Exhibit B

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Copay Plan - $10 ($0 Inpatient) (GR-94-CS/11B)					
No Longer Available for Sale					
TWO TIER	SINGLE	888.70	857.48	784.05	736.42
	FAMILY	2,266.31	2,186.47	1,999.37	1,877.98
THREE TIER	SINGLE	888.70	857.48	784.05	736.42
	DOUBLE	1,866.33	1,800.67	1,646.58	1,546.63
	FAMILY	2,355.06	2,272.26	2,077.78	1,951.66
FOUR TIER	SINGLE	888.70	857.48	784.05	736.42
	DOUBLE	1,955.19	1,886.40	1,724.97	1,620.22
	EMPLOYEE PLUS CHILD(REN)	1,510.89	1,457.70	1,332.93	1,252.02
	FAMILY	2,444.02	2,358.01	2,156.21	2,025.30
Copay Plan - $10 ($240 Inpatient) (GR-94-CS/11B)					
No Longer Available for Sale					
TWO TIER	SINGLE	861.84	831.46	760.27	714.08
	FAMILY	2,197.69	2,120.22	1,938.78	1,820.99
THREE TIER	SINGLE	861.84	831.46	760.27	714.08
	DOUBLE	1,809.85	1,746.11	1,596.63	1,499.64
	FAMILY	2,283.76	2,203.42	2,014.83	1,892.38
**					
FOUR TIER	SINGLE	861.84	831.46	760.27	714.08
	DOUBLE	1,895.99	1,829.26	1,672.66	1,571.08
	EMPLOYEE PLUS CHILD(REN)	1,465.05	1,413.52	1,292.56	1,214.01
	FAMILY	2,369.96	2,286.51	2,090.82	1,963.78
Copay Plan - $10 ($500 Inpatient) (GR-94-CS/11B)					
No Longer Available for Sale					
TWO TIER	SINGLE	855.11	824.47	753.59	707.42
	FAMILY	2,180.49	2,102.45	1,921.55	1,803.84
THREE TIER	SINGLE	855.11	824.47	753.59	707.42
	DOUBLE	1,795.67	1,731.39	1,582.48	1,485.54
	FAMILY	2,265.99	2,184.84	1,996.91	1,874.61
FOUR TIER	SINGLE	855.11	824.47	753.59	707.42
	DOUBLE	1,881.18	1,813.84	1,657.86	1,556.24
	EMPLOYEE PLUS CHILD(REN)	1,453.69	1,401.54	1,281.07	1,202.62
	FAMILY	2,351.50	2,267.34	2,072.29	1,945.37
Copay Plan - $15 ($0 Inpatient) (GR-94-CS/21B)					
No Longer Available for Sale					
TWO TIER	SINGLE	711.10	687.01	638.58	563.92
	FAMILY	1,813.19	1,751.88	1,628.36	1,438.07
THREE TIER	SINGLE	711.10	687.01	638.58	563.92
	DOUBLE	1,493.28	1,442.77	1,340.96	1,184.27
	FAMILY	1,884.28	1,820.58	1,692.19	1,494.44
FOUR TIER	SINGLE	711.10	687.01	638.58	563.92
	DOUBLE	1,564.36	1,511.48	1,404.83	1,240.72
	EMPLOYEE PLUS CHILD(REN)	1,208.80	1,167.99	1,085.56	958.71
	FAMILY	1,955.41	1,889.31	1,756.07	1,550.79
Copay Plan - $15 ($240 Inpatient) (GR-94-CS/21B)					
No Longer Available for Sale					
TWO TIER	SINGLE	808.69	794.34	726.22	641.34
	FAMILY	2,062.29	2,025.45	1,851.94	1,635.34
THREE TIER	SINGLE	808.69	794.34	726.22	641.34
	DOUBLE	1,698.34	1,668.10	1,525.13	1,346.79
	FAMILY	2,143.10	2,104.93	1,924.59	1,699.52
FOUR TIER	SINGLE	808.69	794.34	726.22	641.34
	DOUBLE	1,779.20	1,747.49	1,597.76	1,410.91
	EMPLOYEE PLUS CHILD(REN)	1,374.90	1,350.30	1,234.65	1,090.28
	FAMILY	2,224.03	2,184.33	1,997.16	1,763.60

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Copay Plan - $15 ($500 Inpatient) (GR-94-CS/21B)					
No Longer Available for Sale					
TWO TIER	SINGLE	801.96	787.30	719.54	634.59
	FAMILY	2,045.06	2,007.53	1,834.79	1,618.25
THREE TIER	SINGLE	801.96	787.30	719.54	634.59
	DOUBLE	1,684.20	1,653.27	1,511.00	1,332.68
	FAMILY	2,125.23	2,086.30	1,906.74	1,681.72
FOUR TIER	SINGLE	801.96	787.30	719.54	634.59
	DOUBLE	1,764.41	1,732.00	1,582.91	1,396.20
	EMPLOYEE PLUS CHILD(REN)	1,363.38	1,338.41	1,223.23	1,078.84
	FAMILY	2,205.45	2,165.06	1,978.61	1,745.12
Copay Plan - $20 ($0 Inpatient) (GR-94-CS/41B)					
No Longer Available for Sale					
TWO TIER	SINGLE	737.76	727.29	641.44	607.64
	FAMILY	1,881.17	1,854.58	1,635.74	1,549.50
THREE TIER	SINGLE	737.76	727.29	641.44	607.64
	DOUBLE	1,549.24	1,527.30	1,347.06	1,276.10
	FAMILY	1,955.01	1,927.26	1,699.87	1,610.31
FOUR TIER	SINGLE	737.76	727.29	641.44	607.64
	DOUBLE	1,623.03	1,600.01	1,411.23	1,336.85
	EMPLOYEE PLUS CHILD(REN)	1,254.23	1,236.38	1,090.44	1,033.03
	FAMILY	2,028.74	2,000.10	1,764.01	1,671.06
Copay Plan - $20 ($240 Inpatient) (GR-94-CS/41B)					
No Longer Available for Sale					
TWO TIER	SINGLE	715.29	705.15	621.95	589.13
	FAMILY	1,824.04	1,798.22	1,586.08	1,502.26
THREE TIER	SINGLE	715.29	705.15	621.95	589.13
	DOUBLE	1,502.16	1,480.96	1,306.15	1,237.11
	FAMILY	1,895.57	1,868.78	1,648.24	1,561.16
FOUR TIER	SINGLE	715.29	705.15	621.95	589.13
	DOUBLE	1,573.70	1,551.48	1,368.30	1,296.08
	EMPLOYEE PLUS CHILD(REN)	1,216.04	1,198.82	1,057.38	1,001.51
	FAMILY	1,967.09	1,939.32	1,710.42	1,620.10
Copay Plan - $20 ($500 Inpatient) (GR-94-CS/41B)					
No Longer Available for Sale					
TWO TIER	SINGLE	708.59	698.30	615.24	582.54
	FAMILY	1,806.95	1,780.56	1,569.00	1,485.44
THREE TIER	SINGLE	708.59	698.30	615.24	582.54
	DOUBLE	1,488.10	1,466.40	1,292.14	1,223.35
	FAMILY	1,877.80	1,850.45	1,630.58	1,543.67
FOUR TIER	SINGLE	708.59	698.30	615.24	582.54
	DOUBLE	1,558.97	1,536.24	1,353.70	1,281.57
	EMPLOYEE PLUS CHILD(REN)	1,204.62	1,187.16	1,046.04	990.28
	FAMILY	1,948.66	1,920.20	1,692.09	1,602.01
VALUE Plan - $20 ($500 Inpatient Copay With Direct Access)					
(GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	751.77	736.40	653.26	618.77
	FAMILY	1,917.04	1,877.69	1,665.87	1,577.87
THREE TIER	SINGLE	751.77	736.40	653.26	618.77
	DOUBLE	1,578.77	1,546.41	1,371.95	1,299.40
	FAMILY	1,992.25	1,951.42	1,731.18	1,639.78
FOUR TIER	SINGLE	751.77	736.40	653.26	618.77
	DOUBLE	1,653.95	1,619.99	1,437.19	1,361.32
	EMPLOYEE PLUS CHILD(REN)	1,278.05	1,251.83	1,110.51	1,051.91
	FAMILY	2,067.36	2,024.98	1,796.57	1,701.63

Exhibit B

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
VALUE Plan - $20 ($240 Inpatient Copay With Direct Access)					
(GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	759.63	744.48	661.04	626.61
	FAMILY	1,937.06	1,898.54	1,685.68	1,597.81
THREE TIER	SINGLE	759.63	744.48	661.04	626.61
	DOUBLE	1,595.29	1,563.46	1,388.18	1,315.84
	FAMILY	2,013.08	1,972.94	1,751.81	1,660.47
FOUR TIER	SINGLE	759.63	744.48	661.04	626.61
	DOUBLE	1,671.16	1,637.86	1,454.36	1,378.51
	EMPLOYEE PLUS CHILD(REN)	1,291.43	1,265.68	1,123.74	1,065.22
	FAMILY	2,088.99	2,047.37	1,817.87	1,723.17
VALUE Plan - $20 ($0 Inpatient Copay With Direct Access)					
(GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	766.50	751.52	667.88	633.46
	FAMILY	1,954.57	1,916.51	1,703.09	1,615.27
THREE TIER	SINGLE	766.50	751.52	667.88	633.46
	DOUBLE	1,609.68	1,578.30	1,402.53	1,330.14
	FAMILY	2,031.26	1,991.69	1,769.83	1,678.65
FOUR TIER	SINGLE	766.50	751.52	667.88	633.46
	DOUBLE	1,686.41	1,653.45	1,469.29	1,393.59
	EMPLOYEE PLUS CHILD(REN)	1,303.06	1,277.62	1,135.39	1,076.85
	FAMILY	2,107.95	2,066.81	1,836.63	1,741.94
VALUE Plan - $20 ($500 Inpatient Copay Without Direct Access)					
(GHI HMO GR-CS-02)					
TWO TIER	SINGLE	722.96	708.08	628.14	595.07
	FAMILY	1,843.44	1,805.74	1,601.86	1,517.46
THREE TIER	SINGLE	722.96	708.08	628.14	595.07
	DOUBLE	1,518.17	1,487.06	1,319.15	1,249.58
	FAMILY	1,915.82	1,876.51	1,664.66	1,576.90
FOUR TIER	SINGLE	722.96	708.08	628.14	595.07
	DOUBLE	1,590.46	1,557.85	1,381.99	1,309.16
	EMPLOYEE PLUS CHILD(REN)	1,229.02	1,203.81	1,067.88	1,011.59
	FAMILY	1,988.09	1,947.37	1,727.44	1,636.42
VALUE Plan - $20 ($240 Inpatient Copay Without Direct Access)					
(GHI HMO GR-CS-02)					
TWO TIER	SINGLE	730.45	715.82	635.72	602.55
	FAMILY	1,862.69	1,825.40	1,621.02	1,536.55
THREE TIER	SINGLE	730.45	715.82	635.72	602.55
	DOUBLE	1,534.01	1,503.25	1,334.89	1,265.32
	FAMILY	1,935.76	1,896.99	1,684.54	1,596.80
FOUR TIER	SINGLE	730.45	715.82	635.72	602.55
	DOUBLE	1,607.03	1,574.90	1,398.51	1,325.58
	EMPLOYEE PLUS CHILD(REN)	1,241.76	1,216.95	1,080.65	1,024.26
	FAMILY	2,008.75	1,968.58	1,748.09	1,657.09
VALUE Plan - $20 ($0 Inpatient Copay Without Direct Access)					
(GHI HMO GR-CS-02)					
TWO TIER	SINGLE	737.10	722.69	642.23	609.15
	FAMILY	1,879.54	1,842.79	1,637.72	1,553.26
THREE TIER	SINGLE	737.10	722.69	642.23	609.15
	DOUBLE	1,547.87	1,517.59	1,348.68	1,279.14
	FAMILY	1,953.25	1,915.03	1,701.93	1,614.13
FOUR TIER	SINGLE	737.10	722.69	642.23	609.15
	DOUBLE	1,621.61	1,589.97	1,412.92	1,340.03
	EMPLOYEE PLUS CHILD(REN)	1,253.04	1,228.61	1,091.82	1,035.47
	FAMILY	2,026.99	1,987.41	1,766.17	1,675.08

Exhibit B

Health Insurance Plan of Greater NY (GHI HMO Select Inc.) Premium Rates		NYC RATE REGION GROUPS OF 51+ Jan 2015	HV RATE REGION GROUPS OF 51+ Jan 2015	ULSTER RATE REGION GROUPS OF 51+ Jan 2015	CD RATE REGION GROUPS OF 51+ Jan 2015
VALUE Plan - $25 Plus $500 Inpatient Copay With Direct Access (GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	701.85	677.82	610.18	576.84
	FAMILY	1,789.70	1,728.48	1,555.99	1,470.96
THREE TIER	SINGLE	701.85	677.82	610.18	576.84
	DOUBLE	1,473.87	1,423.45	1,281.40	1,211.38
	FAMILY	1,859.85	1,796.25	1,617.03	1,528.66
FOUR TIER	SINGLE	701.85	677.82	610.18	576.84
	DOUBLE	1,544.01	1,491.24	1,342.42	1,269.05
	EMPLOYEE PLUS CHILD(REN)	1,193.08	1,152.32	1,037.27	980.68
	FAMILY	1,930.04	1,863.99	1,678.03	1,586.33
VALUE Plan - $25 Plus $240 Inpatient Copay With Direct Access (GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	709.36	685.55	617.68	584.41
	FAMILY	1,808.89	1,748.16	1,575.10	1,490.25
THREE TIER	SINGLE	709.36	685.55	617.68	584.41
	DOUBLE	1,489.71	1,439.71	1,297.16	1,227.24
	FAMILY	1,879.90	1,816.76	1,636.88	1,548.66
FOUR TIER	SINGLE	709.36	685.55	617.68	584.41
	DOUBLE	1,560.67	1,508.20	1,358.93	1,285.71
	EMPLOYEE PLUS CHILD(REN)	1,205.95	1,165.45	1,050.07	993.51
	FAMILY	1,950.80	1,885.25	1,698.62	1,607.12
VALUE Plan - $25 Plus $0 Inpatient Copay With Direct Access (GHI HMO GR-CS-02,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	716.02	692.27	624.24	591.01
	FAMILY	1,825.76	1,765.28	1,591.91	1,507.09
THREE TIER	SINGLE	716.02	692.27	624.24	591.01
	DOUBLE	1,503.55	1,453.77	1,310.96	1,241.11
	FAMILY	1,897.36	1,834.48	1,654.35	1,566.18
FOUR TIER	SINGLE	716.02	692.27	624.24	591.01
	DOUBLE	1,575.20	1,522.98	1,373.40	1,300.25
	EMPLOYEE PLUS CHILD(REN)	1,217.18	1,176.83	1,061.24	1,004.71
	FAMILY	1,968.98	1,903.71	1,716.74	1,625.28
VALUE Plan - $25 Plus $500 Inpatient Copay Without Direct Access (GHI HMO GR-CS-02)					
TWO TIER	SINGLE	674.12	651.00	585.92	553.99
	FAMILY	1,718.93	1,660.07	1,494.08	1,412.58
THREE TIER	SINGLE	674.12	651.00	585.92	553.99
	DOUBLE	1,415.58	1,367.16	1,230.44	1,163.31
	FAMILY	1,786.39	1,725.19	1,552.70	1,467.99
FOUR TIER	SINGLE	674.12	651.00	585.92	553.99
	DOUBLE	1,483.01	1,432.21	1,289.04	1,218.67
	EMPLOYEE PLUS CHILD(REN)	1,145.96	1,106.72	996.08	941.71
	FAMILY	1,853.76	1,790.27	1,611.34	1,523.31
VALUE Plan - $25 Plus $240 Inpatient Copay Without Direct Access (GHI HMO GR-CS-02)					
TWO TIER	SINGLE	681.31	658.34	593.21	561.19
	FAMILY	1,737.40	1,678.79	1,512.62	1,430.99
THREE TIER	SINGLE	681.31	658.34	593.21	561.19
	DOUBLE	1,430.76	1,382.54	1,245.69	1,178.44
	FAMILY	1,805.49	1,744.62	1,571.93	1,487.12
FOUR TIER	SINGLE	681.31	658.34	593.21	561.19
	DOUBLE	1,498.92	1,448.41	1,305.02	1,234.58
	EMPLOYEE PLUS CHILD(REN)	1,158.24	1,119.15	1,008.41	953.99
	FAMILY	1,873.67	1,810.48	1,631.27	1,543.21

