37	11.80	na	na	8.08	10.27	13.11
40	4.82	13.01	na	na	8.92	11.33	14.46
60	5.28	14.26	na	na	9.77	12.41	15.84
Unlimited	5.33	14.39	na	na	9.86	12.53	15.99
SMALL GROUP				**$45 Copay**			
20	3.56	9.61	na	na	6.59	8.37	10.68
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.68	12.64	na	na	8.66	11.00	14.04
60	5.11	13.80	na	na	9.45	12.01	15.33
Unlimited	5.15	13.91	na	na	9.53	12.10	15.45
SMALL GROUP				**$50 Copay**			
20	3.47	9.37	na	na	6.42	8.15	10.41
30	4.12	11.12	na	na	7.62	9.68	12.36
40	4.53	12.23	na	na	8.38	10.65	13.59
60	4.96	13.39	na	na	9.18	11.66	14.88
Unlimited	4.99	13.47	na	na	9.23	11.73	14.97
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.30	19.71	na	na	13.51	17.16	21.90
30	8.03	21.68	na	na	14.86	18.87	24.09
40	8.49	22.92	na	na	15.71	19.95	25.47
60	8.96	24.19	na	na	16.58	21.06	26.88
Unlimited	9.06	24.46	na	na	16.76	21.29	27.18
SMALL GROUP				**$5 Copay**			
20	6.86	18.52	na	na	12.69	16.12	20.58
30	7.56	20.41	na	na	13.99	17.77	22.68
40	7.98	21.55	na	na	14.76	18.75	23.94
60	8.45	22.82	na	na	15.63	19.86	25.35
Unlimited	8.52	23.00	na	na	15.76	20.02	25.56
SMALL GROUP				**$10 Copay**			
20	6.40	17.28	na	na	11.84	15.04	19.20
30	7.03	18.98	na	na	13.01	16.52	21.09
40	7.44	20.09	na	na	13.76	17.48	22.32
60	7.85	21.20	na	na	14.52	18.45	23.55
Unlimited	7.93	21.41	na	na	14.67	18.64	23.79
SMALL GROUP				**$15 Copay**			
20	6.03	16.28	na	na	11.16	14.17	18.09
30	6.62	17.87	na	na	12.25	15.56	19.86
40	6.98	18.85	na	na	12.91	16.40	20.94
60	7.37	19.90	na	na	13.63	17.32	22.11
Unlimited	7.45	20.12	na	na	13.78	17.51	22.35
SMALL GROUP				**$20 Copay**			
20	5.65	15.26	na	na	10.45	13.28	16.95
30	6.21	16.77	na	na	11.49	14.59	18.63
40	6.56	17.71	na	na	12.14	15.42	19.68
60	6.93	18.71	na	na	12.82	16.29	20.79
Unlimited	6.98	18.85	na	na	12.91	16.40	20.94
SMALL GROUP				**$25 Copay**			
20	5.26	14.20	na	na	9.73	12.36	15.78
30	5.78	15.61	na	na	10.69	13.58	17.34
40	6.11	16.50	na	na	11.30	14.36	18.33
60	6.45	17.42	na	na	11.93	15.16	19.35
Unlimited	6.51	17.58	na	na	12.04	15.30	19.53
SMALL GROUP				**$30 Copay**			
20	5.07	13.69	na	na	9.38	11.91	15.21
30	5.58	15.07	na	na	10.32	13.11	16.74
40	5.90	15.93	na	na	10.92	13.87	17.70
60	6.23	16.82	na	na	11.53	14.64	18.69
Unlimited	6.26	16.90	na	na	11.58	14.71	18.78
SMALL GROUP				**$35 Copay**			
20	4.92	13.28	na	na	9.10	11.56	14.76
30	5.43	14.66	na	na	10.05	12.76	16.29
40	5.72	15.44	na	na	10.58	13.44	17.16
60	6.06	16.36	na	na	11.21	14.24	18.18
Unlimited	6.09	16.44	na	na	11.27	14.31	18.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	0.10	0.27	na	na	0.18	0.24	0.30
40	0.11	0.29	na	na	0.21	0.26	0.33
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$45 Copay**			
20	0.07	0.19	na	na	0.13	0.17	0.21
30	0.09	0.24	na	na	0.16	0.21	0.27
40	0.11	0.30	na	na	0.21	0.26	0.33
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.12	0.33	na	na	0.22	0.28	0.36
SMALL GROUP				**$50 Copay**			
20	0.08	0.22	na	na	0.15	0.18	0.24
30	0.10	0.27	na	na	0.18	0.23	0.30
40	0.10	0.27	na	na	0.18	0.24	0.30
60	0.12	0.32	na	na	0.23	0.29	0.36
Unlimited	0.12	0.32	na	na	0.22	0.29	0.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	0.17	0.46	na	na	0.32	0.40	0.51
30	0.19	0.51	na	na	0.36	0.45	0.57
40	0.20	0.54	na	na	0.37	0.47	0.60
60	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.22	0.59	na	na	0.41	0.52	0.66
SMALL GROUP				**$5 Copay**			
20	0.16	0.43	na	na	0.29	0.37	0.48
30	0.17	0.46	na	na	0.32	0.40	0.51
40	0.18	0.49	na	na	0.33	0.42	0.54
60	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.20	0.54	na	na	0.37	0.47	0.60
SMALL GROUP				**$10 Copay**			
20	0.15	0.40	na	na	0.28	0.35	0.45
30	0.16	0.43	na	na	0.30	0.38	0.48
40	0.18	0.49	na	na	0.33	0.42	0.54
60	0.18	0.49	na	na	0.33	0.43	0.54
Unlimited	0.18	0.48	na	na	0.33	0.43	0.54
SMALL GROUP				**$15 Copay**			
20	0.15	0.40	na	na	0.28	0.35	0.45
30	0.15	0.40	na	na	0.28	0.36	0.45
40	0.16	0.44	na	na	0.29	0.37	0.48
60	0.17	0.46	na	na	0.31	0.40	0.51
Unlimited	0.18	0.49	na	na	0.33	0.43	0.54
SMALL GROUP				**$20 Copay**			
20	0.13	0.36	na	na	0.24	0.31	0.39
30	0.15	0.41	na	na	0.28	0.35	0.45
40	0.15	0.40	na	na	0.28	0.36	0.45
60	0.16	0.43	na	na	0.30	0.38	0.48
Unlimited	0.16	0.44	na	na	0.29	0.37	0.48
SMALL GROUP				**$25 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.30	0.39
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.15	0.41	na	na	0.27	0.35	0.45
Unlimited	0.15	0.41	na	na	0.27	0.35	0.45
SMALL GROUP				**$30 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.30	0.39
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.15	0.40	na	na	0.28	0.35	0.45
Unlimited	0.14	0.38	na	na	0.26	0.33	0.42
SMALL GROUP				**$35 Copay**			
20	0.11	0.29	na	na	0.20	0.26	0.33
30	0.13	0.35	na	na	0.24	0.30	0.39
40	0.14	0.37	na	na	0.26	0.33	0.42
60	0.15	0.40	na	na	0.28	0.35	0.45
Unlimited	0.14	0.37	na	na	0.26	0.33	0.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	2.3%	2.3%	na	na	2.3%	2.4%	2.3%
40	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
60	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$45 Copay**			
20	2.0%	2.0%	na	na	2.0%	2.1%	2.0%
30	2.2%	2.1%	na	na	2.1%	2.2%	2.2%
40	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$50 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
30	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
40	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
60	2.5%	2.4%	na	na	2.6%	2.6%	2.5%
Unlimited	2.5%	2.4%	na	na	2.4%	2.5%	2.5%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$5 Copay**			
20	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$10 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.3%	2.4%	na	na	2.3%	2.4%	2.3%
Unlimited	2.3%	2.3%	na	na	2.3%	2.4%	2.3%
SMALL GROUP				**$15 Copay**			
20	2.6%	2.5%	na	na	2.6%	2.5%	2.6%
30	2.3%	2.3%	na	na	2.3%	2.4%	2.3%
40	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$20 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$25 Copay**			
20	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.3%	2.4%	na	na	2.4%	2.4%	2.3%
60	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
SMALL GROUP				**$30 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.4%	na	na	2.5%	2.4%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$35 Copay**			
20	2.3%	2.2%	na	na	2.2%	2.3%	2.3%
30	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
Unlimited	2.4%	2.3%	na	na	2.4%	2.4%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$40 Copay**			
20	4.66	12.58	na	na	8.62	10.95	13.98
30	5.14	13.88	na	na	9.51	12.08	15.42
40	5.41	14.61	na	na	10.01	12.71	16.23
60	5.73	15.47	na	na	10.60	13.47	17.19
Unlimited	5.77	15.58	na	na	10.67	13.56	17.31
SMALL GROUP				**$45 Copay**			
20	4.53	12.23	na	na	8.38	10.65	13.59
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.25	14.18	na	na	9.71	12.34	15.75
60	5.55	14.99	na	na	10.27	13.04	16.65
Unlimited	5.59	15.09	na	na	10.34	13.14	16.77
SMALL GROUP				**$50 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	4.82	13.01	na	na	8.92	11.33	14.46
40	5.11	13.80	na	na	9.45	12.01	15.33
60	5.38	14.53	na	na	9.95	12.64	16.14
Unlimited	5.41	14.61	na	na	10.01	12.71	16.23
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$40 Copay**			
20	4.78	12.91	na	na	8.84	11.23	14.34
30	5.26	14.20	na	na	9.73	12.36	15.78
40	5.54	14.96	na	na	10.25	13.02	16.62
60	5.87	15.85	na	na	10.86	13.79	17.61
Unlimited	5.91	15.96	na	na	10.93	13.89	17.73
SMALL GROUP				**$45 Copay**			
20	4.65	12.56	na	na	8.60	10.93	13.95
30	5.08	13.72	na	na	9.40	11.94	15.24
40	5.38	14.53	na	na	9.95	12.64	16.14
60	5.69	15.36	na	na	10.53	13.37	17.07
Unlimited	5.73	15.47	na	na	10.60	13.47	17.19
SMALL GROUP				**$50 Copay**			
20	4.49	12.12	na	na	8.31	10.55	13.47
30	4.93	13.31	na	na	9.12	11.59	14.79
40	5.23	14.12	na	na	9.68	12.29	15.69
60	5.51	14.88	na	na	10.19	12.95	16.53
Unlimited	5.54	14.96	na	na	10.25	13.02	16.62
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
5	0.00	0.00	na	na	0.00	0.00	0.00
10	0.00	0.00	na	na	0.00	0.00	0.00
15	0.00	0.00	na	na	0.00	0.00	0.00
20	0.00	0.00	na	na	0.00	0.00	0.00
25	0.00	0.00	na	na	0.00	0.00	0.00
30	0.00	0.00	na	na	0.00	0.00	0.00
35	0.00	0.00	na	na	0.00	0.00	0.00
40	0.00	0.00	na	na	0.00	0.00	0.00
45	0.00	0.00	na	na	0.00	0.00	0.00
50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	0.12	0.33	na	na	0.22	0.28	0.36
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.32	0.42
Unlimited	0.14	0.38	na	na	0.26	0.33	0.42
SMALL GROUP				**$45 Copay**			
20	0.12	0.33	na	na	0.22	0.28	0.36
30	0.12	0.33	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.30	0.39
60	0.14	0.37	na	na	0.26	0.33	0.42
Unlimited	0.14	0.38	na	na	0.26	0.33	0.42
SMALL GROUP				**$50 Copay**			
20	0.11	0.29	na	na	0.21	0.26	0.33
30	0.11	0.30	na	na	0.20	0.26	0.33
40	0.12	0.32	na	na	0.23	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
30	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$45 Copay**			
20	2.6%	2.7%	na	na	2.6%	2.6%	2.6%
30	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$50 Copay**			
20	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
30	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
40	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
JULY 1, 2012 - SEPTEMBER 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	4.74	12.80	na	na	8.77	11.14	14.22
$0/Max $5000	4.50	12.15	na	na	8.33	10.58	13.50
$0/Max $2500	4.21	11.37	na	na	7.79	9.89	12.63
$25	4.50	12.15	na	na	8.33	10.58	13.50
$50	4.21	11.37	na	na	7.79	9.89	12.63
$100	3.85	10.40	na	na	7.12	9.05	11.55
$500	1.84	4.97	na	na	3.40	4.32	5.52
$5,000	0.31	0.84	na	na	0.57	0.73	0.93
Coinsurance							
80%	3.79	10.23	na	na	7.01	8.91	11.37
75%	3.55	9.59	na	na	6.57	8.34	10.65
70%	3.33	8.99	na	na	6.16	7.83	9.99
Deductible			**Orthotics Riders**				
$0	0.80	2.16	na	na	1.48	1.88	2.40
$0/Max $5000	0.77	2.08	na	na	1.42	1.81	2.31
$0/Max $2500	0.73	1.97	na	na	1.35	1.72	2.19
$25	0.77	2.08	na	na	1.42	1.81	2.31
$50	0.73	1.97	na	na	1.35	1.72	2.19
$100	0.66	1.78	na	na	1.22	1.55	1.98
$500	0.33	0.89	na	na	0.61	0.78	0.99
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.66	1.78	na	na	1.22	1.55	1.98
75%	0.63	1.70	na	na	1.17	1.48	1.89
70%	0.60	1.62	na	na	1.11	1.41	1.80
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.53	4.13	na	na	2.83	3.60	4.59
12 Months	2.48	6.70	na	na	4.59	5.83	7.44
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.41	6.51	na	na	4.46	5.66	7.23
12 Months	3.84	10.37	na	na	7.10	9.02	11.52
			Private Duty Nursing Riders				
In Full	0.58	1.57	na	na	1.07	1.36	1.74
80% hrs 73-504	0.08	0.22	na	na	0.15	0.19	0.24
100% hrs 73-504	0.15	0.41	na	na	0.28	0.35	0.45
			Dental Network Access				
	0.47	1.27	na	na	0.87	1.10	1.41
Limit			**Infertility Rider**				
2 IVF	10.02	27.05	na	na	18.54	23.55	30.06
3 IVF	12.09	32.64	na	na	22.37	28.41	36.27
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.61	12.45	na	na	8.53	10.83	13.83
Health Club Reimbursement							
$200 per year	1.19	3.21	na	na	2.20	2.80	3.57
			Nurse Advice Line Rider				
	0.31	0.84	na	na	0.57	0.73	0.93

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
July 01, 2013 - September 30, 2013 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	4.85	13.10	na	na	8.97	11.40	14.55
$0/Max $5000	4.61	12.45	na	na	8.53	10.83	13.83
$0/Max $2500	4.32	11.66	na	na	7.99	10.15	12.96
$25	4.61	12.45	na	na	8.53	10.83	13.83
$50	4.32	11.66	na	na	7.99	10.15	12.96
$100	3.94	10.64	na	na	7.29	9.26	11.82
$500	1.88	5.08	na	na	3.48	4.42	5.64
$5,000	0.32	0.86	na	na	0.59	0.75	0.96
Coinsurance							
80%	3.87	10.45	na	na	7.16	9.09	11.61
75%	3.64	9.83	na	na	6.73	8.55	10.92
70%	3.41	9.21	na	na	6.31	8.01	10.23
Deductible			**Orthotics Riders**				
$0	0.81	2.19	na	na	1.50	1.90	2.43
$0/Max $5000	0.78	2.11	na	na	1.44	1.83	2.34
$0/Max $2500	0.74	2.00	na	na	1.37	1.74	2.22
$25	0.78	2.11	na	na	1.44	1.83	2.34
$50	0.74	2.00	na	na	1.37	1.74	2.22
$100	0.68	1.84	na	na	1.26	1.60	2.04
$500	0.34	0.92	na	na	0.63	0.80	1.02
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.68	1.84	na	na	1.26	1.60	2.04
75%	0.65	1.76	na	na	1.20	1.53	1.95
70%	0.62	1.67	na	na	1.15	1.46	1.86
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.57	4.24	na	na	2.90	3.69	4.71
12 Months	2.53	6.83	na	na	4.68	5.95	7.59
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.46	6.64	na	na	4.55	5.78	7.38
12 Months	3.93	10.61	na	na	7.27	9.24	11.79
			Private Duty Nursing Riders				
In Full	0.60	1.62	na	na	1.11	1.41	1.80
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
			Dental Network Access				
	0.47	1.27	na	na	0.87	1.10	1.41
Limit			**Infertility Rider**				
2 IVF	10.26	27.70	na	na	18.98	24.11	30.78
3 IVF	12.38	33.43	na	na	22.90	29.09	37.14
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.72	12.74	na	na	8.73	11.09	14.16
Health Club Reimbursement							
$200 per year	1.22	3.29	na	na	2.26	2.87	3.66
			Nurse Advice Line Rider				
	0.32	0.86	na	na	0.59	0.75	0.96

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO 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	0.11	0.30	na	na	0.20	0.26	0.33
$0/Max $5000	0.11	0.30	na	na	0.20	0.25	0.33
$0/Max $2500	0.11	0.29	na	na	0.20	0.26	0.33
$25	0.11	0.30	na	na	0.20	0.25	0.33
$50	0.11	0.29	na	na	0.20	0.26	0.33
$100	0.09	0.24	na	na	0.17	0.21	0.27
$500	0.04	0.11	na	na	0.08	0.10	0.12
$5,000	0.01	0.02	na	na	0.02	0.02	0.03
Coinsurance							
80%	0.08	0.22	na	na	0.15	0.18	0.24
75%	0.09	0.24	na	na	0.16	0.21	0.27
70%	0.08	0.22	na	na	0.15	0.18	0.24
Deductible			**Orthotics Riders**				
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0/Max $5000	0.01	0.03	na	na	0.02	0.02	0.03
$0/Max $2500	0.01	0.03	na	na	0.02	0.02	0.03
$25	0.01	0.03	na	na	0.02	0.02	0.03
$50	0.01	0.03	na	na	0.02	0.02	0.03
$100	0.02	0.06	na	na	0.04	0.05	0.06
$500	0.01	0.03	na	na	0.02	0.02	0.03
$5,000	-	-	na	na	-	-	-
Coinsurance							
80%	0.02	0.06	na	na	0.04	0.05	0.06
75%	0.02	0.06	na	na	0.03	0.05	0.06
70%	0.02	0.05	na	na	0.04	0.05	0.06
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.04	0.11	na	na	0.07	0.09	0.12
12 Months	0.05	0.13	na	na	0.09	0.12	0.15
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.05	0.13	na	na	0.09	0.12	0.15
12 Months	0.09	0.24	na	na	0.17	0.22	0.27
			Private Duty Nursing Riders				
In Full	0.02	0.05	na	na	0.04	0.05	0.06
80% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
100% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
			Dental Network Access				
	-	-	na	na	-	-	-
Limit			**Infertility Rider**				
2 IVF	0.24	0.65	na	na	0.44	0.56	0.72
3 IVF	0.29	0.79	na	na	0.53	0.68	0.87
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	0.11	0.29	na	na	0.20	0.26	0.33
Health Club Reimbursement							
$200 per year	0.03	0.08	na	na	0.06	0.07	0.09
			Nurse Advice Line Rider				
	0.01	0.02	na	na	0.02	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
HIP HMO 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	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0/Max $5000	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
$0/Max $2500	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
$25	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
$50	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
$100	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$500	2.2%	2.2%	na	na	2.4%	2.3%	2.2%
$5,000	3.2%	2.4%	na	na	3.5%	2.7%	3.2%
Coinsurance							
80%	2.1%	2.2%	na	na	2.1%	2.0%	2.1%
75%	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
70%	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
Deductible			**Orthotics Riders**				
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0/Max $5000	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0/Max $2500	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
$25	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$50	1.4%	1.5%	na	na	1.5%	1.2%	1.4%
$100	3.0%	3.4%	na	na	3.3%	3.2%	3.0%
$500	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$5,000	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Coinsurance							
80%	3.0%	3.4%	na	na	3.3%	3.2%	3.0%
75%	3.2%	3.5%	na	na	2.6%	3.4%	3.2%
70%	3.3%	3.1%	na	na	3.6%	3.5%	3.3%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	2.6%	2.7%	na	na	2.5%	2.5%	2.6%
12 Months	2.0%	1.9%	na	na	2.0%	2.1%	2.0%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.1%	2.0%	na	na	2.0%	2.1%	2.1%
12 Months	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
			Private Duty Nursing Riders				
In Full	3.4%	3.2%	na	na	3.7%	3.7%	3.4%
80% hrs 73-504	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
100% hrs 73-504	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
			Dental Network Access				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Limit			**Infertility Rider**				
2 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
3 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
Health Club Reimbursement							
$200 per year	2.5%	2.5%	na	na	2.7%	2.5%	2.5%
			Nurse Advice Line Rider				
24 Months	3.2%	2.4%	na	na	3.5%	2.7%	3.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Small Group *	476.25	1,352.55	na	na	881.06	1,119.19	1,428.75
Small Group *	476.25	1,352.55	na	na	881.06	1,119.19	1,428.75

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee Child(ren	Employee & Spouse	Family
			Effective 07/01/2013 - 09/30/2013 (With WH & Autism)				
Small Group *	500.39	1,421.11	na	na	925.72	1,175.92	1,501.17
			Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)				
	495.45	1,407.08	na	na	916.58	1,164.31	1,486.35

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 07/01/2013 - 09/30/2013 (With WH & Autism)				
Small Group *	24.14	68.56	na	na	44.66	56.73	72.42
			Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)				
Small Group *	19.20	54.53	na	na	35.52	45.12	57.60