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
VALUE Plan - $25 Plus $0 Inpatient Copay Without Direct Access (GHI HMO GR-CS-02)					
TWO TIER	SINGLE	687.72	664.83	599.51	567.51
	FAMILY	1,753.57	1,695.35	1,528.81	1,447.16
THREE TIER	SINGLE	687.72	664.83	599.51	567.51
	DOUBLE	1,444.12	1,396.16	1,258.98	1,191.82
	FAMILY	1,822.42	1,761.82	1,588.75	1,503.89
FOUR TIER	SINGLE	687.72	664.83	599.51	567.51
	DOUBLE	1,512.95	1,462.63	1,318.99	1,248.49
	EMPLOYEE PLUS CHILD(REN)	1,169.06	1,130.19	1,019.20	964.77
	FAMILY	1,891.17	1,828.29	1,648.69	1,560.67
VALUE Plan - $25/$40 Plus $500 Inpatient Copay With Direct Access (GHI HMO LG-CS-06,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	655.49	634.38	569.87	538.76
	FAMILY	1,671.48	1,617.63	1,453.26	1,373.82
THREE TIER	SINGLE	655.49	634.38	569.87	538.76
	DOUBLE	1,376.48	1,332.16	1,196.74	1,131.34
	FAMILY	1,737.01	1,681.01	1,510.21	1,427.66
FOUR TIER	SINGLE	655.49	634.38	569.87	538.76
	DOUBLE	1,442.03	1,395.63	1,253.79	1,185.22
	EMPLOYEE PLUS CHILD(REN)	1,114.28	1,078.46	968.80	915.91
	FAMILY	1,802.56	1,744.48	1,567.17	1,481.55
VALUE Plan - $25/$40 Plus $500 Inpatient Copay Without Direct Access (GHI HMO LG-CS-06)					
TWO TIER	SINGLE	629.56	609.22	547.21	517.35
	FAMILY	1,605.40	1,553.62	1,395.43	1,319.27
THREE TIER	SINGLE	629.56	609.22	547.21	517.35
	DOUBLE	1,322.07	1,279.49	1,149.15	1,086.47
	FAMILY	1,668.41	1,614.53	1,450.14	1,371.00
FOUR TIER	SINGLE	629.56	609.22	547.21	517.35
	DOUBLE	1,385.10	1,340.37	1,203.91	1,138.16
	EMPLOYEE PLUS CHILD(REN)	1,070.25	1,035.76	930.30	879.52
	FAMILY	1,731.30	1,675.44	1,504.87	1,422.73
VALUE Plan - $25/$40 (Plan C") With $500 Inpatient Copay and Direct Access (GHI HMO LG-CS-06,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	641.77	621.11	557.97	527.48
	FAMILY	1,636.51	1,583.78	1,422.85	1,345.06
THREE TIER	SINGLE	641.77	621.11	557.97	527.48
	DOUBLE	1,347.70	1,304.30	1,171.72	1,107.70
	FAMILY	1,700.65	1,645.87	1,478.63	1,397.81
FOUR TIER	SINGLE	641.77	621.11	557.97	527.48
	DOUBLE	1,411.89	1,366.39	1,227.53	1,160.44
	EMPLOYEE PLUS CHILD(REN)	1,090.98	1,055.89	948.53	896.72
	FAMILY	1,764.82	1,708.01	1,534.40	1,450.57
VALUE Plan - $25/$40 (Plan C") With $500 Inpatient Copay and Without Direct Access (GHI HMO LG-CS-06)					
TWO TIER	SINGLE	616.43	596.50	535.78	506.56
	FAMILY	1,571.80	1,521.10	1,366.23	1,291.63
THREE TIER	SINGLE	616.43	596.50	535.78	506.56
	DOUBLE	1,294.44	1,252.70	1,125.11	1,063.75
	FAMILY	1,633.46	1,580.76	1,419.82	1,342.36
FOUR TIER	SINGLE	616.43	596.50	535.78	506.56
	DOUBLE	1,356.10	1,312.34	1,178.72	1,114.38
	EMPLOYEE PLUS CHILD(REN)	1,047.89	1,014.09	910.81	861.12
	FAMILY	1,695.10	1,640.37	1,473.39	1,392.98

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Value Plan - $30/$50 Plus $500 Inpatient Copay With Direct Access					
(GHI HMO LG-CS-06,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	628.95	609.43	546.81	516.94
	FAMILY	1,603.81	1,554.04	1,394.41	1,318.21
THREE TIER	SINGLE	628.95	609.43	546.81	516.94
	DOUBLE	1,320.76	1,279.79	1,148.33	1,085.58
	FAMILY	1,666.70	1,614.95	1,449.07	1,369.94
FOUR TIER	SINGLE	628.95	609.43	546.81	516.94
	DOUBLE	1,383.66	1,340.75	1,203.03	1,137.24
	EMPLOYEE PLUS CHILD(REN)	1,069.22	1,036.05	929.58	878.86
	FAMILY	1,729.58	1,675.90	1,503.76	1,421.60
Value Plan - $30/$50 Plus $500 Inpatient Copay Without Direct Access					
(GHI HMO LG-CS-06)					
TWO TIER	SINGLE	604.10	585.27	525.08	496.41
	FAMILY	1,540.45	1,492.56	1,338.92	1,265.85
THREE TIER	SINGLE	604.10	585.27	525.08	496.41
	DOUBLE	1,268.61	1,229.16	1,102.65	1,042.51
	FAMILY	1,600.85	1,551.06	1,391.46	1,315.51
FOUR TIER	SINGLE	604.10	585.27	525.08	496.41
	DOUBLE	1,329.03	1,287.70	1,155.16	1,092.12
	EMPLOYEE PLUS CHILD(REN)	1,026.93	995.02	892.62	843.92
	FAMILY	1,661.25	1,609.58	1,443.97	1,365.17
Value Plan - $30/$50 Plus $1,000 Inpatient Copay With Direct Access					
(GHI HMO LG-CS-06,GHI HMO-DirAcc-GR-R-53)					
TWO TIER	SINGLE	621.48	602.20	540.33	510.79
	FAMILY	1,584.78	1,535.60	1,377.88	1,302.57
THREE TIER	SINGLE	621.48	602.20	540.33	510.79
	DOUBLE	1,305.10	1,264.61	1,134.66	1,072.69
	FAMILY	1,646.91	1,595.79	1,431.90	1,353.65
FOUR TIER	SINGLE	621.48	602.20	540.33	510.79
	DOUBLE	1,367.26	1,324.84	1,188.75	1,123.76
	EMPLOYEE PLUS CHILD(REN)	1,056.52	1,023.75	918.56	868.39
	FAMILY	1,709.07	1,656.00	1,485.92	1,404.73
Value Plan - $30/$50 Plus $1,000 Inpatient Copay Without Direct Access					
(GHI HMO LG-CS-06)					
TWO TIER	SINGLE	596.95	578.36	518.84	490.52
	FAMILY	1,522.16	1,474.84	1,323.04	1,250.86
THREE TIER	SINGLE	596.95	578.36	518.84	490.52
	DOUBLE	1,253.51	1,214.58	1,089.57	1,030.10
	FAMILY	1,581.83	1,532.65	1,374.94	1,299.90
FOUR TIER	SINGLE	596.95	578.36	518.84	490.52
	DOUBLE	1,313.26	1,272.38	1,141.48	1,079.13
	EMPLOYEE PLUS CHILD(REN)	1,014.74	983.21	882.04	833.86
	FAMILY	1,641.55	1,590.44	1,426.82	1,348.95
VALUE Plan - $20 Value Plan Direct NYSHIP					
(GHI HMO GR-CS-02)					
TWO TIER	SINGLE	746.99	710.02	656.96	624.96
	FAMILY	1,971.81	1,875.87	1,739.26	1,657.00
Senior Health Supplement (Form # GHI-HMO GR-R8)					
SINGLE - $3 Medical Copay, $3 Rx Copay		1,260.89	1,260.89	1,260.89	1,260.89
SINGLE - $10 Medical Copay, $10/20/30 Rx Copay with $2,500 Cap		1,189.18	1,138.65	1,096.03	1,044.78
SINGLE - $10 Medical Copay, $10/20/30 Rx Copay without Cap		1,189.18	1,138.65	1,096.03	1,044.78
SINGLE - $15 Medical Copay, $10/20/30 Rx Copay with $2,500 Cap		1,161.92	1,116.12	1,075.41	981.09
SINGLE - $15 Medical Copay, $10/20/30 Rx Copay without Cap		1,161.92	1,116.12	1,075.41	981.09
SINGLE - $20 Medical Copay, $10/20/30 Rx Copay with $2,500 Cap		1,088.88	1,048.46	987.40	950.61
SINGLE - $20 Medical Copay, $10/20/30 Rx Copay without Cap		1,088.88	1,048.46	987.40	950.61

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Alternative Care Rider $10 Copay (GHI-HMO-GR-R31A)					
No Longer Available for Sale					
TWO TIER	SINGLE	10.52	10.77	10.52	10.52
	FAMILY	26.75	27.39	26.75	26.75
THREE TIER	SINGLE	10.52	10.77	10.52	10.52
	DOUBLE	22.01	22.54	22.01	22.01
	FAMILY	27.82	28.50	27.82	27.82
FOUR TIER	SINGLE	10.52	10.77	10.52	10.52
	DOUBLE	23.13	23.67	23.13	23.13
	EMP/CHILD(REN)	17.86	18.27	17.86	17.86
	FAMILY	28.93	29.61	28.93	28.93
Alternative Care Rider $15 Copay (GHI-HMO-GR-R31A)					
No Longer Available for Sale					
TWO TIER	SINGLE	9.73	9.94	9.73	9.73
	FAMILY	24.70	25.28	24.70	24.70
THREE TIER	SINGLE	9.73	9.94	9.73	9.73
	DOUBLE	20.29	20.79	20.29	20.29
	FAMILY	25.61	26.32	25.61	25.61
FOUR TIER	SINGLE	9.73	9.94	9.73	9.73
	DOUBLE	21.29	21.83	21.29	21.29
	EMP/CHILD(REN)	16.43	16.87	16.43	16.43
	FAMILY	26.63	27.30	26.63	26.63
Alternative Care Rider $20 Copay (GHI-HMO-GR-R31A)					
TWO TIER	SINGLE	9.25	9.52	9.25	9.25
	FAMILY	23.67	24.16	23.67	23.67
THREE TIER	SINGLE	9.25	9.52	9.25	9.25
	DOUBLE	19.44	19.89	19.44	19.44
	FAMILY	24.59	25.14	24.59	24.59
FOUR TIER	SINGLE	9.25	9.52	9.25	9.25
	DOUBLE	20.34	20.86	20.34	20.34
	EMP/CHILD(REN)	15.71	16.13	15.71	15.71
	FAMILY	25.46	26.06	25.46	25.46
Alternative Care Rider $25 Copay (GHI-HMO-GR-R31B)					
TWO TIER	SINGLE	8.40	8.39	8.40	8.40
	FAMILY	21.49	21.48	21.49	21.49
THREE TIER	SINGLE	8.40	8.39	8.40	8.40
	DOUBLE	17.68	17.68	17.68	17.68
	FAMILY	22.30	22.29	22.30	22.30
FOUR TIER	SINGLE	8.40	8.39	8.40	8.40
	DOUBLE	18.53	18.53	18.53	18.53
	EMP/CHILD(REN)	14.26	14.26	14.26	14.26
	FAMILY	23.14	23.14	23.14	23.14
Dependent Grandchild Coverage (GR-R31 NYSHIP)					
No Longer Available for Sale					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	53.87	52.94	52.94	52.94
Extends Non-Student Coverage to the End of the Year of 19th Birthday, and					
Extends Student Coverage to the End of the Year of 23rd Birthday (GR-R7A)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	-	-	-	-
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	-	-	-	-
	FAMILY	-	-	-	-
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	n/a	n/a	n/a	n/a
	EMPLOYEE PLUS CHILD(REN)	-	-	-	-
	FAMILY	-	-	-	-

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Extends Student coverage to End of Year of 25th Birthday (GR-R13A)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	1.06	1.09	1.03	1.03
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	0.84	0.85	0.84	0.84
	FAMILY	1.06	1.07	1.06	1.06
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	n/a	n/a	n/a	n/a
	EMPLOYEE PLUS CHILD(REN)	0.79	0.83	0.78	0.78
	FAMILY	1.07	1.11	1.07	1.07
Extends Non-Student Coverage from Age 19 to 22 (GR-R15)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	12.45	12.61	12.33	12.33
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	9.73	9.80	9.58	9.58
	FAMILY	13.06	13.15	12.91	12.91
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	n/a	n/a	n/a	n/a
	EMPLOYEE PLUS CHILD(REN)	9.45	9.58	9.30	9.30
	FAMILY	13.55	13.73	13.41	13.41
Dependent Students to 23 (GR-R51)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	13.11	12.75	11.50	10.82
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	10.79	10.48	9.46	8.95
	FAMILY	13.87	13.45	12.15	11.51
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	n/a	n/a	n/a	n/a
	EMPLOYEE PLUS CHILD(REN)	9.76	9.48	8.53	8.11
	FAMILY	15.14	14.67	13.24	12.56
Dependent Students to 25 (GR-R51)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	17.45	16.92	15.16	14.43
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	14.42	13.92	12.56	11.91
	FAMILY	18.55	17.99	16.14	15.31
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	n/a	n/a	n/a	n/a
	EMPLOYEE PLUS CHILD(REN)	13.05	12.58	11.32	10.73
	FAMILY	20.25	19.60	17.58	16.71
Inpatient Rehabilitation (GR-R52)					
To be attached to all Copay and $20 and $25 Value Plans					
TWO TIER	SINGLE	2.00	1.95	1.76	1.58
	FAMILY	5.20	4.90	4.37	4.18
THREE TIER	SINGLE	2.00	1.95	1.76	1.58
	DOUBLE	4.28	4.04	3.60	3.41
	FAMILY	5.31	5.15	4.53	4.29
FOUR TIER	SINGLE	2.00	1.95	1.76	1.58
	DOUBLE	4.44	4.29	3.78	3.55
	EMPLOYEE PLUS CHILD(REN)	3.43	3.29	2.89	2.76
	FAMILY	5.58	5.31	4.70	4.38