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee Child(ren	Employee & Spouse	Family
			Effective 07/01/2013 - 09/30/2013 (With WH & Autism)				
Small Group *	5.1%	5.1%	n/a	n/a	5.1%	5.1%	5.1%
			Effective 07/01/2013 - 09/30/2013 (Without WH & Autism)				
Small Group *	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 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	na	na	0.00	0.00	0.00
$5	(4.19)	(11.90)	na	na	(7.75)	(9.85)	(12.57)
$10	(8.80)	(24.99)	na	na	(16.28)	(20.68)	(26.40)
$15	(13.61)	(38.65)	na	na	(25.18)	(31.98)	(40.83)
$20	(19.60)	(55.66)	na	na	(36.26)	(46.06)	(58.80)
$25	(36.38)	(103.32)	na	na	(67.30)	(85.49)	(109.14)
$30	(57.79)	(164.12)	na	na	(106.91)	(135.81)	(173.37)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.40)	(6.82)	na	na	(4.44)	(5.64)	(7.20)
$10	(5.05)	(14.34)	na	na	(9.34)	(11.87)	(15.15)
$15	(7.80)	(22.15)	na	na	(14.43)	(18.33)	(23.40)
$20	(11.24)	(31.92)	na	na	(20.79)	(26.41)	(33.72)
$25	(20.84)	(59.19)	na	na	(38.55)	(48.97)	(62.52)
$30	(33.14)	(94.12)	na	na	(61.31)	(77.88)	(99.42)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.97)	(8.43)	na	na	(5.49)	(6.98)	(8.91)
$10	(6.09)	(17.30)	na	na	(11.27)	(14.31)	(18.27)
$15	(9.24)	(26.24)	na	na	(17.09)	(21.71)	(27.72)
$20	(12.57)	(35.70)	na	na	(23.25)	(29.54)	(37.71)
$25	(18.67)	(53.02)	na	na	(34.54)	(43.87)	(56.01)
$30	(26.36)	(74.86)	na	na	(48.77)	(61.95)	(79.08)
$35	(34.48)	(97.92)	na	na	(63.79)	(81.03)	(103.44)
$40	(43.60)	(123.82)	na	na	(80.66)	(102.46)	(130.80)
$45	(53.80)	(152.79)	na	na	(99.53)	(126.43)	(161.40)
$50	(65.07)	(184.80)	na	na	(120.38)	(152.91)	(195.21)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.49)	(7.07)	na	na	(4.61)	(5.85)	(7.47)
$10	(5.15)	(14.63)	na	na	(9.53)	(12.10)	(15.45)
$15	(7.81)	(22.18)	na	na	(14.45)	(18.35)	(23.43)
$20	(10.63)	(30.19)	na	na	(19.67)	(24.98)	(31.89)
$25	(15.79)	(44.84)	na	na	(29.21)	(37.11)	(47.37)
$30	(22.26)	(63.22)	na	na	(41.18)	(52.31)	(66.78)
$35	(29.14)	(82.76)	na	na	(53.91)	(68.48)	(87.42)
$40	(36.88)	(104.74)	na	na	(68.23)	(86.67)	(110.64)
$45	(45.48)	(129.16)	na	na	(84.14)	(106.88)	(136.44)
$50	(55.02)	(156.26)	na	na	(101.79)	(129.30)	(165.06)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.37)	(6.73)	na	na	(4.38)	(5.57)	(7.11)
$150	(3.96)	(11.25)	na	na	(7.33)	(9.31)	(11.88)
$200	(5.71)	(16.22)	na	na	(10.56)	(13.42)	(17.13)
$250	(8.24)	(23.40)	na	na	(15.24)	(19.36)	(24.72)
$500	(20.26)	(57.54)	na	na	(37.48)	(47.61)	(60.78)
$750	(35.48)	(100.76)	na	na	(65.64)	(83.38)	(106.44)
$1,000	(54.18)	(153.87)	na	na	(100.23)	(127.32)	(162.54)
Copay/Day							
$50 w/3 Day Max	(3.41)	(9.68)	na	na	(6.31)	(8.01)	(10.23)
$50 w/5 Day Max	(4.62)	(13.12)	na	na	(8.55)	(10.86)	(13.86)
$100 w/3 Day Max	(7.28)	(20.68)	na	na	(13.47)	(17.11)	(21.84)
$100 w/5 Day Max	(12.40)	(35.22)	na	na	(22.94)	(29.14)	(37.20)
$250 w/3 Day Max	(24.06)	(68.33)	na	na	(44.51)	(56.54)	(72.18)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.33)	(3.78)	na	na	(2.46)	(3.13)	(3.99)
$75	(2.32)	(6.59)	na	na	(4.29)	(5.45)	(6.96)
$100	(3.49)	(9.91)	na	na	(6.46)	(8.20)	(10.47)
$125	(4.84)	(13.75)	na	na	(8.95)	(11.37)	(14.52)
$150	(6.42)	(18.23)	na	na	(11.88)	(15.09)	(19.26)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.47)	(1.33)	na	na	(0.87)	(1.10)	(1.41)
$25	(0.85)	(2.41)	na	na	(1.57)	(2.00)	(2.55)
$35	(1.44)	(4.09)	na	na	(2.66)	(3.38)	(4.32)
$50	(2.38)	(6.76)	na	na	(4.40)	(5.59)	(7.14)
$60	(3.02)	(8.58)	na	na	(5.59)	(7.10)	(9.06)
$75	(3.89)	(11.05)	na	na	(7.20)	(9.14)	(11.67)
$100	(5.46)	(15.51)	na	na	(10.10)	(12.83)	(16.38)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 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	na	na	0.00	0.00	0.00
$5	(4.36)	(12.38)	na	na	(8.07)	(10.25)	(13.08)
$10	(9.15)	(25.99)	na	na	(16.93)	(21.50)	(27.45)
$15	(14.16)	(40.21)	na	na	(26.20)	(33.28)	(42.48)
$20	(20.39)	(57.91)	na	na	(37.72)	(47.92)	(61.17)
$25	(37.84)	(107.47)	na	na	(70.00)	(88.92)	(113.52)
$30	(60.12)	(170.74)	na	na	(111.22)	(141.28)	(180.36)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.49)	(7.07)	na	na	(4.61)	(5.85)	(7.47)
$10	(5.25)	(14.91)	na	na	(9.71)	(12.34)	(15.75)
$15	(8.11)	(23.03)	na	na	(15.00)	(19.06)	(24.33)
$20	(11.70)	(33.23)	na	na	(21.65)	(27.50)	(35.10)
$25	(21.68)	(61.57)	na	na	(40.11)	(50.95)	(65.04)
$30	(34.47)	(97.89)	na	na	(63.77)	(81.00)	(103.41)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.09)	(8.78)	na	na	(5.72)	(7.26)	(9.27)
$10	(6.33)	(17.98)	na	na	(11.71)	(14.88)	(18.99)
$15	(9.62)	(27.32)	na	na	(17.80)	(22.61)	(28.86)
$20	(13.08)	(37.15)	na	na	(24.20)	(30.74)	(39.24)
$25	(19.42)	(55.15)	na	na	(35.93)	(45.64)	(58.26)
$30	(27.42)	(77.87)	na	na	(50.73)	(64.44)	(82.26)
$35	(35.87)	(101.87)	na	na	(66.36)	(84.29)	(107.61)
$40	(45.36)	(128.82)	na	na	(83.92)	(106.60)	(136.08)
$45	(55.96)	(158.93)	na	na	(103.53)	(131.51)	(167.88)
$50	(67.69)	(192.24)	na	na	(125.23)	(159.07)	(203.07)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.59)	(7.36)	na	na	(4.79)	(6.09)	(7.77)
$10	(5.35)	(15.19)	na	na	(9.90)	(12.57)	(16.05)
$15	(8.12)	(23.06)	na	na	(15.02)	(19.08)	(24.36)
$20	(11.06)	(31.41)	na	na	(20.46)	(25.99)	(33.18)
$25	(16.42)	(46.63)	na	na	(30.38)	(38.59)	(49.26)
$30	(23.16)	(65.77)	na	na	(42.85)	(54.43)	(69.48)
$35	(30.31)	(86.08)	na	na	(56.07)	(71.23)	(90.93)
$40	(38.37)	(108.97)	na	na	(70.98)	(90.17)	(115.11)
$45	(47.31)	(134.36)	na	na	(87.52)	(111.18)	(141.93)
$50	(57.24)	(162.56)	na	na	(105.89)	(134.51)	(171.72)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.46)	(6.99)	na	na	(4.55)	(5.78)	(7.38)
$150	(4.12)	(11.70)	na	na	(7.62)	(9.68)	(12.36)
$200	(5.94)	(16.87)	na	na	(10.99)	(13.96)	(17.82)
$250	(8.57)	(24.34)	na	na	(15.85)	(20.14)	(25.71)
$500	(21.08)	(59.87)	na	na	(39.00)	(49.54)	(63.24)
$750	(36.91)	(104.82)	na	na	(68.28)	(86.74)	(110.73)
$1,000	(56.37)	(160.09)	na	na	(104.28)	(132.47)	(169.11)
Copay/Day							
$50 w/3 Day Max	(3.55)	(10.08)	na	na	(6.57)	(8.34)	(10.65)
$50 w/5 Day Max	(4.81)	(13.66)	na	na	(8.90)	(11.30)	(14.43)
$100 w/3 Day Max	(7.58)	(21.53)	na	na	(14.02)	(17.81)	(22.74)
$100 w/5 Day Max	(12.90)	(36.64)	na	na	(23.87)	(30.32)	(38.70)
$250 w/3 Day Max	(25.03)	(71.09)	na	na	(46.31)	(58.82)	(75.09)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.38)	(3.92)	na	na	(2.55)	(3.24)	(4.14)
$75	(2.41)	(6.84)	na	na	(4.46)	(5.66)	(7.23)
$100	(3.63)	(10.31)	na	na	(6.72)	(8.53)	(10.89)
$125	(5.04)	(14.31)	na	na	(9.32)	(11.84)	(15.12)
$150	(6.68)	(18.97)	na	na	(12.36)	(15.70)	(20.04)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.89)	(2.53)	na	na	(1.65)	(2.09)	(2.67)
$35	(1.49)	(4.23)	na	na	(2.76)	(3.50)	(4.47)
$50	(2.47)	(7.01)	na	na	(4.57)	(5.80)	(7.41)
$60	(3.14)	(8.92)	na	na	(5.81)	(7.38)	(9.42)
$75	(4.05)	(11.50)	na	na	(7.49)	(9.52)	(12.15)
$100	(5.68)	(16.13)	na	na	(10.51)	(13.35)	(17.04)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	-	-	na	na	-	-	-
$5	(0.17)	(0.48)	na	na	(0.32)	(0.40)	(0.51)
$10	(0.35)	(1.00)	na	na	(0.65)	(0.82)	(1.05)
$15	(0.55)	(1.56)	na	na	(1.02)	(1.30)	(1.65)
$20	(0.79)	(2.25)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.46)	(4.15)	na	na	(2.70)	(3.43)	(4.38)
$30	(2.33)	(6.62)	na	na	(4.31)	(5.47)	(6.99)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.09)	(0.25)	na	na	(0.17)	(0.21)	(0.27)
$10	(0.20)	(0.57)	na	na	(0.37)	(0.47)	(0.60)
$15	(0.31)	(0.88)	na	na	(0.57)	(0.73)	(0.93)
$20	(0.46)	(1.31)	na	na	(0.86)	(1.09)	(1.38)
$25	(0.84)	(2.38)	na	na	(1.56)	(1.98)	(2.52)
$30	(1.33)	(3.77)	na	na	(2.46)	(3.12)	(3.99)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.12)	(0.35)	na	na	(0.23)	(0.28)	(0.36)
$10	(0.24)	(0.68)	na	na	(0.44)	(0.57)	(0.72)
$15	(0.38)	(1.08)	na	na	(0.71)	(0.90)	(1.14)
$20	(0.51)	(1.45)	na	na	(0.95)	(1.20)	(1.53)
$25	(0.75)	(2.13)	na	na	(1.39)	(1.77)	(2.25)
$30	(1.06)	(3.01)	na	na	(1.96)	(2.49)	(3.18)
$35	(1.39)	(3.95)	na	na	(2.57)	(3.26)	(4.17)
$40	(1.76)	(5.00)	na	na	(3.26)	(4.14)	(5.28)
$45	(2.16)	(6.14)	na	na	(4.00)	(5.08)	(6.48)
$50	(2.62)	(7.44)	na	na	(4.85)	(6.16)	(7.86)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.10)	(0.29)	na	na	(0.18)	(0.24)	(0.30)
$10	(0.20)	(0.56)	na	na	(0.37)	(0.47)	(0.60)
$15	(0.31)	(0.88)	na	na	(0.57)	(0.73)	(0.93)
$20	(0.43)	(1.22)	na	na	(0.79)	(1.01)	(1.29)
$25	(0.63)	(1.79)	na	na	(1.17)	(1.48)	(1.89)
$30	(0.90)	(2.55)	na	na	(1.67)	(2.12)	(2.70)
$35	(1.17)	(3.32)	na	na	(2.16)	(2.75)	(3.51)
$40	(1.49)	(4.23)	na	na	(2.75)	(3.50)	(4.47)
$45	(1.83)	(5.20)	na	na	(3.38)	(4.30)	(5.49)
$50	(2.22)	(6.30)	na	na	(4.10)	(5.21)	(6.66)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$100	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$150	(0.16)	(0.45)	na	na	(0.29)	(0.37)	(0.48)
$200	(0.23)	(0.65)	na	na	(0.43)	(0.54)	(0.69)
$250	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
$500	(0.82)	(2.33)	na	na	(1.52)	(1.93)	(2.46)
$750	(1.43)	(4.06)	na	na	(2.64)	(3.36)	(4.29)
$1,000	(2.19)	(6.22)	na	na	(4.05)	(5.15)	(6.57)
Copay/Day							
$50 w/3 Day Max	(0.14)	(0.40)	na	na	(0.26)	(0.33)	(0.42)
$50 w/5 Day Max	(0.19)	(0.54)	na	na	(0.35)	(0.44)	(0.57)
$100 w/3 Day Max	(0.30)	(0.85)	na	na	(0.55)	(0.70)	(0.90)
$100 w/5 Day Max	(0.50)	(1.42)	na	na	(0.93)	(1.18)	(1.50)
$250 w/3 Day Max	(0.97)	(2.76)	na	na	(1.80)	(2.28)	(2.91)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$50	(0.05)	(0.14)	na	na	(0.09)	(0.11)	(0.15)
$75	(0.09)	(0.25)	na	na	(0.17)	(0.21)	(0.27)
$100	(0.14)	(0.40)	na	na	(0.26)	(0.33)	(0.42)
$125	(0.20)	(0.56)	na	na	(0.37)	(0.47)	(0.60)
$150	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$15	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$25	(0.04)	(0.12)	na	na	(0.08)	(0.09)	(0.12)
$35	(0.05)	(0.14)	na	na	(0.10)	(0.12)	(0.15)
$50	(0.09)	(0.25)	na	na	(0.17)	(0.21)	(0.27)
$60	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$75	(0.16)	(0.45)	na	na	(0.29)	(0.38)	(0.48)
$100	(0.22)	(0.62)	na	na	(0.41)	(0.52)	(0.66)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
$10	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$15	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%
$20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$25	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	3.8%	3.7%	n/a	n/a	3.8%	3.7%	3.7%
$10	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$15	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$20	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$25	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	4.0%	4.2%	n/a	n/a	4.2%	4.0%	4.0%
$10	3.9%	3.9%	n/a	n/a	3.9%	4.0%	3.9%
$15	4.1%	4.1%	n/a	n/a	4.2%	4.1%	4.1%
$20	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$25	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$35	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$45	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$50	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	4.0%	4.1%	n/a	n/a	3.9%	4.1%	4.0%
$10	3.9%	3.8%	n/a	n/a	3.9%	3.9%	3.9%
$15	4.0%	4.0%	n/a	n/a	3.9%	4.0%	4.0%
$20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$25	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$30	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%
$35	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$45	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$50	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$100	3.8%	3.9%	n/a	n/a	3.9%	3.8%	3.8%
$150	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$200	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
$250	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$500	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%
$750	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$1,000	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Copay/Day							
$50 w/3 Day Max	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$50 w/5 Day Max	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$100 w/3 Day Max	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$100 w/5 Day Max	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
$250 w/3 Day Max	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	3.8%	3.7%	n/a	n/a	3.7%	3.5%	3.8%
$75	3.9%	3.8%	n/a	n/a	4.0%	3.9%	3.9%
$100	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$125	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
$150	4.0%	4.1%	n/a	n/a	4.0%	4.0%	4.0%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	2.1%	2.3%	n/a	n/a	2.3%	2.7%	2.1%
$25	4.7%	5.0%	n/a	n/a	5.1%	4.5%	4.7%
$35	3.5%	3.4%	n/a	n/a	3.8%	3.6%	3.5%
$50	3.8%	3.7%	n/a	n/a	3.9%	3.8%	3.8%
$60	4.0%	4.0%	n/a	n/a	3.9%	3.9%	4.0%
$75	4.1%	4.1%	n/a	n/a	4.0%	4.2%	4.1%
$100	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$125	(7.16)	(20.33)	na	na	(13.25)	(16.83)	(21.48)
$150	(9.02)	(25.62)	na	na	(16.69)	(21.20)	(27.06)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.65	1.85	na	na	1.20	1.53	1.95
60	1.26	3.58	na	na	2.33	2.96	3.78
90	1.88	5.34	na	na	3.48	4.42	5.64
120	2.20	6.25	na	na	4.07	5.17	6.60
Unlimited	2.82	8.01	na	na	5.22	6.63	8.46
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.34)	(0.97)	na	na	(0.63)	(0.80)	(1.02)
40/$15 copay	(0.50)	(1.42)	na	na	(0.93)	(1.18)	(1.50)
40/$20 copay	(0.71)	(2.02)	na	na	(1.31)	(1.67)	(2.13)
40/$25 copay	(0.92)	(2.61)	na	na	(1.70)	(2.16)	(2.76)
60	0.34	0.97	na	na	0.63	0.80	1.02
100	0.82	2.33	na	na	1.52	1.93	2.46
200	2.21	6.28	na	na	4.09	5.19	6.63
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.31)	(3.72)	na	na	(2.42)	(3.08)	(3.93)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.87	2.47	na	na	1.61	2.04	2.61
90	1.82	5.17	na	na	3.37	4.28	5.46
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.77	2.19	na	na	1.42	1.81	2.31
90	1.43	4.06	na	na	2.65	3.36	4.29
120	2.28	6.48	na	na	4.22	5.36	6.84
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.10)	(3.12)	na	na	(2.04)	(2.59)	(3.30)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.32	0.91	na	na	0.59	0.75	0.96
30	0.52	1.48	na	na	0.96	1.22	1.56
Unlimited	0.77	2.19	na	na	1.42	1.81	2.31
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.89	11.05	na	na	7.20	9.14	11.67
60	4.56	12.95	na	na	8.44	10.72	13.68
90	5.44	15.45	na	na	10.06	12.78	16.32
Unlimited	5.51	15.65	na	na	10.19	12.95	16.53
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.27)	(0.77)	na	na	(0.50)	(0.63)	(0.81)
60/$15 copay	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)
60/$20 copay	(0.63)	(1.79)	na	na	(1.17)	(1.48)	(1.89)
60/$25 copay	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
120/$0 copay	0.69	1.96	na	na	1.28	1.62	2.07
120/$5 copay	0.54	1.53	na	na	1.00	1.27	1.62
120/$10 copay	0.34	0.97	na	na	0.63	0.80	1.02
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.32)	(0.91)	na	na	(0.59)	(0.75)	(0.96)
Unlimited/$0 copay	0.79	2.24	na	na	1.46	1.86	2.37
Unlimited/$5 copay	0.64	1.82	na	na	1.18	1.50	1.92
Unlimited/$10 copay	0.41	1.16	na	na	0.76	0.96	1.23
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.19	0.54	na	na	0.35	0.45	0.57
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$125	(7.44)	(21.13)	na	na	(13.76)	(17.48)	(22.32)
$150	(9.38)	(26.64)	na	na	(17.35)	(22.04)	(28.14)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.68	1.93	na	na	1.26	1.60	2.04
60	1.31	3.72	na	na	2.42	3.08	3.93
90	1.96	5.57	na	na	3.63	4.61	5.88
120	2.29	6.50	na	na	4.24	5.38	6.87
Unlimited	2.93	8.32	na	na	5.42	6.89	8.79
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.53)	(1.51)	na	na	(0.98)	(1.25)	(1.59)
40/$20 copay	(0.74)	(2.10)	na	na	(1.37)	(1.74)	(2.22)
40/$25 copay	(0.96)	(2.73)	na	na	(1.78)	(2.26)	(2.88)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.85	2.41	na	na	1.57	2.00	2.55
200	2.30	6.53	na	na	4.26	5.41	6.90
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.36)	(3.86)	na	na	(2.52)	(3.20)	(4.08)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.91	2.58	na	na	1.68	2.14	2.73
90	1.89	5.37	na	na	3.50	4.44	5.67
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.80	2.27	na	na	1.48	1.88	2.40
90	1.48	4.20	na	na	2.74	3.48	4.44
120	2.37	6.73	na	na	4.38	5.57	7.11
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.14)	(3.24)	na	na	(2.11)	(2.68)	(3.42)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.55	1.56	na	na	1.02	1.29	1.65
Unlimited	0.80	2.27	na	na	1.48	1.88	2.40
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.05	11.50	na	na	7.49	9.52	12.15
60	4.75	13.49	na	na	8.79	11.16	14.25
90	5.66	16.07	na	na	10.47	13.30	16.98
Unlimited	5.74	16.30	na	na	10.62	13.49	17.22
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.66)	(1.87)	na	na	(1.22)	(1.55)	(1.98)
60/$25 copay	(0.76)	(2.16)	na	na	(1.41)	(1.79)	(2.28)
120/$0 copay	0.72	2.04	na	na	1.33	1.69	2.16
120/$5 copay	0.57	1.62	na	na	1.05	1.34	1.71
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.82	2.33	na	na	1.52	1.93	2.46
Unlimited/$5 copay	0.67	1.90	na	na	1.24	1.57	2.01
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(0.28)	(0.80)	na	na	(0.51)	(0.65)	(0.84)
$150	(0.36)	(1.02)	na	na	(0.66)	(0.84)	(1.08)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	-	-	na	na	-	-	-
45	0.03	0.08	na	na	0.06	0.07	0.09
60	0.05	0.14	na	na	0.09	0.12	0.15
90	0.08	0.23	na	na	0.15	0.19	0.24
120	0.09	0.25	na	na	0.17	0.21	0.27
Unlimited	0.11	0.31	na	na	0.20	0.26	0.33
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	-	-	na	na	-	-	-
40/$5 copay	-	-	na	na	-	-	-
40/$10 copay	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
40/$15 copay	(0.03)	(0.09)	na	na	(0.05)	(0.07)	(0.09)
40/$20 copay	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
40/$25 copay	(0.04)	(0.12)	na	na	(0.08)	(0.10)	(0.12)
60	0.01	0.02	na	na	0.02	0.02	0.03
100	0.03	0.08	na	na	0.05	0.07	0.09
200	0.09	0.25	na	na	0.17	0.22	0.27
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(0.05)	(0.14)	na	na	(0.10)	(0.12)	(0.15)
30	-	-	na	na	-	-	-
60	0.04	0.11	na	na	0.07	0.10	0.12
90	0.07	0.20	na	na	0.13	0.16	0.21
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	-	-	na	na	-	-	-
60	0.03	0.08	na	na	0.06	0.07	0.09
90	0.05	0.14	na	na	0.09	0.12	0.15
120	0.09	0.25	na	na	0.16	0.21	0.27
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(0.04)	(0.12)	na	na	(0.07)	(0.09)	(0.12)
7	-	-	na	na	-	-	-
21	0.01	0.03	na	na	0.02	0.03	0.03
30	0.03	0.08	na	na	0.06	0.07	0.09
Unlimited	0.03	0.08	na	na	0.06	0.07	0.09
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	-	-	na	na	-	-	-
30	0.16	0.45	na	na	0.29	0.38	0.48
60	0.19	0.54	na	na	0.35	0.44	0.57
90	0.22	0.62	na	na	0.41	0.52	0.66
Unlimited	0.23	0.65	na	na	0.43	0.54	0.69
# 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	-	-	na	na	-	-	-
60/$5 copay	-	-	na	na	-	-	-
60/$10 copay	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
60/$15 copay	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
60/$20 copay	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
60/$25 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
120/$0 copay	0.03	0.08	na	na	0.05	0.07	0.09
120/$5 copay	0.03	0.09	na	na	0.05	0.07	0.09
120/$10 copay	0.01	0.02	na	na	0.02	0.02	0.03
120/$15 copay	-	-	na	na	-	-	-
120/$20 copay	-	-	na	na	-	-	-
120/$25 copay	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
Unlimited/$0 copay	0.03	0.09	na	na	0.06	0.07	0.09
Unlimited/$5 copay	0.03	0.08	na	na	0.06	0.07	0.09
Unlimited/$10 copay	0.01	0.03	na	na	0.02	0.03	0.03
Unlimited/$15 copay	-	-	na	na	-	-	-
Unlimited/$20 copay	-	-	na	na	-	-	-
Unlimited/$25 copay	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.01	0.03	na	na	0.02	0.02	0.03
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	3.9%	3.9%	n/a	n/a	3.8%	3.9%	3.9%
$150	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
45	4.6%	4.3%	n/a	n/a	5.0%	4.6%	4.6%
60	4.0%	3.9%	n/a	n/a	3.9%	4.1%	4.0%
90	4.3%	4.3%	n/a	n/a	4.3%	4.3%	4.3%
120	4.1%	4.0%	n/a	n/a	4.2%	4.1%	4.1%
Unlimited	3.9%	3.9%	n/a	n/a	3.8%	3.9%	3.9%
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
40/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
40/$10 copay	2.9%	2.1%	n/a	n/a	3.2%	2.5%	2.9%
40/$15 copay	6.0%	6.3%	n/a	n/a	5.4%	5.9%	6.0%
40/$20 copay	4.2%	4.0%	n/a	n/a	4.6%	4.2%	4.2%
40/$25 copay	4.3%	4.6%	n/a	n/a	4.7%	4.6%	4.3%
60	2.9%	2.1%	n/a	n/a	3.2%	2.5%	2.9%
100	3.7%	3.4%	n/a	n/a	3.3%	3.6%	3.7%
200	4.1%	4.0%	n/a	n/a	4.2%	4.2%	4.1%
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	3.8%	3.8%	n/a	n/a	4.1%	3.9%	3.8%
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	4.6%	4.5%	n/a	n/a	4.3%	4.9%	4.6%
90	3.8%	3.9%	n/a	n/a	3.9%	3.7%	3.8%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
90	3.5%	3.4%	n/a	n/a	3.4%	3.6%	3.5%
120	3.9%	3.9%	n/a	n/a	3.8%	3.9%	3.9%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	3.6%	3.8%	n/a	n/a	3.4%	3.5%	3.6%
7	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
21	3.1%	3.3%	n/a	n/a	3.4%	4.0%	3.1%
30	5.8%	5.4%	n/a	n/a	6.3%	5.7%	5.8%
Unlimited	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
30	4.1%	4.1%	n/a	n/a	4.0%	4.2%	4.1%
60	4.2%	4.2%	n/a	n/a	4.1%	4.1%	4.2%
90	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%
Unlimited	4.2%	4.2%	n/a	n/a	4.2%	4.2%	4.2%
# 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$10 copay	3.7%	3.9%	n/a	n/a	4.0%	4.8%	3.7%
60/$15 copay	2.3%	2.5%	n/a	n/a	1.3%	2.0%	2.3%
60/$20 copay	4.8%	4.5%	n/a	n/a	4.3%	4.7%	4.8%
60/$25 copay	4.1%	4.3%	n/a	n/a	4.4%	4.1%	4.1%
120/$0 copay	4.3%	4.1%	n/a	n/a	3.9%	4.3%	4.3%
120/$5 copay	5.6%	5.9%	n/a	n/a	5.0%	5.5%	5.6%
120/$10 copay	2.9%	2.1%	n/a	n/a	3.2%	2.5%	2.9%
120/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$25 copay	3.1%	3.3%	n/a	n/a	3.4%	4.0%	3.1%
Unlimited/$0 copay	3.8%	4.0%	n/a	n/a	4.1%	3.8%	3.8%
Unlimited/$5 copay	4.7%	4.4%	n/a	n/a	5.1%	4.7%	4.7%
Unlimited/$10 copay	2.4%	2.6%	n/a	n/a	2.6%	3.1%	2.4%
Unlimited/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$25 copay	4.0%	4.2%	n/a	n/a	4.3%	3.4%	4.0%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	5.3%	5.6%	n/a	n/a	5.7%	4.4%	5.3%
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
JULY 1, 2012 - SEPTEMBER 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	(0.24)	(0.68)	na	na	(0.44)	(0.56)	(0.72)
$25	(0.34)	(0.97)	na	na	(0.63)	(0.80)	(1.02)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.29)	(0.82)	na	na	(0.54)	(0.68)	(0.87)
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$20	(0.69)	(1.96)	na	na	(1.28)	(1.62)	(2.07)
$25	(0.87)	(2.47)	na	na	(1.61)	(2.04)	(2.61)
$30	(1.10)	(3.12)	na	na	(2.04)	(2.59)	(3.30)
$35	(1.28)	(3.64)	na	na	(2.37)	(3.01)	(3.84)
$40	(1.47)	(4.17)	na	na	(2.72)	(3.45)	(4.41)
$45	(1.68)	(4.77)	na	na	(3.11)	(3.95)	(5.04)
$50	(1.87)	(5.31)	na	na	(3.46)	(4.39)	(5.61)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$15	(0.52)	(1.48)	na	na	(0.96)	(1.22)	(1.56)
$20	(0.77)	(2.19)	na	na	(1.42)	(1.81)	(2.31)
$25	(1.04)	(2.95)	na	na	(1.92)	(2.44)	(3.12)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.24)	(0.68)	na	na	(0.44)	(0.56)	(0.72)
$50	(0.36)	(1.02)	na	na	(0.67)	(0.85)	(1.08)
$60	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)
$75	(0.59)	(1.68)	na	na	(1.09)	(1.39)	(1.77)
$100	(0.77)	(2.19)	na	na	(1.42)	(1.81)	(2.31)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$60	(0.29)	(0.82)	na	na	(0.54)	(0.68)	(0.87)
$75	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$100	(0.52)	(1.48)	na	na	(0.96)	(1.22)	(1.56)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.21)	(9.12)	na	na	(5.94)	(7.54)	(9.63)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(5.02)	(14.26)	na	na	(9.29)	(11.80)	(15.06)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.42)	(1.19)	na	na	(0.78)	(0.99)	(1.26)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.72)	(2.04)	na	na	(1.33)	(1.69)	(2.16)
$25	(0.91)	(2.58)	na	na	(1.68)	(2.14)	(2.73)
$30	(1.14)	(3.24)	na	na	(2.11)	(2.68)	(3.42)
$35	(1.33)	(3.78)	na	na	(2.46)	(3.13)	(3.99)
$40	(1.53)	(4.35)	na	na	(2.83)	(3.60)	(4.59)
$45	(1.75)	(4.97)	na	na	(3.24)	(4.11)	(5.25)
$50	(1.95)	(5.54)	na	na	(3.61)	(4.58)	(5.85)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.55)	(1.56)	na	na	(1.02)	(1.29)	(1.65)
$20	(0.80)	(2.27)	na	na	(1.48)	(1.88)	(2.40)
$25	(1.08)	(3.07)	na	na	(2.00)	(2.54)	(3.24)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.62)	(1.76)	na	na	(1.15)	(1.46)	(1.86)
$100	(0.80)	(2.27)	na	na	(1.48)	(1.88)	(2.40)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.55)	(1.56)	na	na	(1.02)	(1.29)	(1.65)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(3.34)	(9.49)	na	na	(6.18)	(7.85)	(10.02)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(5.22)	(14.82)	na	na	(9.66)	(12.27)	(15.66)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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)	na	na	(0.02)	(0.03)	(0.03)
$25	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$15	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$20	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$25	(0.04)	(0.11)	na	na	(0.07)	(0.10)	(0.12)
$30	(0.04)	(0.12)	na	na	(0.07)	(0.09)	(0.12)
$35	(0.05)	(0.14)	na	na	(0.09)	(0.12)	(0.15)
$40	(0.06)	(0.18)	na	na	(0.11)	(0.15)	(0.18)
$45	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$50	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$15	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$20	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$25	(0.04)	(0.12)	na	na	(0.08)	(0.10)	(0.12)
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$50	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$60	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$75	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$100	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$50	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$60	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$75	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$100	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	(0.20)	(0.56)	na	na	(0.37)	(0.47)	(0.60)
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	4.2%	4.4%	n/a	n/a	4.5%	5.4%	4.2%
$25	2.9%	2.1%	n/a	n/a	3.2%	2.5%	2.9%
Copay		**Refractive Eye Exam Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	3.4%	3.7%	n/a	n/a	3.7%	4.4%	3.4%
$15	2.1%	2.2%	n/a	n/a	2.2%	1.8%	2.1%
$20	4.3%	4.1%	n/a	n/a	3.9%	4.3%	4.3%
$25	4.6%	4.5%	n/a	n/a	4.3%	4.9%	4.6%
$30	3.6%	3.8%	n/a	n/a	3.4%	3.5%	3.6%
$35	3.9%	3.8%	n/a	n/a	3.8%	4.0%	3.9%
$40	4.1%	4.3%	n/a	n/a	4.0%	4.3%	4.1%
$45	4.2%	4.2%	n/a	n/a	4.2%	4.1%	4.2%
$50	4.3%	4.3%	n/a	n/a	4.3%	4.3%	4.3%
Copay		**Diabetic Supplies Copay [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	2.7%	2.9%	n/a	n/a	2.9%	2.3%	2.7%
$15	5.8%	5.4%	n/a	n/a	6.3%	5.7%	5.8%
$20	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
$25	3.8%	4.1%	n/a	n/a	4.2%	4.1%	3.8%
		Chemotherapy [std: $0]					
Copay		**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay		**Pre-Hospital Emergency Services [std: $0]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	4.2%	4.4%	n/a	n/a	4.5%	5.4%	4.2%
$50	2.8%	2.9%	n/a	n/a	1.5%	2.4%	2.8%
$60	2.3%	2.5%	n/a	n/a	1.3%	2.0%	2.3%
$75	5.1%	4.8%	n/a	n/a	5.5%	5.0%	5.1%
$100	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
		Ambulance Copay [std: $0]					
Copay		**[Copay same or less than Emergency Room Copay]**					
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$50	4.0%	4.2%	n/a	n/a	4.3%	3.4%	4.0%
$60	3.4%	3.7%	n/a	n/a	3.7%	4.4%	3.4%
$75	2.6%	2.8%	n/a	n/a	2.9%	3.4%	2.6%
$100	5.8%	5.4%	n/a	n/a	6.3%	5.7%	5.8%
		Surgery [std: $0 copay]					
		Copay per procedure of minimum of [20%, $300]					
	4.0%	4.1%	n/a	n/a	4.0%	4.1%	4.0%
		Diagnostic and Therapeutic Radiology [std: $0]					
		Copay per procedure of minimum (20%, $100); $500 annual maximum					
	4.0%	3.9%	n/a	n/a	4.0%	4.0%	4.0%
		Diagnostic Testing [std: $0]					
		Copay per procedure minimum of [20%, $100], $500 annual maximum					
	2.4%	2.5%	n/a	n/a	2.6%	2.0%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
JULY 1, 2012 - SEPTEMBER 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
July 01, 2013 - September 30, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
30	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			Class II Dependents				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.23	12.01	na	na	7.83	9.94	12.69
60	5.06	14.37	na	na	9.36	11.89	15.18
90	5.60	15.90	na	na	10.36	13.16	16.80
Unlimited	5.68	16.13	na	na	10.51	13.35	17.04
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	6.86	19.48	na	na	12.69	16.12	20.58
60	7.24	20.56	na	na	13.39	17.01	21.72
90	7.52	21.36	na	na	13.91	17.67	22.56
Unlimited	7.61	21.61	na	na	14.08	17.88	22.83
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.74	16.30	na	na	10.62	13.49	17.22
30	6.74	19.14	na	na	12.47	15.84	20.22
40	7.39	20.99	na	na	13.67	17.37	22.17
60	8.02	22.78	na	na	14.84	18.85	24.06
Unlimited	8.11	23.03	na	na	15.00	19.06	24.33
SMALL GROUP	**$5 Copay**						
20	5.41	15.36	na	na	10.01	12.71	16.23
30	6.33	17.98	na	na	11.71	14.88	18.99
40	6.94	19.71	na	na	12.84	16.31	20.82
60	7.53	21.39	na	na	13.93	17.70	22.59
Unlimited	7.61	21.61	na	na	14.08	17.88	22.83
SMALL GROUP	**$10 Copay**						
20	5.04	14.31	na	na	9.32	11.84	15.12
30	5.90	16.76	na	na	10.92	13.87	17.70
40	6.47	18.37	na	na	11.97	15.20	19.41
60	7.02	19.94	na	na	12.99	16.50	21.06
Unlimited	7.12	20.22	na	na	13.17	16.73	21.36
SMALL GROUP	**$15 Copay**						
20	4.73	13.43	na	na	8.75	11.12	14.19
30	5.53	15.71	na	na	10.23	13.00	16.59
40	6.07	17.24	na	na	11.23	14.26	18.21
60	6.60	18.74	na	na	12.21	15.51	19.80
Unlimited	6.66	18.91	na	na	12.32	15.65	19.98
SMALL GROUP	**$20 Copay**						
20	4.45	12.64	na	na	8.23	10.46	13.35
30	5.21	14.80	na	na	9.64	12.24	15.63
40	5.71	16.22	na	na	10.56	13.42	17.13
60	6.21	17.64	na	na	11.49	14.59	18.63
Unlimited	6.27	17.81	na	na	11.60	14.73	18.81
SMALL GROUP	**$25 Copay**						
20	4.15	11.79	na	na	7.68	9.75	12.45
30	4.85	13.77	na	na	8.97	11.40	14.55
40	5.29	15.02	na	na	9.79	12.43	15.87
60	5.76	16.36	na	na	10.66	13.54	17.28
Unlimited	5.82	16.53	na	na	10.77	13.68	17.46
SMALL GROUP	**$30 Copay**						
20	3.98	11.30	na	na	7.36	9.35	11.94
30	4.68	13.29	na	na	8.66	11.00	14.04
40	5.11	14.51	na	na	9.45	12.01	15.33
60	5.59	15.88	na	na	10.34	13.14	16.77
Unlimited	5.63	15.99	na	na	10.42	13.23	16.89
SMALL GROUP	**$35 Copay**						
20	3.87	10.99	na	na	7.16	9.09	11.61
30	4.53	12.87	na	na	8.38	10.65	13.59
40	4.99	14.17	na	na	9.23	11.73	14.97
60	5.41	15.36	na	na	10.01	12.71	16.23
Unlimited	5.45	15.48	na	na	10.08	12.81	16.35
SMALL GROUP	**$40 Copay**						
20	3.77	10.71	na	na	6.97	8.86	11.31
30	4.41	12.52	na	na	8.16	10.36	13.23
40	4.83	13.72	na	na	8.94	11.35	14.49
60	5.23	14.85	na	na	9.68	12.29	15.69
Unlimited	5.28	15.00	na	na	9.77	12.41	15.84
SMALL GROUP	**$45 Copay**						
20	3.65	10.37	na	na	6.75	8.58	10.95
30	4.27	12.13	na	na	7.90	10.03	12.81
40	4.67	13.26	na	na	8.64	10.97	14.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.40	12.50	na	na	8.14	10.34	13.20
60	5.26	14.94	na	na	9.73	12.36	15.78
90	5.83	16.56	na	na	10.79	13.70	17.49
Unlimited	5.91	16.78	na	na	10.93	13.89	17.73
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.14	20.28	na	na	13.21	16.78	21.42
60	7.53	21.39	na	na	13.93	17.70	22.59
90	7.83	22.24	na	na	14.49	18.40	23.49
Unlimited	7.92	22.49	na	na	14.65	18.61	23.76
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.97	16.95	na	na	11.04	14.03	17.91
30	7.01	19.91	na	na	12.97	16.47	21.03
40	7.69	21.84	na	na	14.23	18.07	23.07
60	8.34	23.69	na	na	15.43	19.60	25.02
Unlimited	8.43	23.94	na	na	15.60	19.81	25.29
SMALL GROUP	**$5 Copay**						
20	5.63	15.99	na	na	10.42	13.23	16.89
30	6.59	18.72	na	na	12.19	15.49	19.77
40	7.22	20.50	na	na	13.36	16.97	21.66
60	7.84	22.27	na	na	14.50	18.42	23.52
Unlimited	7.92	22.49	na	na	14.65	18.61	23.76
SMALL GROUP	**$10 Copay**						
20	5.24	14.88	na	na	9.69	12.31	15.72
30	6.14	17.44	na	na	11.36	14.43	18.42
40	6.73	19.11	na	na	12.45	15.82	20.19
60	7.30	20.73	na	na	13.51	17.16	21.90
Unlimited	7.40	21.02	na	na	13.69	17.39	22.20
SMALL GROUP	**$15 Copay**						
20	4.92	13.97	na	na	9.10	11.56	14.76
30	5.76	16.36	na	na	10.66	13.54	17.28
40	6.31	17.92	na	na	11.67	14.83	18.93
60	6.87	19.51	na	na	12.71	16.14	20.61
Unlimited	6.93	19.68	na	na	12.82	16.29	20.79
SMALL GROUP	**$20 Copay**						
20	4.63	13.15	na	na	8.57	10.88	13.89
30	5.42	15.39	na	na	10.03	12.74	16.26
40	5.94	16.87	na	na	10.99	13.96	17.82
60	6.46	18.35	na	na	11.95	15.18	19.38
Unlimited	6.52	18.52	na	na	12.06	15.32	19.56
SMALL GROUP	**$25 Copay**						
20	4.31	12.24	na	na	7.97	10.13	12.93
30	5.05	14.34	na	na	9.34	11.87	15.15
40	5.50	15.62	na	na	10.18	12.93	16.50
60	5.99	17.01	na	na	11.08	14.08	17.97
Unlimited	6.05	17.18	na	na	11.19	14.22	18.15
SMALL GROUP	**$30 Copay**						
20	4.14	11.76	na	na	7.66	9.73	12.42
30	4.87	13.83	na	na	9.01	11.44	14.61
40	5.31	15.08	na	na	9.82	12.48	15.93
60	5.82	16.53	na	na	10.77	13.68	17.46
Unlimited	5.86	16.64	na	na	10.84	13.77	17.58
SMALL GROUP	**$35 Copay**						
20	4.03	11.45	na	na	7.46	9.47	12.09
30	4.72	13.40	na	na	8.73	11.09	14.16
40	5.19	14.74	na	na	9.60	12.20	15.57
60	5.63	15.99	na	na	10.42	13.23	16.89
Unlimited	5.67	16.10	na	na	10.49	13.32	17.01
SMALL GROUP	**$40 Copay**						
20	3.92	11.13	na	na	7.25	9.21	11.76
30	4.59	13.04	na	na	8.49	10.79	13.77
40	5.02	14.26	na	na	9.29	11.80	15.06
60	5.44	15.45	na	na	10.06	12.78	16.32
Unlimited	5.49	15.59	na	na	10.16	12.90	16.47
SMALL GROUP	**$45 Copay**						
20	3.80	10.79	na	na	7.03	8.93	11.40
30	4.44	12.61	na	na	8.21	10.43	13.32
40	4.86	13.80	na	na	8.99	11.42	14.58

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.17	0.49	na	na	0.31	0.40	0.51
60	0.20	0.57	na	na	0.37	0.47	0.60
90	0.23	0.66	na	na	0.43	0.54	0.69
Unlimited	0.23	0.65	na	na	0.42	0.54	0.69
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.28	0.80	na	na	0.52	0.66	0.84
60	0.29	0.83	na	na	0.54	0.69	0.87
90	0.31	0.88	na	na	0.58	0.73	0.93
Unlimited	0.31	0.88	na	na	0.57	0.73	0.93
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.23	0.65	na	na	0.42	0.54	0.69
30	0.27	0.77	na	na	0.50	0.63	0.81
40	0.30	0.85	na	na	0.56	0.70	0.90
60	0.32	0.91	na	na	0.59	0.75	0.96
Unlimited	0.32	0.91	na	na	0.60	0.75	0.96
SMALL GROUP	**$5 Copay**						
20	0.22	0.63	na	na	0.41	0.52	0.66
30	0.26	0.74	na	na	0.48	0.61	0.78
40	0.28	0.79	na	na	0.52	0.66	0.84
60	0.31	0.88	na	na	0.57	0.72	0.93
Unlimited	0.31	0.88	na	na	0.57	0.73	0.93
SMALL GROUP	**$10 Copay**						
20	0.20	0.57	na	na	0.37	0.47	0.60
30	0.24	0.68	na	na	0.44	0.56	0.72
40	0.26	0.74	na	na	0.48	0.62	0.78
60	0.28	0.79	na	na	0.52	0.66	0.84
Unlimited	0.28	0.80	na	na	0.52	0.66	0.84
SMALL GROUP	**$15 Copay**						
20	0.19	0.54	na	na	0.35	0.44	0.57
30	0.23	0.65	na	na	0.43	0.54	0.69
40	0.24	0.68	na	na	0.44	0.57	0.72
60	0.27	0.77	na	na	0.50	0.63	0.81
Unlimited	0.27	0.77	na	na	0.50	0.64	0.81
SMALL GROUP	**$20 Copay**						
20	0.18	0.51	na	na	0.34	0.42	0.54
30	0.21	0.59	na	na	0.39	0.50	0.63
40	0.23	0.65	na	na	0.43	0.54	0.69
60	0.25	0.71	na	na	0.46	0.59	0.75
Unlimited	0.25	0.71	na	na	0.46	0.59	0.75
SMALL GROUP	**$25 Copay**						
20	0.16	0.45	na	na	0.29	0.38	0.48
30	0.20	0.57	na	na	0.37	0.47	0.60
40	0.21	0.60	na	na	0.39	0.50	0.63
60	0.23	0.65	na	na	0.42	0.54	0.69
Unlimited	0.23	0.65	na	na	0.42	0.54	0.69
SMALL GROUP	**$30 Copay**						
20	0.16	0.46	na	na	0.30	0.38	0.48
30	0.19	0.54	na	na	0.35	0.44	0.57
40	0.20	0.57	na	na	0.37	0.47	0.60
60	0.23	0.65	na	na	0.43	0.54	0.69
Unlimited	0.23	0.65	na	na	0.42	0.54	0.69
SMALL GROUP	**$35 Copay**						
20	0.16	0.46	na	na	0.30	0.38	0.48
30	0.19	0.53	na	na	0.35	0.44	0.57
40	0.20	0.57	na	na	0.37	0.47	0.60
60	0.22	0.63	na	na	0.41	0.52	0.66
Unlimited	0.22	0.62	na	na	0.41	0.51	0.66
SMALL GROUP	**$40 Copay**						
20	0.15	0.42	na	na	0.28	0.35	0.45
30	0.18	0.52	na	na	0.33	0.43	0.54
40	0.19	0.54	na	na	0.35	0.45	0.57
60	0.21	0.60	na	na	0.38	0.49	0.63
Unlimited	0.21	0.59	na	na	0.39	0.49	0.63
SMALL GROUP	**$45 Copay**						
20	0.15	0.42	na	na	0.28	0.35	0.45
30	0.17	0.48	na	na	0.31	0.40	0.51
40	0.19	0.54	na	na	0.35	0.45	0.57

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.0%	4.1%	n/a	n/a	4.0%	4.0%	4.0%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
90	4.1%	4.2%	n/a	n/a	4.2%	4.1%	4.1%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
60	4.0%	4.0%	n/a	n/a	4.0%	4.1%	4.0%
90	4.1%	4.1%	n/a	n/a	4.2%	4.1%	4.1%
Unlimited	4.1%	4.1%	n/a	n/a	4.0%	4.1%	4.1%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
40	4.1%	4.0%	n/a	n/a	4.1%	4.0%	4.1%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	3.9%	4.0%	n/a	n/a	4.0%	3.9%	3.9%
SMALL GROUP	**$5 Copay**						
20	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
30	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
60	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.1%	4.1%	n/a	n/a	4.0%	4.1%	4.1%
SMALL GROUP	**$10 Copay**						
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	4.1%	4.1%	n/a	n/a	4.0%	4.0%	4.1%
40	4.0%	4.0%	n/a	n/a	4.0%	4.1%	4.0%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	3.9%	4.0%	n/a	n/a	3.9%	3.9%	3.9%
SMALL GROUP	**$15 Copay**						
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	4.2%	4.1%	n/a	n/a	4.2%	4.2%	4.2%
40	4.0%	3.9%	n/a	n/a	3.9%	4.0%	4.0%
60	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
SMALL GROUP	**$20 Copay**						
20	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
30	4.0%	4.0%	n/a	n/a	4.0%	4.1%	4.0%
40	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP	**$25 Copay**						
20	3.9%	3.8%	n/a	n/a	3.8%	3.9%	3.9%
30	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
60	4.0%	4.0%	n/a	n/a	3.9%	4.0%	4.0%
Unlimited	4.0%	3.9%	n/a	n/a	3.9%	3.9%	4.0%
SMALL GROUP	**$30 Copay**						
20	4.0%	4.1%	n/a	n/a	4.1%	4.1%	4.0%
30	4.1%	4.1%	n/a	n/a	4.0%	4.0%	4.1%
40	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
60	4.1%	4.1%	n/a	n/a	4.2%	4.1%	4.1%
Unlimited	4.1%	4.1%	n/a	n/a	4.0%	4.1%	4.1%
SMALL GROUP	**$35 Copay**						
20	4.1%	4.2%	n/a	n/a	4.2%	4.2%	4.1%
30	4.2%	4.1%	n/a	n/a	4.2%	4.1%	4.2%
40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
60	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
SMALL GROUP	**$40 Copay**						
20	4.0%	3.9%	n/a	n/a	4.0%	4.0%	4.0%
30	4.1%	4.2%	n/a	n/a	4.0%	4.2%	4.1%
40	3.9%	3.9%	n/a	n/a	3.9%	4.0%	3.9%
60	4.0%	4.0%	n/a	n/a	3.9%	4.0%	4.0%
Unlimited	4.0%	3.9%	n/a	n/a	4.0%	3.9%	4.0%
SMALL GROUP	**$45 Copay**						
20	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
30	4.0%	4.0%	n/a	n/a	3.9%	4.0%	4.0%
40	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 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	5.08	14.43	na	na	9.40	11.94	15.24
Unlimited	5.11	14.51	na	na	9.45	12.01	15.33
SMALL GROUP				**$50 Copay**			
20	3.53	10.03	na	na	6.53	8.30	10.59
30	4.16	11.81	na	na	7.70	9.78	12.48
40	4.53	12.87	na	na	8.38	10.65	13.59
60	4.91	13.94	na	na	9.08	11.54	14.73
Unlimited	4.97	14.11	na	na	9.19	11.68	14.91
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	6.81	19.34	na	na	12.60	16.00	20.43
30	7.40	21.02	na	na	13.69	17.39	22.20
40	7.74	21.98	na	na	14.32	18.19	23.22
60	8.13	23.09	na	na	15.04	19.11	24.39
Unlimited	8.21	23.32	na	na	15.19	19.29	24.63
SMALL GROUP				**$5 Copay**			
20	6.40	18.18	na	na	11.84	15.04	19.20
30	6.95	19.74	na	na	12.86	16.33	20.85
40	7.28	20.68	na	na	13.47	17.11	21.84
60	7.64	21.70	na	na	14.13	17.95	22.92
Unlimited	7.73	21.95	na	na	14.30	18.17	23.19
SMALL GROUP				**$10 Copay**			
20	5.98	16.98	na	na	11.06	14.05	17.94
30	6.48	18.40	na	na	11.99	15.23	19.44
40	6.80	19.31	na	na	12.58	15.98	20.40
60	7.14	20.28	na	na	13.21	16.78	21.42
Unlimited	7.20	20.45	na	na	13.32	16.92	21.60
SMALL GROUP				**$15 Copay**			
20	5.61	15.93	na	na	10.38	13.18	16.83
30	6.08	17.27	na	na	11.25	14.29	18.24
40	6.37	18.09	na	na	11.78	14.97	19.11
60	6.68	18.97	na	na	12.36	15.70	20.04
Unlimited	6.77	19.23	na	na	12.52	15.91	20.31
SMALL GROUP				**$20 Copay**			
20	5.27	14.97	na	na	9.75	12.38	15.81
30	5.71	16.22	na	na	10.56	13.42	17.13
40	5.99	17.01	na	na	11.08	14.08	17.97
60	6.29	17.86	na	na	11.64	14.78	18.87
Unlimited	6.36	18.06	na	na	11.77	14.95	19.08
SMALL GROUP				**$25 Copay**			
20	4.89	13.89	na	na	9.05	11.49	14.67
30	5.30	15.05	na	na	9.81	12.46	15.90
40	5.58	15.85	na	na	10.32	13.11	16.74
60	5.85	16.61	na	na	10.82	13.75	17.55
Unlimited	5.91	16.78	na	na	10.93	13.89	17.73
SMALL GROUP				**$30 Copay**			
20	4.74	13.46	na	na	8.77	11.14	14.22
30	5.12	14.54	na	na	9.47	12.03	15.36
40	5.40	15.34	na	na	9.99	12.69	16.20
60	5.65	16.05	na	na	10.45	13.28	16.95
Unlimited	5.70	16.19	na	na	10.55	13.40	17.10
SMALL GROUP				**$35 Copay**			
20	4.58	13.01	na	na	8.47	10.76	13.74
30	4.99	14.17	na	na	9.23	11.73	14.97
40	5.21	14.80	na	na	9.64	12.24	15.63
60	5.47	15.53	na	na	10.12	12.85	16.41
Unlimited	5.52	15.68	na	na	10.21	12.97	16.56
SMALL GROUP				**$40 Copay**			
20	4.46	12.67	na	na	8.25	10.48	13.38
30	4.84	13.75	na	na	8.95	11.37	14.52
40	5.06	14.37	na	na	9.36	11.89	15.18
60	5.30	15.05	na	na	9.81	12.46	15.90
Unlimited	5.38	15.28	na	na	9.95	12.64	16.14
SMALL GROUP				**$45 Copay**			
20	4.32	12.27	na	na	7.99	10.15	12.96
30	4.68	13.29	na	na	8.66	11.00	14.04
40	4.90	13.92	na	na	9.07	11.52	14.70
60	5.15	14.63	na	na	9.53	12.10	15.45
Unlimited	5.19	14.74	na	na	9.60	12.20	15.57
SMALL GROUP				**$50 Copay**			
20	4.19	11.90	na	na	7.75	9.85	12.57
30	4.53	12.87	na	na	8.38	10.65	13.59

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	5.28	15.00	na	na	9.77	12.41	15.84
Unlimited	5.31	15.08	na	na	9.82	12.48	15.93
SMALL GROUP				**$50 Copay**			
20	3.68	10.45	na	na	6.81	8.65	11.04
30	4.32	12.27	na	na	7.99	10.15	12.96
40	4.72	13.40	na	na	8.73	11.09	14.16
60	5.11	14.51	na	na	9.45	12.01	15.33
Unlimited	5.17	14.68	na	na	9.56	12.15	15.51
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.08	20.11	na	na	13.10	16.64	21.24
30	7.70	21.87	na	na	14.25	18.10	23.10
40	8.05	22.86	na	na	14.89	18.92	24.15
60	8.45	24.00	na	na	15.63	19.86	25.35
Unlimited	8.54	24.25	na	na	15.80	20.07	25.62
SMALL GROUP				**$5 Copay**			
20	6.66	18.91	na	na	12.32	15.65	19.98
30	7.23	20.53	na	na	13.38	16.99	21.69
40	7.58	21.53	na	na	14.02	17.81	22.74
60	7.95	22.58	na	na	14.71	18.68	23.85
Unlimited	8.04	22.83	na	na	14.87	18.89	24.12
SMALL GROUP				**$10 Copay**			
20	6.22	17.66	na	na	11.51	14.62	18.66
30	6.74	19.14	na	na	12.47	15.84	20.22
40	7.07	20.08	na	na	13.08	16.61	21.21
60	7.42	21.07	na	na	13.73	17.44	22.26
Unlimited	7.49	21.27	na	na	13.86	17.60	22.47
SMALL GROUP				**$15 Copay**			
20	5.84	16.59	na	na	10.80	13.72	17.52
30	6.32	17.95	na	na	11.69	14.85	18.96
40	6.63	18.83	na	na	12.27	15.58	19.89
60	6.95	19.74	na	na	12.86	16.33	20.85
Unlimited	7.04	19.99	na	na	13.02	16.54	21.12
SMALL GROUP				**$20 Copay**			
20	5.48	15.56	na	na	10.14	12.88	16.44
30	5.94	16.87	na	na	10.99	13.96	17.82
40	6.23	17.69	na	na	11.53	14.64	18.69
60	6.54	18.57	na	na	12.10	15.37	19.62
Unlimited	6.62	18.80	na	na	12.25	15.56	19.86
SMALL GROUP				**$25 Copay**			
20	5.09	14.46	na	na	9.42	11.96	15.27
30	5.51	15.65	na	na	10.19	12.95	16.53
40	5.81	16.50	na	na	10.75	13.65	17.43
60	6.09	17.30	na	na	11.27	14.31	18.27
Unlimited	6.15	17.47	na	na	11.38	14.45	18.45
SMALL GROUP				**$30 Copay**			
20	4.93	14.00	na	na	9.12	11.59	14.79
30	5.32	15.11	na	na	9.84	12.50	15.96
40	5.62	15.96	na	na	10.40	13.21	16.86
60	5.88	16.70	na	na	10.88	13.82	17.64
Unlimited	5.93	16.84	na	na	10.97	13.94	17.79
SMALL GROUP				**$35 Copay**			
20	4.77	13.55	na	na	8.82	11.21	14.31
30	5.19	14.74	na	na	9.60	12.20	15.57
40	5.42	15.39	na	na	10.03	12.74	16.26
60	5.69	16.16	na	na	10.53	13.37	17.07
Unlimited	5.75	16.33	na	na	10.64	13.51	17.25
SMALL GROUP				**$40 Copay**			
20	4.64	13.18	na	na	8.58	10.90	13.92
30	5.04	14.31	na	na	9.32	11.84	15.12
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.51	15.65	na	na	10.19	12.95	16.53
Unlimited	5.60	15.90	na	na	10.36	13.16	16.80
SMALL GROUP				**$45 Copay**			
20	4.49	12.75	na	na	8.31	10.55	13.47
30	4.87	13.83	na	na	9.01	11.44	14.61
40	5.10	14.48	na	na	9.44	11.99	15.30
60	5.35	15.19	na	na	9.90	12.57	16.05
Unlimited	5.40	15.34	na	na	9.99	12.69	16.20
SMALL GROUP				**$50 Copay**			
20	4.36	12.38	na	na	8.07	10.25	13.08
30	4.72	13.40	na	na	8.73	11.09	14.16

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	0.20	0.57	na	na	0.37	0.47	0.60
Unlimited	0.20	0.57	na	na	0.37	0.47	0.60
SMALL GROUP				**$50 Copay**			
20	0.15	0.42	na	na	0.28	0.35	0.45
30	0.16	0.46	na	na	0.29	0.37	0.48
40	0.19	0.53	na	na	0.35	0.44	0.57
60	0.20	0.57	na	na	0.37	0.47	0.60
Unlimited	0.20	0.57	na	na	0.37	0.47	0.60
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	0.27	0.77	na	na	0.50	0.64	0.81
30	0.30	0.85	na	na	0.56	0.71	0.90
40	0.31	0.88	na	na	0.57	0.73	0.93
60	0.32	0.91	na	na	0.59	0.75	0.96
Unlimited	0.33	0.93	na	na	0.61	0.78	0.99
SMALL GROUP				**$5 Copay**			
20	0.26	0.73	na	na	0.48	0.61	0.78
30	0.28	0.79	na	na	0.52	0.66	0.84
40	0.30	0.85	na	na	0.55	0.70	0.90
60	0.31	0.88	na	na	0.58	0.73	0.93
Unlimited	0.31	0.88	na	na	0.57	0.72	0.93
SMALL GROUP				**$10 Copay**			
20	0.24	0.68	na	na	0.45	0.57	0.72
30	0.26	0.74	na	na	0.48	0.61	0.78
40	0.27	0.77	na	na	0.50	0.63	0.81
60	0.28	0.79	na	na	0.52	0.66	0.84
Unlimited	0.29	0.82	na	na	0.54	0.68	0.87
SMALL GROUP				**$15 Copay**			
20	0.23	0.66	na	na	0.42	0.54	0.69
30	0.24	0.68	na	na	0.44	0.56	0.72
40	0.26	0.74	na	na	0.49	0.61	0.78
60	0.27	0.77	na	na	0.50	0.63	0.81
Unlimited	0.27	0.76	na	na	0.50	0.63	0.81
SMALL GROUP				**$20 Copay**			
20	0.21	0.59	na	na	0.39	0.50	0.63
30	0.23	0.65	na	na	0.43	0.54	0.69
40	0.24	0.68	na	na	0.45	0.56	0.72
60	0.25	0.71	na	na	0.46	0.59	0.75
Unlimited	0.26	0.74	na	na	0.48	0.61	0.78
SMALL GROUP				**$25 Copay**			
20	0.20	0.57	na	na	0.37	0.47	0.60
30	0.21	0.60	na	na	0.38	0.49	0.63
40	0.23	0.65	na	na	0.43	0.54	0.69
60	0.24	0.69	na	na	0.45	0.56	0.72
Unlimited	0.24	0.69	na	na	0.45	0.56	0.72
SMALL GROUP				**$30 Copay**			
20	0.19	0.54	na	na	0.35	0.45	0.57
30	0.20	0.57	na	na	0.37	0.47	0.60
40	0.22	0.62	na	na	0.41	0.52	0.66
60	0.23	0.65	na	na	0.43	0.54	0.69
Unlimited	0.23	0.65	na	na	0.42	0.54	0.69
SMALL GROUP				**$35 Copay**			
20	0.19	0.54	na	na	0.35	0.45	0.57
30	0.20	0.57	na	na	0.37	0.47	0.60
40	0.21	0.59	na	na	0.39	0.50	0.63
60	0.22	0.63	na	na	0.41	0.52	0.66
Unlimited	0.23	0.65	na	na	0.43	0.54	0.69
SMALL GROUP				**$40 Copay**			
20	0.18	0.51	na	na	0.33	0.42	0.54
30	0.20	0.56	na	na	0.37	0.47	0.60
40	0.20	0.57	na	na	0.37	0.47	0.60
60	0.21	0.60	na	na	0.38	0.49	0.63
Unlimited	0.22	0.62	na	na	0.41	0.52	0.66
SMALL GROUP				**$45 Copay**			
20	0.17	0.48	na	na	0.32	0.40	0.51
30	0.19	0.54	na	na	0.35	0.44	0.57
40	0.20	0.56	na	na	0.37	0.47	0.60
60	0.20	0.56	na	na	0.37	0.47	0.60
Unlimited	0.21	0.60	na	na	0.39	0.49	0.63
SMALL GROUP				**$50 Copay**			
20	0.17	0.48	na	na	0.32	0.40	0.51
30	0.19	0.53	na	na	0.35	0.44	0.57

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	3.9%	4.0%	n/a	n/a	3.9%	3.9%	3.9%
Unlimited	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
SMALL GROUP				**$50 Copay**			
20	4.2%	4.2%	n/a	n/a	4.3%	4.2%	4.2%
30	3.8%	3.9%	n/a	n/a	3.8%	3.8%	3.8%
40	4.2%	4.1%	n/a	n/a	4.2%	4.1%	4.2%
60	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
60	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP				**$5 Copay**			
20	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
40	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
60	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP				**$10 Copay**			
20	4.0%	4.0%	n/a	n/a	4.1%	4.1%	4.0%
30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
40	4.0%	4.0%	n/a	n/a	4.0%	3.9%	4.0%
60	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
Unlimited	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
SMALL GROUP				**$15 Copay**			
20	4.1%	4.1%	n/a	n/a	4.0%	4.1%	4.1%
30	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
40	4.1%	4.1%	n/a	n/a	4.2%	4.1%	4.1%
60	4.0%	4.1%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP				**$20 Copay**			
20	4.0%	3.9%	n/a	n/a	4.0%	4.0%	4.0%
30	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
40	4.0%	4.0%	n/a	n/a	4.1%	4.0%	4.0%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
SMALL GROUP				**$25 Copay**			
20	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
30	4.0%	4.0%	n/a	n/a	3.9%	3.9%	4.0%
40	4.1%	4.1%	n/a	n/a	4.2%	4.1%	4.1%
60	4.1%	4.2%	n/a	n/a	4.2%	4.1%	4.1%
Unlimited	4.1%	4.1%	n/a	n/a	4.1%	4.0%	4.1%
SMALL GROUP				**$30 Copay**			
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	3.9%	3.9%	n/a	n/a	3.9%	3.9%	3.9%
40	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
60	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP				**$35 Copay**			
20	4.1%	4.2%	n/a	n/a	4.1%	4.2%	4.1%
30	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
40	4.0%	4.0%	n/a	n/a	4.0%	4.1%	4.0%
60	4.0%	4.1%	n/a	n/a	4.1%	4.0%	4.0%
Unlimited	4.2%	4.1%	n/a	n/a	4.2%	4.2%	4.2%
SMALL GROUP				**$40 Copay**			
20	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
30	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
40	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
60	4.0%	4.0%	n/a	n/a	3.9%	3.9%	4.0%
Unlimited	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
SMALL GROUP				**$45 Copay**			
20	3.9%	3.9%	n/a	n/a	4.0%	3.9%	3.9%
30	4.1%	4.1%	n/a	n/a	4.0%	4.0%	4.1%
40	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
60	3.9%	3.8%	n/a	n/a	3.9%	3.9%	3.9%
Unlimited	4.0%	4.1%	n/a	n/a	4.1%	4.0%	4.0%
SMALL GROUP				**$50 Copay**			
20	4.1%	4.0%	n/a	n/a	4.1%	4.1%	4.1%
30	4.2%	4.1%	n/a	n/a	4.2%	4.1%	4.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
JULY 1, 2012 - SEPTEMBER 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	4.76	13.52	na	na	8.81	11.19	14.28
60	5.01	14.23	na	na	9.27	11.77	15.03
Unlimited	5.04	14.31	na	na	9.32	11.84	15.12
SMALL GROUP	Small Group Premium Credit - Outpatient Mental Health						
Specialist Copay	**[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40	4.95	14.06	na	na	9.16	11.63	14.85
60	5.21	14.80	na	na	9.64	12.24	15.63
Unlimited	5.24	14.88	na	na	9.69	12.31	15.72
SMALL GROUP	Small Group Premium Credit - Outpatient Mental Health						
Specialist Copay	**[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	0.19	0.54	na	na	0.35	0.44	0.57
60	0.20	0.57	na	na	0.37	0.47	0.60
Unlimited	0.20	0.57	na	na	0.37	0.47	0.60
SMALL GROUP	Small Group Premium Credit - Outpatient Mental Health						
Specialist Copay	**[above rates must be reduced by premium credit] [not yet approved]						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	4.0%	4.0%	n/a	n/a	4.0%	3.9%	4.0%
60	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
Unlimited	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
SMALL GROUP	Small Group Premium Credit - Outpatient Mental Health						
Specialist Copay	**[above rates must be reduced by premium credit] [not yet approved]						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
JULY 1, 2012 - SEPTEMBER 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	5.04	14.31	na	na	9.32	11.84	15.12
$0/Max $5000	4.76	13.52	na	na	8.81	11.19	14.28
$0/Max $2500	4.47	12.69	na	na	8.27	10.50	13.41
$25	4.76	13.52	na	na	8.81	11.19	14.28
$50	4.47	12.69	na	na	8.27	10.50	13.41
$100	4.11	11.67	na	na	7.60	9.66	12.33
$500	1.98	5.62	na	na	3.66	4.65	5.94
$5,000	0.32	0.91	na	na	0.59	0.75	0.96
Coinsurance							
20%	4.03	11.45	na	na	7.46	9.47	12.09
25%	3.79	10.76	na	na	7.01	8.91	11.37
30%	3.52	10.00	na	na	6.51	8.27	10.56
Deductible			**Orthotics Riders**				
$0	0.87	2.47	na	na	1.61	2.04	2.61
$0/Max $5000	0.81	2.30	na	na	1.50	1.90	2.43
$0/Max $2500	0.77	2.19	na	na	1.42	1.81	2.31
$25	0.81	2.30	na	na	1.50	1.90	2.43
$50	0.77	2.19	na	na	1.42	1.81	2.31
$100	0.70	1.99	na	na	1.30	1.65	2.10
$500	0.36	1.02	na	na	0.67	0.85	1.08
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.70	1.99	na	na	1.30	1.65	2.10
25%	0.67	1.90	na	na	1.24	1.57	2.01
30%	0.63	1.79	na	na	1.17	1.48	1.89
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.67	4.74	na	na	3.09	3.92	5.01
12 Months	2.67	7.58	na	na	4.94	6.27	8.01
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.61	7.41	na	na	4.83	6.13	7.83
12 Months	4.16	11.81	na	na	7.70	9.78	12.48
			Private Duty Nursing Riders				
In Full	0.67	1.90	na	na	1.24	1.57	2.01
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.19	0.54	na	na	0.35	0.45	0.57
			Dental Network Access				
	0.50	1.42	na	na	0.93	1.18	1.50
Limit			**Infertility Rider**				
2 IVF	10.63	30.19	na	na	19.67	24.98	31.89
3 IVF	12.85	36.49	na	na	23.77	30.20	38.55
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.39	12.47	na	na	8.12	10.32	13.17
			Health Club Reimbursement				
$200 per year	1.26	3.58	na	na	2.33	2.96	3.78
			Wellness Rider				
Inclusion	1.03	2.93	na	na	1.91	2.42	3.09
			Nurse Advice Line Rider				
	0.32	0.86	na	na	0.59	0.75	0.96

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
July 01, 2013 - September 30, 2013 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	5.24	14.88	na	na	9.69	12.31	15.72
$0/Max $5000	4.95	14.06	na	na	9.16	11.63	14.85
$0/Max $2500	4.65	13.21	na	na	8.60	10.93	13.95
$25	4.95	14.06	na	na	9.16	11.63	14.85
$50	4.65	13.21	na	na	8.60	10.93	13.95
$100	4.27	12.13	na	na	7.90	10.03	12.81
$500	2.06	5.85	na	na	3.81	4.84	6.18
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.19	11.90	na	na	7.75	9.85	12.57
25%	3.94	11.19	na	na	7.29	9.26	11.82
30%	3.67	10.42	na	na	6.79	8.62	11.01
Deductible			**Orthotics Riders**				
$0	0.91	2.58	na	na	1.68	2.14	2.73
$0/Max $5000	0.84	2.39	na	na	1.55	1.97	2.52
$0/Max $2500	0.80	2.27	na	na	1.48	1.88	2.40
$25	0.84	2.39	na	na	1.55	1.97	2.52
$50	0.80	2.27	na	na	1.48	1.88	2.40
$100	0.73	2.07	na	na	1.35	1.72	2.19
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.73	2.07	na	na	1.35	1.72	2.19
25%	0.70	1.99	na	na	1.30	1.65	2.10
30%	0.66	1.87	na	na	1.22	1.55	1.98
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.74	4.94	na	na	3.22	4.09	5.22
12 Months	2.78	7.90	na	na	5.14	6.53	8.34
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.72	7.72	na	na	5.03	6.39	8.16
12 Months	4.32	12.27	na	na	7.99	10.15	12.96
			Private Duty Nursing Riders				
In Full	0.70	1.99	na	na	1.30	1.65	2.10
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.53	1.51	na	na	0.98	1.25	1.59
Limit			**Infertility Rider**				
2 IVF	11.06	31.41	na	na	20.46	25.99	33.18
3 IVF	13.37	37.97	na	na	24.73	31.42	40.11
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.57	12.98	na	na	8.45	10.74	13.71
			Health Club Reimbursement				
$200 per year	1.31	3.72	na	na	2.42	3.08	3.93
			Wellness Rider				
Inclusion	1.07	3.04	na	na	1.98	2.51	3.21
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	0.20	0.57	na	na	0.37	0.47	0.60
$0/Max $5000	0.19	0.54	na	na	0.35	0.44	0.57
$0/Max $2500	0.18	0.52	na	na	0.33	0.43	0.54
$25	0.19	0.54	na	na	0.35	0.44	0.57
$50	0.18	0.52	na	na	0.33	0.43	0.54
$100	0.16	0.46	na	na	0.30	0.37	0.48
$500	0.08	0.23	na	na	0.15	0.19	0.24
$5,000	0.01	0.03	na	na	0.02	0.03	0.03
Coinsurance							
20%	0.16	0.45	na	na	0.29	0.38	0.48
25%	0.15	0.43	na	na	0.28	0.35	0.45
30%	0.15	0.42	na	na	0.28	0.35	0.45
Deductible			**Orthotics Riders**				
$0	0.04	0.11	na	na	0.07	0.10	0.12
$0/Max $5000	0.03	0.09	na	na	0.05	0.07	0.09
$0/Max $2500	0.03	0.08	na	na	0.06	0.07	0.09
$25	0.03	0.09	na	na	0.05	0.07	0.09
$50	0.03	0.08	na	na	0.06	0.07	0.09
$100	0.03	0.08	na	na	0.05	0.07	0.09
$500	0.01	0.03	na	na	0.01	0.02	0.03
$5,000	-	-	na	na	-	-	-
Coinsurance							
20%	0.03	0.08	na	na	0.05	0.07	0.09
25%	0.03	0.09	na	na	0.06	0.08	0.09
30%	0.03	0.08	na	na	0.05	0.07	0.09
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.07	0.20	na	na	0.13	0.17	0.21
12 Months	0.11	0.32	na	na	0.20	0.26	0.33
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.11	0.31	na	na	0.20	0.26	0.33
12 Months	0.16	0.46	na	na	0.29	0.37	0.48
			Private Duty Nursing Riders				
In Full	0.03	0.09	na	na	0.06	0.08	0.09
80% hrs 73-504	-	-	na	na	-	-	-
100% hrs 73-504	0.01	0.03	na	na	0.02	0.02	0.03
			Dental Network Access				
	0.03	0.09	na	na	0.05	0.07	0.09
Limit			**Infertility Rider**				
2 IVF	0.43	1.22	na	na	0.79	1.01	1.29
3 IVF	0.52	1.48	na	na	0.96	1.22	1.56
			Complementary Alternative Medicine (CAM)				
$20 Copay	0.18	0.51	na	na	0.33	0.42	0.54
			Health Club Reimbursement				
$200 per year	0.05	0.14	na	na	0.09	0.12	0.15
			Wellness Rider				
Inclusion	0.04	0.11	na	na	0.07	0.09	0.12
			Nurse Advice Line Rider				
	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
3rd Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
$0/Max $5000	4.0%	4.0%	n/a	n/a	4.0%	3.9%	4.0%
$0/Max $2500	4.0%	4.1%	n/a	n/a	4.0%	4.1%	4.0%
$25	4.0%	4.0%	n/a	n/a	4.0%	3.9%	4.0%
$50	4.0%	4.1%	n/a	n/a	4.0%	4.1%	4.0%
$100	3.9%	3.9%	n/a	n/a	3.9%	3.8%	3.9%
$500	4.0%	4.1%	n/a	n/a	4.1%	4.1%	4.0%
$5,000	3.1%	3.3%	n/a	n/a	3.4%	4.0%	3.1%
Coinsurance							
20%	4.0%	3.9%	n/a	n/a	3.9%	4.0%	4.0%
25%	4.0%	4.0%	n/a	n/a	4.0%	3.9%	4.0%
30%	4.3%	4.2%	n/a	n/a	4.3%	4.2%	4.3%
Deductible			**Orthotics Riders**				
$0	4.6%	4.5%	n/a	n/a	4.3%	4.9%	4.6%
$0/Max $5000	3.7%	3.9%	n/a	n/a	3.3%	3.7%	3.7%
$0/Max $2500	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
$25	3.7%	3.9%	n/a	n/a	3.3%	3.7%	3.7%
$50	3.9%	3.7%	n/a	n/a	4.2%	3.9%	3.9%
$100	4.3%	4.0%	n/a	n/a	3.8%	4.2%	4.3%
$500	2.8%	2.9%	n/a	n/a	1.5%	2.4%	2.8%
$5,000	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Coinsurance							
20%	4.3%	4.0%	n/a	n/a	3.8%	4.2%	4.3%
25%	4.5%	4.7%	n/a	n/a	4.8%	5.1%	4.5%
30%	4.8%	4.5%	n/a	n/a	4.3%	4.7%	4.8%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	4.2%	4.2%	n/a	n/a	4.2%	4.3%	4.2%
12 Months	4.1%	4.2%	n/a	n/a	4.0%	4.1%	4.1%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	4.2%	4.2%	n/a	n/a	4.1%	4.2%	4.2%
12 Months	3.8%	3.9%	n/a	n/a	3.8%	3.8%	3.8%
			Private Duty Nursing Riders				
In Full	4.5%	4.7%	n/a	n/a	4.8%	5.1%	4.5%
80% hrs 73-504	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
100% hrs 73-504	5.3%	5.6%	n/a	n/a	5.7%	4.4%	5.3%
			Dental Network Access				
	6.0%	6.3%	n/a	n/a	5.4%	5.9%	6.0%
Limit			**Infertility Rider**				
2 IVF	4.0%	4.0%	n/a	n/a	4.0%	4.0%	4.0%
3 IVF	4.0%	4.1%	n/a	n/a	4.0%	4.0%	4.0%
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.1%	4.1%	n/a	n/a	4.1%	4.1%	4.1%
			Health Club Reimbursement				
$200 per year	4.0%	3.9%	n/a	n/a	3.9%	4.1%	4.0%
			Wellness Rider				
Inclusion	3.9%	3.8%	n/a	n/a	3.7%	3.7%	3.9%
			Nurse Advice Line Rider				
	3.1%	3.5%	n/a	n/a	3.4%	4.0%	3.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
JULY 1, 2012 - SEPTEMBER 30, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not availa**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2012
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
July 01, 2013 - September 30, 2013 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO	**1.000**	**1.074**
New York City, Westchester, Rockland and Orange Counties			
	HMO	**1.000**	**1.028**
Upstate[2]			
	HMO	**1.000**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	**115%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**-**	**-**
	POS, HIP*access* II	**(1.000)**	**(1.044)**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**-**	**-**
	POS, HIP*access* II	**(1.000)**	**(1.017)**
Upstate[2]			
	HMO, HIP*access* I	**-**	
	POS	**(1.000)**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**-**
Access I Groups	**(1.150)**
POS Groups	**(1.150)**
Access II Groups	**(1.150)**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
Upstate[2]			
	HMO, HIP*access* I	**0.0%**	
	POS	**-100.0%**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**0.0%**
Access I Groups	**-100.0%**
POS Groups	**-100.0%**
Access II Groups	**-100.0%**

Methodology
(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd QUARTER 2012 SMALL GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
JULY 1, 2012 - SEPTEMBER 30, 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

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2011 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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
July 01, 2013 - September 30, 2013 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)
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+ (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

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$2,500	27.61	53.20	6.20
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$5,000	27.61	70.10	9.30
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$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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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

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+ 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	-	-	-
$750 *	-	-	-
$1,000	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
Unlimited	-	-	-

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	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
3rd Quarter Small Group 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.

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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)
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- 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	0.012	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 Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	2.50%
1Q2010-1Q2011	2.50%
2Q2011	4.10%
3Q2011-4Q2011	3.00%
1Q2012	3.00%
2Q2012 - 3Q2012	3.00%

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

$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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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 Adjustmer Applies only to New York City account	-2.0%	
[f] Product Facto HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
	HMO	CompreHealth HMO
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
3Q2013	3.0%	1.0%
[h] Mandatory Women's Preventive Services	0.60	0.61

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

$0	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-
[b] Annual Maximum to also include Generic Drugs:	-
$1,000 (Brand & Generic)	-
$2,000 (Brand & Generic)	-
$2,500 (Brand & Generic)	-
$3,000 (Brand & Generic)	-
$4,000 (Brand & Generic)	-
$5,000 (Brand & Generic)	-
[c] Non Formulary Coverage, Generic Only Plans	-
[d] PICA Adjustm Applies only to New York City account	-
[e] IC Adjustmer Applies only to New York City account	-
[f] Product Facto HMO, Access I, and EPO	-
POS, Access II, and PPO	-
[g] Trend per Quarter	
1Q2010-1Q2011	-
2Q2011	-
3Q2011-4Q2011	-
1Q2012	-
2Q 2012 - 4Q 2012	-
$0	#VALUE!
1Q2013	(0.063)
2Q2013	0.030
3Q2013	0.030
$0	-
$0	-
$0	0.600

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	-	-
Family	-	(0.000)
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	-	-
EE + Child(ren	0.000	(0.000)
EE + Spouse	(0.000)	(0.000)
Family	-	-

$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	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 Adjustmer Applies only to New York City account	0.0%
[f] Product Facto HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
1Q2010-1Q2011	0.0%
2Q2011	0.0%
3Q2011-4Q2011	0.0%
1Q2012	0.0%
2Q 2012 - 4Q 2012	0.0%
$0	#VALUE!
1Q2013	#DIV/0!
$0	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	0.0%	0.0%
Family	0.0%	0.0%
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	0.0%	0.0%
EE + Child(ren	0.0%	0.0%
EE + Spouse	0.0%	0.0%
Family	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small 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

Small Groups

=	(Base Rate
+	Optional Base Benefit Variables (excluding Mental Health)
+	Inpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Inpatient Mental Health Subsidy
+	Outpatient Mental Health Care with or without Unlimited BIO and CSED coverage
+	Small Group Outpatient Mental Health Subsidy
+	Optional Benefit Rider Coverage)
x	Optional Dependent Care Coverage
x	Network Area Factor
x	Sole Proprientor Factor

Example: Small Group HMO Individual Employee Rate Example

=	730.90	4th Quarter	(Base Rate
+	(5.99)	$10 Specialist visit copay	Optional Base Benefit Variables (excluding Mental Health)
+	7.61	30 Days	Inpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	30 Days	Small Group Inpatient Mental Health Subsidy
+	6.59	$10 copay, 20 visits	Outpatient Mental Health Care with Unlimited BIO and CSED coverage
+	-	$10 copay, 20 visits	Small Group Outpatient Mental Health Subsidy
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.00	Standard Coverage	Optional Dependent Care Coverage
x	1.00	Standard Coverage	Network Area Factor
x	1.00	> 1 Employee Group	Sole Proprientor Factor
	739.11		Individual Employee Rate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

4th Quarter Small Group RATE MANUAL

HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS

October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Plan	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Effective 10/01/2013 - 12/31/2013 (With WH & Autism)				
Small Group*	730.90	1,973.43	na	na	1,352.17	1,717.62	2,192.70
Classic*	521.65	1,408.46	na	na	965.05	1,225.88	1,564.95
			Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)				
Small Group*	723.66	1,953.88	na	na	1,338.77	1,700.60	2,170.98
Classic*	516.49	1,394.52	na	na	955.51	1,213.75	1,549.47

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(4.11)	(11.10)	na	na	(7.60)	(9.66)	(12.33)
$10	(8.62)	(23.27)	na	na	(15.95)	(20.26)	(25.86)
$15	(14.33)	(38.69)	na	na	(26.51)	(33.68)	(42.99)
$20	(22.11)	(59.70)	na	na	(40.90)	(51.96)	(66.33)
$25	(29.14)	(78.68)	na	na	(53.91)	(68.48)	(87.42)
$30	(36.83)	(99.44)	na	na	(68.14)	(86.55)	(110.49)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.35)	(6.35)	na	na	(4.35)	(5.52)	(7.05)
$10	(4.93)	(13.31)	na	na	(9.12)	(11.59)	(14.79)
$15	(8.21)	(22.17)	na	na	(15.19)	(19.29)	(24.63)
$20	(12.67)	(34.21)	na	na	(23.44)	(29.77)	(38.01)
$25	(16.69)	(45.06)	na	na	(30.88)	(39.22)	(50.07)
$30	(21.12)	(57.02)	na	na	(39.07)	(49.63)	(63.36)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.89)	(7.80)	na	na	(5.35)	(6.79)	(8.67)
$10	(5.99)	(16.17)	na	na	(11.08)	(14.08)	(17.97)
$15	(9.39)	(25.35)	na	na	(17.37)	(22.07)	(28.17)
$20	(13.24)	(35.75)	na	na	(24.49)	(31.11)	(39.72)
$25	(17.47)	(47.17)	na	na	(32.32)	(41.05)	(52.41)
$30	(22.25)	(60.08)	na	na	(41.16)	(52.29)	(66.75)
$35	(26.75)	(72.23)	na	na	(49.49)	(62.86)	(80.25)
$40	(36.12)	(97.52)	na	na	(66.82)	(84.88)	(108.36)
$45	(36.31)	(98.04)	na	na	(67.17)	(85.33)	(108.93)
$50	(41.45)	(111.92)	na	na	(76.68)	(97.41)	(124.35)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(2.45)	(6.62)	na	na	(4.53)	(5.76)	(7.35)
$10	(5.07)	(13.69)	na	na	(9.38)	(11.91)	(15.21)
$15	(7.94)	(21.44)	na	na	(14.69)	(18.66)	(23.82)
$20	(11.21)	(30.27)	na	na	(20.74)	(26.34)	(33.63)
$25	(14.77)	(39.88)	na	na	(27.32)	(34.71)	(44.31)
$30	(18.82)	(50.81)	na	na	(34.82)	(44.23)	(56.46)
$35	(22.61)	(61.05)	na	na	(41.83)	(53.13)	(67.83)
$40	(30.54)	(82.46)	na	na	(56.50)	(71.77)	(91.62)
$45	(30.69)	(82.86)	na	na	(56.78)	(72.12)	(92.07)
$50	(35.04)	(94.61)	na	na	(64.82)	(82.34)	(105.12)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.20)	(5.94)	na	na	(4.07)	(5.17)	(6.60)
$150	(3.64)	(9.83)	na	na	(6.73)	(8.55)	(10.92)
$200	(5.19)	(14.01)	na	na	(9.60)	(12.20)	(15.57)
$250	(7.43)	(20.06)	na	na	(13.75)	(17.46)	(22.29)
$500	(17.81)	(48.09)	na	na	(32.95)	(41.85)	(53.43)
$750	(30.62)	(82.67)	na	na	(56.65)	(71.96)	(91.86)
$1,000	(46.04)	(124.31)	na	na	(85.17)	(108.19)	(138.12)
Copay/Day							
$50 w/3 Day Max	(2.68)	(7.24)	na	na	(4.96)	(6.30)	(8.04)
$50 w/5 Day Max	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$100 w/3 Day Max	(6.68)	(18.04)	na	na	(12.36)	(15.70)	(20.04)
$100 w/5 Day Max	(9.64)	(26.03)	na	na	(17.83)	(22.65)	(28.92)
$250 w/3 Day Max	(22.19)	(59.91)	na	na	(41.05)	(52.15)	(66.57)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.21)	(3.27)	na	na	(2.24)	(2.84)	(3.63)
$75	(1.97)	(5.32)	na	na	(3.64)	(4.63)	(5.91)
$100	(2.81)	(7.59)	na	na	(5.20)	(6.60)	(8.43)
$125	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$150	(4.60)	(12.42)	na	na	(8.51)	(10.81)	(13.80)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$15	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$25	(0.77)	(2.08)	na	na	(1.42)	(1.81)	(2.31)
$35	(1.29)	(3.48)	na	na	(2.39)	(3.03)	(3.87)
$50	(2.19)	(5.91)	na	na	(4.05)	(5.15)	(6.57)
$60	(2.79)	(7.53)	na	na	(5.16)	(6.56)	(8.37)
$75	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$100	(5.21)	(14.07)	na	na	(9.64)	(12.24)	(15.63)
$125	(6.42)	(17.33)	na	na	(11.88)	(15.09)	(19.26)
$150	(7.67)	(20.71)	na	na	(14.19)	(18.02)	(23.01)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.66	1.78	na	na	1.22	1.55	1.98
60	1.23	3.32	na	na	2.28	2.89	3.69
90	1.86	5.02	na	na	3.44	4.37	5.58
120	2.19	5.91	na	na	4.05	5.15	6.57
Unlimited	2.82	7.61	na	na	5.22	6.63	8.46
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
40/$15 copay	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
40/$20 copay	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
40/$25 copay	(0.93)	(2.51)	na	na	(1.72)	(2.19)	(2.79)
60	0.34	0.92	na	na	0.63	0.80	1.02
100	0.81	2.19	na	na	1.50	1.90	2.43
200	2.19	5.91	na	na	4.05	5.15	6.57
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.31)	(3.54)	na	na	(2.42)	(3.08)	(3.93)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.84	2.27	na	na	1.55	1.97	2.52
90	1.80	4.86	na	na	3.33	4.23	5.40
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.76	2.05	na	na	1.41	1.79	2.28
90	1.42	3.83	na	na	2.63	3.34	4.26
120	2.27	6.13	na	na	4.20	5.33	6.81

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
	Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	(1.09)	(2.94)	na	na	(2.02)	(2.56)	(3.27)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.89	na	na	0.61	0.78	0.99
30	0.49	1.32	na	na	0.91	1.15	1.47
Unlimited	0.76	2.05	na	na	1.41	1.79	2.28
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.86	10.42	na	na	7.14	9.07	11.58
60	4.51	12.18	na	na	8.34	10.60	13.53
90	5.40	14.58	na	na	9.99	12.69	16.20
Unlimited	5.47	14.77	na	na	10.12	12.85	16.41
	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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
60/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
60/$20 copay	(0.67)	(1.81)	na	na	(1.24)	(1.57)	(2.01)
60/$25 copay	(0.78)	(2.11)	na	na	(1.44)	(1.83)	(2.34)
120/$0 copay	0.69	1.86	na	na	1.28	1.62	2.07
120/$5 copay	0.49	1.32	na	na	0.91	1.15	1.47
120/$10 copay	0.31	0.84	na	na	0.57	0.73	0.93
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.38)	(1.03)	na	na	(0.70)	(0.89)	(1.14)
Unlimited/$0 copay	0.77	2.08	na	na	1.42	1.81	2.31
Unlimited/$5 copay	0.62	1.67	na	na	1.15	1.46	1.86
Unlimited/$10 copay	0.38	1.03	na	na	0.70	0.89	1.14
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	0.24	0.65	na	na	0.44	0.56	0.72
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$25	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.73)	(1.97)	na	na	(1.35)	(1.72)	(2.19)
$25	(0.97)	(2.62)	na	na	(1.79)	(2.28)	(2.91)
$30	(1.15)	(3.11)	na	na	(2.13)	(2.70)	(3.45)
$35	(1.38)	(3.73)	na	na	(2.55)	(3.24)	(4.14)
$40	(1.58)	(4.27)	na	na	(2.92)	(3.71)	(4.74)
$45	(1.81)	(4.89)	na	na	(3.35)	(4.25)	(5.43)
$50	(2.02)	(5.45)	na	na	(3.74)	(4.75)	(6.06)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.38)	(1.03)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.57)	(1.54)	na	na	(1.05)	(1.34)	(1.71)
$20	(0.81)	(2.19)	na	na	(1.50)	(1.90)	(2.43)
$25	(1.11)	(3.00)	na	na	(2.05)	(2.61)	(3.33)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$50	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
$75	(0.64)	(1.73)	na	na	(1.18)	(1.50)	(1.92)
$100	(0.81)	(2.19)	na	na	(1.50)	(1.90)	(2.43)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.28)	(0.76)	na	na	(0.52)	(0.66)	(0.84)
$60	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$75	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$100	(0.57)	(1.54)	na	na	(1.05)	(1.34)	(1.71)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.49)	(9.42)	na	na	(6.46)	(8.20)	(10.47)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.39)	(14.55)	na	na	(9.97)	(12.67)	(16.17)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.27	11.53	na	na	7.90	10.03	12.81
60	6.04	16.31	na	na	11.17	14.19	18.12
90	7.16	19.33	na	na	13.25	16.83	21.48
Unlimited	7.24	19.55	na	na	13.39	17.01	21.72
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.61	20.55	na	na	14.08	17.88	22.83
60	8.04	21.71	na	na	14.87	18.89	24.12
90	8.34	22.52	na	na	15.43	19.60	25.02
Unlimited	8.42	22.73	na	na	15.58	19.79	25.26
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.80	15.66	na	na	10.73	13.63	17.40
30	6.90	18.63	na	na	12.77	16.22	20.70
40	7.59	20.49	na	na	14.04	17.84	22.77
60	8.30	22.41	na	na	15.36	19.51	24.90
Unlimited	8.37	22.60	na	na	15.48	19.67	25.11
SMALL GROUP	**$5 Copay**						
20	5.46	14.74	na	na	10.10	12.83	16.38
30	6.48	17.50	na	na	11.99	15.23	19.44
40	7.15	19.31	na	na	13.23	16.80	21.45
60	7.81	21.09	na	na	14.45	18.35	23.43
Unlimited	7.89	21.30	na	na	14.60	18.54	23.67