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Inpatient Rehabilitation (GHIHMO-LG-CD-07)					
To be attached to $25/$40 and $30/$50 plans with $500 IP copays					
TWO TIER	SINGLE	2.00	1.95	1.76	1.58
	FAMILY	5.20	4.90	4.37	4.18
THREE TIER	SINGLE	2.00	1.95	1.76	1.58
	DOUBLE	4.28	4.04	3.60	3.41
	FAMILY	5.31	5.15	4.53	4.29
FOUR TIER	SINGLE	2.00	1.95	1.76	1.58
	DOUBLE	4.44	4.29	3.78	3.55
	EMPLOYEE PLUS CHILD(REN)	3.43	3.29	2.89	2.76
	FAMILY	5.58	5.31	4.70	4.38
Inpatient Rehabilitation (GHIHMO-LG-CD-07)					
To be attached to $30/$50 plans with $1000 IP copays					
TWO TIER	SINGLE	1.76	1.70	1.51	1.39
	FAMILY	4.52	4.29	3.79	3.57
THREE TIER	SINGLE	1.76	1.70	1.51	1.39
	DOUBLE	3.72	3.50	3.16	2.95
	FAMILY	4.65	4.46	3.91	3.73
FOUR TIER	SINGLE	1.76	1.70	1.51	1.39
	DOUBLE	3.86	3.72	3.29	3.07
	EMPLOYEE PLUS CHILD(REN)	2.98	2.86	2.49	2.39
	FAMILY	4.83	4.64	4.14	3.81
Vision Services (GR-R54)					
TWO TIER	SINGLE	10.11	9.92	9.67	9.67
	FAMILY	25.79	25.14	24.59	24.59
THREE TIER	SINGLE	10.11	9.92	9.67	9.67
	DOUBLE	21.26	20.67	20.19	20.19
	FAMILY	26.80	26.08	25.52	25.52
FOUR TIER	SINGLE	10.11	9.92	9.67	9.67
	DOUBLE	22.28	21.68	21.16	21.16
	EMPLOYEE PLUS CHILD(REN)	17.16	16.73	16.36	16.36
	FAMILY	27.82	27.12	26.49	26.49
Vision Exam (LGR-VE-06)					
($40 copay)					
TWO TIER	SINGLE	0.41	0.41	0.41	0.41
	FAMILY	1.02	1.02	1.06	1.02
THREE TIER	SINGLE	0.41	0.41	0.41	0.41
	DOUBLE	0.82	0.82	0.82	0.82
	FAMILY	1.06	1.06	1.09	1.06
FOUR TIER	SINGLE	0.41	0.41	0.41	0.41
	DOUBLE	0.84	0.84	0.84	0.84
	EMPLOYEE PLUS CHILD(REN)	0.69	0.69	0.69	0.69
	FAMILY	1.09	1.09	1.09	1.09
Vision Exam and Appliances (GHI HMO-LG-VIS-06)					
($40 copay)					
TWO TIER	SINGLE	10.73	10.35	10.27	10.27
	FAMILY	27.39	26.39	26.14	26.14
THREE TIER	SINGLE	10.73	10.35	10.27	10.27
	DOUBLE	22.30	21.51	21.37	21.37
	FAMILY	28.47	27.48	27.30	27.30
FOUR TIER	SINGLE	10.73	10.35	10.27	10.27
	DOUBLE	23.67	22.78	22.63	22.63
	EMPLOYEE PLUS CHILD(REN)	18.27	17.62	17.46	17.46
	FAMILY	29.54	28.50	28.30	28.30

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Remove Voluntary Sterilization /Abortion (GR-R14)					
TWO TIER	SINGLE	(4.51)	(4.41)	(4.30)	(4.29)
	FAMILY	(11.52)	(11.19)	(10.96)	(10.91)
THREE TIER	SINGLE	(4.51)	(4.41)	(4.30)	(4.29)
	DOUBLE	(9.49)	(9.24)	(9.02)	(9.44)
	FAMILY	(12.18)	(11.91)	(11.62)	(11.35)
FOUR TIER	SINGLE	(4.51)	(4.41)	(4.30)	(4.29)
	DOUBLE	(9.94)	(9.66)	(9.45)	(9.39)
	EMPLOYEE PLUS CHILD(REN)	(8.59)	(8.31)	(8.17)	(8.11)
	FAMILY	(13.35)	(12.95)	(12.65)	(12.60)
Skilled Nursing (GR-R11)					
TWO TIER	SINGLE	0.82	0.83	0.82	0.82
	FAMILY	2.00	2.04	2.00	2.00
THREE TIER	SINGLE	0.82	0.83	0.82	0.82
	DOUBLE	1.71	1.73	1.71	1.71
	FAMILY	2.07	2.14	2.06	2.11
FOUR TIER	SINGLE	0.82	0.83	0.82	0.82
	DOUBLE	1.80	1.81	1.80	1.80
	EMPLOYEE PLUS CHILD(REN)	1.39	1.39	1.38	1.38
	FAMILY	2.21	2.25	2.21	2.21
Infertility Treatment (GR-R23-FEHBP)					
TWO TIER	SINGLE	7.61	7.72	7.51	7.51
	FAMILY	19.23	19.66	19.19	19.19
Coverage for Organ Donor (GR-R20-FEHBP)					
TWO TIER	SINGLE	0.51	0.50	0.50	0.50
	FAMILY	1.11	1.12	1.09	1.09
Speech and Occupational Therapy (GR-R21-FEHBP)					
TWO TIER	SINGLE	2.02	2.06	2.02	2.02
	FAMILY	5.29	5.37	5.28	5.28
Domestic Partners (GR-R17)					
TWO TIER	SINGLE	n/a	n/a	n/a	n/a
	FAMILY	0.00	0.00	0.00	0.00
THREE TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	0.00	0.00	0.00	0.00
	FAMILY	0.00	0.00	0.00	0.00
FOUR TIER	SINGLE	n/a	n/a	n/a	n/a
	DOUBLE	0.00	0.00	0.00	0.00
	EMPLOYEE PLUS CHILD(REN)	n/a	n/a	n/a	n/a
	FAMILY	0.00	0.00	0.00	0.00
Remove Home Health Care Limit (GR-R-48)					
TWO TIER	SINGLE	2.80	2.87	2.80	2.80
	FAMILY	7.22	7.34	7.22	7.22
THREE TIER	SINGLE	2.80	2.87	2.80	2.80
	DOUBLE	5.90	6.09	5.90	5.90
	FAMILY	7.47	7.64	7.47	7.47
FOUR TIER	SINGLE	2.80	2.87	2.80	2.80
	DOUBLE	6.15	6.31	6.15	6.15
	EE + CHILD(REN)	5.31	5.42	5.31	5.31
	FAMILY	7.74	7.89	7.74	7.74

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Basic-Choice (70%) $500,000 Copay $10 with $0 IP (POS 70 GR-R-55)					
No Longer Available for Sale					
TWO TIER	SINGLE	266.67	249.53	235.45	221.42
	FAMILY	680.18	636.26	600.51	564.44
THREE TIER	SINGLE	266.67	249.53	235.45	221.42
	DOUBLE	560.08	524.03	494.55	464.91
	FAMILY	706.84	661.28	624.03	586.59
FOUR TIER	SINGLE	266.67	249.53	235.45	221.42
	DOUBLE	586.75	548.89	518.08	486.99
	EMPLOYEE PLUS CHILD(REN)	453.41	424.19	400.37	376.32
	FAMILY	733.54	686.14	647.58	608.79
Basic-Choice (70%) $1,000,000 Copay $10 with $0 IP (POS 70 GR-R-55)					
No Longer Available for Sale					
TWO TIER	SINGLE	300.10	280.73	264.92	248.99
	FAMILY	765.16	715.90	675.46	634.98
THREE TIER	SINGLE	300.10	280.73	264.92	248.99
	DOUBLE	630.13	589.56	556.34	522.94
	FAMILY	795.09	744.00	701.96	659.81
FOUR TIER	SINGLE	300.10	280.73	264.92	248.99
	DOUBLE	660.12	617.65	582.75	547.75
	EMPLOYEE PLUS CHILD(REN)	510.05	477.26	450.36	423.35
	FAMILY	825.11	772.14	728.52	684.72
Basic-Choice (70%) $1,000,000 Copay $10 with $240 IP (POS 70 GR-R-55)					
No Longer Available for Sale					
TWO TIER	SINGLE	291.02	272.35	256.94	241.54
	FAMILY	742.16	694.46	655.18	615.92
THREE TIER	SINGLE	291.02	272.35	256.94	241.54
	DOUBLE	611.19	571.85	539.60	507.22
	FAMILY	771.26	721.71	680.88	640.06
FOUR TIER	SINGLE	291.02	272.35	256.94	241.54
	DOUBLE	640.29	599.08	565.29	531.39
	EMPLOYEE PLUS CHILD(REN)	494.79	462.97	436.90	410.61
	FAMILY	800.38	748.88	706.58	664.25
Basic-Choice (70%) $1,000,000 Copay $15 with $0 IP (POS 70 GR-R-55)					
No Longer Available for Sale					
TWO TIER	SINGLE	281.77	268.30	253.18	224.00
	FAMILY	718.48	684.16	645.52	571.07
THREE TIER	SINGLE	281.77	268.30	253.18	224.00
	DOUBLE	591.73	563.39	531.60	470.28
	FAMILY	746.69	710.99	670.85	593.39
FOUR TIER	SINGLE	281.77	268.30	253.18	224.00
	DOUBLE	619.93	590.22	556.94	492.66
	EMPLOYEE PLUS CHILD(REN)	479.00	456.09	430.40	380.70
	FAMILY	774.82	737.84	696.24	615.85
Basic-Choice (70%) $1,000,000 Copay $15 with $240 IP (POS 70 GR-R-55)					
No Longer Available for Sale					
TWO TIER	SINGLE	273.31	260.15	245.65	217.09
	FAMILY	696.92	663.65	626.23	553.79
THREE TIER	SINGLE	273.31	260.15	245.65	217.09
	DOUBLE	573.94	546.54	515.72	456.09
	FAMILY	724.17	689.60	650.78	575.51
FOUR TIER	SINGLE	273.31	260.15	245.65	217.09
	DOUBLE	601.24	572.49	540.25	477.76
	EMPLOYEE PLUS CHILD(REN)	464.55	442.41	417.49	369.19
	FAMILY	751.59	715.64	675.38	597.23

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Basic-Choice (70%) $1,000,000 Copay $20 with $240 IP (POS 70 GR-R-55)					
TWO TIER	SINGLE	253.66	243.20	221.90	210.37
	FAMILY	646.81	620.09	565.80	536.36
THREE TIER	SINGLE	253.66	243.20	221.90	210.37
	DOUBLE	532.66	510.73	465.93	441.73
	FAMILY	672.16	644.42	587.95	557.42
FOUR TIER	SINGLE	253.66	243.20	221.90	210.37
	DOUBLE	558.05	535.05	488.12	462.68
	EMPLOYEE PLUS CHILD(REN)	431.24	413.45	377.21	357.60
	FAMILY	697.56	668.73	610.15	578.45
Basic-Choice (80%) $1,000,000 Copay $10 with $0 IP (POS 80 GR-R-56)					
No Longer Available for Sale					
TWO TIER	SINGLE	333.38	311.92	294.35	276.67
	FAMILY	850.09	795.33	750.64	705.42
THREE TIER	SINGLE	333.38	311.92	294.35	276.67
	DOUBLE	700.12	655.02	618.16	580.96
	FAMILY	883.43	826.51	780.05	733.08
FOUR TIER	SINGLE	333.38	311.92	294.35	276.67
	DOUBLE	733.45	686.24	647.58	608.55
	EMPLOYEE PLUS CHILD(REN)	566.75	530.25	500.46	470.28
	FAMILY	916.83	857.69	809.49	760.82
Basic-Choice (80%) $1,000,000 Copay $10 with $240 IP (POS 80 GR-R-56)					
No Longer Available for Sale					
TWO TIER	SINGLE	323.43	302.56	285.52	268.44
	FAMILY	824.68	771.45	728.13	684.33
THREE TIER	SINGLE	323.43	302.56	285.52	268.44
	DOUBLE	679.20	635.31	599.61	563.64
	FAMILY	857.04	801.73	756.63	711.21
FOUR TIER	SINGLE	323.43	302.56	285.52	268.44
	DOUBLE	711.50	665.61	628.16	590.49
	EMPLOYEE PLUS CHILD(REN)	549.84	514.30	485.41	456.26
	FAMILY	889.37	831.97	785.18	738.02
Basic-Choice (80%) $1,000,000 Copay $15 with $0 IP (POS 80 GR-R-56)					
No Longer Available for Sale					
TWO TIER	SINGLE	313.04	298.01	281.33	248.84
	FAMILY	798.22	760.08	717.39	634.46
THREE TIER	SINGLE	313.04	298.01	281.33	248.84
	DOUBLE	657.41	625.98	590.76	522.43
	FAMILY	829.57	789.83	745.55	659.31
FOUR TIER	SINGLE	313.04	298.01	281.33	248.84
	DOUBLE	688.69	655.74	618.89	547.39
	EMPLOYEE PLUS CHILD(REN)	532.22	506.70	478.27	422.97
	FAMILY	860.87	819.71	773.60	684.25
Basic-Choice (80%) $1,000,000 Copay $15 with $240 IP (POS 80 GR-R-56)					
No Longer Available for Sale					
TWO TIER	SINGLE	303.69	289.17	272.86	241.32
	FAMILY	774.33	737.40	695.82	615.39
THREE TIER	SINGLE	303.69	289.17	272.86	241.32
	DOUBLE	637.68	607.33	573.04	506.84
	FAMILY	804.63	766.35	723.00	639.55
FOUR TIER	SINGLE	303.69	289.17	272.86	241.32
	DOUBLE	668.07	636.20	600.21	530.93
	EMPLOYEE PLUS CHILD(REN)	516.25	491.62	463.84	410.31
	FAMILY	835.00	795.25	750.36	663.65

Exhibit B

Health Insurance Plan of Greater NY (GHI HMO Select Inc.) Premium Rates		NYC RATE REGION GROUPS OF 51+ Jan 2015	HV RATE REGION GROUPS OF 51+ Jan 2015	ULSTER RATE REGION GROUPS OF 51+ Jan 2015	CD RATE REGION GROUPS OF 51+ Jan 2015
$5.00 Generic/$10 Brand Drug with O/C, no limit (F5/10.1)					
No longer avalilable for sale					
TWO TIER	SINGLE	396.88	351.26	364.02	304.62
	FAMILY	1,011.98	895.66	928.27	776.71
THREE TIER	SINGLE	396.88	351.26	364.02	304.62
	DOUBLE	833.39	737.54	764.44	639.66
	FAMILY	1,051.67	930.75	964.67	807.18
FOUR TIER	SINGLE	396.88	351.26	364.02	304.62
	DOUBLE	873.07	772.76	800.86	670.15
	EE + CHILD(REN)	674.60	597.12	618.82	517.83
	FAMILY	1,091.30	965.89	1,001.14	837.64
50% Copayment Drug Rider with O/C, no limit (F50.1)					
TWO TIER	SINGLE	124.12	124.12	124.12	124.12
	FAMILY	316.52	316.52	316.52	316.52
THREE TIER	SINGLE	124.12	124.12	124.12	124.12
	DOUBLE	260.67	260.67	260.67	260.67
	FAMILY	328.94	328.94	328.94	328.94
FOUR TIER	SINGLE	124.12	124.12	124.12	124.12
	DOUBLE	273.06	273.06	273.06	273.06
	EE + CHILD(REN)	211.01	211.01	211.01	211.01
	FAMILY	341.30	341.30	341.30	341.30
$5/$10/$20 3-Tier Mandatory Mail/Generic Drug Copay Plan					
(GR-R-42.5 Rx OC)	**No Longer Available for Sale**				
TWO TIER	SINGLE	238.41	238.41	238.41	238.41
	FAMILY	607.87	607.87	607.87	607.87
THREE TIER	SINGLE	238.41	238.41	238.41	238.41
	DOUBLE	500.56	500.56	500.56	500.56
	FAMILY	631.78	631.78	631.78	631.78
FOUR TIER	SINGLE	238.41	238.41	238.41	238.41
	DOUBLE	524.45	524.45	524.45	524.45
	EE + CHILD(REN)	405.22	405.22	405.22	405.22
	FAMILY	655.57	655.57	655.57	655.57
$8/$16/$30 3-Tier Mandatory Mail/Generic Drug Copay Plan					
(GR-R-42.8 Rx OC)	**No Longer Available for Sale**				
TWO TIER	SINGLE	196.57	196.57	196.57	196.57
	FAMILY	501.18	501.18	501.18	501.18
THREE TIER	SINGLE	196.57	196.57	196.57	196.57
	DOUBLE	412.79	412.79	412.79	412.79
	FAMILY	520.86	520.86	520.86	520.86
FOUR TIER	SINGLE	196.57	196.57	196.57	196.57
	DOUBLE	432.39	432.39	432.39	432.39
	EE + CHILD(REN)	334.13	334.13	334.13	334.13
	FAMILY	540.53	540.53	540.53	540.53
$10/$20/$30 3-Tier Mandatory Mail/Generic Drug Copay Plan					
(Gr-R-42.10 Rx OC)					
TWO TIER	SINGLE	178.86	178.86	178.86	178.86
	FAMILY	456.02	456.02	456.02	456.02
THREE TIER	SINGLE	178.86	178.86	178.86	178.86
	DOUBLE	375.53	375.53	375.53	375.53
	FAMILY	473.86	473.86	473.86	473.86
FOUR TIER	SINGLE	178.86	178.86	178.86	178.86
	DOUBLE	393.42	393.42	393.42	393.42
	EE + CHILD(REN)	303.96	303.96	303.96	303.96
	FAMILY	491.77	491.77	491.77	491.77