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$10 Copay**			
20	5.08	13.72	na	na	9.40	11.94	15.24
30	6.05	16.34	na	na	11.19	14.22	18.15
40	6.65	17.96	na	na	12.30	15.63	19.95
60	7.28	19.66	na	na	13.47	17.11	21.84
Unlimited	7.35	19.85	na	na	13.60	17.27	22.05
SMALL GROUP				**$15 Copay**			
20	4.79	12.93	na	na	8.86	11.26	14.37
30	5.69	15.36	na	na	10.53	13.37	17.07
40	6.26	16.90	na	na	11.58	14.71	18.78
60	6.83	18.44	na	na	12.64	16.05	20.49
Unlimited	6.91	18.66	na	na	12.78	16.24	20.73
SMALL GROUP				**$20 Copay**			
20	4.48	12.10	na	na	8.29	10.53	13.44
30	5.33	14.39	na	na	9.86	12.53	15.99
40	5.87	15.85	na	na	10.86	13.79	17.61
60	6.42	17.33	na	na	11.88	15.09	19.26
Unlimited	6.46	17.44	na	na	11.95	15.18	19.38
SMALL GROUP				**$25 Copay**			
20	4.18	11.29	na	na	7.73	9.82	12.54
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.47	14.77	na	na	10.12	12.85	16.41
60	5.97	16.12	na	na	11.04	14.03	17.91
Unlimited	6.05	16.34	na	na	11.19	14.22	18.15
SMALL GROUP				**$30 Copay**			
20	4.01	10.83	na	na	7.42	9.42	12.03
30	4.80	12.96	na	na	8.88	11.28	14.40
40	5.27	14.23	na	na	9.75	12.38	15.81
60	5.77	15.58	na	na	10.67	13.56	17.31
Unlimited	5.82	15.71	na	na	10.77	13.68	17.46

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$35 Copay**			
20	3.90	10.53	na	na	7.22	9.17	11.70
30	4.64	12.53	na	na	8.58	10.90	13.92
40	5.12	13.82	na	na	9.47	12.03	15.36
60	5.60	15.12	na	na	10.36	13.16	16.80
Unlimited	5.65	15.26	na	na	10.45	13.28	16.95
SMALL GROUP				**$40 Copay**			
20	3.81	10.29	na	na	7.05	8.95	11.43
30	4.50	12.15	na	na	8.33	10.58	13.50
40	4.96	13.39	na	na	9.18	11.66	14.88
60	5.44	14.69	na	na	10.06	12.78	16.32
Unlimited	5.49	14.82	na	na	10.16	12.90	16.47
SMALL GROUP				**$45 Copay**			
20	3.67	9.91	na	na	6.79	8.62	11.01
30	4.37	11.80	na	na	8.08	10.27	13.11
40	4.82	13.01	na	na	8.92	11.33	14.46
60	5.26	14.20	na	na	9.73	12.36	15.78
Unlimited	5.30	14.31	na	na	9.81	12.46	15.90
SMALL GROUP				**$50 Copay**			
20	3.57	9.64	na	na	6.60	8.39	10.71
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.67	12.61	na	na	8.64	10.97	14.01
60	5.11	13.80	na	na	9.45	12.01	15.33
Unlimited	5.14	13.88	na	na	9.51	12.08	15.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.52	20.30	na	na	13.91	17.67	22.56
30	8.27	22.33	na	na	15.30	19.43	24.81
40	8.74	23.60	na	na	16.17	20.54	26.22
60	9.23	24.92	na	na	17.08	21.69	27.69
Unlimited	9.33	25.19	na	na	17.26	21.93	27.99
SMALL GROUP				**$5 Copay**			
20	7.07	19.09	na	na	13.08	16.61	21.21
30	7.79	21.03	na	na	14.41	18.31	23.37
40	8.22	22.19	na	na	15.21	19.32	24.66
60	8.70	23.49	na	na	16.10	20.45	26.10
Unlimited	8.78	23.71	na	na	16.24	20.63	26.34
SMALL GROUP				**$10 Copay**			
20	6.59	17.79	na	na	12.19	15.49	19.77
30	7.24	19.55	na	na	13.39	17.01	21.72
40	7.66	20.68	na	na	14.17	18.00	22.98
60	8.09	21.84	na	na	14.97	19.01	24.27
Unlimited	8.17	22.06	na	na	15.11	19.20	24.51
SMALL GROUP				**$15 Copay**			
20	6.21	16.77	na	na	11.49	14.59	18.63
30	6.82	18.41	na	na	12.62	16.03	20.46
40	7.19	19.41	na	na	13.30	16.90	21.57
60	7.59	20.49	na	na	14.04	17.84	22.77
Unlimited	7.67	20.71	na	na	14.19	18.02	23.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.82	15.71	na	na	10.77	13.68	17.46
30	6.40	17.28	na	na	11.84	15.04	19.20
40	6.76	18.25	na	na	12.51	15.89	20.28
60	7.14	19.28	na	na	13.21	16.78	21.42
Unlimited	7.19	19.41	na	na	13.30	16.90	21.57
SMALL GROUP				**$25 Copay**			
20	5.42	14.63	na	na	10.03	12.74	16.26
30	5.95	16.07	na	na	11.01	13.98	17.85
40	6.29	16.98	na	na	11.64	14.78	18.87
60	6.64	17.93	na	na	12.28	15.60	19.92
Unlimited	6.71	18.12	na	na	12.41	15.77	20.13
SMALL GROUP				**$30 Copay**			
20	5.22	14.09	na	na	9.66	12.27	15.66
30	5.75	15.53	na	na	10.64	13.51	17.25
40	6.08	16.42	na	na	11.25	14.29	18.24
60	6.42	17.33	na	na	11.88	15.09	19.26
Unlimited	6.45	17.42	na	na	11.93	15.16	19.35
SMALL GROUP				**$35 Copay**			
20	5.07	13.69	na	na	9.38	11.91	15.21
30	5.59	15.09	na	na	10.34	13.14	16.77
40	5.89	15.90	na	na	10.90	13.84	17.67
60	6.24	16.85	na	na	11.54	14.66	18.72
Unlimited	6.27	16.93	na	na	11.60	14.73	18.81
SMALL GROUP				**$40 Copay**			
20	4.92	13.28	na	na	9.10	11.56	14.76
30	5.42	14.63	na	na	10.03	12.74	16.26
40	5.71	15.42	na	na	10.56	13.42	17.13
60	6.05	16.34	na	na	11.19	14.22	18.15
Unlimited	6.09	16.44	na	na	11.27	14.31	18.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	4.79	12.93	na	na	8.86	11.26	14.37
30	5.23	14.12	na	na	9.68	12.29	15.69
40	5.54	14.96	na	na	10.25	13.02	16.62
60	5.86	15.82	na	na	10.84	13.77	17.58
Unlimited	5.90	15.93	na	na	10.92	13.87	17.70
SMALL GROUP				**$50 Copay**			
20	4.62	12.47	na	na	8.55	10.86	13.86
30	5.08	13.72	na	na	9.40	11.94	15.24
40	5.39	14.55	na	na	9.97	12.67	16.17
60	5.68	15.34	na	na	10.51	13.35	17.04
Unlimited	5.71	15.42	na	na	10.56	13.42	17.13
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

4th Quarter Small Group RATE MANUAL

HIP HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 01, 2013 - December 31, 2013 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

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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%

Full-time Students

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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%

Class II Dependents

	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
October 01, 2013 - December 31, 2013 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	5.00	13.50	na	na	9.25	11.75	15.00
$0/Max $5000	4.75	12.83	na	na	8.79	11.16	14.25
$0/Max $2500	4.45	12.02	na	na	8.23	10.46	13.35
$25	4.75	12.83	na	na	8.79	11.16	14.25
$50	4.45	12.02	na	na	8.23	10.46	13.35
$100	4.06	10.96	na	na	7.51	9.54	12.18
$500	1.94	5.24	na	na	3.59	4.56	5.82
$5,000	0.33	0.89	na	na	0.61	0.78	0.99
Coinsurance							
80%	3.99	10.77	na	na	7.38	9.38	11.97
75%	3.75	10.13	na	na	6.94	8.81	11.25
70%	3.51	9.48	na	na	6.49	8.25	10.53
Deductible			**Orthotics Riders**				
$0	0.83	2.24	na	na	1.54	1.95	2.49
$0/Max $5000	0.80	2.16	na	na	1.48	1.88	2.40
$0/Max $2500	0.76	2.05	na	na	1.41	1.79	2.28
$25	0.80	2.16	na	na	1.48	1.88	2.40
$50	0.76	2.05	na	na	1.41	1.79	2.28
$100	0.70	1.89	na	na	1.30	1.65	2.10
$500	0.35	0.95	na	na	0.65	0.82	1.05
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.70	1.89	na	na	1.30	1.65	2.10
75%	0.67	1.81	na	na	1.24	1.57	2.01
70%	0.64	1.73	na	na	1.18	1.50	1.92

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.62	4.37	na	na	3.00	3.81	4.86
12 Months	2.61	7.05	na	na	4.83	6.13	7.83
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.53	6.83	na	na	4.68	5.95	7.59
12 Months	4.05	10.94	na	na	7.49	9.52	12.15
			Private Duty Nursing Riders				
In Full	0.62	1.67	na	na	1.15	1.46	1.86
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
			Dental Network Access				
	0.48	1.30	na	na	0.89	1.13	1.44
Limit			**Infertility Rider**				
2 IVF	10.57	28.54	na	na	19.55	24.84	31.71
3 IVF	12.75	34.43	na	na	23.59	29.96	38.25
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.86	13.12	na	na	8.99	11.42	14.58
Health Club Reimbursement							
$200 per year	1.26	3.40	na	na	2.33	2.96	3.78
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99
Subject to			**Wellness Rider**				
DFS Approval	0.82	2.21	na	na	1.52	1.93	2.46

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS

October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Effective 10/01/2013 - 12/31/2013 (With WH & Autism)				
Small Group *	505.39	1,435.31	na	na	934.97	1,187.67	1,516.17
			Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)				
Small Group *	500.40	1,421.14	na	na	925.74	1,175.94	1,501.20

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(4.40)	(12.50)	na	na	(8.14)	(10.34)	(13.20)
$10	(9.24)	(26.24)	na	na	(17.09)	(21.71)	(27.72)
$15	(14.30)	(40.61)	na	na	(26.46)	(33.61)	(42.90)
$20	(20.59)	(58.48)	na	na	(38.09)	(48.39)	(61.77)
$25	(38.22)	(108.54)	na	na	(70.71)	(89.82)	(114.66)
$30	(60.72)	(172.44)	na	na	(112.33)	(142.69)	(182.16)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.51)	(7.13)	na	na	(4.64)	(5.90)	(7.53)
$10	(5.30)	(15.05)	na	na	(9.81)	(12.46)	(15.90)
$15	(8.19)	(23.26)	na	na	(15.15)	(19.25)	(24.57)
$20	(11.82)	(33.57)	na	na	(21.87)	(27.78)	(35.46)
$25	(21.90)	(62.20)	na	na	(40.52)	(51.47)	(65.70)
$30	(34.81)	(98.86)	na	na	(64.40)	(81.80)	(104.43)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.12)	(8.86)	na	na	(5.77)	(7.33)	(9.36)
$10	(6.39)	(18.15)	na	na	(11.82)	(15.02)	(19.17)
$15	(9.72)	(27.60)	na	na	(17.98)	(22.84)	(29.16)
$20	(13.21)	(37.52)	na	na	(24.44)	(31.04)	(39.63)
$25	(19.61)	(55.69)	na	na	(36.28)	(46.08)	(58.83)
$30	(27.69)	(78.64)	na	na	(51.23)	(65.07)	(83.07)
$35	(36.23)	(102.89)	na	na	(67.03)	(85.14)	(108.69)
$40	(45.81)	(130.10)	na	na	(84.75)	(107.65)	(137.43)
$45	(56.52)	(160.52)	na	na	(104.56)	(132.82)	(169.56)
$50	(68.37)	(194.17)	na	na	(126.48)	(160.67)	(205.11)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.62)	(7.44)	na	na	(4.85)	(6.16)	(7.86)
$10	(5.40)	(15.34)	na	na	(9.99)	(12.69)	(16.20)
$15	(8.20)	(23.29)	na	na	(15.17)	(19.27)	(24.60)
$20	(11.17)	(31.72)	na	na	(20.66)	(26.25)	(33.51)
$25	(16.58)	(47.09)	na	na	(30.67)	(38.96)	(49.74)
$30	(23.39)	(66.43)	na	na	(43.27)	(54.97)	(70.17)
$35	(30.61)	(86.93)	na	na	(56.63)	(71.93)	(91.83)
$40	(38.75)	(110.05)	na	na	(71.69)	(91.06)	(116.25)
$45	(47.78)	(135.70)	na	na	(88.39)	(112.28)	(143.34)
$50	(57.81)	(164.18)	na	na	(106.95)	(135.85)	(173.43)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$100	(2.48)	(7.04)	na	na	(4.59)	(5.83)	(7.44)
$150	(4.16)	(11.81)	na	na	(7.70)	(9.78)	(12.48)
$200	(6.00)	(17.04)	na	na	(11.10)	(14.10)	(18.00)
$250	(8.66)	(24.59)	na	na	(16.02)	(20.35)	(25.98)
$500	(21.29)	(60.46)	na	na	(39.39)	(50.03)	(63.87)
$750	(37.28)	(105.88)	na	na	(68.97)	(87.61)	(111.84)
$1,000	(56.93)	(161.68)	na	na	(105.32)	(133.79)	(170.79)
Copay/Day							
$50 w/3 Day Max	(3.59)	(10.20)	na	na	(6.64)	(8.44)	(10.77)
$50 w/5 Day Max	(4.86)	(13.80)	na	na	(8.99)	(11.42)	(14.58)
$100 w/3 Day Max	(7.66)	(21.75)	na	na	(14.17)	(18.00)	(22.98)
$100 w/5 Day Max	(13.03)	(37.01)	na	na	(24.11)	(30.62)	(39.09)
$250 w/3 Day Max	(25.28)	(71.80)	na	na	(46.77)	(59.41)	(75.84)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.39)	(3.95)	na	na	(2.57)	(3.27)	(4.17)
$75	(2.43)	(6.90)	na	na	(4.50)	(5.71)	(7.29)
$100	(3.67)	(10.42)	na	na	(6.79)	(8.62)	(11.01)
$125	(5.09)	(14.46)	na	na	(9.42)	(11.96)	(15.27)
$150	(6.75)	(19.17)	na	na	(12.49)	(15.86)	(20.25)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.90)	(2.56)	na	na	(1.67)	(2.12)	(2.70)
$35	(1.50)	(4.26)	na	na	(2.78)	(3.53)	(4.50)
$50	(2.49)	(7.07)	na	na	(4.61)	(5.85)	(7.47)
$60	(3.17)	(9.00)	na	na	(5.86)	(7.45)	(9.51)
$75	(4.09)	(11.62)	na	na	(7.57)	(9.61)	(12.27)
$100	(5.74)	(16.30)	na	na	(10.62)	(13.49)	(17.22)
$125	(7.51)	(21.33)	na	na	(13.89)	(17.65)	(22.53)
$150	(9.47)	(26.89)	na	na	(17.52)	(22.25)	(28.41)
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.69	1.96	na	na	1.28	1.62	2.07
60	1.32	3.75	na	na	2.44	3.10	3.96
90	1.98	5.62	na	na	3.66	4.65	5.94
120	2.31	6.56	na	na	4.27	5.43	6.93
Unlimited	2.96	8.41	na	na	5.48	6.96	8.88

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
40/$20 copay	(0.75)	(2.13)	na	na	(1.39)	(1.76)	(2.25)
40/$25 copay	(0.97)	(2.75)	na	na	(1.79)	(2.28)	(2.91)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.86	2.44	na	na	1.59	2.02	2.58
200	2.32	6.59	na	na	4.29	5.45	6.96
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.37)	(3.89)	na	na	(2.53)	(3.22)	(4.11)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.92	2.61	na	na	1.70	2.16	2.76
90	1.91	5.42	na	na	3.53	4.49	5.73
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit]**				
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.81	2.30	na	na	1.50	1.90	2.43
90	1.49	4.23	na	na	2.76	3.50	4.47
120	2.39	6.79	na	na	4.42	5.62	7.17
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	(1.15)	(3.27)	na	na	(2.13)	(2.70)	(3.45)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.56	1.59	na	na	1.04	1.32	1.68
Unlimited	0.81	2.30	na	na	1.50	1.90	2.43
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.09	11.62	na	na	7.57	9.61	12.27
60	4.80	13.63	na	na	8.88	11.28	14.40
90	5.72	16.24	na	na	10.58	13.44	17.16
Unlimited	5.80	16.47	na	na	10.73	13.63	17.40

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.67)	(1.90)	na	na	(1.24)	(1.57)	(2.01)
60/$25 copay	(0.77)	(2.19)	na	na	(1.42)	(1.81)	(2.31)
120/$0 copay	0.73	2.07	na	na	1.35	1.72	2.19
120/$5 copay	0.58	1.65	na	na	1.07	1.36	1.74
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.83	2.36	na	na	1.54	1.95	2.49
Unlimited/$5 copay	0.68	1.93	na	na	1.26	1.60	2.04
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay	**Refractive Eye Exam Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
$25	(0.92)	(2.61)	na	na	(1.70)	(2.16)	(2.76)
$30	(1.15)	(3.27)	na	na	(2.13)	(2.70)	(3.45)
$35	(1.34)	(3.81)	na	na	(2.48)	(3.15)	(4.02)
$40	(1.55)	(4.40)	na	na	(2.87)	(3.64)	(4.65)
$45	(1.77)	(5.03)	na	na	(3.27)	(4.16)	(5.31)
$50	(1.97)	(5.59)	na	na	(3.64)	(4.63)	(5.91)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.56)	(1.59)	na	na	(1.04)	(1.32)	(1.68)
$20	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
$25	(1.09)	(3.10)	na	na	(2.02)	(2.56)	(3.27)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.63)	(1.79)	na	na	(1.17)	(1.48)	(1.89)
$100	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.56)	(1.59)	na	na	(1.04)	(1.32)	(1.68)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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]							
	(3.37)	(9.57)	na	na	(6.23)	(7.92)	(10.11)
Diagnostic and Therapeutic Radiology [std: $0]							
Copay per procedure of minimum (20%, $100); $500 annual maximum							
	(5.27)	(14.97)	na	na	(9.75)	(12.38)	(15.81)
Diagnostic Testing [std: $0]							
Copay per procedure minimum of [20%, $100], $500 annual maximum							
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.44	12.61	na	na	8.21	10.43	13.32
60	5.31	15.08	na	na	9.82	12.48	15.93
90	5.89	16.73	na	na	10.90	13.84	17.67
Unlimited	5.97	16.95	na	na	11.04	14.03	17.91
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.21	20.48	na	na	13.34	16.94	21.63
60	7.61	21.61	na	na	14.08	17.88	22.83
90	7.91	22.46	na	na	14.63	18.59	23.73
Unlimited	8.00	22.72	na	na	14.80	18.80	24.00
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	6.03	17.13	na	na	11.16	14.17	18.09
30	7.08	20.11	na	na	13.10	16.64	21.24
40	7.77	22.07	na	na	14.37	18.26	23.31
60	8.42	23.91	na	na	15.58	19.79	25.26
Unlimited	8.51	24.17	na	na	15.74	20.00	25.53
SMALL GROUP	**$5 Copay**						
20	5.69	16.16	na	na	10.53	13.37	17.07
30	6.66	18.91	na	na	12.32	15.65	19.98
40	7.29	20.70	na	na	13.49	17.13	21.87
60	7.92	22.49	na	na	14.65	18.61	23.76
Unlimited	8.00	22.72	na	na	14.80	18.80	24.00
SMALL GROUP	**$10 Copay**						
20	5.29	15.02	na	na	9.79	12.43	15.87
30	6.20	17.61	na	na	11.47	14.57	18.60
40	6.80	19.31	na	na	12.58	15.98	20.40
60	7.37	20.93	na	na	13.63	17.32	22.11
Unlimited	7.47	21.21	na	na	13.82	17.55	22.41

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$15 Copay**			
20	4.97	14.11	na	na	9.19	11.68	14.91
30	5.82	16.53	na	na	10.77	13.68	17.46
40	6.37	18.09	na	na	11.78	14.97	19.11
60	6.94	19.71	na	na	12.84	16.31	20.82
Unlimited	7.00	19.88	na	na	12.95	16.45	21.00
SMALL GROUP				**$20 Copay**			
20	4.68	13.29	na	na	8.66	11.00	14.04
30	5.47	15.53	na	na	10.12	12.85	16.41
40	6.00	17.04	na	na	11.10	14.10	18.00
60	6.52	18.52	na	na	12.06	15.32	19.56
Unlimited	6.59	18.72	na	na	12.19	15.49	19.77
SMALL GROUP				**$25 Copay**			
20	4.35	12.35	na	na	8.05	10.22	13.05
30	5.10	14.48	na	na	9.44	11.99	15.30
40	5.56	15.79	na	na	10.29	13.07	16.68
60	6.05	17.18	na	na	11.19	14.22	18.15
Unlimited	6.11	17.35	na	na	11.30	14.36	18.33
SMALL GROUP				**$30 Copay**			
20	4.18	11.87	na	na	7.73	9.82	12.54
30	4.92	13.97	na	na	9.10	11.56	14.76
40	5.36	15.22	na	na	9.92	12.60	16.08
60	5.88	16.70	na	na	10.88	13.82	17.64
Unlimited	5.92	16.81	na	na	10.95	13.91	17.76
SMALL GROUP				**$35 Copay**			
20	4.07	11.56	na	na	7.53	9.56	12.21
30	4.77	13.55	na	na	8.82	11.21	14.31
40	5.24	14.88	na	na	9.69	12.31	15.72
60	5.69	16.16	na	na	10.53	13.37	17.07
Unlimited	5.73	16.27	na	na	10.60	13.47	17.19
SMALL GROUP				**$40 Copay**			
20	3.96	11.25	na	na	7.33	9.31	11.88
30	4.64	13.18	na	na	8.58	10.90	13.92
40	5.07	14.40	na	na	9.38	11.91	15.21
60	5.49	15.59	na	na	10.16	12.90	16.47
Unlimited	5.54	15.73	na	na	10.25	13.02	16.62

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$45 Copay**			
20	3.84	10.91	na	na	7.10	9.02	11.52
30	4.48	12.72	na	na	8.29	10.53	13.44
40	4.91	13.94	na	na	9.08	11.54	14.73
60	5.33	15.14	na	na	9.86	12.53	15.99
Unlimited	5.36	15.22	na	na	9.92	12.60	16.08
SMALL GROUP				**$50 Copay**			
20	3.72	10.56	na	na	6.88	8.74	11.16
30	4.36	12.38	na	na	8.07	10.25	13.08
40	4.77	13.55	na	na	8.82	11.21	14.31
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.22	14.82	na	na	9.66	12.27	15.66
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.15	20.31	na	na	13.23	16.80	21.45
30	7.78	22.10	na	na	14.39	18.28	23.34
40	8.13	23.09	na	na	15.04	19.11	24.39
60	8.53	24.23	na	na	15.78	20.05	25.59
Unlimited	8.63	24.51	na	na	15.97	20.28	25.89
SMALL GROUP				**$5 Copay**			
20	6.73	19.11	na	na	12.45	15.82	20.19
30	7.30	20.73	na	na	13.51	17.16	21.90
40	7.66	21.75	na	na	14.17	18.00	22.98
60	8.03	22.81	na	na	14.86	18.87	24.09
Unlimited	8.12	23.06	na	na	15.02	19.08	24.36
SMALL GROUP				**$10 Copay**			
20	6.28	17.84	na	na	11.62	14.76	18.84
30	6.81	19.34	na	na	12.60	16.00	20.43
40	7.14	20.28	na	na	13.21	16.78	21.42
60	7.49	21.27	na	na	13.86	17.60	22.47
Unlimited	7.56	21.47	na	na	13.99	17.77	22.68
SMALL GROUP				**$15 Copay**			
20	5.90	16.76	na	na	10.92	13.87	17.70
30	6.38	18.12	na	na	11.80	14.99	19.14
40	6.70	19.03	na	na	12.40	15.75	20.10
60	7.02	19.94	na	na	12.99	16.50	21.06
Unlimited	7.11	20.19	na	na	13.15	16.71	21.33

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$20 Copay**			
20	5.53	15.71	na	na	10.23	13.00	16.59
30	6.00	17.04	na	na	11.10	14.10	18.00
40	6.29	17.86	na	na	11.64	14.78	18.87
60	6.61	18.77	na	na	12.23	15.53	19.83
Unlimited	6.69	19.00	na	na	12.38	15.72	20.07
SMALL GROUP				**$25 Copay**			
20	5.14	14.60	na	na	9.51	12.08	15.42
30	5.57	15.82	na	na	10.30	13.09	16.71
40	5.87	16.67	na	na	10.86	13.79	17.61
60	6.15	17.47	na	na	11.38	14.45	18.45
Unlimited	6.21	17.64	na	na	11.49	14.59	18.63
SMALL GROUP				**$30 Copay**			
20	4.98	14.14	na	na	9.21	11.70	14.94
30	5.37	15.25	na	na	9.93	12.62	16.11
40	5.68	16.13	na	na	10.51	13.35	17.04
60	5.94	16.87	na	na	10.99	13.96	17.82
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP				**$35 Copay**			
20	4.82	13.69	na	na	8.92	11.33	14.46
30	5.24	14.88	na	na	9.69	12.31	15.72
40	5.47	15.53	na	na	10.12	12.85	16.41
60	5.75	16.33	na	na	10.64	13.51	17.25
Unlimited	5.81	16.50	na	na	10.75	13.65	17.43
SMALL GROUP				**$40 Copay**			
20	4.69	13.32	na	na	8.68	11.02	14.07
30	5.09	14.46	na	na	9.42	11.96	15.27
40	5.31	15.08	na	na	9.82	12.48	15.93
60	5.57	15.82	na	na	10.30	13.09	16.71
Unlimited	5.66	16.07	na	na	10.47	13.30	16.98
SMALL GROUP				**$45 Copay**			
20	4.53	12.87	na	na	8.38	10.65	13.59
30	4.92	13.97	na	na	9.10	11.56	14.76
40	5.15	14.63	na	na	9.53	12.10	15.45
60	5.40	15.34	na	na	9.99	12.69	16.20
Unlimited	5.45	15.48	na	na	10.08	12.81	16.35

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
SMALL GROUP				**$50 Copay**			
20	4.40	12.50	na	na	8.14	10.34	13.20
30	4.77	13.55	na	na	8.82	11.21	14.31
40	5.00	14.20	na	na	9.25	11.75	15.00
60	5.26	14.94	na	na	9.73	12.36	15.78
Unlimited	5.29	15.02	na	na	9.79	12.43	15.87
SMALL GROUP	**Small Group Premium Credit - Outpatient Mental Health**						
Specialist Copay	****[above rates must be reduced by premium credit] [not yet approved]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK

4th Quarter Small Group RATE MANUAL

HIP COMPREHEALTH HMO GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 01, 2013 - December 31, 2013 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				
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
			Full-time Students				
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%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
October 01, 2013 - December 31, 2013 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	5.29	15.02	na	na	9.79	12.43	15.87
$0/Max $5000	5.00	14.20	na	na	9.25	11.75	15.00
$0/Max $2500	4.70	13.35	na	na	8.70	11.05	14.10
$25	5.00	14.20	na	na	9.25	11.75	15.00
$50	4.70	13.35	na	na	8.70	11.05	14.10
$100	4.31	12.24	na	na	7.97	10.13	12.93
$500	2.08	5.91	na	na	3.85	4.89	6.24
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.23	12.01	na	na	7.83	9.94	12.69
25%	3.98	11.30	na	na	7.36	9.35	11.94
30%	3.71	10.54	na	na	6.86	8.72	11.13
Deductible			**Orthotics Riders**				
$0	0.92	2.61	na	na	1.70	2.16	2.76
$0/Max $5000	0.85	2.41	na	na	1.57	2.00	2.55
$0/Max $2500	0.81	2.30	na	na	1.50	1.90	2.43
$25	0.85	2.41	na	na	1.57	2.00	2.55
$50	0.81	2.30	na	na	1.50	1.90	2.43
$100	0.74	2.10	na	na	1.37	1.74	2.22
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
20%	0.74	2.10	na	na	1.37	1.74	2.22
25%	0.71	2.02	na	na	1.31	1.67	2.13
30%	0.67	1.90	na	na	1.24	1.57	2.01
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.76	5.00	na	na	3.26	4.14	5.28
12 Months	2.81	7.98	na	na	5.20	6.60	8.43
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.75	7.81	na	na	5.09	6.46	8.25
12 Months	4.36	12.38	na	na	8.07	10.25	13.08

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Private Duty Nursing Riders				
In Full	0.71	2.02	na	na	1.31	1.67	2.13
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.54	1.53	na	na	1.00	1.27	1.62
Limit			**Infertility Rider**				
2 IVF	11.17	31.72	na	na	20.66	26.25	33.51
3 IVF	13.50	38.34	na	na	24.98	31.73	40.50
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.62	13.12	na	na	8.55	10.86	13.86
			Health Club Reimbursement				
$200 per year	1.32	3.75	na	na	2.44	3.10	3.96
			Wellness Rider				
Inclusion	1.08	3.07	na	na	2.00	2.54	3.24
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HMO Factors
October 01, 2013 - December 31, 2013

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO	1.000	1.074
New York City, Westchester, Rockland and Orange Counties			
	HMO	1.000	1.028
Upstate[2]			
	HMO	1.000	not available

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	115%

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.
(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
October 01, 2013 - December 31, 2013 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[g]
+ applicable pmpm for Women's Preventive Services Table 4 [h]
x tier conversion factors

GROUP CONTRACT - DRUG RIDERS

MONTHLY PREMIUMS EFFECTIVE 2011 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*

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 Adjustmer Applies only to New York City account	-2.0%	
[f] Product Factc HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
	HMO	CompreHealth HMO
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
3Q2103	3.0%	1.0%
4Q2103	3.0%	1.0%
[h] Mandatory Women's Preventive Services	$0.61	$0.61

Table 5: Tier Conversion Factors

	HIP	Emblem Coordinated Care Plans
	Small Group	Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(rer	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

Health Insurance Plan of Greater New York
and HIP Insurance Company of New York

Rating Region Definitions

County	Region
Bronx	Downstate
Kings	Downstate
Nassau	Downstate
New York	Downstate
Orange	Downstate
Queens	Downstate
Richmond	Downstate
Rockland	Downstate
Suffolk	Downstate
Westchester	Downstate

Commissions Schedule

Please see SERFF filing # HPHP-127874918

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
OCTOBER 1, 2012 - DECEMBER 31, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 11/1/2012-12/31/2012 (WIT WH & Autism)							
Small Group*	713.84	1,927.37	na	na	1,320.60	1,677.52	2,141.52
Classic*	509.49	1,375.62	na	na	942.56	1,197.30	1,528.47
Effective 10/1/12-10/31/2012 (without & Autism)							
Small Group*	706.78	1,908.31	na	na	1,307.54	1,660.93	2,120.34
Classic*	504.44	1,361.99	na	na	933.21	1,185.43	1,513.32

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Group*	730.90	1,973.43	na	na	1,352.17	1,717.62	2,192.70
Classic*	521.65	1,408.46	na	na	965.05	1,225.88	1,564.95
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
Small Group*	723.66	1,953.88	na	na	1,338.77	1,700.60	2,170.98
Classic*	516.49	1,394.52	na	na	955.51	1,213.75	1,549.47

* Base rates exclude premium component for mandatory mental health coverage

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Gro	17.06	46.06	na	na	31.57	40.10	51.18
Classic*	12.16	32.84	na	na	22.49	28.58	36.48
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
Classic*	16.88	45.57	na	na	31.23	39.67	50.64
Classic*	12.05	32.53	na	na	22.30	28.32	36.15