Exhibit B

Health Insurance Plan of Greater NY (GHI HMO Select Inc.) Premium Rates		NYC RATE REGION GROUPS OF 51+ Jan 2015	HV RATE REGION GROUPS OF 51+ Jan 2015	ULSTER RATE REGION GROUPS OF 51+ Jan 2015	CD RATE REGION GROUPS OF 51+ Jan 2015
$5/$10/$20 3-Tier Mandatory Mail/Generic Drug Copay Plan ($2,500 Limit)					
(Gr-R-42.5 Rx OC CAP)	**No Longer Available for Sale**				
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	222.44	222.44	222.44	222.44
	FAMILY	567.15	567.15	567.15	567.15
THREE TIER	SINGLE	222.44	222.44	222.44	222.44
	DOUBLE	467.08	467.08	467.08	467.08
	FAMILY	589.45	589.45	589.45	589.45
FOUR TIER	SINGLE	222.44	222.44	222.44	222.44
	DOUBLE	489.32	489.32	489.32	489.32
	EE + CHILD(REN)	378.11	378.11	378.11	378.11
	FAMILY	611.64	611.64	611.64	611.64
$8/$16/$30 3-Tier Mandatory Drug Copay Plan ($2,500 Limit)					
(Gr-R-42.8 Rx OC CAP)	**No Longer Available for Sale**				
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	181.26	181.26	181.26	181.26
	FAMILY	462.20	462.20	462.20	462.20
THREE TIER	SINGLE	181.26	181.26	181.26	181.26
	DOUBLE	380.68	380.68	380.68	380.68
	FAMILY	480.39	480.39	480.39	480.39
FOUR TIER	SINGLE	181.26	181.26	181.26	181.26
	DOUBLE	398.79	398.79	398.79	398.79
	EE + CHILD(REN)	308.16	308.16	308.16	308.16
	FAMILY	498.48	498.48	498.48	498.48
$10/$20/$30 3-Tier Mandatory Drug Copay Plan ($2,500 Limit)					
(Gr-R-42.10 Rx OC CAP)	**No Longer Available for Sale**				
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	163.66	163.66	163.66	163.66
	FAMILY	417.41	417.41	417.41	417.41
THREE TIER	SINGLE	163.66	163.66	163.66	163.66
	DOUBLE	343.79	343.79	343.79	343.79
	FAMILY	433.76	433.76	433.76	433.76
FOUR TIER	SINGLE	163.66	163.66	163.66	163.66
	DOUBLE	360.14	360.14	360.14	360.14
	EE + CHILD(REN)	278.28	278.28	278.28	278.28
	FAMILY	450.17	450.17	450.17	450.17
$10/$20/$30 3-Tier Voluntary Mail/Generic Drug Copay Plan					
(Gr-R-43.10 Rx OC V)	**No Longer Available for Sale**				
TWO TIER	SINGLE	199.74	199.74	199.74	199.74
	FAMILY	509.39	509.39	509.39	509.39
THREE TIER	SINGLE	199.74	199.74	199.74	199.74
	DOUBLE	419.49	419.49	419.49	419.49
	FAMILY	529.39	529.39	529.39	529.39
FOUR TIER	SINGLE	199.74	199.74	199.74	199.74
	DOUBLE	439.51	439.51	439.51	439.51
	EE + CHILD(REN)	339.54	339.54	339.54	339.54
	FAMILY	549.34	549.34	549.34	549.34
$3/6/20 3-Tier Voluntary Drug Copay Plan ($2,500 Limit)					
(Gr-R-43.3 Rx OC CAP V)	**No Longer Available for Sale**				
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	326.93	326.93	326.93	326.93
	FAMILY	833.59	833.59	833.59	833.59
THREE TIER	SINGLE	326.93	326.93	326.93	326.93
	DOUBLE	686.51	686.51	686.51	686.51
	FAMILY	866.30	866.30	866.30	866.30
FOUR TIER	SINGLE	326.93	326.93	326.93	326.93
	DOUBLE	719.19	719.19	719.19	719.19
	EE + CHILD(REN)	555.71	555.71	555.71	555.71
	FAMILY	899.03	899.03	899.03	899.03

Exhibit B

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
$8/16/30 3-Tier Voluntary Drug Copay Plan ($2,500 Limit)					
(Gr-R-43.8 Rx OC CAP V) No Longer Available for Sale					
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	185.58	185.58	185.58	185.58
	FAMILY	473.12	473.12	473.12	473.12
THREE TIER	SINGLE	185.58	185.58	185.58	185.58
	DOUBLE	389.66	389.66	389.66	389.66
	FAMILY	491.69	491.69	491.69	491.69
FOUR TIER	SINGLE	185.58	185.58	185.58	185.58
	DOUBLE	408.25	408.25	408.25	408.25
	EE + CHILD(REN)	315.48	315.48	315.48	315.48
	FAMILY	510.25	510.25	510.25	510.25
$10/$30/$50 Drug Rider - Voluntary Mail Order					
(LG-RX2-2006)					
TWO TIER	SINGLE	150.89	150.89	150.89	150.89
	FAMILY	384.72	384.72	384.72	384.72
THREE TIER	SINGLE	150.89	150.89	150.89	150.89
	DOUBLE	316.81	316.81	316.81	316.81
	FAMILY	399.81	399.81	399.81	399.81
FOUR TIER	SINGLE	150.89	150.89	150.89	150.89
	DOUBLE	331.90	331.90	331.90	331.90
	EE + CHILD(REN)	256.48	256.48	256.48	256.48
	FAMILY	414.90	414.90	414.90	414.90
$10/$30/$50 Drug Rider with $50 Deductible and $1,000 Retail Max - Voluntary Mail Order					
(LG-RX4-2006)					
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	99.67	99.67	99.67	99.67
	FAMILY	254.17	254.17	254.17	254.17
THREE TIER	SINGLE	99.67	99.67	99.67	99.67
	DOUBLE	209.31	209.31	209.31	209.31
	FAMILY	264.14	264.14	264.14	264.14
FOUR TIER	SINGLE	99.67	99.67	99.67	99.67
	DOUBLE	219.30	219.30	219.30	219.30
	EE + CHILD(REN)	169.43	169.43	169.43	169.43
	FAMILY	274.10	274.10	274.10	274.10
$10/$30 Drug Rider with High Performance Formulary - Voluntary Mail Order					
(LG-RX5-2006)					
TWO TIER	SINGLE	101.40	101.40	101.40	101.40
	FAMILY	258.55	258.55	258.55	258.55
THREE TIER	SINGLE	101.40	101.40	101.40	101.40
	DOUBLE	212.92	212.92	212.92	212.92
	FAMILY	268.69	268.69	268.69	268.69
FOUR TIER	SINGLE	101.40	101.40	101.40	101.40
	DOUBLE	223.07	223.07	223.07	223.07
	EE + CHILD(REN)	172.40	172.40	172.40	172.40
	FAMILY	278.90	278.90	278.90	278.90
Low Cost Rx Rider (Gr-R-44 Rx)					
$15/25/40 copay; $50 retail deductible; $750 retail max					
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	107.43	107.43	107.43	107.43
	FAMILY	273.93	273.93	273.93	273.93
THREE TIER	SINGLE	107.43	107.43	107.43	107.43
	DOUBLE	225.62	225.62	225.62	225.62
	FAMILY	284.68	284.68	284.68	284.68
FOUR TIER	SINGLE	107.43	107.43	107.43	107.43
	DOUBLE	236.30	236.30	236.30	236.30
	EE + CHILD(REN)	182.57	182.57	182.57	182.57
	FAMILY	295.40	295.40	295.40	295.40

		NYC RATE REGION GROUPS OF 51+	HV RATE REGION GROUPS OF 51+	ULSTER RATE REGION GROUPS OF 51+	CD RATE REGION GROUPS OF 51+
Health Insurance Plan of Greater NY (GHI HMO Select Inc.)					
Premium Rates		**Jan 2015**	**Jan 2015**	**Jan 2015**	**Jan 2015**
Low Cost Rx Rider (Gr-R-44 Rx)					
$10/25/40 copay; $50 retail deductible; $1000 retail max					
Rx limits removed for PPACA; effective 4Q10					
TWO TIER	SINGLE	120.72	120.72	120.72	120.72
	FAMILY	307.77	307.77	307.77	307.77
THREE TIER	SINGLE	120.72	120.72	120.72	120.72
	DOUBLE	253.44	253.44	253.44	253.44
	FAMILY	319.88	319.88	319.88	319.88
FOUR TIER	SINGLE	120.72	120.72	120.72	120.72
	DOUBLE	265.53	265.53	265.53	265.53
	EE + CHILD(REN)	205.17	205.17	205.17	205.17
	FAMILY	331.85	331.85	331.85	331.85
GHI HMO-GR-R-51 Rx - Removal of Oral Contraceptives					
TWO TIER	SINGLE				
	FAMILY				
THREE TIER	SINGLE				
	DOUBLE	-2.38% of Drug Riders Listed Above	-2.38% of Drug Riders Listed Above	-2.38% of Drug Riders Listed Above	-2.38% of Drug Riders Listed Above
	FAMILY				
FOUR TIER	SINGLE				
	DOUBLE				
	EE + CHILD(REN)				
	FAMILY				
Biologically Based Mental Illness Rider					
GHI HMO-GR-R-TLBB					
TWO TIER	SINGLE	0.77	0.77	0.77	0.77
	FAMILY	1.98	1.98	1.98	1.98
THREE TIER	SINGLE	0.77	0.77	0.77	0.77
	DOUBLE	1.63	1.63	1.63	1.63
	FAMILY	2.06	2.06	2.06	2.06
FOUR TIER	SINGLE	0.77	0.77	0.77	0.77
	DOUBLE	1.69	1.69	1.69	1.69
	EMPLOYEE PLUS CHILD(REN)	1.33	1.33	1.33	1.33
	FAMILY	2.16	2.16	2.16	2.16

"Age 29" Young Adult Option (GHI HMO-GR-R-YAO and GHI HMO GR-R-58A-NYSHIP)	**Individual Rate**	**Individual Rate**	**Individual Rate**	**Individual Rate**
"Age 29" Make Available Option (GHI HMO-R-29MMA) Copay Plans (GHI HMO GR04) and all riders attached to base	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**
"Age 29" Make Available Option (GHI HMO-R-29MMA) Value Plans (GHI HMO.20.ValuePlan) and all riders attached to base	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**	**2-Tier Family = 3.5%** **3-Tier 2-Party = 2.5%** **3-Tier Family = 4.5%** **4-Tier Par/Ch = 4.0%** **4-Tier Family =4.0%**
"Age 29" Make Available Option (GHI HMO-R-29MMA) All direct pay products	**2-Tier Family = 9.5%**	**2-Tier Family = 9.5%**	**2-Tier Family = 9.5%**	**2-Tier Family = 9.5%**
Mental Health Parity (GHIHMO-GR-R-MHPEA)	**1.3%**	**1.3%**	**1.3%**	**1.3%**
Mental Health Parity - Formula to include benefit (Base plan GHI HMO GR04, GHIHMO.20.Direct NYSHIP)	**(Base x 1.3%) - GR-R-TLBB**	**(Base x 1.3%) - GR-R-TLBB**	**(Base x 1.3%) - GR-R-TLBB**	**(Base x 1.3%) - GR-R-TLBB**
Mental Health Parity - Formula to include benefit (Base plan GHI-HMO.20.Value Plan with $20 and $25 copays)	**[(Base + GR-R52) x 1.3%] - GR-R-TLBB**	**[(Base + GR-R52) x 1.3%] - GR-R-TLBB**	**[(Base + GR-R52) x 1.3%] - GR-R-TLBB**	**[(Base + GR-R52) x 1.3%] - GR-R-TLBB**
Mental Health Parity - Formula to include benefit (Base plan GHI HMO.20.Value Plan with $25/$40 and $30/$50 copays)	**[(Base + LG-CD-07) x 1.3%] - GR-R-TLBB**	**[(Base + LG-CD-07) x 1.3%] - GR-R-TLBB**	**[(Base + LG-CD-07) x 1.3%] - GR-R-TLBB**	**[(Base + LG-CD-07) x 1.3%] - GR-R-TLBB**

GHI HMO Select, Inc.
LARGE GROUP (51+)
Monthly Premium Rate Adjustments
Grandfathered Groups Only
Effective 1/1/2015

Adjustments for Reinstatement of PPACA Preventive Care Cost Sharing

US Preventive Service Task Force - "A" and "B" Services
Medical Adjustment: -0.2%

Immunizations
Medical Adjustment: -0.1%

Infant/Child/Adolescent Care
Medical Adjustment: -0.1%

Women's Health
Medical Adjustment: -0.3%

RX Adjustment:

TWO TIER	SINGLE	$	(0.66)
	FAMILY	$	(1.69)
THREE TIER	SINGLE	$	(0.66)
	DOUBLE	$	(1.39)
	FAMILY	$	(1.75)
FOUR TIER	SINGLE	$	(0.66)
	DOUBLE	$	(1.46)
	EMPLOYEE PLUS CHILD(REN)	$	(1.13)
	FAMILY	$	(1.82)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Rate Calculation

Prime and Access Rate Formula

Large groups

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

Example: Large Group HMO Individual Employee Rate Example

=	583.91	1st Quarter	(Base Rate
+	(6.76)	$10 Specialist visit copay	Optional Base Benefit Variables (exlcuding Mental Health)
+	10.37	Unlimited days	Inpatient Mental Health Care with unlimited BIO and CSED coverage
+	12.49	$10 copay, Unlimited visits	Outpatient Mental Health Care with unlimited BIO and CSED coverage
+	-	Not covered	Optional Benefit Rider Coverage)
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	0.985	Mid-Hudson Region	Rating Region Factor
x	1.00	Standard Coverage	Network Area Factor
	600.01	Medical Rate	
+	20.00		Drug Rider
x	1.02	Standard Coverage	Dependends to Age 26 end-of-month
x	1.00	Standard Coverage	Network Area Factor
	20.40	Drug Rate	
	620.41	Total Rate	

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFITS
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Base Rates - Non-Grandfathered Groups				
Large Group	567.04	1,389.25	1,035.42	1,648.39	1,054.69	1,134.08	1,734.58
			Base Rates - Benefits Grandfathered Groups				
Large Group	565.37	1,385.16	1,032.37	1,643.53	1,051.59	1,130.74	1,729.47