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Gro	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Classic*	2.4%	2.4%	na	na	2.4%	2.4%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	na	na	0.00	0.00	0.00
$5	(4.01)	(10.83)	na	na	(7.42)	(9.42)	(12.03)
$10	(8.42)	(22.73)	na	na	(15.58)	(19.79)	(25.26)
$15	(13.99)	(37.77)	na	na	(25.88)	(32.88)	(41.97)
$20	(21.59)	(58.29)	na	na	(39.94)	(50.74)	(64.77)
$25	(28.46)	(76.84)	na	na	(52.65)	(66.88)	(85.38)
$30	(35.98)	(97.15)	na	na	(66.56)	(84.55)	(107.94)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.29)	(6.18)	na	na	(4.24)	(5.38)	(6.87)
$10	(4.81)	(12.99)	na	na	(8.90)	(11.30)	(14.43)
$15	(8.01)	(21.63)	na	na	(14.82)	(18.82)	(24.03)
$20	(12.37)	(33.40)	na	na	(22.88)	(29.07)	(37.11)
$25	(16.30)	(44.01)	na	na	(30.16)	(38.31)	(48.90)
$30	(20.62)	(55.67)	na	na	(38.15)	(48.46)	(61.86)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.83)	(7.64)	na	na	(5.24)	(6.65)	(8.49)
$10	(5.86)	(15.82)	na	na	(10.84)	(13.77)	(17.58)
$15	(9.17)	(24.76)	na	na	(16.96)	(21.55)	(27.51)
$20	(12.93)	(34.91)	na	na	(23.92)	(30.39)	(38.79)
$25	(17.06)	(46.06)	na	na	(31.56)	(40.09)	(51.18)
$30	(21.73)	(58.67)	na	na	(40.20)	(51.07)	(65.19)
$35	(26.13)	(70.55)	na	na	(48.34)	(61.41)	(78.39)
$40	(35.28)	(95.26)	na	na	(65.27)	(82.91)	(105.84)
$45	(35.45)	(95.72)	na	na	(65.58)	(83.31)	(106.35)
$50	(40.48)	(109.30)	na	na	(74.89)	(95.13)	(121.44)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.39)	(6.45)	na	na	(4.42)	(5.62)	(7.17)
$10	(4.95)	(13.37)	na	na	(9.16)	(11.63)	(14.85)
$15	(7.76)	(20.95)	na	na	(14.36)	(18.24)	(23.28)
$20	(10.94)	(29.54)	na	na	(20.24)	(25.71)	(32.82)
$25	(14.42)	(38.93)	na	na	(26.68)	(33.89)	(43.26)
$30	(18.38)	(49.63)	na	na	(34.00)	(43.19)	(55.14)
$35	(22.08)	(59.62)	na	na	(40.85)	(51.89)	(66.24)
$40	(29.83)	(80.54)	na	na	(55.19)	(70.10)	(89.49)
$45	(29.98)	(80.95)	na	na	(55.46)	(70.45)	(89.94)
$50	(34.23)	(92.42)	na	na	(63.33)	(80.44)	(102.69)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.16)	(5.83)	na	na	(4.00)	(5.08)	(6.48)
$150	(3.55)	(9.59)	na	na	(6.57)	(8.34)	(10.65)
$200	(5.07)	(13.69)	na	na	(9.38)	(11.91)	(15.21)
$250	(7.26)	(19.60)	na	na	(13.43)	(17.06)	(21.78)
$500	(17.40)	(46.98)	na	na	(32.19)	(40.89)	(52.20)
$750	(29.90)	(80.73)	na	na	(55.32)	(70.27)	(89.70)
$1,000	(44.97)	(121.42)	na	na	(83.19)	(105.68)	(134.91)
Copay/Day							
$50 w/3 Day Max	(2.61)	(7.05)	na	na	(4.83)	(6.13)	(7.83)
$50 w/5 Day Max	(3.59)	(9.69)	na	na	(6.64)	(8.44)	(10.77)
$100 w/3 Day Max	(6.53)	(17.63)	na	na	(12.08)	(15.35)	(19.59)
$100 w/5 Day Max	(9.42)	(25.43)	na	na	(17.43)	(22.14)	(28.26)
$250 w/3 Day Max	(21.66)	(58.48)	na	na	(40.07)	(50.90)	(64.98)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.18)	(3.19)	na	na	(2.18)	(2.77)	(3.54)
$75	(1.92)	(5.18)	na	na	(3.55)	(4.51)	(5.76)
$100	(2.74)	(7.40)	na	na	(5.07)	(6.44)	(8.22)
$125	(3.59)	(9.69)	na	na	(6.64)	(8.44)	(10.77)
$150	(4.49)	(12.12)	na	na	(8.31)	(10.55)	(13.47)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$25	(0.76)	(2.05)	na	na	(1.41)	(1.79)	(2.28)
$35	(1.25)	(3.38)	na	na	(2.31)	(2.94)	(3.75)
$50	(2.14)	(5.78)	na	na	(3.96)	(5.03)	(6.42)
$60	(2.72)	(7.34)	na	na	(5.03)	(6.39)	(8.16)
$75	(3.59)	(9.69)	na	na	(6.64)	(8.44)	(10.77)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(4.11)	(11.10)	na	na	(7.60)	(9.66)	(12.33)
$10	(8.62)	(23.27)	na	na	(15.95)	(20.26)	(25.86)
$15	(14.33)	(38.69)	na	na	(26.51)	(33.68)	(42.99)
$20	(22.11)	(59.70)	na	na	(40.90)	(51.96)	(66.33)
$25	(29.14)	(78.68)	na	na	(53.91)	(68.48)	(87.42)
$30	(36.83)	(99.44)	na	na	(68.14)	(86.55)	(110.49)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.35)	(6.35)	na	na	(4.35)	(5.52)	(7.05)
$10	(4.93)	(13.31)	na	na	(9.12)	(11.59)	(14.79)
$15	(8.21)	(22.17)	na	na	(15.19)	(19.29)	(24.63)
$20	(12.67)	(34.21)	na	na	(23.44)	(29.77)	(38.01)
$25	(16.69)	(45.06)	na	na	(30.88)	(39.22)	(50.07)
$30	(21.12)	(57.02)	na	na	(39.07)	(49.63)	(63.36)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.89)	(7.80)	na	na	(5.35)	(6.79)	(8.67)
$10	(5.99)	(16.17)	na	na	(11.08)	(14.08)	(17.97)
$15	(9.39)	(25.35)	na	na	(17.37)	(22.07)	(28.17)
$20	(13.24)	(35.75)	na	na	(24.49)	(31.11)	(39.72)
$25	(17.47)	(47.17)	na	na	(32.32)	(41.05)	(52.41)
$30	(22.25)	(60.08)	na	na	(41.16)	(52.29)	(66.75)
$35	(26.75)	(72.23)	na	na	(49.49)	(62.86)	(80.25)
$40	(36.12)	(97.52)	na	na	(66.82)	(84.88)	(108.36)
$45	(36.31)	(98.04)	na	na	(67.17)	(85.33)	(108.93)
$50	(41.45)	(111.92)	na	na	(76.68)	(97.41)	(124.35)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.45)	(6.62)	na	na	(4.53)	(5.76)	(7.35)
$10	(5.07)	(13.69)	na	na	(9.38)	(11.91)	(15.21)
$15	(7.94)	(21.44)	na	na	(14.69)	(18.66)	(23.82)
$20	(11.21)	(30.27)	na	na	(20.74)	(26.34)	(33.63)
$25	(14.77)	(39.88)	na	na	(27.32)	(34.71)	(44.31)
$30	(18.82)	(50.81)	na	na	(34.82)	(44.23)	(56.46)
$35	(22.61)	(61.05)	na	na	(41.83)	(53.13)	(67.83)
$40	(30.54)	(82.46)	na	na	(56.50)	(71.77)	(91.62)
$45	(30.69)	(82.86)	na	na	(56.78)	(72.12)	(92.07)
$50	(35.04)	(94.61)	na	na	(64.82)	(82.34)	(105.12)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.20)	(5.94)	na	na	(4.07)	(5.17)	(6.60)
$150	(3.64)	(9.83)	na	na	(6.73)	(8.55)	(10.92)
$200	(5.19)	(14.01)	na	na	(9.60)	(12.20)	(15.57)
$250	(7.43)	(20.06)	na	na	(13.75)	(17.46)	(22.29)
$500	(17.81)	(48.09)	na	na	(32.95)	(41.85)	(53.43)
$750	(30.62)	(82.67)	na	na	(56.65)	(71.96)	(91.86)
$1,000	(46.04)	(124.31)	na	na	(85.17)	(108.19)	(138.12)
Copay/Day							
$50 w/3 Day Max	(2.68)	(7.24)	na	na	(4.96)	(6.30)	(8.04)
$50 w/5 Day Max	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$100 w/3 Day Max	(6.68)	(18.04)	na	na	(12.36)	(15.70)	(20.04)
$100 w/5 Day Max	(9.64)	(26.03)	na	na	(17.83)	(22.65)	(28.92)
$250 w/3 Day Max	(22.19)	(59.91)	na	na	(41.05)	(52.15)	(66.57)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.21)	(3.27)	na	na	(2.24)	(2.84)	(3.63)
$75	(1.97)	(5.32)	na	na	(3.64)	(4.63)	(5.91)
$100	(2.81)	(7.59)	na	na	(5.20)	(6.60)	(8.43)
$125	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)
$150	(4.60)	(12.42)	na	na	(8.51)	(10.81)	(13.80)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.42)	(1.13)	na	na	(0.78)	(0.99)	(1.26)
$25	(0.77)	(2.08)	na	na	(1.42)	(1.81)	(2.31)
$35	(1.29)	(3.48)	na	na	(2.39)	(3.03)	(3.87)
$50	(2.19)	(5.91)	na	na	(4.05)	(5.15)	(6.57)
$60	(2.79)	(7.53)	na	na	(5.16)	(6.56)	(8.37)
$75	(3.67)	(9.91)	na	na	(6.79)	(8.62)	(11.01)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	-	-	na	na	-	-	-
$0	(0.10)	(0.27)	na	na	(0.18)	(0.24)	(0.30)
$0	(0.20)	(0.54)	na	na	(0.37)	(0.47)	(0.60)
$0	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$0	(0.52)	(1.41)	na	na	(0.96)	(1.22)	(1.56)
$0	(0.68)	(1.84)	na	na	(1.26)	(1.60)	(2.04)
$0	(0.85)	(2.29)	na	na	(1.58)	(2.00)	(2.55)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.12)	(0.32)	na	na	(0.22)	(0.29)	(0.36)
$0	(0.20)	(0.54)	na	na	(0.37)	(0.47)	(0.60)
$0	(0.30)	(0.81)	na	na	(0.56)	(0.70)	(0.90)
$0	(0.39)	(1.05)	na	na	(0.72)	(0.91)	(1.17)
$0	(0.50)	(1.35)	na	na	(0.92)	(1.17)	(1.50)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$0	(0.22)	(0.59)	na	na	(0.41)	(0.52)	(0.66)
$0	(0.31)	(0.84)	na	na	(0.57)	(0.72)	(0.93)
$0	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
$0	(0.52)	(1.41)	na	na	(0.96)	(1.22)	(1.56)
$0	(0.62)	(1.68)	na	na	(1.15)	(1.45)	(1.86)
$0	(0.84)	(2.26)	na	na	(1.55)	(1.97)	(2.52)
$0	(0.86)	(2.32)	na	na	(1.59)	(2.02)	(2.58)
$0	(0.97)	(2.62)	na	na	(1.79)	(2.28)	(2.91)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$0	(0.12)	(0.32)	na	na	(0.22)	(0.28)	(0.36)
$0	(0.18)	(0.49)	na	na	(0.33)	(0.42)	(0.54)
$0	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$0	(0.35)	(0.95)	na	na	(0.64)	(0.82)	(1.05)
$0	(0.44)	(1.18)	na	na	(0.82)	(1.04)	(1.32)
$0	(0.53)	(1.43)	na	na	(0.98)	(1.24)	(1.59)
$0	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
$0	(0.71)	(1.91)	na	na	(1.32)	(1.67)	(2.13)
$0	(0.81)	(2.19)	na	na	(1.49)	(1.90)	(2.43)
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
$0	(0.09)	(0.24)	na	na	(0.16)	(0.21)	(0.27)
$0	(0.12)	(0.32)	na	na	(0.22)	(0.29)	(0.36)
$0	(0.17)	(0.46)	na	na	(0.32)	(0.40)	(0.51)
$0	(0.41)	(1.11)	na	na	(0.76)	(0.96)	(1.23)
$0	(0.72)	(1.94)	na	na	(1.33)	(1.69)	(2.16)
$0	(1.07)	(2.89)	na	na	(1.98)	(2.51)	(3.21)
Copay/Day							
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.08)	(0.22)	na	na	(0.15)	(0.18)	(0.24)
$0	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$0	(0.22)	(0.60)	na	na	(0.40)	(0.51)	(0.66)
$0	(0.53)	(1.43)	na	na	(0.98)	(1.25)	(1.59)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	(0.03)	(0.08)	na	na	(0.06)	(0.07)	(0.09)
$0	(0.05)	(0.14)	na	na	(0.09)	(0.12)	(0.15)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$0	(0.08)	(0.22)	na	na	(0.15)	(0.18)	(0.24)
$0	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	(0.04)	(0.10)	na	na	(0.08)	(0.09)	(0.12)
$0	(0.05)	(0.13)	na	na	(0.09)	(0.12)	(0.15)
$0	(0.07)	(0.19)	na	na	(0.13)	(0.17)	(0.21)
$0	(0.08)	(0.22)	na	na	(0.15)	(0.18)	(0.24)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.6%	2.8%	na	na	2.6%	2.6%	2.6%
$0	2.5%	2.5%	na	na	2.5%	2.6%	2.5%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.1%	2.1%	na	na	2.1%	2.1%	2.1%
$0	2.2%	2.2%	na	na	2.2%	2.3%	2.2%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.9%	1.9%	na	na	1.8%	1.8%	1.9%
$0	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
$0	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Copay/Day							
$0	2.7%	2.7%	na	na	2.7%	2.8%	2.7%
$0	2.2%	2.3%	na	na	2.3%	2.1%	2.2%
$0	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
$0	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
$0	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.5%	2.5%	na	na	2.8%	2.5%	2.5%
$0	2.6%	2.7%	na	na	2.5%	2.7%	2.6%
$0	2.6%	2.6%	na	na	2.6%	2.5%	2.6%
$0	2.2%	2.3%	na	na	2.3%	2.1%	2.2%
$0	2.4%	2.5%	na	na	2.4%	2.5%	2.4%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.3%	1.5%	na	na	0.7%	1.1%	1.3%
$0	3.2%	3.0%	na	na	3.5%	3.1%	3.2%
$0	2.3%	2.2%	na	na	2.3%	2.4%	2.3%
$0	2.6%	2.6%	na	na	2.6%	2.7%	2.6%
$0	2.2%	2.3%	na	na	2.3%	2.1%	2.2%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(5.09)	(13.74)	na	na	(9.42)	(11.96)	(15.27)
$125	(6.27)	(16.93)	na	na	(11.60)	(14.73)	(18.81)
$150	(7.49)	(20.22)	na	na	(13.86)	(17.60)	(22.47)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.64	1.73	na	na	1.18	1.50	1.92
60	1.21	3.27	na	na	2.24	2.84	3.63
90	1.83	4.94	na	na	3.39	4.30	5.49
120	2.14	5.78	na	na	3.96	5.03	6.42
Unlimited	2.75	7.43	na	na	5.09	6.46	8.25
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
40/$10 copay	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
40/$15 copay	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
40/$20 copay	(0.69)	(1.86)	na	na	(1.28)	(1.62)	(2.07)
40/$25 copay	(0.90)	(2.43)	na	na	(1.67)	(2.12)	(2.70)
60	0.33	0.89	na	na	0.61	0.78	0.99
100	0.80	2.16	na	na	1.48	1.88	2.40
200	2.14	5.78	na	na	3.96	5.03	6.42
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
0	(1.27)	(3.43)	na	na	(2.35)	(2.98)	(3.81)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.83	2.24	na	na	1.54	1.95	2.49
90	1.76	4.75	na	na	3.26	4.14	5.28
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.75	2.03	na	na	1.39	1.76	2.25
90	1.39	3.75	na	na	2.57	3.27	4.17
120	2.22	5.99	na	na	4.11	5.22	6.66
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
0	(1.07)	(2.89)	na	na	(1.98)	(2.51)	(3.21)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.32	0.86	na	na	0.59	0.75	0.96
30	0.49	1.32	na	na	0.91	1.15	1.47
Unlimited	0.75	2.03	na	na	1.39	1.76	2.25
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
0	0.00	0.00	na	na	0.00	0.00	0.00
30	3.77	10.18	na	na	6.97	8.86	11.31
60	4.41	11.91	na	na	8.16	10.36	13.23
90	5.27	14.23	na	na	9.75	12.38	15.81
Unlimited	5.35	14.45	na	na	9.90	12.57	16.05
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
60/$10 copay	(0.30)	(0.81)	na	na	(0.56)	(0.71)	(0.90)
60/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
60/$20 copay	(0.65)	(1.76)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.77)	(2.08)	na	na	(1.42)	(1.81)	(2.31)
120/$0 copay	0.67	1.81	na	na	1.24	1.57	2.01
120/$5 copay	0.49	1.32	na	na	0.91	1.15	1.47
120/$10 copay	0.30	0.81	na	na	0.56	0.71	0.90
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.16)	(0.43)	na	na	(0.30)	(0.38)	(0.48)
120/$25 copay	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
Unlimited/$0 copay	0.76	2.05	na	na	1.41	1.79	2.28
Unlimited/$5 copay	0.60	1.62	na	na	1.11	1.41	1.80
Unlimited/$10 copay	0.37	1.00	na	na	0.68	0.87	1.11
Unlimited/$15 copay	0.08	0.22	na	na	0.15	0.19	0.24
Unlimited/$20 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
Unlimited/$25 copay	(0.32)	(0.86)	na	na	(0.59)	(0.75)	(0.96)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.22	0.59	na	na	0.41	0.52	0.66
$5	0.08	0.22	na	na	0.15	0.19	0.24
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$100	(5.21)	(14.07)	na	na	(9.64)	(12.24)	(15.63)
$125	(6.42)	(17.33)	na	na	(11.88)	(15.09)	(19.26)
$150	(7.67)	(20.71)	na	na	(14.19)	(18.02)	(23.01)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.66	1.78	na	na	1.22	1.55	1.98
$60	1.23	3.32	na	na	2.28	2.89	3.69
$90	1.86	5.02	na	na	3.44	4.37	5.58
$120	2.19	5.91	na	na	4.05	5.15	6.57
Unlimited	2.82	7.61	na	na	5.22	6.63	8.46
# Visits		**Home Health Care Limit [std: 40 visits]**					
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
40/$10 copay	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
40/$15 copay	(0.48)	(1.30)	na	na	(0.89)	(1.13)	(1.44)
40/$20 copay	(0.71)	(1.92)	na	na	(1.31)	(1.67)	(2.13)
40/$25 copay	(0.93)	(2.51)	na	na	(1.72)	(2.19)	(2.79)
$60	0.34	0.92	na	na	0.63	0.80	1.02
$100	0.81	2.19	na	na	1.50	1.90	2.43
$200	2.19	5.91	na	na	4.05	5.15	6.57
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	(1.31)	(3.54)	na	na	(2.42)	(3.08)	(3.93)
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.84	2.27	na	na	1.55	1.97	2.52
$90	1.80	4.86	na	na	3.33	4.23	5.40
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$30	0.00	0.00	na	na	0.00	0.00	0.00
$60	0.76	2.05	na	na	1.41	1.79	2.28
$90	1.42	3.83	na	na	2.63	3.34	4.26
$120	2.27	6.13	na	na	4.20	5.33	6.81
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(1.09)	(2.94)	na	na	(2.02)	(2.56)	(3.27)
$7	0.00	0.00	na	na	0.00	0.00	0.00
$21	0.33	0.89	na	na	0.61	0.78	0.99
$30	0.49	1.32	na	na	0.91	1.15	1.47
Unlimited	0.76	2.05	na	na	1.41	1.79	2.28
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.00	0.00	na	na	0.00	0.00	0.00
$30	3.86	10.42	na	na	7.14	9.07	11.58
$60	4.51	12.18	na	na	8.34	10.60	13.53
$90	5.40	14.58	na	na	9.99	12.69	16.20
Unlimited	5.47	14.77	na	na	10.12	12.85	16.41
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.31)	(0.84)	na	na	(0.57)	(0.73)	(0.93)
60/$15 copay	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
60/$20 copay	(0.67)	(1.81)	na	na	(1.24)	(1.57)	(2.01)
60/$25 copay	(0.78)	(2.11)	na	na	(1.44)	(1.83)	(2.34)
120/$0 copay	0.69	1.86	na	na	1.28	1.62	2.07
120/$5 copay	0.49	1.32	na	na	0.91	1.15	1.47
120/$10 copay	0.31	0.84	na	na	0.57	0.73	0.93
120/$15 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$20 copay	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
120/$25 copay	(0.38)	(1.03)	na	na	(0.70)	(0.89)	(1.14)
Unlimited/$0 copay	0.77	2.08	na	na	1.42	1.81	2.31
Unlimited/$5 copay	0.62	1.67	na	na	1.15	1.46	1.86
Unlimited/$10 copay	0.38	1.03	na	na	0.70	0.89	1.14
Unlimited/$15 copay	0.07	0.19	na	na	0.13	0.16	0.21
Unlimited/$20 copay	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
Unlimited/$25 copay	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.24	0.65	na	na	0.44	0.56	0.72
$5	0.07	0.19	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.12)	(0.33)	na	na	(0.22)	(0.28)	(0.36)
$0	(0.15)	(0.40)	na	na	(0.28)	(0.36)	(0.45)
$0	(0.18)	(0.49)	na	na	(0.33)	(0.42)	(0.54)
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	-	-	na	na	-	-	-
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.03	0.08	na	na	0.05	0.07	0.09
$0	0.05	0.13	na	na	0.09	0.12	0.15
$0	0.07	0.18	na	na	0.13	0.17	0.21
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	0.05	0.13	na	na	0.09	0.12	0.15
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	(0.04)	(0.11)	na	na	(0.07)	(0.10)	(0.12)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.04	0.11	na	na	0.07	0.09	0.12
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	0.03	0.08	na	na	0.06	0.07	0.09
$0	0.05	0.14	na	na	0.09	0.11	0.15
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	-	-	na	na	-	-	-
$0	0.09	0.24	na	na	0.17	0.21	0.27
$0	0.10	0.27	na	na	0.18	0.24	0.30
$0	0.13	0.35	na	na	0.24	0.31	0.39
$0	0.12	0.32	na	na	0.22	0.28	0.36
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.03	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.02	0.05	na	na	0.04	0.05	0.06
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	0.02	0.06	na	na	0.03	0.04	0.06
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
# Days		**Skilled Nursing Facility Care Limit [std: 30 days]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.1%	2.9%	na	na	3.4%	3.3%	3.1%
$0	1.7%	1.5%	na	na	1.8%	1.8%	1.7%
$0	1.6%	1.6%	na	na	1.5%	1.6%	1.6%
$0	2.3%	2.2%	na	na	2.3%	2.4%	2.3%
$0	2.5%	2.4%	na	na	2.6%	2.6%	2.5%
# Visits		**Home Health Care Limit [std: 40 visits]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.9%	3.2%	na	na	2.3%	3.1%	2.9%
$0	3.3%	3.3%	na	na	3.0%	3.3%	3.3%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0	2.3%	2.2%	na	na	2.3%	2.4%	2.3%
	** 40 visits/$30 copay no longer offered, benefit must be switched to 40 visits/$25 copay*						
# Days		**Inpatient Therapies Limit [std: 30 days]**					
$0	3.1%	3.2%	na	na	3.0%	3.4%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.2%	1.3%	na	na	0.6%	1.0%	1.2%
$0	2.3%	2.3%	na	na	2.1%	2.2%	2.3%
# Visits		**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.3%	1.0%	na	na	1.4%	1.7%	1.3%
$0	2.2%	2.1%	na	na	2.3%	2.1%	2.2%
$0	2.3%	2.3%	na	na	2.2%	2.1%	2.3%
# Days		**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**					
$0	1.9%	1.7%	na	na	2.0%	2.0%	1.9%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.3%	1.0%	na	na	1.4%	1.7%	1.3%
# Days		**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
$0	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
# Visits		**Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits] [Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**					
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.1%	2.8%	na	na	3.3%	2.6%	3.1%
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0	3.0%	2.8%	na	na	3.2%	3.2%	3.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.3%	3.7%	na	na	1.8%	2.8%	3.3%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.3%	-4.7%	na	na	-6.7%	-7.9%	-6.2%
$0	2.7%	3.0%	na	na	2.9%	2.3%	2.7%
$0	1.3%	1.5%	na	na	0.7%	1.1%	1.3%
$0	3.3%	3.1%	na	na	3.6%	3.5%	3.3%
$0	2.7%	3.0%	na	na	2.9%	2.3%	2.7%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
Copay		**Dialysis Treatment Copay [std: $10]**					
$0	9.1%	10.2%	na	na	7.3%	7.7%	9.1%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-10.0%	-11.1%	na	na	-10.5%	-12.5%	-10.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO 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	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$25	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.72)	(1.94)	na	na	(1.33)	(1.69)	(2.16)
$25	(0.94)	(2.54)	na	na	(1.74)	(2.21)	(2.82)
$30	(1.13)	(3.05)	na	na	(2.09)	(2.66)	(3.39)
$35	(1.35)	(3.65)	na	na	(2.50)	(3.17)	(4.05)
$40	(1.55)	(4.19)	na	na	(2.87)	(3.64)	(4.65)
$45	(1.77)	(4.78)	na	na	(3.27)	(4.16)	(5.31)
$50	(1.96)	(5.29)	na	na	(3.63)	(4.61)	(5.88)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$15	(0.54)	(1.46)	na	na	(1.00)	(1.27)	(1.62)
$20	(0.80)	(2.16)	na	na	(1.48)	(1.88)	(2.40)
$25	(1.09)	(2.94)	na	na	(2.02)	(2.56)	(3.27)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
$25	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.68)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.36)	(0.97)	na	na	(0.67)	(0.85)	(1.08)
$60	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
$75	(0.62)	(1.67)	na	na	(1.15)	(1.46)	(1.86)
$100	(0.80)	(2.16)	na	na	(1.48)	(1.88)	(2.40)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.11)	(0.30)	na	na	(0.20)	(0.26)	(0.33)
$35	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$60	(0.33)	(0.89)	na	na	(0.61)	(0.78)	(0.99)
$75	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$100	(0.54)	(1.46)	na	na	(1.00)	(1.27)	(1.62)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.40)	(9.18)	na	na	(6.29)	(7.99)	(10.20)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.26)	(14.20)	na	na	(9.73)	(12.36)	(15.78)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.41)	na	na	(0.28)	(0.35)	(0.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.27)	(0.73)	na	na	(0.50)	(0.63)	(0.81)
$25	(0.35)	(0.95)	na	na	(0.65)	(0.82)	(1.05)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$15	(0.49)	(1.32)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.73)	(1.97)	na	na	(1.35)	(1.72)	(2.19)
$25	(0.97)	(2.62)	na	na	(1.79)	(2.28)	(2.91)
$30	(1.15)	(3.11)	na	na	(2.13)	(2.70)	(3.45)
$35	(1.38)	(3.73)	na	na	(2.55)	(3.24)	(4.14)
$40	(1.58)	(4.27)	na	na	(2.92)	(3.71)	(4.74)
$45	(1.81)	(4.89)	na	na	(3.35)	(4.25)	(5.43)
$50	(2.02)	(5.45)	na	na	(3.74)	(4.75)	(6.06)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$10	(0.38)	(1.03)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.57)	(1.54)	na	na	(1.05)	(1.34)	(1.71)
$20	(0.81)	(2.19)	na	na	(1.50)	(1.90)	(2.43)
$25	(1.11)	(3.00)	na	na	(2.05)	(2.61)	(3.33)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.19)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$35	(0.26)	(0.70)	na	na	(0.48)	(0.61)	(0.78)
$50	(0.37)	(1.00)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.45)	(1.22)	na	na	(0.83)	(1.06)	(1.35)
$75	(0.64)	(1.73)	na	na	(1.18)	(1.50)	(1.92)
$100	(0.81)	(2.19)	na	na	(1.50)	(1.90)	(2.43)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.10)	(0.27)	na	na	(0.19)	(0.24)	(0.30)
$35	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)
$50	(0.28)	(0.76)	na	na	(0.52)	(0.66)	(0.84)
$60	(0.34)	(0.92)	na	na	(0.63)	(0.80)	(1.02)
$75	(0.40)	(1.08)	na	na	(0.74)	(0.94)	(1.20)
$100	(0.57)	(1.54)	na	na	(1.05)	(1.34)	(1.71)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	(3.49)	(9.42)	na	na	(6.46)	(8.20)	(10.47)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	(5.39)	(14.55)	na	na	(9.97)	(12.67)	(16.17)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	(0.44)	(1.19)	na	na	(0.81)	(1.03)	(1.32)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.14)	(0.38)	na	na	(0.26)	(0.33)	(0.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
$0	(0.06)	(0.16)	na	na	(0.11)	(0.14)	(0.18)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.02	0.03	0.03
$0	0.01	0.03	na	na	0.01	0.02	0.03
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	-	-	na	na	-	-	-
$0	0.01	0.02	na	na	0.02	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.02)	na	na	(0.02)	(0.02)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.01)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.02)	(0.06)	na	na	(0.03)	(0.04)	(0.06)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	-	-	na	na	-	-	-
$0	-	-	na	na	-	-	-
$0	0.01	0.03	na	na	0.01	0.02	0.03
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
$0	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$0	-	-	na	na	-	-	-
$0	(0.03)	(0.08)	na	na	(0.05)	(0.07)	(0.09)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	(0.09)	(0.24)	na	na	(0.17)	(0.21)	(0.27)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	(0.13)	(0.35)	na	na	(0.24)	(0.31)	(0.39)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	-	-	na	na	-	-	-
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$0	0.01	0.03	na	na	0.02	0.02	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
$0	3.8%	4.3%	na	na	4.2%	3.3%	3.8%
$0	2.9%	3.3%	na	na	3.2%	2.5%	2.9%
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-7.1%	-7.9%	na	na	-7.7%	-6.1%	-7.1%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	1.4%	1.5%	na	na	1.5%	1.8%	1.4%
$0	3.2%	3.1%	na	na	2.9%	3.2%	3.2%
$0	1.8%	2.0%	na	na	1.9%	1.5%	1.8%
$0	2.2%	2.2%	na	na	2.0%	2.2%	2.2%
$0	1.9%	1.9%	na	na	1.7%	1.9%	1.9%
$0	2.3%	2.3%	na	na	2.4%	2.2%	2.3%
$0	3.1%	3.0%	na	na	3.0%	3.0%	3.1%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	2.7%	3.0%	na	na	2.9%	2.3%	2.7%
$0	5.6%	5.5%	na	na	5.0%	5.5%	5.6%
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0	1.8%	2.0%	na	na	1.5%	2.0%	1.8%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-11.1%	-8.3%	na	na	-11.8%	-9.5%	-11.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	4.0%	2.9%	na	na	4.3%	3.4%	4.0%
$0	2.8%	3.1%	na	na	1.5%	2.4%	2.8%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	3.2%	3.6%	na	na	2.6%	2.7%	3.2%
$0	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	-9.1%	-10.0%	na	na	-5.0%	-7.7%	-9.1%
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
$0	3.7%	4.1%	na	na	4.0%	4.8%	3.7%
$0	3.0%	3.4%	na	na	3.3%	2.6%	3.0%
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
$0	5.6%	5.5%	na	na	5.0%	5.5%	5.6%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
$0	2.6%	2.6%	na	na	2.7%	2.6%	2.6%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
$0	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
$0	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$0	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
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
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
October 01, 2013 - December 31, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
				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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
				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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
				Class II Dependents			
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Year			
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age				**End of Year**			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				End of Month			
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
				Grandchildren			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
				Class II Dependents			
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.17	11.26	na	na	7.71	9.80	12.51
60	5.89	15.90	na	na	10.90	13.84	17.67
90	6.99	18.87	na	na	12.93	16.43	20.97
Unlimited	7.08	19.12	na	na	13.10	16.64	21.24
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.43	20.06	na	na	13.75	17.46	22.29
60	7.85	21.20	na	na	14.52	18.45	23.55
90	8.14	21.98	na	na	15.06	19.13	24.42
Unlimited	8.22	22.19	na	na	15.21	19.32	24.66
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
npatient Mental Hlt	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	5.67	15.31	na	na	10.49	13.32	17.01
30	6.73	18.17	na	na	12.45	15.82	20.19
40	7.42	20.03	na	na	13.73	17.44	22.26
60	8.11	21.90	na	na	15.00	19.06	24.33
Unlimited	8.18	22.09	na	na	15.13	19.22	24.54
SMALL GROUP				**$5 Copay**			
20	5.34	14.42	na	na	9.88	12.55	16.02
30	6.33	17.09	na	na	11.71	14.88	18.99
40	6.98	18.85	na	na	12.91	16.40	20.94
60	7.63	20.60	na	na	14.12	17.93	22.89
Unlimited	7.71	20.82	na	na	14.26	18.12	23.13
SMALL GROUP				**$10 Copay**			
20	4.96	13.39	na	na	9.18	11.66	14.88
30	5.90	15.93	na	na	10.92	13.87	17.70
40	6.50	17.55	na	na	12.03	15.28	19.50
60	7.11	19.20	na	na	13.15	16.71	21.33
Unlimited	7.18	19.39	na	na	13.28	16.87	21.54
SMALL GROUP				**$15 Copay**			
20	4.67	12.61	na	na	8.64	10.97	14.01
30	5.55	14.99	na	na	10.27	13.04	16.65
40	6.11	16.50	na	na	11.30	14.36	18.33
60	6.67	18.01	na	na	12.34	15.67	20.01
Unlimited	6.75	18.23	na	na	12.49	15.86	20.25
SMALL GROUP				**$20 Copay**			
20	4.38	11.83	na	na	8.10	10.29	13.14
30	5.20	14.04	na	na	9.62	12.22	15.60
40	5.73	15.47	na	na	10.60	13.47	17.19
60	6.26	16.90	na	na	11.58	14.71	18.78
Unlimited	6.31	17.04	na	na	11.67	14.83	18.93
SMALL GROUP				**$25 Copay**			
20	4.09	11.04	na	na	7.57	9.61	12.27
30	4.85	13.10	na	na	8.97	11.40	14.55
40	5.35	14.45	na	na	9.90	12.57	16.05
60	5.84	15.77	na	na	10.80	13.72	17.52
Unlimited	5.90	15.93	na	na	10.92	13.87	17.70
SMALL GROUP				**$30 Copay**			
20	3.92	10.58	na	na	7.25	9.21	11.76
30	4.68	12.64	na	na	8.66	11.00	14.04
40	5.16	13.93	na	na	9.55	12.13	15.48
60	5.63	15.20	na	na	10.42	13.23	16.89
Unlimited	5.69	15.36	na	na	10.53	13.37	17.07
SMALL GROUP				**$35 Copay**			
20	3.81	10.29	na	na	7.05	8.95	11.43
30	4.53	12.23	na	na	8.38	10.65	13.59
40	5.00	13.50	na	na	9.25	11.75	15.00
60	5.47	14.77	na	na	10.12	12.85	16.41
Unlimited	5.52	14.90	na	na	10.21	12.97	16.56
SMALL GROUP				**$40 Copay**			
20	3.72	10.04	na	na	6.88	8.74	11.16

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	4.27	11.53	na	na	7.90	10.03	12.81
60	6.04	16.31	na	na	11.17	14.19	18.12
90	7.16	19.33	na	na	13.25	16.83	21.48
Unlimited	7.24	19.55	na	na	13.39	17.01	21.72
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	7.61	20.55	na	na	14.08	17.88	22.83
60	8.04	21.71	na	na	14.87	18.89	24.12
90	8.34	22.52	na	na	15.43	19.60	25.02
Unlimited	8.42	22.73	na	na	15.58	19.79	25.26
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	5.80	15.66	na	na	10.73	13.63	17.40
30	6.90	18.63	na	na	12.77	16.22	20.70
40	7.59	20.49	na	na	14.04	17.84	22.77
60	8.30	22.41	na	na	15.36	19.51	24.90
Unlimited	8.37	22.60	na	na	15.48	19.67	25.11
SMALL GROUP				**$5 Copay**			
20	5.46	14.74	na	na	10.10	12.83	16.38
30	6.48	17.50	na	na	11.99	15.23	19.44
40	7.15	19.31	na	na	13.23	16.80	21.45
60	7.81	21.09	na	na	14.45	18.35	23.43
Unlimited	7.89	21.30	na	na	14.60	18.54	23.67
SMALL GROUP				**$10 Copay**			
20	5.08	13.72	na	na	9.40	11.94	15.24
30	6.05	16.34	na	na	11.19	14.22	18.15
40	6.65	17.96	na	na	12.30	15.63	19.95
60	7.28	19.66	na	na	13.47	17.11	21.84
Unlimited	7.35	19.85	na	na	13.60	17.27	22.05
SMALL GROUP				**$15 Copay**			
20	4.79	12.93	na	na	8.86	11.26	14.37
30	5.69	15.36	na	na	10.53	13.37	17.07
40	6.26	16.90	na	na	11.58	14.71	18.78
60	6.83	18.44	na	na	12.64	16.05	20.49
Unlimited	6.91	18.66	na	na	12.78	16.24	20.73
SMALL GROUP				**$20 Copay**			
20	4.48	12.10	na	na	8.29	10.53	13.44
30	5.33	14.39	na	na	9.86	12.53	15.99
40	5.87	15.85	na	na	10.86	13.79	17.61
60	6.42	17.33	na	na	11.88	15.09	19.26
Unlimited	6.46	17.44	na	na	11.95	15.18	19.38
SMALL GROUP				**$25 Copay**			
20	4.18	11.29	na	na	7.73	9.82	12.54
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.47	14.77	na	na	10.12	12.85	16.41
60	5.97	16.12	na	na	11.04	14.03	17.91
Unlimited	6.05	16.34	na	na	11.19	14.22	18.15
SMALL GROUP				**$30 Copay**			
20	4.01	10.83	na	na	7.42	9.42	12.03
30	4.80	12.96	na	na	8.88	11.28	14.40
40	5.27	14.23	na	na	9.75	12.38	15.81
60	5.77	15.58	na	na	10.67	13.56	17.31
Unlimited	5.82	15.71	na	na	10.77	13.68	17.46
SMALL GROUP				**$35 Copay**			
20	3.90	10.53	na	na	7.22	9.17	11.70
30	4.64	12.53	na	na	8.58	10.90	13.92
40	5.12	13.82	na	na	9.47	12.03	15.36
60	5.60	15.12	na	na	10.36	13.16	16.80
Unlimited	5.65	15.26	na	na	10.45	13.28	16.95
SMALL GROUP				**$40 Copay**			
20	3.81	10.29	na	na	7.05	8.95	11.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.10	0.27	na	na	0.19	0.23	0.30
60	0.15	0.41	na	na	0.27	0.35	0.45
90	0.17	0.46	na	na	0.32	0.40	0.51
Unlimited	0.16	0.43	na	na	0.29	0.37	0.48
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	0.18	0.49	na	na	0.33	0.42	0.54
60	0.19	0.51	na	na	0.35	0.44	0.57
90	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.20	0.54	na	na	0.37	0.47	0.60
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	0.13	0.35	na	na	0.24	0.31	0.39
30	0.17	0.46	na	na	0.32	0.40	0.51
40	0.17	0.46	na	na	0.31	0.40	0.51
60	0.19	0.51	na	na	0.36	0.45	0.57
Unlimited	0.19	0.51	na	na	0.35	0.45	0.57
SMALL GROUP				**$5 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.15	0.41	na	na	0.28	0.35	0.45
40	0.17	0.46	na	na	0.32	0.40	0.51
60	0.18	0.49	na	na	0.33	0.42	0.54
Unlimited	0.18	0.48	na	na	0.34	0.42	0.54
SMALL GROUP				**$10 Copay**			
20	0.12	0.33	na	na	0.22	0.28	0.36
30	0.15	0.41	na	na	0.27	0.35	0.45
40	0.15	0.41	na	na	0.27	0.35	0.45
60	0.17	0.46	na	na	0.32	0.40	0.51
Unlimited	0.17	0.46	na	na	0.32	0.40	0.51
SMALL GROUP				**$15 Copay**			
20	0.12	0.32	na	na	0.22	0.29	0.36
30	0.14	0.37	na	na	0.26	0.33	0.42
40	0.15	0.40	na	na	0.28	0.35	0.45
60	0.16	0.43	na	na	0.30	0.38	0.48
Unlimited	0.16	0.43	na	na	0.29	0.38	0.48
SMALL GROUP				**$20 Copay**			
20	0.10	0.27	na	na	0.19	0.24	0.30
30	0.13	0.35	na	na	0.24	0.31	0.39
40	0.14	0.38	na	na	0.26	0.32	0.42
60	0.16	0.43	na	na	0.30	0.38	0.48
Unlimited	0.15	0.40	na	na	0.28	0.35	0.45
SMALL GROUP				**$25 Copay**			
20	0.09	0.25	na	na	0.16	0.21	0.27
30	0.11	0.29	na	na	0.21	0.26	0.33
40	0.12	0.32	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.15	0.41	na	na	0.27	0.35	0.45
SMALL GROUP				**$30 Copay**			
20	0.09	0.25	na	na	0.17	0.21	0.27
30	0.12	0.32	na	na	0.22	0.28	0.36
40	0.11	0.30	na	na	0.20	0.25	0.33
60	0.14	0.38	na	na	0.25	0.33	0.42
Unlimited	0.13	0.35	na	na	0.24	0.31	0.39
SMALL GROUP				**$35 Copay**			
20	0.09	0.24	na	na	0.17	0.22	0.27
30	0.11	0.30	na	na	0.20	0.25	0.33
40	0.12	0.32	na	na	0.22	0.28	0.36
60	0.13	0.35	na	na	0.24	0.31	0.39
Unlimited	0.13	0.36	na	na	0.24	0.31	0.39
SMALL GROUP				**$40 Copay**			
20	0.09	0.25	na	na	0.17	0.21	0.27

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.4%	2.4%	na	na	2.5%	2.3%	2.4%
60	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
90	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Unlimited	2.3%	2.2%	na	na	2.2%	2.2%	2.3%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] * [not yet approved]**						
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
90	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient MH	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] **						
	[Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP				**$0 Copay**			
20	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
30	2.5%	2.5%	na	na	2.6%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$5 Copay**			
20	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.3%	2.3%	2.4%
Unlimited	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
SMALL GROUP				**$10 Copay**			
20	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
30	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
40	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$15 Copay**			
20	2.6%	2.5%	na	na	2.5%	2.6%	2.6%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.5%	2.4%	na	na	2.5%	2.4%	2.5%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
SMALL GROUP				**$20 Copay**			
20	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.4%	2.5%	na	na	2.5%	2.4%	2.4%
60	2.6%	2.5%	na	na	2.6%	2.6%	2.6%
Unlimited	2.4%	2.3%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$25 Copay**			
20	2.2%	2.3%	na	na	2.1%	2.2%	2.2%
30	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
40	2.2%	2.2%	na	na	2.2%	2.2%	2.2%
60	2.2%	2.2%	na	na	2.2%	2.3%	2.2%
Unlimited	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$30 Copay**			
20	2.3%	2.4%	na	na	2.3%	2.3%	2.3%
30	2.6%	2.5%	na	na	2.5%	2.5%	2.6%
40	2.1%	2.2%	na	na	2.1%	2.1%	2.1%
60	2.5%	2.5%	na	na	2.4%	2.5%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
SMALL GROUP				**$35 Copay**			
20	2.4%	2.3%	na	na	2.4%	2.5%	2.4%
30	2.4%	2.5%	na	na	2.4%	2.3%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$40 Copay**			
20	2.4%	2.5%	na	na	2.5%	2.4%	2.4%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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	4.40	11.88	na	na	8.14	10.34	13.20
40	4.85	13.10	na	na	8.97	11.40	14.55
60	5.31	14.34	na	na	9.82	12.48	15.93
Unlimited	5.36	14.47	na	na	9.92	12.60	16.08
SMALL GROUP				**$45 Copay**			
20	3.59	9.69	na	na	6.64	8.44	10.77
30	4.27	11.53	na	na	7.90	10.03	12.81
40	4.71	12.72	na	na	8.71	11.07	14.13
60	5.14	13.88	na	na	9.51	12.08	15.42
Unlimited	5.18	13.99	na	na	9.58	12.17	15.54
SMALL GROUP				**$50 Copay**			
20	3.49	9.42	na	na	6.46	8.20	10.47
30	4.14	11.18	na	na	7.66	9.73	12.42
40	4.56	12.31	na	na	8.44	10.72	13.68
60	4.99	13.47	na	na	9.23	11.73	14.97
Unlimited	5.02	13.55	na	na	9.29	11.80	15.06
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.34	19.82	na	na	13.58	17.25	22.02
30	8.08	21.82	na	na	14.95	18.99	24.24
40	8.54	23.06	na	na	15.80	20.07	25.62
60	9.02	24.35	na	na	16.69	21.20	27.06
Unlimited	9.11	24.60	na	na	16.85	21.41	27.33
SMALL GROUP				**$5 Copay**			
20	6.90	18.63	na	na	12.77	16.22	20.70
30	7.61	20.55	na	na	14.08	17.88	22.83
40	8.03	21.68	na	na	14.86	18.87	24.09
60	8.50	22.95	na	na	15.73	19.98	25.50
Unlimited	8.57	23.14	na	na	15.85	20.14	25.71
SMALL GROUP				**$10 Copay**			
20	6.44	17.39	na	na	11.91	15.13	19.32
30	7.08	19.12	na	na	13.10	16.64	21.24
40	7.48	20.20	na	na	13.84	17.58	22.44
60	7.90	21.33	na	na	14.62	18.57	23.70
Unlimited	7.98	21.55	na	na	14.76	18.75	23.94
SMALL GROUP				**$15 Copay**			
20	6.06	16.36	na	na	11.21	14.24	18.18
30	6.66	17.98	na	na	12.32	15.65	19.98
40	7.02	18.95	na	na	12.99	16.50	21.06
60	7.42	20.03	na	na	13.73	17.44	22.26
Unlimited	7.49	20.22	na	na	13.86	17.60	22.47
SMALL GROUP				**$20 Copay**			
20	5.69	15.36	na	na	10.53	13.37	17.07
30	6.24	16.85	na	na	11.54	14.66	18.72
40	6.60	17.82	na	na	12.21	15.51	19.80
60	6.97	18.82	na	na	12.89	16.38	20.91
Unlimited	7.02	18.95	na	na	12.99	16.50	21.06
SMALL GROUP				**$25 Copay**			
20	5.29	14.28	na	na	9.79	12.43	15.87
30	5.82	15.71	na	na	10.77	13.68	17.46
40	6.15	16.61	na	na	11.38	14.45	18.45
60	6.49	17.52	na	na	12.01	15.25	19.47
Unlimited	6.55	17.69	na	na	12.12	15.39	19.65
SMALL GROUP				**$30 Copay**			
20	5.10	13.77	na	na	9.44	11.99	15.30
30	5.61	15.15	na	na	10.38	13.18	16.83
40	5.93	16.01	na	na	10.97	13.94	17.79
60	6.26	16.90	na	na	11.58	14.71	18.78
Unlimited	6.30	17.01	na	na	11.66	14.81	18.90
SMALL GROUP				**$35 Copay**			
20	4.95	13.37	na	na	9.16	11.63	14.85
30	5.46	14.74	na	na	10.10	12.83	16.38
40	5.75	15.53	na	na	10.64	13.51	17.25
60	6.09	16.44	na	na	11.27	14.31	18.27
Unlimited	6.13	16.55	na	na	11.34	14.41	18.39

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
30	4.50	12.15	na	na	8.33	10.58	13.50
40	4.96	13.39	na	na	9.18	11.66	14.88
60	5.44	14.69	na	na	10.06	12.78	16.32
Unlimited	5.49	14.82	na	na	10.16	12.90	16.47
SMALL GROUP				**$45 Copay**			
20	3.67	9.91	na	na	6.79	8.62	11.01
30	4.37	11.80	na	na	8.08	10.27	13.11
40	4.82	13.01	na	na	8.92	11.33	14.46
60	5.26	14.20	na	na	9.73	12.36	15.78
Unlimited	5.30	14.31	na	na	9.81	12.46	15.90
SMALL GROUP				**$50 Copay**			
20	3.57	9.64	na	na	6.60	8.39	10.71
30	4.24	11.45	na	na	7.84	9.96	12.72
40	4.67	12.61	na	na	8.64	10.97	14.01
60	5.11	13.80	na	na	9.45	12.01	15.33
Unlimited	5.14	13.88	na	na	9.51	12.08	15.42
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	7.52	20.30	na	na	13.91	17.67	22.56
30	8.27	22.33	na	na	15.30	19.43	24.81
40	8.74	23.60	na	na	16.17	20.54	26.22
60	9.23	24.92	na	na	17.08	21.69	27.69
Unlimited	9.33	25.19	na	na	17.26	21.93	27.99
SMALL GROUP				**$5 Copay**			
20	7.07	19.09	na	na	13.08	16.61	21.21
30	7.79	21.03	na	na	14.41	18.31	23.37
40	8.22	22.19	na	na	15.21	19.32	24.66
60	8.70	23.49	na	na	16.10	20.45	26.10
Unlimited	8.78	23.71	na	na	16.24	20.63	26.34
SMALL GROUP				**$10 Copay**			
20	6.59	17.79	na	na	12.19	15.49	19.77
30	7.24	19.55	na	na	13.39	17.01	21.72
40	7.66	20.68	na	na	14.17	18.00	22.98
60	8.09	21.84	na	na	14.97	19.01	24.27
Unlimited	8.17	22.06	na	na	15.11	19.20	24.51
SMALL GROUP				**$15 Copay**			
20	6.21	16.77	na	na	11.49	14.59	18.63
30	6.82	18.41	na	na	12.62	16.03	20.46
40	7.19	19.41	na	na	13.30	16.90	21.57
60	7.59	20.49	na	na	14.04	17.84	22.77
Unlimited	7.67	20.71	na	na	14.19	18.02	23.01
SMALL GROUP				**$20 Copay**			
20	5.82	15.71	na	na	10.77	13.68	17.46
30	6.40	17.28	na	na	11.84	15.04	19.20
40	6.76	18.25	na	na	12.51	15.89	20.28
60	7.14	19.28	na	na	13.21	16.78	21.42
Unlimited	7.19	19.41	na	na	13.30	16.90	21.57
SMALL GROUP				**$25 Copay**			
20	5.42	14.63	na	na	10.03	12.74	16.26
30	5.95	16.07	na	na	11.01	13.98	17.85
40	6.29	16.98	na	na	11.64	14.78	18.87
60	6.64	17.93	na	na	12.28	15.60	19.92
Unlimited	6.71	18.12	na	na	12.41	15.77	20.13
SMALL GROUP				**$30 Copay**			
20	5.22	14.09	na	na	9.66	12.27	15.66
30	5.75	15.53	na	na	10.64	13.51	17.25
40	6.08	16.42	na	na	11.25	14.29	18.24
60	6.42	17.33	na	na	11.88	15.09	19.26
Unlimited	6.45	17.42	na	na	11.93	15.16	19.35
SMALL GROUP				**$35 Copay**			
20	5.07	13.69	na	na	9.38	11.91	15.21
30	5.59	15.09	na	na	10.34	13.14	16.77
40	5.89	15.90	na	na	10.90	13.84	17.67
60	6.24	16.85	na	na	11.54	14.66	18.72
Unlimited	6.27	16.93	na	na	11.60	14.73	18.81

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	0.10	0.27	na	na	0.19	0.24	0.30
40	0.11	0.29	na	na	0.21	0.26	0.33
60	0.13	0.35	na	na	0.24	0.30	0.39
Unlimited	0.13	0.35	na	na	0.24	0.30	0.39
SMALL GROUP				**$45 Copay**			
20	0.08	0.22	na	na	0.15	0.18	0.24
30	0.10	0.27	na	na	0.18	0.24	0.30
40	0.11	0.29	na	na	0.21	0.26	0.33
60	0.12	0.32	na	na	0.22	0.28	0.36
Unlimited	0.12	0.32	na	na	0.23	0.29	0.36
SMALL GROUP				**$50 Copay**			
20	0.08	0.22	na	na	0.14	0.19	0.24
30	0.10	0.27	na	na	0.18	0.23	0.30
40	0.11	0.30	na	na	0.20	0.25	0.33
60	0.12	0.33	na	na	0.22	0.28	0.36
Unlimited	0.12	0.33	na	na	0.22	0.28	0.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	0.18	0.48	na	na	0.33	0.42	0.54
30	0.19	0.51	na	na	0.35	0.44	0.57
40	0.20	0.54	na	na	0.37	0.47	0.60
60	0.21	0.57	na	na	0.39	0.49	0.63
Unlimited	0.22	0.59	na	na	0.41	0.52	0.66
SMALL GROUP				**$5 Copay**			
20	0.17	0.46	na	na	0.31	0.39	0.51
30	0.18	0.48	na	na	0.33	0.43	0.54
40	0.19	0.51	na	na	0.35	0.45	0.57
60	0.20	0.54	na	na	0.37	0.47	0.60
Unlimited	0.21	0.57	na	na	0.39	0.49	0.63
SMALL GROUP				**$10 Copay**			
20	0.15	0.40	na	na	0.28	0.36	0.45
30	0.16	0.43	na	na	0.29	0.37	0.48
40	0.18	0.48	na	na	0.33	0.42	0.54
60	0.19	0.51	na	na	0.35	0.44	0.57
Unlimited	0.19	0.51	na	na	0.35	0.45	0.57
SMALL GROUP				**$15 Copay**			
20	0.15	0.41	na	na	0.28	0.35	0.45
30	0.16	0.43	na	na	0.30	0.38	0.48
40	0.17	0.46	na	na	0.31	0.40	0.51
60	0.17	0.46	na	na	0.31	0.40	0.51
Unlimited	0.18	0.49	na	na	0.33	0.42	0.54
SMALL GROUP				**$20 Copay**			
20	0.13	0.35	na	na	0.24	0.31	0.39
30	0.16	0.43	na	na	0.30	0.38	0.48
40	0.16	0.43	na	na	0.30	0.38	0.48
60	0.17	0.46	na	na	0.32	0.40	0.51
Unlimited	0.17	0.46	na	na	0.31	0.40	0.51
SMALL GROUP				**$25 Copay**			
20	0.13	0.35	na	na	0.24	0.31	0.39
30	0.13	0.36	na	na	0.24	0.30	0.39
40	0.14	0.37	na	na	0.26	0.33	0.42
60	0.15	0.41	na	na	0.27	0.35	0.45
Unlimited	0.16	0.43	na	na	0.29	0.38	0.48
SMALL GROUP				**$30 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.14	0.38	na	na	0.26	0.33	0.42
40	0.15	0.41	na	na	0.28	0.35	0.45
60	0.16	0.43	na	na	0.30	0.38	0.48
Unlimited	0.15	0.41	na	na	0.27	0.35	0.45
SMALL GROUP				**$35 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.31	0.39
40	0.14	0.37	na	na	0.26	0.33	0.42
60	0.15	0.41	na	na	0.27	0.35	0.45
Unlimited	0.14	0.38	na	na	0.26	0.32	0.42

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
40	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$45 Copay**			
20	2.2%	2.3%	na	na	2.3%	2.1%	2.2%
30	2.3%	2.3%	na	na	2.3%	2.4%	2.3%
40	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
SMALL GROUP				**$50 Copay**			
20	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
30	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.3%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit]**						
SMALL GROUP				**$0 Copay**			
20	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
30	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
40	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$5 Copay**			
20	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
30	2.4%	2.3%	na	na	2.3%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
SMALL GROUP				**$10 Copay**			
20	2.3%	2.3%	na	na	2.4%	2.4%	2.3%
30	2.3%	2.2%	na	na	2.2%	2.2%	2.3%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
Unlimited	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
SMALL GROUP				**$15 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$20 Copay**			
20	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
30	2.6%	2.6%	na	na	2.6%	2.6%	2.6%
40	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
60	2.4%	2.4%	na	na	2.5%	2.4%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$25 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.2%	2.3%	na	na	2.2%	2.2%	2.2%
40	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
60	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
Unlimited	2.4%	2.4%	na	na	2.4%	2.5%	2.4%
SMALL GROUP				**$30 Copay**			
20	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.5%	2.6%	na	na	2.6%	2.5%	2.5%
60	2.6%	2.5%	na	na	2.6%	2.6%	2.6%
Unlimited	2.4%	2.4%	na	na	2.3%	2.4%	2.4%
SMALL GROUP				**$35 Copay**			
20	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
30	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.5%	2.5%	na	na	2.4%	2.4%	2.5%
Unlimited	2.3%	2.3%	na	na	2.3%	2.2%	2.3%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	4.80	12.96	na	na	8.88	11.28	14.40
30	5.29	14.28	na	na	9.79	12.43	15.87
40	5.57	15.04	na	na	10.30	13.09	16.71
60	5.90	15.93	na	na	10.92	13.87	17.70
Unlimited	5.94	16.04	na	na	10.99	13.96	17.82
SMALL GROUP				**$45 Copay**			
20	4.67	12.61	na	na	8.64	10.97	14.01
30	5.11	13.80	na	na	9.45	12.01	15.33
40	5.41	14.61	na	na	10.01	12.71	16.23
60	5.72	15.44	na	na	10.58	13.44	17.16
Unlimited	5.76	15.55	na	na	10.66	13.54	17.28
SMALL GROUP				**$50 Copay**			
20	4.51	12.18	na	na	8.34	10.60	13.53
30	4.96	13.39	na	na	9.18	11.66	14.88
40	5.26	14.20	na	na	9.73	12.36	15.78
60	5.54	14.96	na	na	10.25	13.02	16.62
Unlimited	5.57	15.04	na	na	10.30	13.09	16.71
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL GROUP CONTRACT - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
SMALL GROUP				**$40 Copay**			
20	4.92	13.28	na	na	9.10	11.56	14.76
30	5.42	14.63	na	na	10.03	12.74	16.26
40	5.71	15.42	na	na	10.56	13.42	17.13
60	6.05	16.34	na	na	11.19	14.22	18.15
Unlimited	6.09	16.44	na	na	11.27	14.31	18.27
SMALL GROUP				**$45 Copay**			
20	4.79	12.93	na	na	8.86	11.26	14.37
30	5.23	14.12	na	na	9.68	12.29	15.69
40	5.54	14.96	na	na	10.25	13.02	16.62
60	5.86	15.82	na	na	10.84	13.77	17.58
Unlimited	5.90	15.93	na	na	10.92	13.87	17.70
SMALL GROUP				**$50 Copay**			
20	4.62	12.47	na	na	8.55	10.86	13.86
30	5.08	13.72	na	na	9.40	11.94	15.24
40	5.39	14.55	na	na	9.97	12.67	16.17
60	5.68	15.34	na	na	10.51	13.35	17.04
Unlimited	5.71	15.42	na	na	10.56	13.42	17.13
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
5	0.00	0.00	na	na	0.00	0.00	0.00
10	0.00	0.00	na	na	0.00	0.00	0.00
15	0.00	0.00	na	na	0.00	0.00	0.00
20	0.00	0.00	na	na	0.00	0.00	0.00
25	0.00	0.00	na	na	0.00	0.00	0.00
30	0.00	0.00	na	na	0.00	0.00	0.00
35	0.00	0.00	na	na	0.00	0.00	0.00
40	0.00	0.00	na	na	0.00	0.00	0.00
45	0.00	0.00	na	na	0.00	0.00	0.00
50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	0.12	0.32	na	na	0.22	0.28	0.36
30	0.13	0.35	na	na	0.24	0.31	0.39
40	0.14	0.38	na	na	0.26	0.33	0.42
60	0.15	0.41	na	na	0.27	0.35	0.45
Unlimited	0.15	0.40	na	na	0.28	0.35	0.45
SMALL GROUP				**$45 Copay**			
20	0.12	0.32	na	na	0.22	0.29	0.36
30	0.12	0.32	na	na	0.23	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.33	0.42
Unlimited	0.14	0.38	na	na	0.26	0.33	0.42
SMALL GROUP				**$50 Copay**			
20	0.11	0.29	na	na	0.21	0.26	0.33
30	0.12	0.33	na	na	0.22	0.28	0.36
40	0.13	0.35	na	na	0.24	0.31	0.39
60	0.14	0.38	na	na	0.26	0.33	0.42
Unlimited	0.14	0.38	na	na	0.26	0.33	0.42
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO SMALL 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
SMALL GROUP				**$40 Copay**			
20	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
30	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP				**$45 Copay**			
20	2.6%	2.5%	na	na	2.5%	2.6%	2.6%
30	2.3%	2.3%	na	na	2.4%	2.3%	2.3%
40	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
60	2.4%	2.5%	na	na	2.5%	2.5%	2.4%
Unlimited	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
SMALL GROUP				**$50 Copay**			
20	2.4%	2.4%	na	na	2.5%	2.5%	2.4%
30	2.4%	2.5%	na	na	2.4%	2.4%	2.4%
40	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
60	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
Unlimited	2.5%	2.5%	na	na	2.5%	2.5%	2.5%
SMALL GROUP Specialist Copay	**Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit]**						
$0	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
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
Deductible			**Durable Medical Equipment Riders**				
$0	4.88	13.18	na	na	9.03	11.47	14.64
$0/Max $5000	4.64	12.53	na	na	8.58	10.90	13.92
$0/Max $2500	4.34	11.72	na	na	8.03	10.20	13.02
$25	4.64	12.53	na	na	8.58	10.90	13.92
$50	4.34	11.72	na	na	8.03	10.20	13.02
$100	3.97	10.72	na	na	7.34	9.33	11.91
$500	1.90	5.13	na	na	3.52	4.47	5.70
$5,000	0.32	0.86	na	na	0.59	0.75	0.96
Coinsurance							
80%	3.90	10.53	na	na	7.22	9.17	11.70
75%	3.66	9.88	na	na	6.77	8.60	10.98
70%	3.43	9.26	na	na	6.35	8.06	10.29
Deductible			**Orthotics Riders**				
$0	0.82	2.21	na	na	1.52	1.93	2.46
$0/Max $5000	0.79	2.13	na	na	1.46	1.86	2.37
$0/Max $2500	0.75	2.03	na	na	1.39	1.76	2.25
$25	0.79	2.13	na	na	1.46	1.86	2.37
$50	0.75	2.03	na	na	1.39	1.76	2.25
$100	0.68	1.84	na	na	1.26	1.60	2.04
$500	0.34	0.92	na	na	0.63	0.80	1.02
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.68	1.84	na	na	1.26	1.60	2.04
75%	0.65	1.76	na	na	1.20	1.53	1.95
70%	0.62	1.67	na	na	1.15	1.46	1.86
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.58	4.27	na	na	2.92	3.71	4.74
12 Months	2.55	6.89	na	na	4.72	5.99	7.65
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.48	6.70	na	na	4.59	5.83	7.44
12 Months	3.96	10.69	na	na	7.33	9.31	11.88
			Private Duty Nursing Riders				
In Full	0.60	1.62	na	na	1.11	1.41	1.80
80% hrs 73-504	0.08	0.22	na	na	0.15	0.19	0.24
100% hrs 73-504	0.15	0.41	na	na	0.28	0.35	0.45
			Dental Network Access				
	0.48	1.30	na	na	0.89	1.13	1.44
Limit			**Infertility Rider**				
2 IVF	10.32	27.86	na	na	19.09	24.25	30.96
3 IVF	12.45	33.62	na	na	23.03	29.26	37.35
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.75	12.83	na	na	8.79	11.16	14.25
Health Club Reimbursement							
$200 per year	1.23	3.32	na	na	2.28	2.89	3.69
			Nurse Advice Line Rider				
	0.32	0.86	na	na	0.59	0.75	0.96

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO GROUP CONTRACT - RIDERS
October 01, 2013 - December 31, 2013 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	5.00	13.50	na	na	9.25	11.75	15.00
$0/Max $5000	4.75	12.83	na	na	8.79	11.16	14.25
$0/Max $2500	4.45	12.02	na	na	8.23	10.46	13.35
$25	4.75	12.83	na	na	8.79	11.16	14.25
$50	4.45	12.02	na	na	8.23	10.46	13.35
$100	4.06	10.96	na	na	7.51	9.54	12.18
$500	1.94	5.24	na	na	3.59	4.56	5.82
$5,000	0.33	0.89	na	na	0.61	0.78	0.99
Coinsurance							
80%	3.99	10.77	na	na	7.38	9.38	11.97
75%	3.75	10.13	na	na	6.94	8.81	11.25
70%	3.51	9.48	na	na	6.49	8.25	10.53
Deductible			**Orthotics Riders**				
$0	0.83	2.24	na	na	1.54	1.95	2.49
$0/Max $5000	0.80	2.16	na	na	1.48	1.88	2.40
$0/Max $2500	0.76	2.05	na	na	1.41	1.79	2.28
$25	0.80	2.16	na	na	1.48	1.88	2.40
$50	0.76	2.05	na	na	1.41	1.79	2.28
$100	0.70	1.89	na	na	1.30	1.65	2.10
$500	0.35	0.95	na	na	0.65	0.82	1.05
$5,000	0.03	0.08	na	na	0.06	0.07	0.09
Coinsurance							
80%	0.70	1.89	na	na	1.30	1.65	2.10
75%	0.67	1.81	na	na	1.24	1.57	2.01
70%	0.64	1.73	na	na	1.18	1.50	1.92
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.62	4.37	na	na	3.00	3.81	4.86
12 Months	2.61	7.05	na	na	4.83	6.13	7.83
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.53	6.83	na	na	4.68	5.95	7.59
12 Months	4.05	10.94	na	na	7.49	9.52	12.15
			Private Duty Nursing Riders				
In Full	0.62	1.67	na	na	1.15	1.46	1.86
80% hrs 73-504	0.07	0.19	na	na	0.13	0.16	0.21
100% hrs 73-504	0.14	0.38	na	na	0.26	0.33	0.42
			Dental Network Access				
	0.48	1.30	na	na	0.89	1.13	1.44
Limit			**Infertility Rider**				
2 IVF	10.57	28.54	na	na	19.55	24.84	31.71
3 IVF	12.75	34.43	na	na	23.59	29.96	38.25
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	4.86	13.12	na	na	8.99	11.42	14.58
Health Club Reimbursement							
$200 per year	1.26	3.40	na	na	2.33	2.96	3.78
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO 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	0.12	0.32	na	na	0.22	0.28	0.36
$0/Max $5000	0.11	0.30	na	na	0.21	0.26	0.33
$0/Max $2500	0.11	0.30	na	na	0.20	0.26	0.33
$25	0.11	0.30	na	na	0.21	0.26	0.33
$50	0.11	0.30	na	na	0.20	0.26	0.33
$100	0.09	0.24	na	na	0.17	0.21	0.27
$500	0.04	0.11	na	na	0.07	0.09	0.12
$5,000	0.01	0.03	na	na	0.02	0.03	0.03
Coinsurance							
80%	0.09	0.24	na	na	0.16	0.21	0.27
75%	0.09	0.25	na	na	0.17	0.21	0.27
70%	0.08	0.22	na	na	0.14	0.19	0.24
Deductible			**Orthotics Riders**				
$0	0.01	0.03	na	na	0.02	0.02	0.03
$0/Max $5000	0.01	0.03	na	na	0.02	0.02	0.03
$0/Max $2500	0.01	0.02	na	na	0.02	0.03	0.03
$25	0.01	0.03	na	na	0.02	0.02	0.03
$50	0.01	0.02	na	na	0.02	0.03	0.03
$100	0.02	0.05	na	na	0.04	0.05	0.06
$500	0.01	0.03	na	na	0.02	0.02	0.03
$5,000	-	-	na	na	-	-	-
Coinsurance							
80%	0.02	0.05	na	na	0.04	0.05	0.06
75%	0.02	0.05	na	na	0.04	0.04	0.06
70%	0.02	0.06	na	na	0.03	0.04	0.06
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.04	0.10	na	na	0.08	0.10	0.12
12 Months	0.06	0.16	na	na	0.11	0.14	0.18
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.05	0.13	na	na	0.09	0.12	0.15
12 Months	0.09	0.25	na	na	0.16	0.21	0.27
			Private Duty Nursing Riders				
In Full	0.02	0.05	na	na	0.04	0.05	0.06
80% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.03)	(0.03)
100% hrs 73-504	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
			Dental Network Access				
	-	-	na	na	-	-	-
Limit			**Infertility Rider**				
2 IVF	0.25	0.68	na	na	0.46	0.59	0.75
3 IVF	0.30	0.81	na	na	0.56	0.70	0.90
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	0.11	0.29	na	na	0.20	0.26	0.33
Health Club Reimbursement							
$200 per year	0.03	0.08	na	na	0.05	0.07	0.09
			Nurse Advice Line Rider				
	0.01	0.03	na	na	0.02	0.03	0.03

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
HIP HMO 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	2.5%	2.4%	na	na	2.4%	2.4%	2.5%
$0/Max $5000	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$0/Max $2500	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
$25	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
$50	2.5%	2.6%	na	na	2.5%	2.5%	2.5%
$100	2.3%	2.2%	na	na	2.3%	2.3%	2.3%
$500	2.1%	2.1%	na	na	2.0%	2.0%	2.1%
$5,000	3.1%	3.5%	na	na	3.4%	4.0%	3.1%
Coinsurance							
80%	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
75%	2.5%	2.5%	na	na	2.5%	2.4%	2.5%
70%	2.3%	2.4%	na	na	2.2%	2.4%	2.3%
Deductible			**Orthotics Riders**				
$0	1.2%	1.4%	na	na	1.3%	1.0%	1.2%
$0/Max $5000	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$0/Max $2500	1.3%	1.0%	na	na	1.4%	1.7%	1.3%
$25	1.3%	1.4%	na	na	1.4%	1.1%	1.3%
$50	1.3%	1.0%	na	na	1.4%	1.7%	1.3%
$100	2.9%	2.7%	na	na	3.2%	3.1%	2.9%
$500	2.9%	3.3%	na	na	3.2%	2.5%	2.9%
$5,000	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Coinsurance							
80%	2.9%	2.7%	na	na	3.2%	3.1%	2.9%
75%	3.1%	2.8%	na	na	3.3%	2.6%	3.1%
70%	3.2%	3.6%	na	na	2.6%	2.7%	3.2%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	na	na	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	2.5%	2.3%	na	na	2.7%	2.7%	2.5%
12 Months	2.4%	2.3%	na	na	2.3%	2.3%	2.4%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.0%	1.9%	na	na	2.0%	2.1%	2.0%
12 Months	2.3%	2.3%	na	na	2.2%	2.3%	2.3%
			Private Duty Nursing Riders				
In Full	3.3%	3.1%	na	na	3.6%	3.5%	3.3%
80% hrs 73-504	-12.5%	-13.6%	na	na	-13.3%	-15.8%	-12.5%
100% hrs 73-504	-6.7%	-7.3%	na	na	-7.1%	-5.7%	-6.7%
			Dental Network Access				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Limit			**Infertility Rider**				
2 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
3 IVF	2.4%	2.4%	na	na	2.4%	2.4%	2.4%
			Applicable to Classic only				
Complementary Alternative Medicine (CAM)							
$20 Copay	2.3%	2.3%	na	na	2.3%	2.3%	2.3%
Health Club Reimbursement							
$200 per year	2.4%	2.4%	na	na	2.2%	2.4%	2.4%
			Nurse Advice Line Rider				
24 Months	3.1%	3.5%	na	na	3.4%	4.0%	3.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
OCTOBER 1, 2012 - DECEMBER 31, 2012 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 11/1/2012-12/31/2012 (With WH & Autism)							
Small Group *	495.44	1,407.05	na	na	916.56	1,164.28	1,486.32
Effective 10/1/12-10/31/2012 (without WH & Autism)							
Small Group *	490.54	1,393.13	na	na	907.50	1,152.77	1,471.62

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Group *	505.39	1,435.31	na	na	934.97	1,187.67	1,516.17
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
	500.40	1,421.14	na	na	925.74	1,175.94	1,501.20

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
DOLLAR CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Group *	9.95	28.26	na	na	18.41	23.39	29.85
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
Small Group *	9.86	28.01	na	na	18.24	23.17	29.58

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - BASE BENEFITS
PERCENTAGE CHANGE IN RATES

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Effective 10/01/2013 - 12/31/2013 (With WH & Autism)							
Small Group *	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Effective 10/01/2013 - 12/31/2013 (Without WH & Autism)							
Small Group *	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	na	na	0.00	0.00	0.00
$5	(4.32)	(12.27)	na	na	(7.99)	(10.15)	(12.96)
$10	(9.06)	(25.73)	na	na	(16.76)	(21.29)	(27.18)
$15	(14.02)	(39.82)	na	na	(25.94)	(32.95)	(42.06)
$20	(20.19)	(57.34)	na	na	(37.35)	(47.45)	(60.57)
$25	(37.47)	(106.41)	na	na	(69.32)	(88.05)	(112.41)
$30	(59.52)	(169.04)	na	na	(110.11)	(139.87)	(178.56)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.47)	(7.01)	na	na	(4.57)	(5.80)	(7.41)
$10	(5.20)	(14.77)	na	na	(9.62)	(12.22)	(15.60)
$15	(8.03)	(22.81)	na	na	(14.86)	(18.87)	(24.09)
$20	(11.58)	(32.89)	na	na	(21.42)	(27.21)	(34.74)
$25	(21.47)	(60.97)	na	na	(39.72)	(50.45)	(64.41)
$30	(34.13)	(96.93)	na	na	(63.14)	(80.21)	(102.39)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.06)	(8.69)	na	na	(5.66)	(7.19)	(9.18)
$10	(6.27)	(17.81)	na	na	(11.60)	(14.73)	(18.81)
$15	(9.52)	(27.04)	na	na	(17.61)	(22.37)	(28.56)
$20	(12.95)	(36.78)	na	na	(23.96)	(30.43)	(38.85)
$25	(19.23)	(54.61)	na	na	(35.58)	(45.19)	(57.69)
$30	(27.15)	(77.11)	na	na	(50.23)	(63.80)	(81.45)
$35	(35.51)	(100.85)	na	na	(65.69)	(83.45)	(106.53)
$40	(44.91)	(127.54)	na	na	(83.08)	(105.54)	(134.73)
$45	(55.41)	(157.36)	na	na	(102.51)	(130.21)	(166.23)
$50	(67.02)	(190.34)	na	na	(123.99)	(157.50)	(201.06)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.56)	(7.27)	na	na	(4.74)	(6.02)	(7.68)
$10	(5.30)	(15.05)	na	na	(9.81)	(12.46)	(15.90)
$15	(8.04)	(22.83)	na	na	(14.87)	(18.89)	(24.12)
$20	(10.95)	(31.10)	na	na	(20.26)	(25.73)	(32.85)
$25	(16.26)	(46.18)	na	na	(30.08)	(38.21)	(48.78)
$30	(22.93)	(65.12)	na	na	(42.42)	(53.89)	(68.79)
$35	(30.01)	(85.23)	na	na	(55.52)	(70.52)	(90.03)
$40	(37.99)	(107.89)	na	na	(70.28)	(89.28)	(113.97)
$45	(46.84)	(133.03)	na	na	(86.65)	(110.07)	(140.52)
$50	(56.67)	(160.94)	na	na	(104.84)	(133.17)	(170.01)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.44)	(6.93)	na	na	(4.51)	(5.73)	(7.32)
$150	(4.08)	(11.59)	na	na	(7.55)	(9.59)	(12.24)
$200	(5.88)	(16.70)	na	na	(10.88)	(13.82)	(17.64)
$250	(8.49)	(24.11)	na	na	(15.71)	(19.95)	(25.47)
$500	(20.87)	(59.27)	na	na	(38.61)	(49.04)	(62.61)
$750	(36.54)	(103.77)	na	na	(67.60)	(85.87)	(109.62)
$1,000	(55.81)	(158.50)	na	na	(103.25)	(131.15)	(167.43)
Copay/Day							
$50 w/3 Day Max	(3.51)	(9.97)	na	na	(6.49)	(8.25)	(10.53)
$50 w/5 Day Max	(4.76)	(13.52)	na	na	(8.81)	(11.19)	(14.28)
$100 w/3 Day Max	(7.50)	(21.30)	na	na	(13.88)	(17.63)	(22.50)
$100 w/5 Day Max	(12.77)	(36.27)	na	na	(23.62)	(30.01)	(38.31)
$250 w/3 Day Max	(24.78)	(70.38)	na	na	(45.84)	(58.23)	(74.34)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.37)	(3.89)	na	na	(2.53)	(3.22)	(4.11)
$75	(2.39)	(6.79)	na	na	(4.42)	(5.62)	(7.17)
$100	(3.59)	(10.20)	na	na	(6.64)	(8.44)	(10.77)
$125	(4.99)	(14.17)	na	na	(9.23)	(11.73)	(14.97)
$150	(6.61)	(18.77)	na	na	(12.23)	(15.53)	(19.83)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.88)	(2.50)	na	na	(1.63)	(2.07)	(2.64)
$35	(1.48)	(4.20)	na	na	(2.74)	(3.48)	(4.44)
$50	(2.45)	(6.96)	na	na	(4.53)	(5.76)	(7.35)
$60	(3.11)	(8.83)	na	na	(5.75)	(7.31)	(9.33)
$75	(4.01)	(11.39)	na	na	(7.42)	(9.42)	(12.03)
$100	(5.62)	(15.96)	na	na	(10.40)	(13.21)	(16.86)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 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	na	na	0.00	0.00	0.00
$5	(4.40)	(12.50)	na	na	(8.14)	(10.34)	(13.20)
$10	(9.24)	(26.24)	na	na	(17.09)	(21.71)	(27.72)
$15	(14.30)	(40.61)	na	na	(26.46)	(33.61)	(42.90)
$20	(20.59)	(58.48)	na	na	(38.09)	(48.39)	(61.77)
$25	(38.22)	(108.54)	na	na	(70.71)	(89.82)	(114.66)
$30	(60.72)	(172.44)	na	na	(112.33)	(142.69)	(182.16)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.51)	(7.13)	na	na	(4.64)	(5.90)	(7.53)
$10	(5.30)	(15.05)	na	na	(9.81)	(12.46)	(15.90)
$15	(8.19)	(23.26)	na	na	(15.15)	(19.25)	(24.57)
$20	(11.82)	(33.57)	na	na	(21.87)	(27.78)	(35.46)
$25	(21.90)	(62.20)	na	na	(40.52)	(51.47)	(65.70)
$30	(34.81)	(98.86)	na	na	(64.40)	(81.80)	(104.43)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(3.12)	(8.86)	na	na	(5.77)	(7.33)	(9.36)
$10	(6.39)	(18.15)	na	na	(11.82)	(15.02)	(19.17)
$15	(9.72)	(27.60)	na	na	(17.98)	(22.84)	(29.16)
$20	(13.21)	(37.52)	na	na	(24.44)	(31.04)	(39.63)
$25	(19.61)	(55.69)	na	na	(36.28)	(46.08)	(58.83)
$30	(27.69)	(78.64)	na	na	(51.23)	(65.07)	(83.07)
$35	(36.23)	(102.89)	na	na	(67.03)	(85.14)	(108.69)
$40	(45.81)	(130.10)	na	na	(84.75)	(107.65)	(137.43)
$45	(56.52)	(160.52)	na	na	(104.56)	(132.82)	(169.56)
$50	(68.37)	(194.17)	na	na	(126.48)	(160.67)	(205.11)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(2.62)	(7.44)	na	na	(4.85)	(6.16)	(7.86)
$10	(5.40)	(15.34)	na	na	(9.99)	(12.69)	(16.20)
$15	(8.20)	(23.29)	na	na	(15.17)	(19.27)	(24.60)
$20	(11.17)	(31.72)	na	na	(20.66)	(26.25)	(33.51)
$25	(16.58)	(47.09)	na	na	(30.67)	(38.96)	(49.74)
$30	(23.39)	(66.43)	na	na	(43.27)	(54.97)	(70.17)
$35	(30.61)	(86.93)	na	na	(56.63)	(71.93)	(91.83)
$40	(38.75)	(110.05)	na	na	(71.69)	(91.06)	(116.25)
$45	(47.78)	(135.70)	na	na	(88.39)	(112.28)	(143.34)
$50	(57.81)	(164.18)	na	na	(106.95)	(135.85)	(173.43)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$100	(2.48)	(7.04)	na	na	(4.59)	(5.83)	(7.44)
$150	(4.16)	(11.81)	na	na	(7.70)	(9.78)	(12.48)
$200	(6.00)	(17.04)	na	na	(11.10)	(14.10)	(18.00)
$250	(8.66)	(24.59)	na	na	(16.02)	(20.35)	(25.98)
$500	(21.29)	(60.46)	na	na	(39.39)	(50.03)	(63.87)
$750	(37.28)	(105.88)	na	na	(68.97)	(87.61)	(111.84)
$1,000	(56.93)	(161.68)	na	na	(105.32)	(133.79)	(170.79)
Copay/Day							
$50 w/3 Day Max	(3.59)	(10.20)	na	na	(6.64)	(8.44)	(10.77)
$50 w/5 Day Max	(4.86)	(13.80)	na	na	(8.99)	(11.42)	(14.58)
$100 w/3 Day Max	(7.66)	(21.75)	na	na	(14.17)	(18.00)	(22.98)
$100 w/5 Day Max	(13.03)	(37.01)	na	na	(24.11)	(30.62)	(39.09)
$250 w/3 Day Max	(25.28)	(71.80)	na	na	(46.77)	(59.41)	(75.84)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$50	(1.39)	(3.95)	na	na	(2.57)	(3.27)	(4.17)
$75	(2.43)	(6.90)	na	na	(4.50)	(5.71)	(7.29)
$100	(3.67)	(10.42)	na	na	(6.79)	(8.62)	(11.01)
$125	(5.09)	(14.46)	na	na	(9.42)	(11.96)	(15.27)
$150	(6.75)	(19.17)	na	na	(12.49)	(15.86)	(20.25)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.48)	(1.36)	na	na	(0.89)	(1.13)	(1.44)
$25	(0.90)	(2.56)	na	na	(1.67)	(2.12)	(2.70)
$35	(1.50)	(4.26)	na	na	(2.78)	(3.53)	(4.50)
$50	(2.49)	(7.07)	na	na	(4.61)	(5.85)	(7.47)
$60	(3.17)	(9.00)	na	na	(5.86)	(7.45)	(9.51)
$75	(4.09)	(11.62)	na	na	(7.57)	(9.61)	(12.27)
$100	(5.74)	(16.30)	na	na	(10.62)	(13.49)	(17.22)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	-	-	na	na	-	-	-
$5	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$10	(0.18)	(0.51)	na	na	(0.33)	(0.42)	(0.54)
$15	(0.28)	(0.79)	na	na	(0.52)	(0.66)	(0.84)
$20	(0.40)	(1.14)	na	na	(0.74)	(0.94)	(1.20)
$25	(0.75)	(2.13)	na	na	(1.39)	(1.77)	(2.25)
$30	(1.20)	(3.40)	na	na	(2.22)	(2.82)	(3.60)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.04)	(0.12)	na	na	(0.07)	(0.10)	(0.12)
$10	(0.10)	(0.28)	na	na	(0.19)	(0.24)	(0.30)
$15	(0.16)	(0.45)	na	na	(0.29)	(0.38)	(0.48)
$20	(0.24)	(0.68)	na	na	(0.45)	(0.57)	(0.72)
$25	(0.43)	(1.23)	na	na	(0.80)	(1.02)	(1.29)
$30	(0.68)	(1.93)	na	na	(1.26)	(1.59)	(2.04)
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$10	(0.12)	(0.34)	na	na	(0.22)	(0.29)	(0.36)
$15	(0.20)	(0.56)	na	na	(0.37)	(0.47)	(0.60)
$20	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$25	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$30	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
$35	(0.72)	(2.04)	na	na	(1.34)	(1.69)	(2.16)
$40	(0.90)	(2.56)	na	na	(1.67)	(2.11)	(2.70)
$45	(1.11)	(3.16)	na	na	(2.05)	(2.61)	(3.33)
$50	(1.35)	(3.83)	na	na	(2.49)	(3.17)	(4.05)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	-	-	na	na	-	-	-
$5	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$10	(0.10)	(0.29)	na	na	(0.18)	(0.23)	(0.30)
$15	(0.16)	(0.46)	na	na	(0.30)	(0.38)	(0.48)
$20	(0.22)	(0.62)	na	na	(0.40)	(0.52)	(0.66)
$25	(0.32)	(0.91)	na	na	(0.59)	(0.75)	(0.96)
$30	(0.46)	(1.31)	na	na	(0.85)	(1.08)	(1.38)
$35	(0.60)	(1.70)	na	na	(1.11)	(1.41)	(1.80)
$40	(0.76)	(2.16)	na	na	(1.41)	(1.78)	(2.28)
$45	(0.94)	(2.67)	na	na	(1.74)	(2.21)	(2.82)
$50	(1.14)	(3.24)	na	na	(2.11)	(2.68)	(3.42)