Base rates exclude premium component for mandatory mental health coverage
Non Grandfathered Rates include benfefits from the 2012 Women's Health Mandate and Autism M
Grandfathered Rates included benefits from the 2012 Autism Mandate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 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 visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.25)	(7.96)	(5.93)	(9.45)	(6.04)	(6.50)	(9.95)
$10	(6.10)	(14.95)	(11.14)	(17.73)	(11.34)	(12.20)	(18.66)
$15	(8.62)	(21.12)	(15.74)	(25.05)	(16.03)	(17.24)	(26.37)
$20	(10.86)	(26.61)	(19.83)	(31.57)	(20.20)	(21.72)	(33.22)
$25	(13.06)	(32.00)	(23.85)	(37.96)	(24.29)	(26.12)	(39.95)
$30	(15.05)	(36.88)	(27.48)	(43.75)	(27.99)	(30.10)	(46.04)
$35	(17.02)	(41.70)	(31.08)	(49.48)	(31.66)	(34.04)	(52.06)
$40	(19.23)	(47.11)	(35.11)	(55.90)	(35.77)	(38.46)	(58.82)
$45	(21.18)	(51.89)	(38.67)	(61.57)	(39.39)	(42.36)	(64.79)
$50	(23.25)	(56.96)	(42.45)	(67.59)	(43.25)	(46.50)	(71.12)
Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.88)	(4.60)	(3.44)	(5.46)	(3.50)	(3.76)	(5.75)
$10	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$15	(4.96)	(12.16)	(9.06)	(14.41)	(9.23)	(9.92)	(15.17)
$20	(6.23)	(15.26)	(11.38)	(18.11)	(11.59)	(12.46)	(19.06)
$25	(7.49)	(18.35)	(13.68)	(21.78)	(13.94)	(14.98)	(22.91)
$30	(8.62)	(21.12)	(15.74)	(25.05)	(16.03)	(17.24)	(26.37)
$35	(9.77)	(23.94)	(17.84)	(28.40)	(18.17)	(19.54)	(29.89)
$40	(11.03)	(27.02)	(20.14)	(32.06)	(20.52)	(22.06)	(33.74)
$45	(12.15)	(29.77)	(22.19)	(35.32)	(22.60)	(24.30)	(37.17)
$50	(13.33)	(32.66)	(24.34)	(38.75)	(24.79)	(26.66)	(40.78)
Copay	**PCP Office Visit Copay [EXCLUDES Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.14)	(7.69)	(5.73)	(9.13)	(5.84)	(6.28)	(9.61)
$10	(5.90)	(14.46)	(10.77)	(17.15)	(10.97)	(11.80)	(18.05)
$15	(8.34)	(20.43)	(15.23)	(24.24)	(15.51)	(16.68)	(25.51)
$20	(10.51)	(25.75)	(19.19)	(30.55)	(19.55)	(21.02)	(32.15)
$25	(12.64)	(30.97)	(23.08)	(36.74)	(23.51)	(25.28)	(38.67)
$30	(14.57)	(35.70)	(26.60)	(42.35)	(27.10)	(29.14)	(44.57)
$35	(16.49)	(40.40)	(30.11)	(47.94)	(30.67)	(32.98)	(50.44)
$40	(18.63)	(45.64)	(34.02)	(54.16)	(34.65)	(37.26)	(56.99)
$45	(20.52)	(50.27)	(37.47)	(59.65)	(38.17)	(41.04)	(62.77)
$50	(22.52)	(55.17)	(41.12)	(65.47)	(41.89)	(45.04)	(68.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 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 with $0 Child Copay [EXCLUDES Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.81)	(4.43)	(3.31)	(5.26)	(3.37)	(3.62)	(5.54)
$10	(3.39)	(8.31)	(6.19)	(9.85)	(6.31)	(6.78)	(10.37)
$15	(4.79)	(11.74)	(8.75)	(13.92)	(8.91)	(9.58)	(14.65)
$20	(6.03)	(14.77)	(11.01)	(17.53)	(11.22)	(12.06)	(18.45)
$25	(7.25)	(17.76)	(13.24)	(21.08)	(13.49)	(14.50)	(22.18)
$30	(8.35)	(20.46)	(15.25)	(24.27)	(15.53)	(16.70)	(25.54)
$35	(9.46)	(23.18)	(17.27)	(27.50)	(17.60)	(18.92)	(28.94)
$40	(10.68)	(26.17)	(19.50)	(31.05)	(19.86)	(21.36)	(32.67)
$45	(11.77)	(28.84)	(21.49)	(34.22)	(21.89)	(23.54)	(36.00)
$50	(12.92)	(31.65)	(23.59)	(37.56)	(24.03)	(25.84)	(39.52)
Copay	**Urgent Care Visit Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$10	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$15	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$20	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$25	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$30	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$35	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$40	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
$45	(0.66)	(1.62)	(1.21)	(1.92)	(1.23)	(1.32)	(2.02)
$50	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$55	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
$60	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
$65	(0.89)	(2.18)	(1.63)	(2.59)	(1.66)	(1.78)	(2.72)
$70	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$75	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$80	(1.06)	(2.60)	(1.94)	(3.08)	(1.97)	(2.12)	(3.24)
$85	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$90	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$95	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$100	(1.28)	(3.14)	(2.34)	(3.72)	(2.38)	(2.56)	(3.92)
Copay	**Urgent Care Visit Copay with $0 Child Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$10	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$20	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$25	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$30	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
$35	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
$40	(0.35)	(0.86)	(0.64)	(1.02)	(0.65)	(0.70)	(1.07)
$45	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$50	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$55	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$60	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$65	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$70	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$75	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$80	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$85	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$90	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$95	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$100	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 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 [incl. Chiropractic visits] [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.51)	(8.60)	(6.41)	(10.20)	(6.53)	(7.02)	(10.74)
$10	(6.56)	(16.07)	(11.98)	(19.07)	(12.20)	(13.12)	(20.07)
$15	(9.24)	(22.64)	(16.87)	(26.86)	(17.19)	(18.48)	(28.27)
$20	(11.60)	(28.42)	(21.18)	(33.72)	(21.58)	(23.20)	(35.48)
$25	(13.92)	(34.10)	(25.42)	(40.47)	(25.89)	(27.84)	(42.58)
$30	(15.97)	(39.13)	(29.16)	(46.42)	(29.70)	(31.94)	(48.85)
$35	(18.03)	(44.17)	(32.92)	(52.41)	(33.54)	(36.06)	(55.15)
$40	(20.36)	(49.88)	(37.18)	(59.19)	(37.87)	(40.72)	(62.28)
$45	(22.39)	(54.86)	(40.88)	(65.09)	(41.65)	(44.78)	(68.49)
$50	(24.57)	(60.20)	(44.86)	(71.42)	(45.70)	(49.14)	(75.16)
$55	(26.59)	(65.15)	(48.55)	(77.30)	(49.46)	(53.18)	(81.34)
$60	(28.60)	(70.07)	(52.22)	(83.14)	(53.20)	(57.20)	(87.49)
$65	(30.61)	(74.99)	(55.89)	(88.98)	(56.93)	(61.22)	(93.64)
$70	(32.63)	(79.94)	(59.58)	(94.86)	(60.69)	(65.26)	(99.82)
$75	(34.64)	(84.87)	(63.25)	(100.70)	(64.43)	(69.28)	(105.96)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
$10	(5.55)	(13.60)	(10.13)	(16.13)	(10.32)	(11.10)	(16.98)
$15	(7.82)	(19.16)	(14.28)	(22.73)	(14.55)	(15.64)	(23.92)
$20	(9.81)	(24.03)	(17.91)	(28.52)	(18.25)	(19.62)	(30.01)
$25	(11.76)	(28.81)	(21.47)	(34.19)	(21.87)	(23.52)	(35.97)
$30	(13.50)	(33.08)	(24.65)	(39.24)	(25.11)	(27.00)	(41.30)
$35	(15.25)	(37.36)	(27.85)	(44.33)	(28.37)	(30.50)	(46.65)
$40	(17.22)	(42.19)	(31.44)	(50.06)	(32.03)	(34.44)	(52.68)
$45	(18.93)	(46.38)	(34.57)	(55.03)	(35.21)	(37.86)	(57.91)
$50	(20.77)	(50.89)	(37.93)	(60.38)	(38.63)	(41.54)	(63.54)
$55	(22.47)	(55.05)	(41.03)	(65.32)	(41.79)	(44.94)	(68.74)
$60	(24.17)	(59.22)	(44.13)	(70.26)	(44.96)	(48.34)	(73.94)
$65	(25.87)	(63.38)	(47.24)	(75.20)	(48.12)	(51.74)	(79.14)
$70	(27.58)	(67.57)	(50.36)	(80.18)	(51.30)	(55.16)	(84.37)
$75	(29.28)	(71.74)	(53.47)	(85.12)	(54.46)	(58.56)	(89.57)
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
$150	(0.98)	(2.40)	(1.79)	(2.85)	(1.82)	(1.96)	(3.00)
$200	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$250	(1.63)	(3.99)	(2.98)	(4.74)	(3.03)	(3.26)	(4.99)
$500	(3.26)	(7.99)	(5.95)	(9.48)	(6.06)	(6.52)	(9.97)
$750	(4.89)	(11.98)	(8.93)	(14.22)	(9.10)	(9.78)	(14.96)
$1,000	(6.47)	(15.85)	(11.81)	(18.81)	(12.03)	(12.94)	(19.79)
$1,500	(9.62)	(23.57)	(17.57)	(27.97)	(17.89)	(19.24)	(29.43)
$2,000	(12.78)	(31.31)	(23.34)	(37.15)	(23.77)	(25.56)	(39.09)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Day							
$50 w/3 Day Max	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
$50 w/5 Day Max	(0.96)	(2.35)	(1.75)	(2.79)	(1.79)	(1.92)	(2.94)
$100 w/3 Day Max	(1.52)	(3.72)	(2.78)	(4.42)	(2.83)	(3.04)	(4.65)
$100 w/5 Day Max	(1.92)	(4.70)	(3.51)	(5.58)	(3.57)	(3.84)	(5.87)
$250 w/3 Day Max	(3.82)	(9.36)	(6.98)	(11.10)	(7.11)	(7.64)	(11.69)
$250 w/5 Day Max	(4.82)	(11.81)	(8.80)	(14.01)	(8.97)	(9.64)	(14.74)
$500 w/3 Day Max	(7.55)	(18.50)	(13.79)	(21.95)	(14.04)	(15.10)	(23.10)
$500 w/5 Day Max	(9.48)	(23.23)	(17.31)	(27.56)	(17.63)	(18.96)	(29.00)
$750 w/3 Day Max	(11.24)	(27.54)	(20.52)	(32.67)	(20.91)	(22.48)	(34.38)
$750 w/5 Day Max	(14.14)	(34.64)	(25.82)	(41.10)	(26.30)	(28.28)	(43.25)
Copay			**Ambulatory Surgery Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$75	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$100	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$125	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
$150	(1.09)	(2.67)	(1.99)	(3.17)	(2.03)	(2.18)	(3.33)
$200	(1.46)	(3.58)	(2.67)	(4.24)	(2.72)	(2.92)	(4.47)
$250	(1.82)	(4.46)	(3.32)	(5.29)	(3.39)	(3.64)	(5.57)
$300	(2.18)	(5.34)	(3.98)	(6.34)	(4.05)	(4.36)	(6.67)
$350	(2.54)	(6.22)	(4.64)	(7.38)	(4.72)	(5.08)	(7.77)
$400	(2.90)	(7.11)	(5.30)	(8.43)	(5.39)	(5.80)	(8.87)
$450	(3.27)	(8.01)	(5.97)	(9.51)	(6.08)	(6.54)	(10.00)
$500	(3.63)	(8.89)	(6.63)	(10.55)	(6.75)	(7.26)	(11.10)
$550	(3.99)	(9.78)	(7.29)	(11.60)	(7.42)	(7.98)	(12.21)
$600	(4.36)	(10.68)	(7.96)	(12.67)	(8.11)	(8.72)	(13.34)
$650	(4.72)	(11.56)	(8.62)	(13.72)	(8.78)	(9.44)	(14.44)
$700	(5.09)	(12.47)	(9.29)	(14.80)	(9.47)	(10.18)	(15.57)
$750	(5.45)	(13.35)	(9.95)	(15.84)	(10.14)	(10.90)	(16.67)
Copay			**Hospital Emergency Room Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.41)	(1.00)	(0.75)	(1.19)	(0.76)	(0.82)	(1.25)
$25	(3.08)	(7.55)	(5.62)	(8.95)	(5.73)	(6.16)	(9.42)
$35	(3.33)	(8.16)	(6.08)	(9.68)	(6.19)	(6.66)	(10.19)
$50	(5.48)	(13.43)	(10.01)	(15.93)	(10.19)	(10.96)	(16.76)
$60	(5.71)	(13.99)	(10.43)	(16.60)	(10.62)	(11.42)	(17.47)
$75	(7.22)	(17.69)	(13.18)	(20.99)	(13.43)	(14.44)	(22.09)
$100	(8.58)	(21.02)	(15.67)	(24.94)	(15.96)	(17.16)	(26.25)
$125	(9.14)	(22.39)	(16.69)	(26.57)	(17.00)	(18.28)	(27.96)
$150	(10.24)	(25.09)	(18.70)	(29.77)	(19.05)	(20.48)	(31.32)
$200	(11.74)	(28.76)	(21.44)	(34.13)	(21.84)	(23.48)	(35.91)
$250	(13.21)	(32.36)	(24.12)	(38.40)	(24.57)	(26.42)	(40.41)
$300	(14.26)	(34.94)	(26.04)	(41.45)	(26.52)	(28.52)	(43.62)
$350	(15.30)	(37.49)	(27.94)	(44.48)	(28.46)	(30.60)	(46.80)
$400	(16.35)	(40.06)	(29.86)	(47.53)	(30.41)	(32.70)	(50.01)
$450	(17.40)	(42.63)	(31.77)	(50.58)	(32.36)	(34.80)	(53.23)
$500	(18.45)	(45.20)	(33.69)	(53.63)	(34.32)	(36.90)	(56.44)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.65	1.59	1.19	1.89	1.21	1.30	1.99
60	1.25	3.06	2.28	3.63	2.33	2.50	3.82
90	1.89	4.63	3.45	5.49	3.52	3.78	5.78
120	2.25	5.51	4.11	6.54	4.19	4.50	6.88
Unlimited	2.86	7.01	5.22	8.31	5.32	5.72	8.75
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
40/$10 copay	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
40/$15 copay	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
40/$20 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
40/$25 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
40/$30 copay	(0.65)	(1.59)	(1.19)	(1.89)	(1.21)	(1.30)	(1.99)
40/$35 copay	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
40/$40 copay	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
40/$45 copay	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
40/$50 copay	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
40/$55 copay	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
40/$60 copay	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
40/$65 copay	(1.41)	(3.45)	(2.57)	(4.10)	(2.62)	(2.82)	(4.31)
40/$70 copay	(1.51)	(3.70)	(2.76)	(4.39)	(2.81)	(3.02)	(4.62)
40/$75 copay	(1.62)	(3.97)	(2.96)	(4.71)	(3.01)	(3.24)	(4.96)
60/$0 copay	0.35	0.86	0.64	1.02	0.65	0.70	1.07
60/$5 copay	0.23	0.56	0.42	0.67	0.43	0.46	0.70
60/$10 copay	0.12	0.29	0.22	0.35	0.22	0.24	0.37
60/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$20 copay	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
60/$25 copay	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
60/$30 copay	(0.34)	(0.83)	(0.62)	(0.99)	(0.63)	(0.68)	(1.04)
60/$35 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
60/$60 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
60/$45 copay	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
60/$50 copay	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
60/$55 copay	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
60/$60 copay	(1.03)	(2.52)	(1.88)	(2.99)	(1.92)	(2.06)	(3.15)
60/$65 copay	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
60/$70 copay	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
60/$75 copay	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
100/$0 copay	0.83	2.03	1.52	2.41	1.54	1.66	2.54
100/$5 copay	0.70	1.72	1.28	2.03	1.30	1.40	2.14
100/$10 copay	0.57	1.40	1.04	1.66	1.06	1.14	1.74
100/$15 copay	0.46	1.13	0.84	1.34	0.86	0.92	1.41
100/$20 copay	0.33	0.81	0.60	0.96	0.61	0.66	1.01
100/$25 copay	0.20	0.49	0.37	0.58	0.37	0.40	0.61
100/$30 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100/$35 copay	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
100/$100 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
100/$45 copay	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
100/$50 copay	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
100/$55 copay	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
100/$100 copay	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
100/$65 copay	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
100/$70 copay	(0.91)	(2.23)	(1.66)	(2.65)	(1.69)	(1.82)	(2.78)
100/$75 copay	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
200/$0 copay	2.25	5.51	4.11	6.54	4.19	4.50	6.88
200/$5 copay	2.10	5.15	3.83	6.10	3.91	4.20	6.42
200/$10 copay	1.95	4.78	3.56	5.67	3.63	3.90	5.97
200/$15 copay	1.80	4.41	3.29	5.23	3.35	3.60	5.51
200/$20 copay	1.64	4.02	2.99	4.77	3.05	3.28	5.02
200/$25 copay	1.50	3.68	2.74	4.36	2.79	3.00	4.59
200/$30 copay	1.34	3.28	2.45	3.90	2.49	2.68	4.10
200/$35 copay	1.18	2.89	2.15	3.43	2.19	2.36	3.61
200/$200 copay	1.04	2.55	1.90	3.02	1.93	2.08	3.18
200/$45 copay	0.88	2.16	1.61	2.56	1.64	1.76	2.69
200/$50 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
200/$55 copay	0.58	1.42	1.06	1.69	1.08	1.16	1.77
200/$200 copay	0.43	1.05	0.79	1.25	0.80	0.86	1.32
200/$65 copay	0.27	0.66	0.49	0.78	0.50	0.54	0.83
200/$70 copay	0.13	0.32	0.24	0.38	0.24	0.26	0.40
200/$75 copay	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
# Days			**Inpatient Therapies Limit [std: 30 days]**				
0	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.85	2.08	1.55	2.47	1.58	1.70	2.60
90	1.83	4.48	3.34	5.32	3.40	3.66	5.60
# Visits			**Outpatient Therapies Limit [std: 30 visits] [Copay same as Specialist Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.77	1.89	1.41	2.24	1.43	1.54	2.36
90	1.42	3.48	2.59	4.13	2.64	2.84	4.34
120	2.33	5.71	4.25	6.77	4.33	4.66	7.13
			(Verizon Benefit)				
Unlimted PT, 90 visits for all other	1.79	4.39	3.27	5.20	3.33	3.58	5.48

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 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]**						
Unlimited	0.77	1.89	1.41	2.24	1.43	1.54	2.36
	Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]						
# Days	**[Copay same as Inpatient Facility]**						
Unlimited	5.54	13.57	10.12	16.10	10.30	11.08	16.95
	Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]						
# Visits	**[Copay same as Specialist Physician Office Visit, Not to Exceed $30 Copay]**						
Unlimited/$0 copay	0.78	1.91	1.42	2.27	1.45	1.56	2.39
Unlimited/$5 copay	0.77	1.89	1.41	2.24	1.43	1.54	2.36
Unlimited/$10 copay	0.75	1.84	1.37	2.18	1.40	1.50	2.29
Unlimited/$15 copay	0.74	1.81	1.35	2.15	1.38	1.48	2.26
Unlimited/$20 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
Unlimited/$25 copay	0.72	1.76	1.31	2.09	1.34	1.44	2.20
Unlimited/$30 copay	0.70	1.72	1.28	2.03	1.30	1.40	2.14
Unlimited/$35 copay	0.69	1.69	1.26	2.01	1.28	1.38	2.11
Unlimited/$40 copay	0.68	1.67	1.24	1.98	1.26	1.36	2.08
Unlimited/$45 copay	0.66	1.62	1.21	1.92	1.23	1.32	2.02
Unlimited/$50 copay	0.65	1.59	1.19	1.89	1.21	1.30	1.99
Unlimited/$55 copay	0.64	1.57	1.17	1.86	1.19	1.28	1.96
Unlimited/$60 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
Unlimited/$65 copay	0.61	1.49	1.11	1.77	1.13	1.22	1.87
Unlimited/$70 copay	0.60	1.47	1.10	1.74	1.12	1.20	1.84
Unlimited/$75 copay	0.59	1.45	1.08	1.72	1.10	1.18	1.80
Copay	**Dialysis Treatment Copay [std: $10]**						
$0	0.03	0.07	0.05	0.09	0.06	0.06	0.09
$5	0.01	0.02	0.02	0.03	0.02	0.02	0.03
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$20	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$35	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$40	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$45	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$50	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$55	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$60	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$65	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$70	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$75	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$10	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$15	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$20	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$25	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$30	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$35	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$40	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$45	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$50	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$55	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$60	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$65	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$70	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$75	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$10	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$15	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$20	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
$25	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$30	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$35	(1.38)	(3.38)	(2.52)	(4.01)	(2.57)	(2.76)	(4.22)
$40	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
$45	(1.78)	(4.36)	(3.25)	(5.17)	(3.31)	(3.56)	(5.45)
$50	(1.98)	(4.85)	(3.62)	(5.76)	(3.68)	(3.96)	(6.06)
$55	(2.18)	(5.34)	(3.98)	(6.34)	(4.05)	(4.36)	(6.67)
$60	(2.37)	(5.81)	(4.33)	(6.89)	(4.41)	(4.74)	(7.25)
$65	(2.57)	(6.30)	(4.69)	(7.47)	(4.78)	(5.14)	(7.86)
$70	(2.77)	(6.79)	(5.06)	(8.05)	(5.15)	(5.54)	(8.47)
$75	(2.96)	(7.25)	(5.40)	(8.60)	(5.51)	(5.92)	(9.05)
			Chemotherapy [std: $0]				
Copay							
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$20	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$35	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$40	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$45	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$55	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$60	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$65	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$70	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$75	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 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	0.00	0.00	0.00	0.00	0.00
$15	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$25	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$60	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$75	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$100	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$150	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$200	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$250	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
			Ambulance Copay [std: $0]				
Copay			**[Copay same or less than Emergency Room Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$25	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$35	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$50	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$60	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$75	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$100	(0.49)	(1.20)	(0.89)	(1.42)	(0.91)	(0.98)	(1.50)
$125	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
$150	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$200	(0.97)	(2.38)	(1.77)	(2.82)	(1.80)	(1.94)	(2.97)
$250	(1.21)	(2.96)	(2.21)	(3.52)	(2.25)	(2.42)	(3.70)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Surgery and Surgeon Services (Inpatient Facility) [std: $0 copay]				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$100	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$150	(1.11)	(2.72)	(2.03)	(3.23)	(2.06)	(2.22)	(3.40)
$200	(1.48)	(3.63)	(2.70)	(4.30)	(2.75)	(2.96)	(4.53)
$250	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$300	(2.21)	(5.41)	(4.04)	(6.42)	(4.11)	(4.42)	(6.76)
minimum of [20%, $300]	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
			Surgery and Surgeon Services (Outpatient Facility) [std: $0 copay]				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.51)	(1.25)	(0.93)	(1.48)	(0.95)	(1.02)	(1.56)
$100	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$150	(1.53)	(3.75)	(2.79)	(4.45)	(2.85)	(3.06)	(4.68)
$200	(2.05)	(5.02)	(3.74)	(5.96)	(3.81)	(4.10)	(6.27)
$250	(2.55)	(6.25)	(4.66)	(7.41)	(4.74)	(5.10)	(7.80)
$300	(3.07)	(7.52)	(5.61)	(8.92)	(5.71)	(6.14)	(9.39)
minimum of [20%, $300]	(2.77)	(6.79)	(5.06)	(8.05)	(5.15)	(5.54)	(8.47)
			Radiology (Outpatient Facility) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$10	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$15	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.26)	(0.64)	(0.47)	(0.76)	(0.48)	(0.52)	(0.80)
$30	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$35	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$40	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$45	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$50	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$55	(0.58)	(1.42)	(1.06)	(1.69)	(1.08)	(1.16)	(1.77)
$60	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$65	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$70	(0.75)	(1.84)	(1.37)	(2.18)	(1.40)	(1.50)	(2.29)
$75	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
minimum (20%, $100); $500 annual maximum	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
			Radiology Professional) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$10	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$15	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
$20	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
$25	(0.59)	(1.45)	(1.08)	(1.72)	(1.10)	(1.18)	(1.80)
$30	(0.71)	(1.74)	(1.30)	(2.06)	(1.32)	(1.42)	(2.17)
$35	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
$40	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$45	(1.07)	(2.62)	(1.95)	(3.11)	(1.99)	(2.14)	(3.27)
$50	(1.18)	(2.89)	(2.15)	(3.43)	(2.19)	(2.36)	(3.61)
$55	(1.30)	(3.19)	(2.37)	(3.78)	(2.42)	(2.60)	(3.98)
$60	(1.42)	(3.48)	(2.59)	(4.13)	(2.64)	(2.84)	(4.34)
$65	(1.54)	(3.77)	(2.81)	(4.48)	(2.86)	(3.08)	(4.71)
$70	(1.66)	(4.07)	(3.03)	(4.83)	(3.09)	(3.32)	(5.08)
$75	(1.78)	(4.36)	(3.25)	(5.17)	(3.31)	(3.56)	(5.45)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Diagnostic Testing (Outpatient Facility) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$10	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$15	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$20	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$25	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$30	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$35	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
$40	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$45	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)
$50	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$55	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$60	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$65	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$70	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$75	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
minimum of [20%, $100], $500 annual maximum	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
			Diagnostic Testing (Professional) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
$10	(0.54)	(1.32)	(0.99)	(1.57)	(1.00)	(1.08)	(1.65)
$15	(0.82)	(2.01)	(1.50)	(2.38)	(1.53)	(1.64)	(2.51)
$20	(1.10)	(2.70)	(2.01)	(3.20)	(2.05)	(2.20)	(3.36)
$25	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
$30	(1.64)	(4.02)	(2.99)	(4.77)	(3.05)	(3.28)	(5.02)
$35	(1.91)	(4.68)	(3.49)	(5.55)	(3.55)	(3.82)	(5.84)
$40	(2.18)	(5.34)	(3.98)	(6.34)	(4.05)	(4.36)	(6.67)
$45	(2.46)	(6.03)	(4.49)	(7.15)	(4.58)	(4.92)	(7.53)
$50	(2.74)	(6.71)	(5.00)	(7.97)	(5.10)	(5.48)	(8.38)
$55	(3.01)	(7.37)	(5.50)	(8.75)	(5.60)	(6.02)	(9.21)
$60	(3.28)	(8.04)	(5.99)	(9.53)	(6.10)	(6.56)	(10.03)
$65	(3.55)	(8.70)	(6.48)	(10.32)	(6.60)	(7.10)	(10.86)
$70	(3.83)	(9.38)	(6.99)	(11.13)	(7.12)	(7.66)	(11.72)
$75	(4.10)	(10.05)	(7.49)	(11.92)	(7.63)	(8.20)	(12.54)
Copay			**Mammogram Copay [std: $0] (HealthPass]**				
$10/15/20	(0.15)	(0.37)	(0.27)	(0.44)	(0.28)	(0.30)	(0.46)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

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

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

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

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

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

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

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

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT

DEPENDENT VARIABLES - APPLIED TO TOTAL HMO PREMIUM
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO GROUP COMMUNITY CONTRACT - MENTAL HEALTH
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
LARGE GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [Copay same as Inpatient Facility]**						
# Days							
Unlimited	10.07	24.67	18.39	29.27	18.73	20.14	30.80
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverag						
# Visits	**[Copay same or less than Primary Physician Office Visit]**						
$0 Copay	12.57	30.80	22.95	36.54	23.38	25.14	38.45
$5 Copay	12.35	30.26	22.55	35.90	22.97	24.70	37.78
$10 Copay	12.13	29.72	22.15	35.26	22.56	24.26	37.11
$15 Copay	11.92	29.20	21.77	34.65	22.17	23.84	36.46
$20 Copay	11.70	28.67	21.36	34.01	21.76	23.40	35.79
$25 Copay	11.49	28.15	20.98	33.40	21.37	22.98	35.15
$30 Copay	11.26	27.59	20.56	32.73	20.94	22.52	34.44
$35 Copay	11.05	27.07	20.18	32.12	20.55	22.10	33.80
$40 Copay	10.84	26.56	19.79	31.51	20.16	21.68	33.16
$45 Copay	10.62	26.02	19.39	30.87	19.75	21.24	32.49
$50 Copay	10.40	25.48	18.99	30.23	19.34	20.80	31.81
$55 Copay	10.19	24.97	18.61	29.62	18.95	20.38	31.17
$60 Copay	9.97	24.43	18.21	28.98	18.54	19.94	30.50
$65 Copay	9.75	23.89	17.80	28.34	18.14	19.50	29.83
$70 Copay	9.54	23.37	17.42	27.73	17.74	19.08	29.18
$75 Copay	9.32	22.83	17.02	27.09	17.34	18.64	28.51

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - RIDERS
January 01, 2015 - December 31, 2015 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	5.07	12.42	9.26	14.74	9.43	10.14	15.51
$0/Max $5000	4.82	11.81	8.80	14.01	8.97	9.64	14.74
$0/Max $2500	4.50	11.03	8.22	13.08	8.37	9.00	13.77
$25	4.82	11.81	8.80	14.01	8.97	9.64	14.74
$50	4.50	11.03	8.22	13.08	8.37	9.00	13.77
$100	4.15	10.17	7.58	12.06	7.72	8.30	12.69
$500	1.96	4.80	3.58	5.70	3.65	3.92	6.00
$5,000	0.34	0.83	0.62	0.99	0.63	0.68	1.04
Coinsurance							
80%	4.09	10.02	7.47	11.89	7.61	8.18	12.51
75%	3.79	9.29	6.92	11.02	7.05	7.58	11.59
70%	3.57	8.75	6.52	10.38	6.64	7.14	10.92
Deductible			**Orthotics Riders**				
$0	0.84	2.06	1.53	2.44	1.56	1.68	2.57
$0/Max $5000	0.81	1.98	1.48	2.35	1.51	1.62	2.48
$0/Max $2500	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$25	0.81	1.98	1.48	2.35	1.51	1.62	2.48
$50	0.77	1.89	1.41	2.24	1.43	1.54	2.36
$100	0.71	1.74	1.30	2.06	1.32	1.42	2.17
$500	0.36	0.88	0.66	1.05	0.67	0.72	1.10
$5,000	0.03	0.07	0.05	0.09	0.06	0.06	0.09
Coinsurance							
80%	0.71	1.74	1.30	2.06	1.32	1.42	2.17
75%	0.66	1.62	1.21	1.92	1.23	1.32	2.02
70%	0.63	1.54	1.15	1.83	1.17	1.26	1.93

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - RIDERS
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Optical Riders							
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.67	4.09	3.05	4.85	3.11	3.34	5.11
12 Months	2.64	6.47	4.82	7.67	4.91	5.28	8.08
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.57	6.30	4.69	7.47	4.78	5.14	7.86
12 Months	4.14	10.14	7.56	12.03	7.70	8.28	12.66
Private Duty Nursing Riders							
In Full	0.61	1.49	1.11	1.77	1.13	1.22	1.87
80% hrs 73-504	0.09	0.22	0.16	0.26	0.17	0.18	0.28
100% hrs 73-504	0.16	0.39	0.29	0.47	0.30	0.32	0.49
Dental Network Access							
	0.53	1.30	0.97	1.54	0.99	1.06	1.62
Infertility Rider							
Limit							
2 IVF	10.72	26.26	19.57	31.16	19.94	21.44	32.79
3 IVF	12.96	31.75	23.66	37.67	24.11	25.92	39.64
Hearing Aid (Verizon Benefit)							
Hearing Aid Benefit, $1,500 per ear every 2 years, must be sold in conjunction with a DME Rider							
24 Months	3.19	7.82	5.82	9.27	5.93	6.38	9.76
Nurse Advice Line Rider							
	0.35	0.86	0.64	1.02	0.65	0.70	1.07
Wellness Rider							
	0.88	2.16	1.61	2.56	1.64	1.76	2.69
Maximum Out of Pocket							
MOOP	**Mandatory for all non grandfathered groups effective 1/1/2015**						
$6,600/$13,200*	0.00	0.00	0.00	0.00	0.00	0.00	0.00

**** Amount is subject to change when amended by law***

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIPaccess 1 HMO LARGE COMMUNITY GROUP CONTRACT - BASE BENEFITS

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Base Rates - Non-Grandfathered Groups				
Large Group	591.39	1,448.91	1,079.88	1,719.17	1,099.99	1,182.78	1,809.06
			Base Rates - Benefits Grandfathered Groups				
Large Group	584.97	1,433.18	1,068.16	1,700.51	1,088.04	1,169.94	1,789.42

Base rates exclude premium component for mandatory mental health coverage

Non Grandfathered Rates include benfefits from the 2012 Women's Health Mandate and Autism Mandate

Grandfathered Rates included benefits from the 2012 Autism Mandate

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 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 visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.38)	(8.28)	(6.17)	(9.83)	(6.28)	(6.76)	(10.34)
$10	(6.37)	(15.60)	(11.63)	(18.52)	(11.85)	(12.74)	(19.48)
$15	(8.99)	(22.03)	(16.42)	(26.13)	(16.72)	(17.98)	(27.50)
$20	(11.33)	(27.76)	(20.69)	(32.94)	(21.08)	(22.66)	(34.66)
$25	(13.63)	(33.40)	(24.88)	(39.62)	(25.35)	(27.26)	(41.70)
$30	(15.70)	(38.47)	(28.67)	(45.64)	(29.20)	(31.40)	(48.03)
$35	(17.75)	(43.49)	(32.41)	(51.60)	(33.01)	(35.50)	(54.29)
$40	(20.05)	(49.12)	(36.61)	(58.28)	(37.29)	(40.10)	(61.34)
$45	(22.09)	(54.12)	(40.34)	(64.22)	(41.08)	(44.18)	(67.57)
$50	(24.25)	(59.41)	(44.28)	(70.50)	(45.10)	(48.50)	(74.18)