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$100	(0.04)	(0.11)	na	na	(0.08)	(0.10)	(0.12)
$150	(0.08)	(0.22)	na	na	(0.15)	(0.19)	(0.24)
$200	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)
$250	(0.17)	(0.48)	na	na	(0.31)	(0.40)	(0.51)
$500	(0.42)	(1.19)	na	na	(0.78)	(0.99)	(1.26)
$750	(0.74)	(2.11)	na	na	(1.37)	(1.74)	(2.22)
$1,000	(1.12)	(3.18)	na	na	(2.07)	(2.64)	(3.36)
Copay/Day							
$50 w/3 Day Max	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$50 w/5 Day Max	(0.10)	(0.28)	na	na	(0.18)	(0.23)	(0.30)
$100 w/3 Day Max	(0.16)	(0.45)	na	na	(0.29)	(0.37)	(0.48)
$100 w/5 Day Max	(0.26)	(0.74)	na	na	(0.49)	(0.61)	(0.78)
$250 w/3 Day Max	(0.50)	(1.42)	na	na	(0.93)	(1.18)	(1.50)
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$50	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$75	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
$100	(0.08)	(0.22)	na	na	(0.15)	(0.18)	(0.24)
$125	(0.10)	(0.29)	na	na	(0.19)	(0.23)	(0.30)
$150	(0.14)	(0.40)	na	na	(0.26)	(0.33)	(0.42)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$35	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$50	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
$60	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$75	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$100	(0.12)	(0.34)	na	na	(0.22)	(0.28)	(0.36)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
$10	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$15	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$25	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care facility visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	1.6%	1.7%	n/a	n/a	1.5%	1.7%	1.6%
$10	1.9%	1.9%	n/a	n/a	2.0%	2.0%	1.9%
$15	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$20	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
$25	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Copay	**Specialist Office Visit Copay [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	2.0%	2.0%	n/a	n/a	1.9%	1.9%	2.0%
$10	1.9%	1.9%	n/a	n/a	1.9%	2.0%	1.9%
$15	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
$20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$25	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$35	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$45	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$50	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	2.3%	2.3%	n/a	n/a	2.3%	2.3%	2.3%
$10	1.9%	1.9%	n/a	n/a	1.8%	1.8%	1.9%
$15	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$25	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$35	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$45	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$50	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%

** $0 child copay also applies to home health, x-rays, diag. & lab tests, outp. mh, outp. s/a rehab, outp. therapies*

Copay/Admit	**Inpatient Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$100	1.6%	1.6%	n/a	n/a	1.8%	1.7%	1.6%
$150	2.0%	1.9%	n/a	n/a	2.0%	2.0%	2.0%
$200	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$250	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$500	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$750	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$1,000	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Copay/Day							
$50 w/3 Day Max	2.3%	2.3%	n/a	n/a	2.3%	2.3%	2.3%
$50 w/5 Day Max	2.1%	2.1%	n/a	n/a	2.0%	2.1%	2.1%
$100 w/3 Day Max	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
$100 w/5 Day Max	2.0%	2.0%	n/a	n/a	2.1%	2.0%	2.0%
$250 w/3 Day Max	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	1.5%	1.5%	n/a	n/a	1.6%	1.6%	1.5%
$75	1.7%	1.6%	n/a	n/a	1.8%	1.6%	1.7%
$100	2.2%	2.2%	n/a	n/a	2.3%	2.1%	2.2%
$125	2.0%	2.0%	n/a	n/a	2.1%	2.0%	2.0%
$150	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	2.3%	2.4%	n/a	n/a	2.5%	2.4%	2.3%
$35	1.4%	1.4%	n/a	n/a	1.5%	1.4%	1.4%
$50	1.6%	1.6%	n/a	n/a	1.8%	1.6%	1.6%
$60	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
$75	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$100	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(7.37)	(20.93)	na	na	(13.63)	(17.32)	(22.11)
$150	(9.29)	(26.38)	na	na	(17.19)	(21.83)	(27.87)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.67	1.90	na	na	1.24	1.57	2.01
60	1.30	3.69	na	na	2.41	3.06	3.90
90	1.94	5.51	na	na	3.59	4.56	5.82
120	2.27	6.45	na	na	4.20	5.33	6.81
Unlimited	2.90	8.24	na	na	5.37	6.82	8.70
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.52)	(1.48)	na	na	(0.96)	(1.22)	(1.56)
40/$20 copay	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
40/$25 copay	(0.95)	(2.70)	na	na	(1.76)	(2.23)	(2.85)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.84	2.39	na	na	1.55	1.97	2.52
200	2.28	6.48	na	na	4.22	5.36	6.84
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.35)	(3.83)	na	na	(2.50)	(3.17)	(4.05)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.90	2.56	na	na	1.67	2.12	2.70
90	1.87	5.31	na	na	3.46	4.39	5.61
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.79	2.24	na	na	1.46	1.86	2.37
90	1.47	4.17	na	na	2.72	3.45	4.41
120	2.35	6.67	na	na	4.35	5.52	7.05
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.54	1.53	na	na	1.00	1.27	1.62
Unlimited	0.79	2.24	na	na	1.46	1.86	2.37
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.01	11.39	na	na	7.42	9.42	12.03
60	4.70	13.35	na	na	8.70	11.05	14.10
90	5.60	15.90	na	na	10.36	13.16	16.80
Unlimited	5.68	16.13	na	na	10.51	13.35	17.04
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.65)	(1.85)	na	na	(1.20)	(1.53)	(1.95)
60/$25 copay	(0.75)	(2.13)	na	na	(1.39)	(1.76)	(2.25)
120/$0 copay	0.71	2.02	na	na	1.31	1.67	2.13
120/$5 copay	0.56	1.59	na	na	1.04	1.32	1.68
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.81	2.30	na	na	1.50	1.90	2.43
Unlimited/$5 copay	0.66	1.87	na	na	1.22	1.55	1.98
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$125	(7.51)	(21.33)	na	na	(13.89)	(17.65)	(22.53)
$150	(9.47)	(26.89)	na	na	(17.52)	(22.25)	(28.41)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
45	0.69	1.96	na	na	1.28	1.62	2.07
60	1.32	3.75	na	na	2.44	3.10	3.96
90	1.98	5.62	na	na	3.66	4.65	5.94
120	2.31	6.56	na	na	4.27	5.43	6.93
Unlimited	2.96	8.41	na	na	5.48	6.96	8.88
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	0.00	0.00	na	na	0.00	0.00	0.00
40/$5 copay	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
40/$10 copay	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
40/$15 copay	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
40/$20 copay	(0.75)	(2.13)	na	na	(1.39)	(1.76)	(2.25)
40/$25 copay	(0.97)	(2.75)	na	na	(1.79)	(2.28)	(2.91)
60	0.35	0.99	na	na	0.65	0.82	1.05
100	0.86	2.44	na	na	1.59	2.02	2.58
200	2.32	6.59	na	na	4.29	5.45	6.96
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.37)	(3.89)	na	na	(2.53)	(3.22)	(4.11)
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.92	2.61	na	na	1.70	2.16	2.76
90	1.91	5.42	na	na	3.53	4.49	5.73
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	0.00	0.00	na	na	0.00	0.00	0.00
60	0.81	2.30	na	na	1.50	1.90	2.43
90	1.49	4.23	na	na	2.76	3.50	4.47
120	2.39	6.79	na	na	4.42	5.62	7.17
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(1.15)	(3.27)	na	na	(2.13)	(2.70)	(3.45)
7	0.00	0.00	na	na	0.00	0.00	0.00
21	0.33	0.94	na	na	0.61	0.78	0.99
30	0.56	1.59	na	na	1.04	1.32	1.68
Unlimited	0.81	2.30	na	na	1.50	1.90	2.43
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	0.00	0.00	na	na	0.00	0.00	0.00
30	4.09	11.62	na	na	7.57	9.61	12.27
60	4.80	13.63	na	na	8.88	11.28	14.40
90	5.72	16.24	na	na	10.58	13.44	17.16
Unlimited	5.80	16.47	na	na	10.73	13.63	17.40
# 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	na	na	0.00	0.00	0.00
60/$5 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
60/$10 copay	(0.28)	(0.80)	na	na	(0.52)	(0.66)	(0.84)
60/$15 copay	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
60/$20 copay	(0.67)	(1.90)	na	na	(1.24)	(1.57)	(2.01)
60/$25 copay	(0.77)	(2.19)	na	na	(1.42)	(1.81)	(2.31)
120/$0 copay	0.73	2.07	na	na	1.35	1.72	2.19
120/$5 copay	0.58	1.65	na	na	1.07	1.36	1.74
120/$10 copay	0.35	0.99	na	na	0.65	0.82	1.05
120/$15 copay	0.07	0.20	na	na	0.13	0.16	0.21
120/$20 copay	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
120/$25 copay	(0.33)	(0.94)	na	na	(0.61)	(0.78)	(0.99)
Unlimited/$0 copay	0.83	2.36	na	na	1.54	1.95	2.49
Unlimited/$5 copay	0.68	1.93	na	na	1.26	1.60	2.04
Unlimited/$10 copay	0.42	1.19	na	na	0.78	0.99	1.26
Unlimited/$15 copay	0.13	0.37	na	na	0.24	0.31	0.39
Unlimited/$20 copay	(0.03)	(0.09)	na	na	(0.06)	(0.07)	(0.09)
Unlimited/$25 copay	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.20	0.57	na	na	0.37	0.47	0.60
$5	0.07	0.20	na	na	0.13	0.16	0.21
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	(0.14)	(0.40)	na	na	(0.26)	(0.33)	(0.42)
$150	(0.18)	(0.51)	na	na	(0.33)	(0.42)	(0.54)
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	-	-	na	na	-	-	-
45	0.02	0.06	na	na	0.04	0.05	0.06
60	0.02	0.06	na	na	0.03	0.04	0.06
90	0.04	0.11	na	na	0.07	0.09	0.12
120	0.04	0.11	na	na	0.07	0.10	0.12
Unlimited	0.06	0.17	na	na	0.11	0.14	0.18
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	-	-	na	na	-	-	-
40/$5 copay	-	-	na	na	-	-	-
40/$10 copay	-	-	na	na	-	-	-
40/$15 copay	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
40/$20 copay	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
40/$25 copay	(0.02)	(0.05)	na	na	(0.03)	(0.05)	(0.06)
60	-	-	na	na	-	-	-
100	0.02	0.05	na	na	0.04	0.05	0.06
200	0.04	0.11	na	na	0.07	0.09	0.12
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
30	-	-	na	na	-	-	-
60	0.02	0.05	na	na	0.03	0.04	0.06
90	0.04	0.11	na	na	0.07	0.10	0.12
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	-	-	na	na	-	-	-
60	0.02	0.06	na	na	0.04	0.04	0.06
90	0.02	0.06	na	na	0.04	0.05	0.06
120	0.04	0.12	na	na	0.07	0.10	0.12
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
7	-	-	na	na	-	-	-
21	-	-	na	na	-	-	-
30	0.02	0.06	na	na	0.04	0.05	0.06
Unlimited	0.02	0.06	na	na	0.04	0.04	0.06
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	-	-	na	na	-	-	-
30	0.08	0.23	na	na	0.15	0.19	0.24
60	0.10	0.28	na	na	0.18	0.23	0.30
90	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
# 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	-	-	na	na	-	-	-
60/$5 copay	-	-	na	na	-	-	-
60/$10 copay	-	-	na	na	-	-	-
60/$15 copay	-	-	na	na	-	-	-
60/$20 copay	(0.02)	(0.05)	na	na	(0.04)	(0.04)	(0.06)
60/$25 copay	(0.02)	(0.06)	na	na	(0.03)	(0.05)	(0.06)
120/$0 copay	0.02	0.05	na	na	0.04	0.05	0.06
120/$5 copay	0.02	0.06	na	na	0.03	0.04	0.06
120/$10 copay	-	-	na	na	-	-	-
120/$15 copay	-	-	na	na	-	-	-
120/$20 copay	-	-	na	na	-	-	-
120/$25 copay	-	-	na	na	-	-	-
Unlimited/$0 copay	0.02	0.06	na	na	0.04	0.05	0.06
Unlimited/$5 copay	0.02	0.06	na	na	0.04	0.05	0.06
Unlimited/$10 copay	-	-	na	na	-	-	-
Unlimited/$15 copay	-	-	na	na	-	-	-
Unlimited/$20 copay	-	-	na	na	-	-	-
Unlimited/$25 copay	-	-	na	na	-	-	-
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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
$125	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
$150	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
# Days	**Skilled Nursing Facility Care Limit [std: 30 days]**						
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
45	3.0%	3.2%	n/a	n/a	3.2%	3.2%	3.0%
60	1.5%	1.6%	n/a	n/a	1.2%	1.3%	1.5%
90	2.1%	2.0%	n/a	n/a	1.9%	2.0%	2.1%
120	1.8%	1.7%	n/a	n/a	1.7%	1.9%	1.8%
Unlimited	2.1%	2.1%	n/a	n/a	2.0%	2.1%	2.1%
# Visits	**Home Health Care Limit [std: 40 visits]**						
40/$0 copay	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
40/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
40/$10 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
40/$15 copay	3.8%	3.4%	n/a	n/a	4.2%	4.1%	3.8%
40/$20 copay	2.7%	2.9%	n/a	n/a	3.0%	2.3%	2.7%
40/$25 copay	2.1%	1.9%	n/a	n/a	1.7%	2.2%	2.1%
60	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
100	2.4%	2.1%	n/a	n/a	2.6%	2.5%	2.4%
200	1.8%	1.7%	n/a	n/a	1.7%	1.7%	1.8%
# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	1.5%	1.6%	n/a	n/a	1.2%	1.6%	1.5%
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	2.2%	2.0%	n/a	n/a	1.8%	1.9%	2.2%
90	2.1%	2.1%	n/a	n/a	2.0%	2.3%	2.1%
# Visits	**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Physician Office Visit]**						
30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
90	1.4%	1.4%	n/a	n/a	1.5%	1.4%	1.4%
120	1.7%	1.8%	n/a	n/a	1.6%	1.8%	1.7%
# Days	**Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days] [Copay same as Inpatient Facility]**						
0	1.8%	1.9%	n/a	n/a	1.9%	1.5%	1.8%
7	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
21	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
30	3.7%	3.9%	n/a	n/a	4.0%	3.9%	3.7%
Unlimited	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
# Days	**Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days] [Copay same as Inpatient Facility]**						
0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
90	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
Unlimited	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
# 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	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
60/$5 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$10 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
60/$20 copay	3.1%	2.7%	n/a	n/a	3.3%	2.6%	3.1%
60/$25 copay	2.7%	2.8%	n/a	n/a	2.2%	2.8%	2.7%
120/$0 copay	2.8%	2.5%	n/a	n/a	3.1%	3.0%	2.8%
120/$5 copay	3.6%	3.8%	n/a	n/a	2.9%	3.0%	3.6%
120/$10 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
120/$25 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$0 copay	2.5%	2.6%	n/a	n/a	2.7%	2.6%	2.5%
Unlimited/$5 copay	3.0%	3.2%	n/a	n/a	3.3%	3.2%	3.0%
Unlimited/$10 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$15 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$20 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Unlimited/$25 copay	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.71)	(2.02)	na	na	(1.31)	(1.67)	(2.13)
$25	(0.90)	(2.56)	na	na	(1.67)	(2.12)	(2.70)
$30	(1.13)	(3.21)	na	na	(2.09)	(2.66)	(3.39)
$35	(1.32)	(3.75)	na	na	(2.44)	(3.10)	(3.96)
$40	(1.51)	(4.29)	na	na	(2.79)	(3.55)	(4.53)
$45	(1.73)	(4.91)	na	na	(3.20)	(4.07)	(5.19)
$50	(1.93)	(5.48)	na	na	(3.57)	(4.54)	(5.79)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
$20	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
$25	(1.07)	(3.04)	na	na	(1.98)	(2.51)	(3.21)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.61)	(1.73)	na	na	(1.13)	(1.43)	(1.83)
$100	(0.79)	(2.24)	na	na	(1.46)	(1.86)	(2.37)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.54)	(1.53)	na	na	(1.00)	(1.27)	(1.62)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.31)	(9.40)	na	na	(6.12)	(7.78)	(9.93)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.17)	(14.68)	na	na	(9.56)	(12.15)	(15.51)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - BASE BENEFIT VARIABLES
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
$20	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$25	(0.35)	(0.99)	na	na	(0.65)	(0.82)	(1.05)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.13)	(0.37)	na	na	(0.24)	(0.31)	(0.39)
$10	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$15	(0.49)	(1.39)	na	na	(0.91)	(1.15)	(1.47)
$20	(0.73)	(2.07)	na	na	(1.35)	(1.72)	(2.19)
$25	(0.92)	(2.61)	na	na	(1.70)	(2.16)	(2.76)
$30	(1.15)	(3.27)	na	na	(2.13)	(2.70)	(3.45)
$35	(1.34)	(3.81)	na	na	(2.48)	(3.15)	(4.02)
$40	(1.55)	(4.40)	na	na	(2.87)	(3.64)	(4.65)
$45	(1.77)	(5.03)	na	na	(3.27)	(4.16)	(5.31)
$50	(1.97)	(5.59)	na	na	(3.64)	(4.63)	(5.91)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$10	(0.38)	(1.08)	na	na	(0.70)	(0.89)	(1.14)
$15	(0.56)	(1.59)	na	na	(1.04)	(1.32)	(1.68)
$20	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
$25	(1.09)	(3.10)	na	na	(2.02)	(2.56)	(3.27)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	(0.01)	(0.03)	na	na	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$20	(0.07)	(0.20)	na	na	(0.13)	(0.16)	(0.21)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.08)	(0.23)	na	na	(0.15)	(0.19)	(0.24)
$25	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$35	(0.25)	(0.71)	na	na	(0.46)	(0.59)	(0.75)
$50	(0.37)	(1.05)	na	na	(0.68)	(0.87)	(1.11)
$60	(0.44)	(1.25)	na	na	(0.81)	(1.03)	(1.32)
$75	(0.63)	(1.79)	na	na	(1.17)	(1.48)	(1.89)
$100	(0.81)	(2.30)	na	na	(1.50)	(1.90)	(2.43)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	na	na	0.00	0.00	0.00
$15	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
$25	(0.09)	(0.26)	na	na	(0.17)	(0.21)	(0.27)
$35	(0.15)	(0.43)	na	na	(0.28)	(0.35)	(0.45)
$50	(0.26)	(0.74)	na	na	(0.48)	(0.61)	(0.78)
$60	(0.30)	(0.85)	na	na	(0.56)	(0.71)	(0.90)
$75	(0.39)	(1.11)	na	na	(0.72)	(0.92)	(1.17)
$100	(0.56)	(1.59)	na	na	(1.04)	(1.32)	(1.68)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(3.37)	(9.57)	na	na	(6.23)	(7.92)	(10.11)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(5.27)	(14.97)	na	na	(9.75)	(12.38)	(15.81)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	(0.43)	(1.22)	na	na	(0.80)	(1.01)	(1.29)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	(0.02)	(0.05)	na	na	(0.04)	(0.05)	(0.06)
$25	(0.02)	(0.05)	na	na	(0.03)	(0.04)	(0.06)
$30	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$35	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$40	(0.04)	(0.11)	na	na	(0.08)	(0.09)	(0.12)
$45	(0.04)	(0.12)	na	na	(0.07)	(0.09)	(0.12)
$50	(0.04)	(0.11)	na	na	(0.07)	(0.09)	(0.12)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$20	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
$25	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-
$60	-	-	na	na	-	-	-
$75	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
$100	(0.02)	(0.06)	na	na	(0.04)	(0.04)	(0.06)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-
$60	-	-	na	na	-	-	-
$75	-	-	na	na	-	-	-
$100	(0.02)	(0.06)	na	na	(0.04)	(0.05)	(0.06)
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	(0.06)	(0.17)	na	na	(0.11)	(0.14)	(0.18)
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	(0.10)	(0.29)	na	na	(0.19)	(0.23)	(0.30)
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO - 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%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$20	2.8%	2.5%	n/a	n/a	3.1%	3.0%	2.8%
$25	2.2%	2.0%	n/a	n/a	1.8%	1.9%	2.2%
$30	1.8%	1.9%	n/a	n/a	1.9%	1.5%	1.8%
$35	1.5%	1.6%	n/a	n/a	1.6%	1.6%	1.5%
$40	2.6%	2.6%	n/a	n/a	2.9%	2.5%	2.6%
$45	2.3%	2.4%	n/a	n/a	2.2%	2.2%	2.3%
$50	2.1%	2.0%	n/a	n/a	2.0%	2.0%	2.1%
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	3.7%	3.9%	n/a	n/a	4.0%	3.9%	3.7%
$20	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
$25	1.9%	2.0%	n/a	n/a	2.0%	2.0%	1.9%
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $25 Copay]**				
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$10	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$20	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Copay			**Pre-Hospital Emergency Services [std: $0]**				
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$50	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$60	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$75	3.3%	3.5%	n/a	n/a	3.5%	3.5%	3.3%
$100	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$25	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$35	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$50	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$60	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$75	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$100	3.7%	3.9%	n/a	n/a	4.0%	3.9%	3.7%
			Surgery [std: $0 copay]				
			Copay per procedure of minimum of [20%, $300]				
	1.8%	1.8%	n/a	n/a	1.8%	1.8%	1.8%
			Diagnostic and Therapeutic Radiology [std: $0]				
			Copay per procedure of minimum (20%, $100); $500 annual maximum				
	1.9%	2.0%	n/a	n/a	2.0%	1.9%	1.9%
			Diagnostic Testing [std: $0]				
			Copay per procedure minimum of [20%, $100], $500 annual maximum				
	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
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
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%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC HMO PREMIUM
October 01, 2013 - December 31, 2013 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	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%
30	0.0%	7.2%	n/a	n/a	9.5%	0.0%	9.5%
			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%	6.3%	n/a	n/a	8.4%	0.0%	8.4%
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	0.0%	1.7%	n/a	n/a	2.3%	0.0%	2.3%
			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%	0.3%	n/a	n/a	0.4%	0.0%	0.4%
			Class II Dependents				
	0.0%	2.9%	n/a	n/a	3.8%	0.0%	3.8%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
30	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%
			Class II Dependents				
	0.0%	0.0%	na	na	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COPMREHEALTH HMO
DEPENDENT VARIABLES - APPLIED TO TOTAL ECC 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	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
30	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Year				
19	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
20	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
21	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
22	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
Full-time Students [std: covered to 23 end of year]							
Age			**End of Year**				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			End of Month				
23	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
24	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
25	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
26	#VALUE!	#VALUE!	na	na	#VALUE!	#VALUE!	#######
			Grandchildren				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%
			Class II Dependents				
	#DIV/0!	0.0%	na	na	0.0%	#DIV/0!	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.36	12.38	na	na	8.07	10.25	13.08
60	5.21	14.80	na	na	9.64	12.24	15.63
90	5.77	16.39	na	na	10.67	13.56	17.31
Unlimited	5.85	16.61	na	na	10.82	13.75	17.55
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.07	20.08	na	na	13.08	16.61	21.21
60	7.46	21.19	na	na	13.80	17.53	22.38
90	7.75	22.01	na	na	14.34	18.21	23.25
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	5.91	16.78	na	na	10.93	13.89	17.73
30	6.94	19.71	na	na	12.84	16.31	20.82
40	7.61	21.61	na	na	14.08	17.88	22.83
60	8.26	23.46	na	na	15.28	19.41	24.78
Unlimited	8.35	23.71	na	na	15.45	19.62	25.05
SMALL GROUP	**$5 Copay**						
20	5.57	15.82	na	na	10.30	13.09	16.71
30	6.52	18.52	na	na	12.06	15.32	19.56
40	7.15	20.31	na	na	13.23	16.80	21.45
60	7.76	22.04	na	na	14.36	18.24	23.28
Unlimited	7.84	22.27	na	na	14.50	18.42	23.52
SMALL GROUP	**$10 Copay**						
20	5.19	14.74	na	na	9.60	12.20	15.57
30	6.08	17.27	na	na	11.25	14.29	18.24
40	6.66	18.91	na	na	12.32	15.65	19.98
60	7.23	20.53	na	na	13.38	16.99	21.69
Unlimited	7.33	20.82	na	na	13.56	17.23	21.99
SMALL GROUP	**$15 Copay**						
20	4.87	13.83	na	na	9.01	11.44	14.61
30	5.70	16.19	na	na	10.55	13.40	17.10
40	6.25	17.75	na	na	11.56	14.69	18.75
60	6.80	19.31	na	na	12.58	15.98	20.40
Unlimited	6.86	19.48	na	na	12.69	16.12	20.58
SMALL GROUP	**$20 Copay**						
20	4.58	13.01	na	na	8.47	10.76	13.74
30	5.37	15.25	na	na	9.93	12.62	16.11
40	5.88	16.70	na	na	10.88	13.82	17.64
60	6.40	18.18	na	na	11.84	15.04	19.20
Unlimited	6.46	18.35	na	na	11.95	15.18	19.38
SMALL GROUP	**$25 Copay**						
20	4.27	12.13	na	na	7.90	10.03	12.81
30	5.00	14.20	na	na	9.25	11.75	15.00
40	5.45	15.48	na	na	10.08	12.81	16.35
60	5.93	16.84	na	na	10.97	13.94	17.79
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP	**$30 Copay**						
20	4.10	11.64	na	na	7.59	9.64	12.30
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.26	14.94	na	na	9.73	12.36	15.78
60	5.76	16.36	na	na	10.66	13.54	17.28
Unlimited	5.80	16.47	na	na	10.73	13.63	17.40
SMALL GROUP	**$35 Copay**						
20	3.99	11.33	na	na	7.38	9.38	11.97
30	4.67	13.26	na	na	8.64	10.97	14.01
40	5.14	14.60	na	na	9.51	12.08	15.42
60	5.57	15.82	na	na	10.30	13.09	16.71
Unlimited	5.61	15.93	na	na	10.38	13.18	16.83
SMALL GROUP	**$40 Copay**						
20	3.88	11.02	na	na	7.18	9.12	11.64
30	4.54	12.89	na	na	8.40	10.67	13.62
40	4.97	14.11	na	na	9.19	11.68	14.91
60	5.39	15.31	na	na	9.97	12.67	16.17
Unlimited	5.44	15.45	na	na	10.06	12.78	16.32
SMALL GROUP	**$45 Copay**						
20	3.76	10.68	na	na	6.96	8.84	11.28
30	4.40	12.50	na	na	8.14	10.34	13.20
40	4.81	13.66	na	na	8.90	11.30	14.43

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	4.44	12.61	na	na	8.21	10.43	13.32
60	5.31	15.08	na	na	9.82	12.48	15.93
90	5.89	16.73	na	na	10.90	13.84	17.67
Unlimited	5.97	16.95	na	na	11.04	14.03	17.91
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	7.21	20.48	na	na	13.34	16.94	21.63
60	7.61	21.61	na	na	14.08	17.88	22.83
90	7.91	22.46	na	na	14.63	18.59	23.73
Unlimited	8.00	22.72	na	na	14.80	18.80	24.00
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	0.00	0.00	na	na	0.00	0.00	0.00
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	6.03	17.13	na	na	11.16	14.17	18.09
30	7.08	20.11	na	na	13.10	16.64	21.24
40	7.77	22.07	na	na	14.37	18.26	23.31
60	8.42	23.91	na	na	15.58	19.79	25.26
Unlimited	8.51	24.17	na	na	15.74	20.00	25.53
SMALL GROUP	**$5 Copay**						
20	5.69	16.16	na	na	10.53	13.37	17.07
30	6.66	18.91	na	na	12.32	15.65	19.98
40	7.29	20.70	na	na	13.49	17.13	21.87
60	7.92	22.49	na	na	14.65	18.61	23.76
Unlimited	8.00	22.72	na	na	14.80	18.80	24.00
SMALL GROUP	**$10 Copay**						
20	5.29	15.02	na	na	9.79	12.43	15.87
30	6.20	17.61	na	na	11.47	14.57	18.60
40	6.80	19.31	na	na	12.58	15.98	20.40
60	7.37	20.93	na	na	13.63	17.32	22.11
Unlimited	7.47	21.21	na	na	13.82	17.55	22.41
SMALL GROUP	**$15 Copay**						
20	4.97	14.11	na	na	9.19	11.68	14.91
30	5.82	16.53	na	na	10.77	13.68	17.46
40	6.37	18.09	na	na	11.78	14.97	19.11
60	6.94	19.71	na	na	12.84	16.31	20.82
Unlimited	7.00	19.88	na	na	12.95	16.45	21.00
SMALL GROUP	**$20 Copay**						
20	4.68	13.29	na	na	8.66	11.00	14.04
30	5.47	15.53	na	na	10.12	12.85	16.41
40	6.00	17.04	na	na	11.10	14.10	18.00
60	6.52	18.52	na	na	12.06	15.32	19.56
Unlimited	6.59	18.72	na	na	12.19	15.49	19.77
SMALL GROUP	**$25 Copay**						
20	4.35	12.35	na	na	8.05	10.22	13.05
30	5.10	14.48	na	na	9.44	11.99	15.30
40	5.56	15.79	na	na	10.29	13.07	16.68
60	6.05	17.18	na	na	11.19	14.22	18.15
Unlimited	6.11	17.35	na	na	11.30	14.36	18.33
SMALL GROUP	**$30 Copay**						
20	4.18	11.87	na	na	7.73	9.82	12.54
30	4.92	13.97	na	na	9.10	11.56	14.76
40	5.36	15.22	na	na	9.92	12.60	16.08
60	5.88	16.70	na	na	10.88	13.82	17.64
Unlimited	5.92	16.81	na	na	10.95	13.91	17.76
SMALL GROUP	**$35 Copay**						
20	4.07	11.56	na	na	7.53	9.56	12.21
30	4.77	13.55	na	na	8.82	11.21	14.31
40	5.24	14.88	na	na	9.69	12.31	15.72
60	5.69	16.16	na	na	10.53	13.37	17.07
Unlimited	5.73	16.27	na	na	10.60	13.47	17.19
SMALL GROUP	**$40 Copay**						
20	3.96	11.25	na	na	7.33	9.31	11.88
30	4.64	13.18	na	na	8.58	10.90	13.92
40	5.07	14.40	na	na	9.38	11.91	15.21
60	5.49	15.59	na	na	10.16	12.90	16.47
Unlimited	5.54	15.73	na	na	10.25	13.02	16.62
SMALL GROUP	**$45 Copay**						
20	3.84	10.91	na	na	7.10	9.02	11.52
30	4.48	12.72	na	na	8.29	10.53	13.44
40	4.91	13.94	na	na	9.08	11.54	14.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.08	0.23	na	na	0.14	0.18	0.24
60	0.10	0.28	na	na	0.18	0.24	0.30
90	0.12	0.34	na	na	0.23	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	0.14	0.40	na	na	0.26	0.33	0.42
60	0.15	0.42	na	na	0.28	0.35	0.45
90	0.16	0.45	na	na	0.29	0.38	0.48
Unlimited	0.16	0.45	na	na	0.30	0.38	0.48
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	-	-	na	na	-	-	-
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	0.12	0.35	na	na	0.23	0.28	0.36
30	0.14	0.40	na	na	0.26	0.33	0.42
40	0.16	0.46	na	na	0.29	0.38	0.48
60	0.16	0.45	na	na	0.30	0.38	0.48
Unlimited	0.16	0.46	na	na	0.29	0.38	0.48
SMALL GROUP	**$5 Copay**						
20	0.12	0.34	na	na	0.23	0.28	0.36
30	0.14	0.39	na	na	0.26	0.33	0.42
40	0.14	0.39	na	na	0.26	0.33	0.42
60	0.16	0.45	na	na	0.29	0.37	0.48
Unlimited	0.16	0.45	na	na	0.30	0.38	0.48
SMALL GROUP	**$10 Copay**						
20	0.10	0.28	na	na	0.19	0.23	0.30
30	0.12	0.34	na	na	0.22	0.28	0.36
40	0.14	0.40	na	na	0.26	0.33	0.42
60	0.14	0.40	na	na	0.25	0.33	0.42
Unlimited	0.14	0.39	na	na	0.26	0.32	0.42
SMALL GROUP	**$15 Copay**						
20	0.10	0.28	na	na	0.18	0.24	0.30
30	0.12	0.34	na	na	0.22	0.28	0.36
40	0.12	0.34	na	na	0.22	0.28	0.36
60	0.14	0.40	na	na	0.26	0.33	0.42
Unlimited	0.14	0.40	na	na	0.26	0.33	0.42
SMALL GROUP	**$20 Copay**						
20	0.10	0.28	na	na	0.19	0.24	0.30
30	0.10	0.28	na	na	0.19	0.23	0.30
40	0.12	0.34	na	na	0.22	0.28	0.36
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.13	0.37	na	na	0.24	0.31	0.39
SMALL GROUP	**$25 Copay**						
20	0.08	0.22	na	na	0.15	0.19	0.24
30	0.10	0.28	na	na	0.19	0.24	0.30
40	0.11	0.31	na	na	0.21	0.26	0.33
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP	**$30 Copay**						
20	0.08	0.23	na	na	0.14	0.18	0.24
30	0.10	0.28	na	na	0.18	0.23	0.30
40	0.10	0.28	na	na	0.19	0.24	0.30
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP	**$35 Copay**						
20	0.08	0.23	na	na	0.15	0.18	0.24
30	0.10	0.29	na	na	0.18	0.24	0.30
40	0.10	0.28	na	na	0.18	0.23	0.30
60	0.12	0.34	na	na	0.23	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.29	0.36
SMALL GROUP	**$40 Copay**						
20	0.08	0.23	na	na	0.15	0.19	0.24
30	0.10	0.29	na	na	0.18	0.23	0.30
40	0.10	0.29	na	na	0.19	0.23	0.30
60	0.10	0.28	na	na	0.19	0.23	0.30
Unlimited	0.10	0.28	na	na	0.19	0.24	0.30
SMALL GROUP	**$45 Copay**						
20	0.08	0.23	na	na	0.14	0.18	0.24
30	0.08	0.22	na	na	0.15	0.19	0.24
40	0.10	0.28	na	na	0.18	0.24	0.30