Copay	**PCP Office Visit Copay with $0 Child Copay [inc. Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.95)	(4.78)	(3.56)	(5.67)	(3.63)	(3.90)	(5.96)
$10	(3.66)	(8.97)	(6.69)	(10.64)	(6.81)	(7.32)	(11.20)
$15	(5.16)	(12.65)	(9.42)	(15.00)	(9.60)	(10.32)	(15.78)
$20	(6.50)	(15.92)	(11.87)	(18.90)	(12.09)	(13.00)	(19.88)
$25	(7.81)	(19.13)	(14.26)	(22.71)	(14.53)	(15.62)	(23.89)
$30	(8.99)	(22.03)	(16.41)	(26.13)	(16.72)	(17.98)	(27.50)
$35	(10.19)	(24.96)	(18.60)	(29.62)	(18.96)	(20.38)	(31.17)
$40	(11.51)	(28.20)	(21.02)	(33.46)	(21.41)	(23.02)	(35.21)
$45	(12.67)	(31.04)	(23.14)	(36.83)	(23.56)	(25.34)	(38.75)
$50	(13.91)	(34.08)	(25.40)	(40.44)	(25.87)	(27.82)	(42.55)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**PCP Office Visit Copay [EXCLUDES Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.27)	(8.01)	(5.97)	(9.51)	(6.08)	(6.54)	(10.00)
$10	(6.16)	(15.09)	(11.25)	(17.91)	(11.46)	(12.32)	(18.84)
$15	(8.70)	(21.32)	(15.89)	(25.29)	(16.18)	(17.40)	(26.61)
$20	(10.96)	(26.85)	(20.01)	(31.86)	(20.39)	(21.92)	(33.53)
$25	(13.19)	(32.32)	(24.08)	(38.34)	(24.53)	(26.38)	(40.35)
$30	(15.20)	(37.24)	(27.76)	(44.19)	(28.27)	(30.40)	(46.50)
$35	(17.20)	(42.14)	(31.41)	(50.00)	(31.99)	(34.40)	(52.61)
$40	(19.42)	(47.58)	(35.46)	(56.45)	(36.12)	(38.84)	(59.41)
$45	(21.40)	(52.43)	(39.08)	(62.21)	(39.80)	(42.80)	(65.46)
$50	(23.49)	(57.55)	(42.89)	(68.29)	(43.69)	(46.98)	(71.86)
Copay	**PCP Office Visit Copay with $0 Child Copay [EXCLUDES Urgent Care visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(1.88)	(4.61)	(3.43)	(5.47)	(3.50)	(3.76)	(5.75)
$10	(3.53)	(8.65)	(6.45)	(10.26)	(6.57)	(7.06)	(10.80)
$15	(4.99)	(12.23)	(9.11)	(14.51)	(9.28)	(9.98)	(15.26)
$20	(6.29)	(15.41)	(11.49)	(18.29)	(11.70)	(12.58)	(19.24)
$25	(7.56)	(18.52)	(13.80)	(21.98)	(14.06)	(15.12)	(23.13)
$30	(8.71)	(21.34)	(15.90)	(25.32)	(16.20)	(17.42)	(26.64)
$35	(9.87)	(24.18)	(18.02)	(28.69)	(18.36)	(19.74)	(30.19)
$40	(11.14)	(27.29)	(20.34)	(32.38)	(20.72)	(22.28)	(34.08)
$45	(12.27)	(30.06)	(22.41)	(35.67)	(22.82)	(24.54)	(37.53)
$50	(13.47)	(33.00)	(24.60)	(39.16)	(25.05)	(26.94)	(41.20)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Urgent Care Visit Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$10	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$15	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$20	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$25	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$30	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$35	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$40	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
$45	(0.69)	(1.69)	(1.26)	(2.01)	(1.28)	(1.38)	(2.11)
$50	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$55	(0.81)	(1.98)	(1.48)	(2.35)	(1.51)	(1.62)	(2.48)
$60	(0.87)	(2.13)	(1.59)	(2.53)	(1.62)	(1.74)	(2.66)
$65	(0.93)	(2.28)	(1.70)	(2.70)	(1.73)	(1.86)	(2.84)
$70	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$75	(1.04)	(2.55)	(1.90)	(3.02)	(1.93)	(2.08)	(3.18)
$80	(1.11)	(2.72)	(2.03)	(3.23)	(2.06)	(2.22)	(3.40)
$85	(1.17)	(2.87)	(2.14)	(3.40)	(2.18)	(2.34)	(3.58)
$90	(1.22)	(2.99)	(2.23)	(3.55)	(2.27)	(2.44)	(3.73)
$95	(1.27)	(3.11)	(2.32)	(3.69)	(2.36)	(2.54)	(3.88)
$100	(1.34)	(3.28)	(2.45)	(3.90)	(2.49)	(2.68)	(4.10)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay	**Urgent Care Visit Copay with $0 Child Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$10	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$20	(0.21)	(0.51)	(0.38)	(0.61)	(0.39)	(0.42)	(0.64)
$25	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
$30	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$35	(0.32)	(0.78)	(0.58)	(0.93)	(0.60)	(0.64)	(0.98)
$40	(0.37)	(0.91)	(0.68)	(1.08)	(0.69)	(0.74)	(1.13)
$45	(0.40)	(0.98)	(0.73)	(1.16)	(0.74)	(0.80)	(1.22)
$50	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
$55	(0.47)	(1.15)	(0.86)	(1.37)	(0.87)	(0.94)	(1.44)
$60	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$65	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$70	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$75	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
$80	(0.64)	(1.57)	(1.17)	(1.86)	(1.19)	(1.28)	(1.96)
$85	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$90	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
$95	(0.73)	(1.79)	(1.33)	(2.12)	(1.36)	(1.46)	(2.23)
$100	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 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 [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.66)	(8.97)	(6.68)	(10.64)	(6.81)	(7.32)	(11.20)
$10	(6.85)	(16.78)	(12.51)	(19.91)	(12.74)	(13.70)	(20.95)
$15	(9.64)	(23.62)	(17.60)	(28.02)	(17.93)	(19.28)	(29.49)
$20	(12.10)	(29.65)	(22.09)	(35.17)	(22.51)	(24.20)	(37.01)
$25	(14.52)	(35.57)	(26.51)	(42.21)	(27.01)	(29.04)	(44.42)
$30	(16.66)	(40.82)	(30.42)	(48.43)	(30.99)	(33.32)	(50.96)
$35	(18.81)	(46.08)	(34.35)	(54.68)	(34.99)	(37.62)	(57.54)
$40	(21.24)	(52.04)	(38.78)	(61.74)	(39.51)	(42.48)	(64.97)
$45	(23.35)	(57.21)	(42.64)	(67.88)	(43.43)	(46.70)	(71.43)
$50	(25.63)	(62.79)	(46.80)	(74.51)	(47.67)	(51.26)	(78.40)
$55	(27.73)	(67.94)	(50.63)	(80.61)	(51.58)	(55.46)	(84.83)
$60	(29.83)	(73.08)	(54.47)	(86.72)	(55.48)	(59.66)	(91.25)
$65	(31.93)	(78.23)	(58.30)	(92.82)	(59.39)	(63.86)	(97.67)
$70	(34.03)	(83.37)	(62.14)	(98.93)	(63.30)	(68.06)	(104.10)
$75	(36.12)	(88.49)	(65.96)	(105.00)	(67.18)	(72.24)	(110.49)
Copay	**Specialist Office Visit Copay with $0 Child copay* [incl. Chiropractic visits] [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(3.09)	(7.57)	(5.64)	(8.98)	(5.75)	(6.18)	(9.45)
$10	(5.80)	(14.21)	(10.59)	(16.86)	(10.79)	(11.60)	(17.74)
$15	(8.16)	(19.99)	(14.90)	(23.72)	(15.18)	(16.32)	(24.96)
$20	(10.23)	(25.06)	(18.68)	(29.74)	(19.03)	(20.46)	(31.29)
$25	(12.26)	(30.04)	(22.39)	(35.64)	(22.80)	(24.52)	(37.50)
$30	(14.08)	(34.50)	(25.71)	(40.93)	(26.19)	(28.16)	(43.07)
$35	(15.91)	(38.98)	(29.05)	(46.25)	(29.59)	(31.82)	(48.67)
$40	(17.96)	(44.00)	(32.79)	(52.21)	(33.41)	(35.92)	(54.94)
$45	(19.74)	(48.36)	(36.05)	(57.38)	(36.72)	(39.48)	(60.38)
$50	(21.67)	(53.09)	(39.57)	(62.99)	(40.31)	(43.34)	(66.29)
$55	(23.44)	(57.43)	(42.80)	(68.14)	(43.60)	(46.88)	(71.70)
$60	(25.21)	(61.76)	(46.03)	(73.29)	(46.89)	(50.42)	(77.12)
$65	(26.99)	(66.13)	(49.28)	(78.46)	(50.20)	(53.98)	(82.56)
$70	(28.76)	(70.46)	(52.52)	(83.61)	(53.49)	(57.52)	(87.98)
$75	(30.54)	(74.82)	(55.77)	(88.78)	(56.80)	(61.08)	(93.42)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay/Admit			**Inpatient Facility Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$100	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
$150	(1.02)	(2.50)	(1.86)	(2.97)	(1.90)	(2.04)	(3.12)
$200	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$250	(1.70)	(4.17)	(3.10)	(4.94)	(3.16)	(3.40)	(5.20)
$500	(3.40)	(8.33)	(6.21)	(9.88)	(6.32)	(6.80)	(10.40)
$750	(5.11)	(12.52)	(9.33)	(14.85)	(9.50)	(10.22)	(15.63)
$1,000	(6.75)	(16.54)	(12.33)	(19.62)	(12.56)	(13.50)	(20.65)
$1,500	(10.04)	(24.60)	(18.33)	(29.19)	(18.67)	(20.08)	(30.71)
$2,000	(13.33)	(32.66)	(24.34)	(38.75)	(24.79)	(26.66)	(40.78)
Copay/Day							
$50 w/3 Day Max	(0.80)	(1.96)	(1.46)	(2.33)	(1.49)	(1.60)	(2.45)
$50 w/5 Day Max	(1.00)	(2.45)	(1.83)	(2.91)	(1.86)	(2.00)	(3.06)
$100 w/3 Day Max	(1.59)	(3.90)	(2.90)	(4.62)	(2.96)	(3.18)	(4.86)
$100 w/5 Day Max	(2.01)	(4.92)	(3.67)	(5.84)	(3.74)	(4.02)	(6.15)
$250 w/3 Day Max	(3.98)	(9.75)	(7.27)	(11.57)	(7.40)	(7.96)	(12.17)
$250 w/5 Day Max	(5.02)	(12.30)	(9.17)	(14.59)	(9.34)	(10.04)	(15.36)
$500 w/3 Day Max	(7.87)	(19.28)	(14.37)	(22.88)	(14.64)	(15.74)	(24.07)
$500 w/5 Day Max	(9.89)	(24.23)	(18.06)	(28.75)	(18.40)	(19.78)	(30.25)
$750 w/3 Day Max	(11.72)	(28.71)	(21.40)	(34.07)	(21.80)	(23.44)	(35.85)
$750 w/5 Day Max	(14.75)	(36.14)	(26.93)	(42.88)	(27.44)	(29.50)	(45.12)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**Ambulatory Surgery Facility Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$75	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$100	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$125	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
$150	(1.14)	(2.79)	(2.08)	(3.31)	(2.12)	(2.28)	(3.49)
$200	(1.51)	(3.70)	(2.76)	(4.39)	(2.81)	(3.02)	(4.62)
$250	(1.89)	(4.63)	(3.45)	(5.49)	(3.52)	(3.78)	(5.78)
$300	(2.27)	(5.56)	(4.15)	(6.60)	(4.22)	(4.54)	(6.94)
$350	(2.65)	(6.49)	(4.84)	(7.70)	(4.93)	(5.30)	(8.11)
$400	(3.03)	(7.42)	(5.53)	(8.81)	(5.64)	(6.06)	(9.27)
$450	(3.41)	(8.35)	(6.23)	(9.91)	(6.34)	(6.82)	(10.43)
$500	(3.79)	(9.29)	(6.92)	(11.02)	(7.05)	(7.58)	(11.59)
$550	(4.17)	(10.22)	(7.61)	(12.12)	(7.76)	(8.34)	(12.76)
$600	(4.54)	(11.12)	(8.29)	(13.20)	(8.44)	(9.08)	(13.89)
$650	(4.92)	(12.05)	(8.98)	(14.30)	(9.15)	(9.84)	(15.05)
$700	(5.31)	(13.01)	(9.70)	(15.44)	(9.88)	(10.62)	(16.24)
$750	(5.68)	(13.92)	(10.37)	(16.51)	(10.56)	(11.36)	(17.38)
Copay	**Hospital Emergency Room Copay [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.43)	(1.05)	(0.79)	(1.25)	(0.80)	(0.86)	(1.32)
$25	(3.21)	(7.86)	(5.86)	(9.33)	(5.97)	(6.42)	(9.82)
$35	(3.48)	(8.53)	(6.35)	(10.12)	(6.47)	(6.96)	(10.65)
$50	(5.71)	(13.99)	(10.43)	(16.60)	(10.62)	(11.42)	(17.47)
$60	(5.95)	(14.58)	(10.86)	(17.30)	(11.07)	(11.90)	(18.20)
$75	(7.54)	(18.47)	(13.77)	(21.92)	(14.02)	(15.08)	(23.06)
$100	(8.95)	(21.93)	(16.34)	(26.02)	(16.65)	(17.90)	(27.38)
$125	(9.53)	(23.35)	(17.40)	(27.70)	(17.73)	(19.06)	(29.15)
$150	(10.67)	(26.14)	(19.48)	(31.02)	(19.85)	(21.34)	(32.64)
$200	(12.25)	(30.01)	(22.37)	(35.61)	(22.79)	(24.50)	(37.47)
$250	(13.77)	(33.74)	(25.14)	(40.03)	(25.61)	(27.54)	(42.12)
$300	(14.87)	(36.43)	(27.15)	(43.23)	(27.66)	(29.74)	(45.49)
$350	(15.96)	(39.10)	(29.14)	(46.40)	(29.69)	(31.92)	(48.82)
$400	(17.05)	(41.77)	(31.13)	(49.56)	(31.71)	(34.10)	(52.16)
$450	(18.15)	(44.47)	(33.14)	(52.76)	(33.76)	(36.30)	(55.52)
$500	(19.25)	(47.16)	(35.15)	(55.96)	(35.81)	(38.50)	(58.89)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
# Days			**Skilled Nursing Facility Care Limit [std: 30 days]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
45	0.68	1.67	1.24	1.98	1.26	1.36	2.08
60	1.30	3.19	2.37	3.78	2.42	2.60	3.98
90	1.98	4.85	3.62	5.76	3.68	3.96	6.06
120	2.35	5.76	4.29	6.83	4.37	4.70	7.19
Unlimited	2.99	7.33	5.46	8.69	5.56	5.98	9.15
# Visits			**Home Health Care Limit [std: 40 visits]**				
40/$0 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40/$5 copay	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
40/$10 copay	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
40/$15 copay	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
40/$20 copay	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
40/$25 copay	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
40/$30 copay	(0.68)	(1.67)	(1.24)	(1.98)	(1.26)	(1.36)	(2.08)
40/$35 copay	(0.79)	(1.94)	(1.44)	(2.30)	(1.47)	(1.58)	(2.42)
40/$40 copay	(0.90)	(2.21)	(1.64)	(2.62)	(1.67)	(1.80)	(2.75)
40/$45 copay	(1.01)	(2.47)	(1.84)	(2.94)	(1.88)	(2.02)	(3.09)
40/$50 copay	(1.13)	(2.77)	(2.06)	(3.28)	(2.10)	(2.26)	(3.46)
40/$55 copay	(1.24)	(3.04)	(2.26)	(3.60)	(2.31)	(2.48)	(3.79)
40/$60 copay	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
40/$65 copay	(1.47)	(3.60)	(2.68)	(4.27)	(2.73)	(2.94)	(4.50)
40/$70 copay	(1.58)	(3.87)	(2.89)	(4.59)	(2.94)	(3.16)	(4.83)
40/$75 copay	(1.69)	(4.14)	(3.09)	(4.91)	(3.14)	(3.38)	(5.17)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
60/$0 copay	0.36	0.88	0.66	1.05	0.67	0.72	1.10
60/$5 copay	0.24	0.59	0.44	0.70	0.45	0.48	0.73
60/$10 copay	0.12	0.29	0.22	0.35	0.22	0.24	0.37
60/$15 copay	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60/$20 copay	(0.12)	(0.29)	(0.22)	(0.35)	(0.22)	(0.24)	(0.37)
60/$25 copay	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
60/$30 copay	(0.36)	(0.88)	(0.66)	(1.05)	(0.67)	(0.72)	(1.10)
60/$35 copay	(0.48)	(1.18)	(0.88)	(1.40)	(0.89)	(0.96)	(1.47)
60/$60 copay	(0.60)	(1.47)	(1.10)	(1.74)	(1.12)	(1.20)	(1.84)
60/$45 copay	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
60/$50 copay	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
60/$55 copay	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
60/$60 copay	(1.08)	(2.65)	(1.97)	(3.14)	(2.01)	(2.16)	(3.30)
60/$65 copay	(1.19)	(2.92)	(2.17)	(3.46)	(2.21)	(2.38)	(3.64)
60/$70 copay	(1.32)	(3.23)	(2.41)	(3.84)	(2.46)	(2.64)	(4.04)
60/$75 copay	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
100/$0 copay	0.85	2.08	1.55	2.47	1.58	1.70	2.60
100/$5 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
100/$10 copay	0.59	1.45	1.08	1.72	1.10	1.18	1.80
100/$15 copay	0.48	1.18	0.88	1.40	0.89	0.96	1.47
100/$20 copay	0.34	0.83	0.62	0.99	0.63	0.68	1.04
100/$25 copay	0.21	0.51	0.38	0.61	0.39	0.42	0.64
100/$30 copay	0.08	0.20	0.15	0.23	0.15	0.16	0.24
100/$35 copay	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
100/$100 copay	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
100/$45 copay	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
100/$50 copay	(0.44)	(1.08)	(0.80)	(1.28)	(0.82)	(0.88)	(1.35)
100/$55 copay	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
100/$100 copay	(0.70)	(1.72)	(1.28)	(2.03)	(1.30)	(1.40)	(2.14)
100/$65 copay	(0.83)	(2.03)	(1.52)	(2.41)	(1.54)	(1.66)	(2.54)
100/$70 copay	(0.95)	(2.33)	(1.73)	(2.76)	(1.77)	(1.90)	(2.91)
100/$75 copay	(1.09)	(2.67)	(1.99)	(3.17)	(2.03)	(2.18)	(3.33)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
200/$0 copay	2.35	5.76	4.29	6.83	4.37	4.70	7.19
200/$5 copay	2.19	5.37	4.00	6.37	4.07	4.38	6.70
200/$10 copay	2.04	5.00	3.73	5.93	3.79	4.08	6.24
200/$15 copay	1.87	4.58	3.41	5.44	3.48	3.74	5.72
200/$20 copay	1.71	4.19	3.12	4.97	3.18	3.42	5.23
200/$25 copay	1.56	3.82	2.85	4.53	2.90	3.12	4.77
200/$30 copay	1.40	3.43	2.56	4.07	2.60	2.80	4.28
200/$35 copay	1.23	3.01	2.25	3.58	2.29	2.46	3.76
200/$200 copay	1.09	2.67	1.99	3.17	2.03	2.18	3.33
200/$45 copay	0.92	2.25	1.68	2.67	1.71	1.84	2.81
200/$50 copay	0.76	1.86	1.39	2.21	1.41	1.52	2.32
200/$55 copay	0.61	1.49	1.11	1.77	1.13	1.22	1.87
200/$200 copay	0.45	1.10	0.82	1.31	0.84	0.90	1.38
200/$65 copay	0.28	0.69	0.51	0.81	0.52	0.56	0.86
200/$70 copay	0.14	0.34	0.26	0.41	0.26	0.28	0.43
200/$75 copay	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)