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
SMALL GROUP	**Inpatient Mental Health Care [minimum mandatory coverage: 30 days]**						
# Days	**[Copay same as Inpatient Facility] ***						
30	1.8%	1.9%	n/a	n/a	1.7%	1.8%	1.8%
60	1.9%	1.9%	n/a	n/a	1.9%	2.0%	1.9%
90	2.1%	2.1%	n/a	n/a	2.2%	2.1%	2.1%
Unlimited	2.1%	2.0%	n/a	n/a	2.0%	2.0%	2.1%
SMALL GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage**						
# Days	**[Copay same as Inpatient Facility] ***						
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
90	2.1%	2.0%	n/a	n/a	2.0%	2.1%	2.1%
Unlimited	2.0%	2.0%	n/a	n/a	2.1%	2.1%	2.0%
SMALL GROUP	**** Small Group Premium Credit [above rates must be reduced by premium credit]***						
Inpatient Mental Hlth	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
	Outpatient Mental Health Care [minimum mandatory coverage: 20 visit limit] ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]						
SMALL GROUP	**$0 Copay**						
20	2.0%	2.1%	n/a	n/a	2.1%	2.0%	2.0%
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
40	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
60	1.9%	1.9%	n/a	n/a	2.0%	2.0%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
SMALL GROUP	**$5 Copay**						
20	2.2%	2.1%	n/a	n/a	2.2%	2.1%	2.2%
30	2.1%	2.1%	n/a	n/a	2.2%	2.2%	2.1%
40	2.0%	1.9%	n/a	n/a	2.0%	2.0%	2.0%
60	2.1%	2.0%	n/a	n/a	2.0%	2.0%	2.1%
Unlimited	2.0%	2.0%	n/a	n/a	2.1%	2.1%	2.0%
SMALL GROUP	**$10 Copay**						
20	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
40	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
60	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
SMALL GROUP	**$15 Copay**						
20	2.1%	2.0%	n/a	n/a	2.0%	2.1%	2.1%
30	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
40	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
60	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
Unlimited	2.0%	2.1%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP	**$20 Copay**						
20	2.2%	2.2%	n/a	n/a	2.2%	2.2%	2.2%
30	1.9%	1.8%	n/a	n/a	1.9%	1.8%	1.9%
40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP	**$25 Copay**						
20	1.9%	1.8%	n/a	n/a	1.9%	1.9%	1.9%
30	2.0%	2.0%	n/a	n/a	2.1%	2.0%	2.0%
40	2.0%	2.0%	n/a	n/a	2.1%	2.0%	2.0%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP	**$30 Copay**						
20	2.0%	2.0%	n/a	n/a	1.8%	1.9%	2.0%
30	2.1%	2.0%	n/a	n/a	2.0%	2.0%	2.1%
40	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
60	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
Unlimited	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
SMALL GROUP	**$35 Copay**						
20	2.0%	2.0%	n/a	n/a	2.0%	1.9%	2.0%
30	2.1%	2.2%	n/a	n/a	2.1%	2.2%	2.1%
40	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
60	2.2%	2.1%	n/a	n/a	2.2%	2.1%	2.2%
Unlimited	2.1%	2.1%	n/a	n/a	2.1%	2.2%	2.1%
SMALL GROUP	**$40 Copay**						
20	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
30	2.2%	2.2%	n/a	n/a	2.1%	2.2%	2.2%
40	2.0%	2.1%	n/a	n/a	2.1%	2.0%	2.0%
60	1.9%	1.8%	n/a	n/a	1.9%	1.8%	1.9%
Unlimited	1.8%	1.8%	n/a	n/a	1.9%	1.9%	1.8%
SMALL GROUP	**$45 Copay**						
20	2.1%	2.2%	n/a	n/a	2.0%	2.0%	2.1%
30	1.8%	1.8%	n/a	n/a	1.8%	1.8%	1.8%
40	2.1%	2.0%	n/a	n/a	2.0%	2.1%	2.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	5.23	14.85	na	na	9.68	12.29	15.69
Unlimited	5.26	14.94	na	na	9.73	12.36	15.78
SMALL GROUP				**$50 Copay**			
20	3.64	10.34	na	na	6.73	8.55	10.92
30	4.28	12.16	na	na	7.92	10.06	12.84
40	4.67	13.26	na	na	8.64	10.97	14.01
60	5.06	14.37	na	na	9.36	11.89	15.18
Unlimited	5.12	14.54	na	na	9.47	12.03	15.36
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.01	19.91	na	na	12.97	16.47	21.03
30	7.62	21.64	na	na	14.10	17.91	22.86
40	7.97	22.63	na	na	14.74	18.73	23.91
60	8.37	23.77	na	na	15.48	19.67	25.11
Unlimited	8.46	24.03	na	na	15.65	19.88	25.38
SMALL GROUP				**$5 Copay**			
20	6.59	18.72	na	na	12.19	15.49	19.77
30	7.16	20.33	na	na	13.25	16.83	21.48
40	7.50	21.30	na	na	13.88	17.63	22.50
60	7.87	22.35	na	na	14.56	18.49	23.61
Unlimited	7.96	22.61	na	na	14.73	18.71	23.88
SMALL GROUP				**$10 Copay**			
20	6.16	17.49	na	na	11.40	14.48	18.48
30	6.67	18.94	na	na	12.34	15.67	20.01
40	7.00	19.88	na	na	12.95	16.45	21.00
60	7.35	20.87	na	na	13.60	17.27	22.05
Unlimited	7.42	21.07	na	na	13.73	17.44	22.26
SMALL GROUP				**$15 Copay**			
20	5.78	16.42	na	na	10.69	13.58	17.34
30	6.26	17.78	na	na	11.58	14.71	18.78
40	6.56	18.63	na	na	12.14	15.42	19.68
60	6.88	19.54	na	na	12.73	16.17	20.64
Unlimited	6.97	19.79	na	na	12.89	16.38	20.91
SMALL GROUP				**$20 Copay**			
20	5.43	15.42	na	na	10.05	12.76	16.29
30	5.88	16.70	na	na	10.88	13.82	17.64
40	6.17	17.52	na	na	11.41	14.50	18.51
60	6.48	18.40	na	na	11.99	15.23	19.44
Unlimited	6.55	18.60	na	na	12.12	15.39	19.65
SMALL GROUP				**$25 Copay**			
20	5.04	14.31	na	na	9.32	11.84	15.12
30	5.46	15.51	na	na	10.10	12.83	16.38
40	5.75	16.33	na	na	10.64	13.51	17.25
60	6.03	17.13	na	na	11.16	14.17	18.09
Unlimited	6.09	17.30	na	na	11.27	14.31	18.27
SMALL GROUP				**$30 Copay**			
20	4.88	13.86	na	na	9.03	11.47	14.64
30	5.27	14.97	na	na	9.75	12.38	15.81
40	5.56	15.79	na	na	10.29	13.07	16.68
60	5.82	16.53	na	na	10.77	13.68	17.46
Unlimited	5.87	16.67	na	na	10.86	13.79	17.61
SMALL GROUP				**$35 Copay**			
20	4.72	13.40	na	na	8.73	11.09	14.16
30	5.14	14.60	na	na	9.51	12.08	15.42
40	5.37	15.25	na	na	9.93	12.62	16.11
60	5.63	15.99	na	na	10.42	13.23	16.89
Unlimited	5.69	16.16	na	na	10.53	13.37	17.07
SMALL GROUP				**$40 Copay**			
20	4.59	13.04	na	na	8.49	10.79	13.77
30	4.99	14.17	na	na	9.23	11.73	14.97
40	5.21	14.80	na	na	9.64	12.24	15.63
60	5.46	15.51	na	na	10.10	12.83	16.38
Unlimited	5.54	15.73	na	na	10.25	13.02	16.62
SMALL GROUP				**$45 Copay**			
20	4.45	12.64	na	na	8.23	10.46	13.35
30	4.82	13.69	na	na	8.92	11.33	14.46
40	5.05	14.34	na	na	9.34	11.87	15.15
60	5.30	15.05	na	na	9.81	12.46	15.90
Unlimited	5.35	15.19	na	na	9.90	12.57	16.05
SMALL GROUP				**$50 Copay**			
20	4.32	12.27	na	na	7.99	10.15	12.96
30	4.67	13.26	na	na	8.64	10.97	14.01

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
60	5.33	15.14	na	na	9.86	12.53	15.99
Unlimited	5.36	15.22	na	na	9.92	12.60	16.08
SMALL GROUP				**$50 Copay**			
20	3.72	10.56	na	na	6.88	8.74	11.16
30	4.36	12.38	na	na	8.07	10.25	13.08
40	4.77	13.55	na	na	8.82	11.21	14.31
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.22	14.82	na	na	9.66	12.27	15.66
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	7.15	20.31	na	na	13.23	16.80	21.45
30	7.78	22.10	na	na	14.39	18.28	23.34
40	8.13	23.09	na	na	15.04	19.11	24.39
60	8.53	24.23	na	na	15.78	20.05	25.59
Unlimited	8.63	24.51	na	na	15.97	20.28	25.89
SMALL GROUP				**$5 Copay**			
20	6.73	19.11	na	na	12.45	15.82	20.19
30	7.30	20.73	na	na	13.51	17.16	21.90
40	7.66	21.75	na	na	14.17	18.00	22.98
60	8.03	22.81	na	na	14.86	18.87	24.09
Unlimited	8.12	23.06	na	na	15.02	19.08	24.36
SMALL GROUP				**$10 Copay**			
20	6.28	17.84	na	na	11.62	14.76	18.84
30	6.81	19.34	na	na	12.60	16.00	20.43
40	7.14	20.28	na	na	13.21	16.78	21.42
60	7.49	21.27	na	na	13.86	17.60	22.47
Unlimited	7.56	21.47	na	na	13.99	17.77	22.68
SMALL GROUP				**$15 Copay**			
20	5.90	16.76	na	na	10.92	13.87	17.70
30	6.38	18.12	na	na	11.80	14.99	19.14
40	6.70	19.03	na	na	12.40	15.75	20.10
60	7.02	19.94	na	na	12.99	16.50	21.06
Unlimited	7.11	20.19	na	na	13.15	16.71	21.33
SMALL GROUP				**$20 Copay**			
20	5.53	15.71	na	na	10.23	13.00	16.59
30	6.00	17.04	na	na	11.10	14.10	18.00
40	6.29	17.86	na	na	11.64	14.78	18.87
60	6.61	18.77	na	na	12.23	15.53	19.83
Unlimited	6.69	19.00	na	na	12.38	15.72	20.07
SMALL GROUP				**$25 Copay**			
20	5.14	14.60	na	na	9.51	12.08	15.42
30	5.57	15.82	na	na	10.30	13.09	16.71
40	5.87	16.67	na	na	10.86	13.79	17.61
60	6.15	17.47	na	na	11.38	14.45	18.45
Unlimited	6.21	17.64	na	na	11.49	14.59	18.63
SMALL GROUP				**$30 Copay**			
20	4.98	14.14	na	na	9.21	11.70	14.94
30	5.37	15.25	na	na	9.93	12.62	16.11
40	5.68	16.13	na	na	10.51	13.35	17.04
60	5.94	16.87	na	na	10.99	13.96	17.82
Unlimited	5.99	17.01	na	na	11.08	14.08	17.97
SMALL GROUP				**$35 Copay**			
20	4.82	13.69	na	na	8.92	11.33	14.46
30	5.24	14.88	na	na	9.69	12.31	15.72
40	5.47	15.53	na	na	10.12	12.85	16.41
60	5.75	16.33	na	na	10.64	13.51	17.25
Unlimited	5.81	16.50	na	na	10.75	13.65	17.43
SMALL GROUP				**$40 Copay**			
20	4.69	13.32	na	na	8.68	11.02	14.07
30	5.09	14.46	na	na	9.42	11.96	15.27
40	5.31	15.08	na	na	9.82	12.48	15.93
60	5.57	15.82	na	na	10.30	13.09	16.71
Unlimited	5.66	16.07	na	na	10.47	13.30	16.98
SMALL GROUP				**$45 Copay**			
20	4.53	12.87	na	na	8.38	10.65	13.59
30	4.92	13.97	na	na	9.10	11.56	14.76
40	5.15	14.63	na	na	9.53	12.10	15.45
60	5.40	15.34	na	na	9.99	12.69	16.20
Unlimited	5.45	15.48	na	na	10.08	12.81	16.35
SMALL GROUP				**$50 Copay**			
20	4.40	12.50	na	na	8.14	10.34	13.20
30	4.77	13.55	na	na	8.82	11.21	14.31

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	0.10	0.29	na	na	0.18	0.24	0.30
Unlimited	0.10	0.28	na	na	0.19	0.24	0.30
SMALL GROUP				**$50 Copay**			
20	0.08	0.22	na	na	0.15	0.19	0.24
30	0.08	0.22	na	na	0.15	0.19	0.24
40	0.10	0.29	na	na	0.18	0.24	0.30
60	0.10	0.28	na	na	0.19	0.24	0.30
Unlimited	0.10	0.28	na	na	0.19	0.24	0.30
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	0.14	0.40	na	na	0.26	0.33	0.42
30	0.16	0.46	na	na	0.29	0.37	0.48
40	0.16	0.46	na	na	0.30	0.38	0.48
60	0.16	0.46	na	na	0.30	0.38	0.48
Unlimited	0.17	0.48	na	na	0.32	0.40	0.51
SMALL GROUP				**$5 Copay**			
20	0.14	0.39	na	na	0.26	0.33	0.42
30	0.14	0.40	na	na	0.26	0.33	0.42
40	0.16	0.45	na	na	0.29	0.37	0.48
60	0.16	0.46	na	na	0.30	0.38	0.48
Unlimited	0.16	0.45	na	na	0.29	0.37	0.48
SMALL GROUP				**$10 Copay**			
20	0.12	0.35	na	na	0.22	0.28	0.36
30	0.14	0.40	na	na	0.26	0.33	0.42
40	0.14	0.40	na	na	0.26	0.33	0.42
60	0.14	0.40	na	na	0.26	0.33	0.42
Unlimited	0.14	0.40	na	na	0.26	0.33	0.42
SMALL GROUP				**$15 Copay**			
20	0.12	0.34	na	na	0.23	0.29	0.36
30	0.12	0.34	na	na	0.22	0.28	0.36
40	0.14	0.40	na	na	0.26	0.33	0.42
60	0.14	0.40	na	na	0.26	0.33	0.42
Unlimited	0.14	0.40	na	na	0.26	0.33	0.42
SMALL GROUP				**$20 Copay**			
20	0.10	0.29	na	na	0.18	0.24	0.30
30	0.12	0.34	na	na	0.22	0.28	0.36
40	0.12	0.34	na	na	0.23	0.28	0.36
60	0.13	0.37	na	na	0.24	0.30	0.39
Unlimited	0.14	0.40	na	na	0.26	0.33	0.42
SMALL GROUP				**$25 Copay**			
20	0.10	0.29	na	na	0.19	0.24	0.30
30	0.11	0.31	na	na	0.20	0.26	0.33
40	0.12	0.34	na	na	0.22	0.28	0.36
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP				**$30 Copay**			
20	0.10	0.28	na	na	0.18	0.23	0.30
30	0.10	0.28	na	na	0.18	0.24	0.30
40	0.12	0.34	na	na	0.22	0.28	0.36
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.29	0.36
SMALL GROUP				**$35 Copay**			
20	0.10	0.29	na	na	0.19	0.24	0.30
30	0.10	0.28	na	na	0.18	0.23	0.30
40	0.10	0.28	na	na	0.19	0.23	0.30
60	0.12	0.34	na	na	0.22	0.28	0.36
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP				**$40 Copay**			
20	0.10	0.28	na	na	0.19	0.23	0.30
30	0.10	0.29	na	na	0.19	0.23	0.30
40	0.10	0.28	na	na	0.18	0.24	0.30
60	0.11	0.31	na	na	0.20	0.26	0.33
Unlimited	0.12	0.34	na	na	0.22	0.28	0.36
SMALL GROUP				**$45 Copay**			
20	0.08	0.23	na	na	0.15	0.19	0.24
30	0.10	0.28	na	na	0.18	0.23	0.30
40	0.10	0.29	na	na	0.19	0.23	0.30
60	0.10	0.29	na	na	0.18	0.23	0.30
Unlimited	0.10	0.29	na	na	0.18	0.24	0.30
SMALL GROUP				**$50 Copay**			
20	0.08	0.23	na	na	0.15	0.19	0.24
30	0.10	0.29	na	na	0.18	0.24	0.30

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
60	1.9%	2.0%	n/a	n/a	1.9%	2.0%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
SMALL GROUP				**$50 Copay**			
20	2.2%	2.1%	n/a	n/a	2.2%	2.2%	2.2%
30	1.9%	1.8%	n/a	n/a	1.9%	1.9%	1.9%
40	2.1%	2.2%	n/a	n/a	2.1%	2.2%	2.1%
60	2.0%	1.9%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.0%	1.9%	n/a	n/a	2.0%	2.0%	2.0%
# Visits	**Outpatient Mental Health Care with Unlimited Bio and CSED Coverage ** [Copay same or less than Specialist Physician Office Visit] [not yet approved]**						
SMALL GROUP				**$0 Copay**			
20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
30	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP				**$5 Copay**			
20	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
40	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
60	2.0%	2.1%	n/a	n/a	2.1%	2.1%	2.0%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP				**$10 Copay**			
20	1.9%	2.0%	n/a	n/a	1.9%	1.9%	1.9%
30	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
SMALL GROUP				**$15 Copay**			
20	2.1%	2.1%	n/a	n/a	2.2%	2.1%	2.1%
30	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
40	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP				**$20 Copay**			
20	1.8%	1.9%	n/a	n/a	1.8%	1.9%	1.8%
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
40	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.1%	2.2%	n/a	n/a	2.1%	2.1%	2.1%
SMALL GROUP				**$25 Copay**			
20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
30	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
40	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
SMALL GROUP				**$30 Copay**			
20	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
30	1.9%	1.9%	n/a	n/a	1.8%	1.9%	1.9%
40	2.2%	2.2%	n/a	n/a	2.1%	2.1%	2.2%
60	2.1%	2.1%	n/a	n/a	2.0%	2.0%	2.1%
Unlimited	2.0%	2.0%	n/a	n/a	2.0%	2.1%	2.0%
SMALL GROUP				**$35 Copay**			
20	2.1%	2.2%	n/a	n/a	2.2%	2.2%	2.1%
30	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
40	1.9%	1.8%	n/a	n/a	1.9%	1.8%	1.9%
60	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
Unlimited	2.1%	2.1%	n/a	n/a	2.1%	2.1%	2.1%
SMALL GROUP				**$40 Copay**			
20	2.2%	2.1%	n/a	n/a	2.2%	2.1%	2.2%
30	2.0%	2.0%	n/a	n/a	2.1%	2.0%	2.0%
40	1.9%	1.9%	n/a	n/a	1.9%	2.0%	1.9%
60	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
Unlimited	2.2%	2.2%	n/a	n/a	2.1%	2.2%	2.2%
SMALL GROUP				**$45 Copay**			
20	1.8%	1.8%	n/a	n/a	1.8%	1.8%	1.8%
30	2.1%	2.0%	n/a	n/a	2.0%	2.0%	2.1%
40	2.0%	2.0%	n/a	n/a	2.0%	1.9%	2.0%
60	1.9%	1.9%	n/a	n/a	1.8%	1.8%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	1.8%	1.9%	1.9%
SMALL GROUP				**$50 Copay**			
20	1.9%	1.9%	n/a	n/a	1.9%	1.9%	1.9%
30	2.1%	2.2%	n/a	n/a	2.1%	2.2%	2.1%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	4.90	13.92	na	na	9.07	11.52	14.70
60	5.16	14.65	na	na	9.55	12.13	15.48
Unlimited	5.19	14.74	na	na	9.60	12.20	15.57
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - MENTAL HEALTH
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
40	5.00	14.20	na	na	9.25	11.75	15.00
60	5.26	14.94	na	na	9.73	12.36	15.78
Unlimited	5.29	15.02	na	na	9.79	12.43	15.87
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	0.00	0.00	na	na	0.00	0.00	0.00
$5	0.00	0.00	na	na	0.00	0.00	0.00
$10	0.00	0.00	na	na	0.00	0.00	0.00
$15	0.00	0.00	na	na	0.00	0.00	0.00
$20	0.00	0.00	na	na	0.00	0.00	0.00
$25	0.00	0.00	na	na	0.00	0.00	0.00
$30	0.00	0.00	na	na	0.00	0.00	0.00
$35	0.00	0.00	na	na	0.00	0.00	0.00
$40	0.00	0.00	na	na	0.00	0.00	0.00
$45	0.00	0.00	na	na	0.00	0.00	0.00
$50	0.00	0.00	na	na	0.00	0.00	0.00

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	0.10	0.28	na	na	0.18	0.23	0.30
60	0.10	0.29	na	na	0.18	0.23	0.30
Unlimited	0.10	0.28	na	na	0.19	0.23	0.30
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	-	-	na	na	-	-	-
$5	-	-	na	na	-	-	-
$10	-	-	na	na	-	-	-
$15	-	-	na	na	-	-	-
$20	-	-	na	na	-	-	-
$25	-	-	na	na	-	-	-
$30	-	-	na	na	-	-	-
$35	-	-	na	na	-	-	-
$40	-	-	na	na	-	-	-
$45	-	-	na	na	-	-	-
$50	-	-	na	na	-	-	-

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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
40	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
60	1.9%	2.0%	n/a	n/a	1.9%	1.9%	1.9%
Unlimited	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
SMALL GROUP Specialist Copay	Small Group Premium Credit - Outpatient Mental Health **[above rates must be reduced by premium credit] [not yet approved]						
$0	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$5	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$10	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$15	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$20	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$25	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$30	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$35	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$40	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$45	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
$50	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!

Bio = Biologically Based
CSED = Childhood Serious Emotional Disturbances

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	5.19	14.74	na	na	9.60	12.20	15.57
$0/Max $5000	4.90	13.92	na	na	9.07	11.52	14.70
$0/Max $2500	4.60	13.06	na	na	8.51	10.81	13.80
$25	4.90	13.92	na	na	9.07	11.52	14.70
$50	4.60	13.06	na	na	8.51	10.81	13.80
$100	4.23	12.01	na	na	7.83	9.94	12.69
$500	2.04	5.79	na	na	3.77	4.79	6.12
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.15	11.79	na	na	7.68	9.75	12.45
25%	3.90	11.08	na	na	7.22	9.17	11.70
30%	3.63	10.31	na	na	6.72	8.53	10.89
Deductible			**Orthotics Riders**				
$0	0.90	2.56	na	na	1.67	2.12	2.70
$0/Max $5000	0.83	2.36	na	na	1.54	1.95	2.49
$0/Max $2500	0.79	2.24	na	na	1.46	1.86	2.37
$25	0.83	2.36	na	na	1.54	1.95	2.49
$50	0.79	2.24	na	na	1.46	1.86	2.37
$100	0.72	2.04	na	na	1.33	1.69	2.16
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.72	2.04	na	na	1.33	1.69	2.16
25%	0.69	1.96	na	na	1.28	1.62	2.07
30%	0.65	1.85	na	na	1.20	1.53	1.95
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.72	4.88	na	na	3.18	4.04	5.16
12 Months	2.75	7.81	na	na	5.09	6.46	8.25
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.69	7.64	na	na	4.98	6.32	8.07
12 Months	4.28	12.16	na	na	7.92	10.06	12.84
			Private Duty Nursing Riders				
In Full	0.69	1.96	na	na	1.28	1.62	2.07
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.52	1.48	na	na	0.96	1.22	1.56
Limit			**Infertility Rider**				
2 IVF	10.95	31.10	na	na	20.26	25.73	32.85
3 IVF	13.24	37.60	na	na	24.49	31.11	39.72
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.52	12.84	na	na	8.36	10.62	13.56
			Health Club Reimbursement				
$200 per year	1.30	3.69	na	na	2.41	3.06	3.90
			Wellness Rider				
Inclusion	1.06	3.01	na	na	1.96	2.49	3.18
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - RIDERS
October 01, 2013 - December 31, 2013 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	5.29	15.02	na	na	9.79	12.43	15.87
$0/Max $5000	5.00	14.20	na	na	9.25	11.75	15.00
$0/Max $2500	4.70	13.35	na	na	8.70	11.05	14.10
$25	5.00	14.20	na	na	9.25	11.75	15.00
$50	4.70	13.35	na	na	8.70	11.05	14.10
$100	4.31	12.24	na	na	7.97	10.13	12.93
$500	2.08	5.91	na	na	3.85	4.89	6.24
$5,000	0.33	0.94	na	na	0.61	0.78	0.99
Coinsurance							
20%	4.23	12.01	na	na	7.83	9.94	12.69
25%	3.98	11.30	na	na	7.36	9.35	11.94
30%	3.71	10.54	na	na	6.86	8.72	11.13
Deductible			**Orthotics Riders**				
$0	0.92	2.61	na	na	1.70	2.16	2.76
$0/Max $5000	0.85	2.41	na	na	1.57	2.00	2.55
$0/Max $2500	0.81	2.30	na	na	1.50	1.90	2.43
$25	0.85	2.41	na	na	1.57	2.00	2.55
$50	0.81	2.30	na	na	1.50	1.90	2.43
$100	0.74	2.10	na	na	1.37	1.74	2.22
$500	0.37	1.05	na	na	0.68	0.87	1.11
$5,000	0.03	0.09	na	na	0.06	0.07	0.09
Coinsurance							
20%	0.74	2.10	na	na	1.37	1.74	2.22
25%	0.71	2.02	na	na	1.31	1.67	2.13
30%	0.67	1.90	na	na	1.24	1.57	2.01
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	na	na	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.76	5.00	na	na	3.26	4.14	5.28
12 Months	2.81	7.98	na	na	5.20	6.60	8.43
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.75	7.81	na	na	5.09	6.46	8.25
12 Months	4.36	12.38	na	na	8.07	10.25	13.08
			Private Duty Nursing Riders				
In Full	0.71	2.02	na	na	1.31	1.67	2.13
80% hrs 73-504	0.09	0.26	na	na	0.17	0.21	0.27
100% hrs 73-504	0.20	0.57	na	na	0.37	0.47	0.60
			Dental Network Access				
	0.54	1.53	na	na	1.00	1.27	1.62
Limit			**Infertility Rider**				
2 IVF	11.17	31.72	na	na	20.66	26.25	33.51
3 IVF	13.50	38.34	na	na	24.98	31.73	40.50
			Complementary Alternative Medicine (CAM)				
$20 Copay	4.62	13.12	na	na	8.55	10.86	13.86
			Health Club Reimbursement				
$200 per year	1.32	3.75	na	na	2.44	3.10	3.96
			Wellness Rider				
Inclusion	1.08	3.07	na	na	2.00	2.54	3.24
			Nurse Advice Line Rider				
	0.33	0.89	na	na	0.61	0.78	0.99

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	0.10	0.28	na	na	0.19	0.23	0.30
$0/Max $5000	0.10	0.28	na	na	0.18	0.23	0.30
$0/Max $2500	0.10	0.29	na	na	0.19	0.24	0.30
$25	0.10	0.28	na	na	0.18	0.23	0.30
$50	0.10	0.29	na	na	0.19	0.24	0.30
$100	0.08	0.23	na	na	0.14	0.19	0.24
$500	0.04	0.12	na	na	0.08	0.10	0.12
$5,000	-	-	na	na	-	-	-
Coinsurance							
20%	0.08	0.22	na	na	0.15	0.19	0.24
25%	0.08	0.22	na	na	0.14	0.18	0.24
30%	0.08	0.23	na	na	0.14	0.19	0.24
Deductible			**Orthotics Riders**				
$0	0.02	0.05	na	na	0.03	0.04	0.06
$0/Max $5000	0.02	0.05	na	na	0.03	0.05	0.06
$0/Max $2500	0.02	0.06	na	na	0.04	0.04	0.06
$25	0.02	0.05	na	na	0.03	0.05	0.06
$50	0.02	0.06	na	na	0.04	0.04	0.06
$100	0.02	0.06	na	na	0.04	0.05	0.06
$500	-	-	na	na	-	-	-
$5,000	-	-	na	na	-	-	-
Coinsurance							
20%	0.02	0.06	na	na	0.04	0.05	0.06
25%	0.02	0.06	na	na	0.03	0.05	0.06
30%	0.02	0.05	na	na	0.04	0.04	0.06
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	-	-	na	na	-	-	-
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	0.04	0.12	na	na	0.08	0.10	0.12
12 Months	0.06	0.17	na	na	0.11	0.14	0.18
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	0.06	0.17	na	na	0.11	0.14	0.18
12 Months	0.08	0.22	na	na	0.15	0.19	0.24
			Private Duty Nursing Riders				
In Full	0.02	0.06	na	na	0.03	0.05	0.06
80% hrs 73-504	-	-	na	na	-	-	-
100% hrs 73-504	-	-	na	na	-	-	-
			Dental Network Access				
	0.02	0.05	na	na	0.04	0.05	0.06
Limit			**Infertility Rider**				
2 IVF	0.22	0.62	na	na	0.40	0.52	0.66
3 IVF	0.26	0.74	na	na	0.49	0.62	0.78
			Complementary Alternative Medicine (CAM)				
$20 Copay	0.10	0.28	na	na	0.19	0.24	0.30
			Health Club Reimbursement				
$200 per year	0.02	0.06	na	na	0.03	0.04	0.06
			Wellness Rider				
Inclusion	0.02	0.06	na	na	0.04	0.05	0.06
			Nurse Advice Line Rider				
	-	-	na	na	-	-	-

HEALTH INSURANCE PLAN OF GREATER NEW YORK
4th Quarter Small Group RATE MANUAL
EMBLEMHEALTH COMPREHEALTH HMO - 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	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
$0/Max $5000	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$0/Max $2500	2.2%	2.2%	n/a	n/a	2.2%	2.2%	2.2%
$25	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
$50	2.2%	2.2%	n/a	n/a	2.2%	2.2%	2.2%
$100	1.9%	1.9%	n/a	n/a	1.8%	1.9%	1.9%
$500	2.0%	2.1%	n/a	n/a	2.1%	2.1%	2.0%
$5,000	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Coinsurance							
20%	1.9%	1.9%	n/a	n/a	2.0%	1.9%	1.9%
25%	2.1%	2.0%	n/a	n/a	1.9%	2.0%	2.1%
30%	2.2%	2.2%	n/a	n/a	2.1%	2.2%	2.2%
Deductible			**Orthotics Riders**				
$0	2.2%	2.0%	n/a	n/a	1.8%	1.9%	2.2%
$0/Max $5000	2.4%	2.1%	n/a	n/a	1.9%	2.6%	2.4%
$0/Max $2500	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
$25	2.4%	2.1%	n/a	n/a	1.9%	2.6%	2.4%
$50	2.5%	2.7%	n/a	n/a	2.7%	2.2%	2.5%
$100	2.8%	2.9%	n/a	n/a	3.0%	3.0%	2.8%
$500	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
$5,000	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
Coinsurance							
20%	2.8%	2.9%	n/a	n/a	3.0%	3.0%	2.8%
25%	2.9%	3.1%	n/a	n/a	2.3%	3.1%	2.9%
30%	3.1%	2.7%	n/a	n/a	3.3%	2.6%	3.1%
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	#DIV/0!	#DIV/0!	n/a	n/a	#DIV/0!	#DIV/0!	#DIV/0!
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	2.3%	2.5%	n/a	n/a	2.5%	2.5%	2.3%
12 Months	2.2%	2.2%	n/a	n/a	2.2%	2.2%	2.2%
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.2%	2.2%	n/a	n/a	2.2%	2.2%	2.2%
12 Months	1.9%	1.8%	n/a	n/a	1.9%	1.9%	1.9%
			Private Duty Nursing Riders				
In Full	2.9%	3.1%	n/a	n/a	2.3%	3.1%	2.9%
80% hrs 73-504	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
100% hrs 73-504	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%
			Dental Network Access				
	3.8%	3.4%	n/a	n/a	4.2%	4.1%	3.8%
Limit			**Infertility Rider**				
2 IVF	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
3 IVF	2.0%	2.0%	n/a	n/a	2.0%	2.0%	2.0%
			Complementary Alternative Medicine (CAM)				
$20 Copay	2.2%	2.2%	n/a	n/a	2.3%	2.3%	2.2%
			Health Club Reimbursement				
$200 per year	1.5%	1.6%	n/a	n/a	1.2%	1.3%	1.5%
			Wellness Rider				
Inclusion	1.9%	2.0%	n/a	n/a	2.0%	2.0%	1.9%
			Nurse Advice Line Rider				
	0.0%	0.0%	n/a	n/a	0.0%	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
OCTOBER 1, 2012 - DECEMBER 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

GROUP CONTRACT - DRUG RIDERS
MONTHLY PREMIUMS EFFECTIVE 2011 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	(a) Deductible	(b) Deductible	(c) Generic & Brand Formulary	(d) Non-Formulary Brand

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
October 01, 2013 - December 31, 2013 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	(a) Deductible	(b) Deductible	(c) Generic & Brand Formulary	(d) Non-Formulary Brand

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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	-	-	-
$750 *	-	-	-
$1,000	-	-	-
$2,000	-	-	-
$2,500	-	-	-
$3,000	-	-	-
$4,000	-	-	-
$5,000	-	-	-
Unlimited	-	-	-

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	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

Table 3: Other Drug Rider Values pmpm

Brand	(a) Deductible	(b) Deductible	(c) Generic & Brand Formulary	(d) Non-Formulary Brand

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
GROUP CONTRACT - DRUG RIDERS

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	(a) Deductible	(b) Deductible	(c) Generic & Brand Formulary	(d) Non-Formulary Brand

Maximum	incl Generics	excl Generics	Coinsurance	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 Adjustm Applies only to New York City account	-10.0%
[e] IC Adjustmer Applies only to New York City account	-2.0%
[f] Product Facto HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
$0	2.50%
$0	0.00%
1Q2010-1Q2011	2.50%
2Q2011	4.10%
3Q2011-4Q2011	3.00%
1Q2012	3.00%
2Q2012 - 4Q2012	3.00%

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

Maximum	incl Generics	excl Generics	Coinsurance	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 Adjustm Applies only to New York City account	-10.0%	
[e] IC Adjustmer Applies only to New York City account	-2.0%	
[f] Product Facto HMO, Access I, and EPO	0.0%	
POS, Access II, and PPO	0.0%	
[g] Trend per Quarter		
1Q2010-1Q2011	2.5%	
2Q2011	4.1%	
3Q2011-4Q2011	3.0%	
1Q2012	3.0%	
2Q 2012 - 4Q 2012	3.0%	
1Q2013	-6.3%	0.0%
2Q2013	3.0%	0.0%
3Q2103	3.0%	1.0%
4Q2103	3.0%	1.0%
[h] Mandatory Women's Preventive Services	0.61	0.61

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	1.2179	1.2108
Family	3.2883	3.4387
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	1.2179	1.2108
EE + Child(ren	2.2531	2.2400
EE + Spouse	2.8621	2.8454
Family	3.6537	3.6324

Maximum	incl Generics	excl Generics	Coinsurance	Coinsurance
$0	-	-	-	-
$750 *	-	-	-	-
$1,000	-	-	-	-
$2,000	-	-	-	-
$2,500	-	-	-	-
$3,000	-	-	-	-
$4,000	-	-	-	-
$5,000	-	-	-	-
Unlimited	-	-	-	-

** Available to EmblemHealth Coordinated Care Plans only*

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates	
[a] Exclude Contraceptives	-	
[b] Annual Maximum to also include Generic Drugs:	-	
$1,000 (Brand & Generic)	-	
$2,000 (Brand & Generic)	-	
$2,500 (Brand & Generic)	-	
$3,000 (Brand & Generic)	-	
$4,000 (Brand & Generic)	-	
$5,000 (Brand & Generic)	-	
[c] Non Formulary Coverage, Generic Only Plans	-	
[d] PICA Adjustm Applies only to New York City account	-	
[e] IC Adjustmer Applies only to New York City account	-	
[f] Product Facto HMO, Access I, and EPO	-	
POS, Access II, and PPO	-	
[g] Trend per Quarter		
1Q2010-1Q2011	0.025	
2Q2011	0.016	
3Q2011-4Q2011	(0.011)	
1Q2012	-	
2Q 2012 - 4Q 2012	-	
$0	(0.030)	-
1Q2013	(0.063)	-
2Q2013	0.030	-
3Q2103	0.030	0.010
$0 4Q2103	0.030	0.010
$0	-	-
	0.610	0.610
$0		-

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	-	-
Family	-	-
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	-	-
EE + Child(ren	-	-
EE + Spouse	-	-
Family	-	-

Maximum	incl Generics	excl Generics	Coinsurance	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	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 Adjustmer Applies only to New York City account	0.0%
[f] Product Facto HMO, Access I, and EPO	#DIV/0!
POS, Access II, and PPO	#DIV/0!
[g] Trend per Quarter	-100.0%
1Q2010-1Q2011	#DIV/0!
2Q2011	64.0%
3Q2011-4Q2011	-26.8%
1Q2012	0.0%
2Q 2012 - 4Q 2012	0.0%
$0	-100.0%
1Q2013	#DIV/0!
$0	#DIV/0!

Table 5: Tier Conversion Factors

	HIP Small Group	Emblem Coordinated Care Plans Small Group
Two Tier		
Individual EE	0.0%	0.0%
Family	0.0%	0.0%
Three Tier		
Individual EE		
Two Persons		
Family		
Four Tier		
Individual EE	0.0%	0.0%
EE + Child(ren	0.0%	0.0%
EE + Spouse	0.0%	0.0%
Family	0.0%	0.0%

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th QUARTER 2012 SMALL GROUP RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
OCTOBER 1, 2012 - DECEMBER 31, 2012 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	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**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**1.000**	**not available**
	HIP*access* II	**not available**	**not available**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2012
HMO Groups	**115%**
Access I Groups	**115%**
POS Groups	**115%**
Access II Groups	**115%**

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
October 01, 2013 - December 31, 2013 MONTHLY PREMIUMS

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**1.000**	**1.074**
	POS, HIP*access* II	**-**	**-**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**1.000**	**1.028**
	POS, HIP*access* II	**-**	**-**
Upstate[2]			
	HMO, HIP*access* I	**1.000**	**not available**
	POS	**-**	**-**
	HIP*access* II	**-**	**-**

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2013
HMO Groups	**115%**
Access I Groups	**0%**
POS Groups	**0%**
Access II Groups	**0%**

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**-**	**-**
	POS, HIP*access* II	**(1.000)**	**(1.044)**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**-**	**-**
	POS, HIP*access* II	**(1.000)**	**(1.017)**
Upstate[2]			
	HMO, HIP*access* I	**-**	
	POS	**(1.000)**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**-**
Access I Groups	**(1.150)**
POS Groups	**(1.150)**
Access II Groups	**(1.150)**

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).

HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HIP INSURANCE COMPANY OF NEW YORK
4th Quarter Small Group RATE MANUAL
HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors

NETWORK AREA FACTORS

Area[1]/Plans	Product	HIP Prime	VYTRA Premium
Long Island			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
New York City, Westchester, Rockland and Orange Counties			
	HMO, HIP*access* I	**0.0%**	**0.0%**
	POS, HIP*access* II	**-100.0%**	**-100.0%**
Upstate[2]			
	HMO, HIP*access* I	**0.0%**	
	POS	**-100.0%**	
	HIP*access* II		

1 Based on employer location
2 Upstate counties include Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington counties

SOLE PROPIETOR FACTORS

	2011
HMO Groups	**0.0%**
Access I Groups	**-100.0%**
POS Groups	**-100.0%**
Access II Groups	**-100.0%**

Methodology

(1) Determine from the Rate Manual the premium rates that would apply to a small group contract with the the requested benefit program.

(2) Sole Proprietor premium rates are equal to the small group tier rates calculated in (1) multiplied by the Sole Proprietor rate factor (rounded down).