# Days	**Inpatient Therapies Limit [std: 30 days]**						
0	(1.37)	(3.36)	(2.50)	(3.98)	(2.55)	(2.74)	(4.19)
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.88	2.16	1.61	2.56	1.64	1.76	2.69
90	1.89	4.63	3.45	5.49	3.52	3.78	5.78

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
			Outpatient Therapies Limit [std: 30 visits]				
# Visits			**[Copay same as Specialist Office Visit]**				
30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
60	0.80	1.96	1.46	2.33	1.49	1.60	2.45
90	1.49	3.65	2.72	4.33	2.77	2.98	4.56
120	2.43	5.95	4.44	7.06	4.52	4.86	7.43
			(Verizon Benefit)				
Unlimted PT, 90 visits for all other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
			Inpatient Alcohol/Substance Abuse Detoxification Limit [std: 7 days]				
# Days			**[Copay same as Inpatient Facility]**				
Unlimited	0.80	1.96	1.46	2.33	1.49	1.60	2.45
			Inpatient Alcohol/Substance Abuse Rehabilitation Limit [std: 0 days]				
# Days			**[Copay same as Inpatient Facility]**				
Unlimited	5.78	14.16	10.55	16.80	10.75	11.56	17.68
			Outpatient Alcoholism/Substance Abuse Rehab Limit [std: 60 visits]				
# Visits			**[Copay same as Specialist Physician Office Visit, Not to Exceed $30 Copay]**				
Unlimited/$0 copay	0.81	1.98	1.48	2.35	1.51	1.62	2.48
Unlimited/$5 copay	0.80	1.96	1.46	2.33	1.49	1.60	2.45
Unlimited/$10 copay	0.78	1.91	1.42	2.27	1.45	1.56	2.39
Unlimited/$15 copay	0.77	1.89	1.41	2.24	1.43	1.54	2.36
Unlimited/$20 copay	0.76	1.86	1.39	2.21	1.41	1.52	2.32
Unlimited/$25 copay	0.75	1.84	1.37	2.18	1.40	1.50	2.29
Unlimited/$30 copay	0.73	1.79	1.33	2.12	1.36	1.46	2.23
Unlimited/$35 copay	0.72	1.76	1.31	2.09	1.34	1.44	2.20
Unlimited/$40 copay	0.71	1.74	1.30	2.06	1.32	1.42	2.17
Unlimited/$45 copay	0.69	1.69	1.26	2.01	1.28	1.38	2.11
Unlimited/$50 copay	0.68	1.67	1.24	1.98	1.26	1.36	2.08
Unlimited/$55 copay	0.67	1.64	1.22	1.95	1.25	1.34	2.05
Unlimited/$60 copay	0.64	1.57	1.17	1.86	1.19	1.28	1.96
Unlimited/$65 copay	0.63	1.54	1.15	1.83	1.17	1.26	1.93
Unlimited/$70 copay	0.62	1.52	1.13	1.80	1.15	1.24	1.90
Unlimited/$75 copay	0.61	1.49	1.11	1.77	1.13	1.22	1.87

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 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	0.03	0.07	0.05	0.09	0.06	0.06	0.09
$5	0.01	0.02	0.02	0.03	0.02	0.02	0.03
$10	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$20	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$35	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$40	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$45	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$50	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$55	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$60	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$65	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$70	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$75	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
Copay			**Refractive Eye Exam Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$10	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$15	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$20	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$25	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$30	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
$35	(0.29)	(0.71)	(0.53)	(0.84)	(0.54)	(0.58)	(0.89)
$40	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$45	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$50	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$55	(0.46)	(1.13)	(0.84)	(1.34)	(0.86)	(0.92)	(1.41)
$60	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$65	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$70	(0.57)	(1.40)	(1.04)	(1.66)	(1.06)	(1.14)	(1.74)
$75	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
Copay			**Diabetic Supplies Copay [std: $0]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$10	(0.42)	(1.03)	(0.77)	(1.22)	(0.78)	(0.84)	(1.28)
$15	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
$20	(0.82)	(2.01)	(1.50)	(2.38)	(1.53)	(1.64)	(2.51)
$25	(1.03)	(2.52)	(1.88)	(2.99)	(1.92)	(2.06)	(3.15)
$30	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$35	(1.44)	(3.53)	(2.63)	(4.19)	(2.68)	(2.88)	(4.40)
$40	(1.65)	(4.04)	(3.01)	(4.80)	(3.07)	(3.30)	(5.05)
$45	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)
$50	(2.07)	(5.07)	(3.78)	(6.02)	(3.85)	(4.14)	(6.33)
$55	(2.27)	(5.56)	(4.15)	(6.60)	(4.22)	(4.54)	(6.94)
$60	(2.47)	(6.05)	(4.51)	(7.18)	(4.59)	(4.94)	(7.56)
$65	(2.68)	(6.57)	(4.89)	(7.79)	(4.98)	(5.36)	(8.20)
$70	(2.88)	(7.06)	(5.26)	(8.37)	(5.36)	(5.76)	(8.81)
$75	(3.09)	(7.57)	(5.64)	(8.98)	(5.75)	(6.18)	(9.45)
			Chemotherapy [std: $0]				
Copay			**[Copay same as Specialist Physician Office Visit, Not to Exceed $30 Copay]**				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.01)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)
$10	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$15	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$20	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$25	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$30	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$35	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$40	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$45	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$50	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$55	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$60	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$65	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$70	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$75	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
Copay	**Pre-Hospital Emergency Services [std: $0]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$25	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$35	(0.04)	(0.10)	(0.07)	(0.12)	(0.07)	(0.08)	(0.12)
$50	(0.06)	(0.15)	(0.11)	(0.17)	(0.11)	(0.12)	(0.18)
$60	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$75	(0.09)	(0.22)	(0.16)	(0.26)	(0.17)	(0.18)	(0.28)
$100	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$150	(0.19)	(0.47)	(0.35)	(0.55)	(0.35)	(0.38)	(0.58)
$200	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
$250	(0.31)	(0.76)	(0.57)	(0.90)	(0.58)	(0.62)	(0.95)
	Ambulance Copay [std: $0]						
Copay	**[Copay same or less than Emergency Room Copay]**						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$15	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$25	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$35	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$50	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
$60	(0.30)	(0.74)	(0.55)	(0.87)	(0.56)	(0.60)	(0.92)
$75	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$100	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$125	(0.63)	(1.54)	(1.15)	(1.83)	(1.17)	(1.26)	(1.93)
$150	(0.76)	(1.86)	(1.39)	(2.21)	(1.41)	(1.52)	(2.32)
$200	(1.01)	(2.47)	(1.84)	(2.94)	(1.88)	(2.02)	(3.09)
$250	(1.26)	(3.09)	(2.30)	(3.66)	(2.34)	(2.52)	(3.85)
	Surgery and Surgeon Services (Inpatient Facility) [std: $0 copay]						
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$100	(0.77)	(1.89)	(1.41)	(2.24)	(1.43)	(1.54)	(2.36)
$150	(1.16)	(2.84)	(2.12)	(3.37)	(2.16)	(2.32)	(3.55)
$200	(1.54)	(3.77)	(2.81)	(4.48)	(2.86)	(3.08)	(4.71)
$250	(1.92)	(4.70)	(3.51)	(5.58)	(3.57)	(3.84)	(5.87)
$300	(2.31)	(5.66)	(4.22)	(6.72)	(4.30)	(4.62)	(7.07)
minimum of [20%, $300]	(2.08)	(5.10)	(3.80)	(6.05)	(3.87)	(4.16)	(6.36)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Surgery and Surgeon Services (Outpatient Facility) [std: $0 copay]				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$50	(0.53)	(1.30)	(0.97)	(1.54)	(0.99)	(1.06)	(1.62)
$100	(1.07)	(2.62)	(1.95)	(3.11)	(1.99)	(2.14)	(3.27)
$150	(1.60)	(3.92)	(2.92)	(4.65)	(2.98)	(3.20)	(4.89)
$200	(2.14)	(5.24)	(3.91)	(6.22)	(3.98)	(4.28)	(6.55)
$250	(2.66)	(6.52)	(4.86)	(7.73)	(4.95)	(5.32)	(8.14)
$300	(3.20)	(7.84)	(5.84)	(9.30)	(5.95)	(6.40)	(9.79)
minimum of [20%, $300]	(2.88)	(7.06)	(5.26)	(8.37)	(5.36)	(5.76)	(8.81)
			Radiology (Outpatient Facility) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$10	(0.11)	(0.27)	(0.20)	(0.32)	(0.20)	(0.22)	(0.34)
$15	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$20	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$25	(0.27)	(0.66)	(0.49)	(0.78)	(0.50)	(0.54)	(0.83)
$30	(0.33)	(0.81)	(0.60)	(0.96)	(0.61)	(0.66)	(1.01)
$35	(0.39)	(0.96)	(0.71)	(1.13)	(0.73)	(0.78)	(1.19)
$40	(0.45)	(1.10)	(0.82)	(1.31)	(0.84)	(0.90)	(1.38)
$45	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$50	(0.55)	(1.35)	(1.00)	(1.60)	(1.02)	(1.10)	(1.68)
$55	(0.61)	(1.49)	(1.11)	(1.77)	(1.13)	(1.22)	(1.87)
$60	(0.67)	(1.64)	(1.22)	(1.95)	(1.25)	(1.34)	(2.05)
$65	(0.72)	(1.76)	(1.31)	(2.09)	(1.34)	(1.44)	(2.20)
$70	(0.78)	(1.91)	(1.42)	(2.27)	(1.45)	(1.56)	(2.39)
$75	(0.84)	(2.06)	(1.53)	(2.44)	(1.56)	(1.68)	(2.57)
minimum (20%, $100); $500 annual maximum	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Radiology Professional) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$10	(0.24)	(0.59)	(0.44)	(0.70)	(0.45)	(0.48)	(0.73)
$15	(0.38)	(0.93)	(0.69)	(1.10)	(0.71)	(0.76)	(1.16)
$20	(0.50)	(1.23)	(0.91)	(1.45)	(0.93)	(1.00)	(1.53)
$25	(0.62)	(1.52)	(1.13)	(1.80)	(1.15)	(1.24)	(1.90)
$30	(0.74)	(1.81)	(1.35)	(2.15)	(1.38)	(1.48)	(2.26)
$35	(0.86)	(2.11)	(1.57)	(2.50)	(1.60)	(1.72)	(2.63)
$40	(0.99)	(2.43)	(1.81)	(2.88)	(1.84)	(1.98)	(3.03)
$45	(1.12)	(2.74)	(2.05)	(3.26)	(2.08)	(2.24)	(3.43)
$50	(1.23)	(3.01)	(2.25)	(3.58)	(2.29)	(2.46)	(3.76)
$55	(1.36)	(3.33)	(2.48)	(3.95)	(2.53)	(2.72)	(4.16)
$60	(1.48)	(3.63)	(2.70)	(4.30)	(2.75)	(2.96)	(4.53)
$65	(1.61)	(3.94)	(2.94)	(4.68)	(2.99)	(3.22)	(4.92)
$70	(1.73)	(4.24)	(3.16)	(5.03)	(3.22)	(3.46)	(5.29)
$75	(1.85)	(4.53)	(3.38)	(5.38)	(3.44)	(3.70)	(5.66)

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIP HMO LARGE GROUP COMMUNITY CONTRACT - BASE BENEFIT VARIABLES
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
Rider	**Individual**	**Family**	**Two Persons**	**Family**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**
			Diagnostic Testing (Outpatient Facility) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.02)	(0.05)	(0.04)	(0.06)	(0.04)	(0.04)	(0.06)
$10	(0.03)	(0.07)	(0.05)	(0.09)	(0.06)	(0.06)	(0.09)
$15	(0.05)	(0.12)	(0.09)	(0.15)	(0.09)	(0.10)	(0.15)
$20	(0.07)	(0.17)	(0.13)	(0.20)	(0.13)	(0.14)	(0.21)
$25	(0.08)	(0.20)	(0.15)	(0.23)	(0.15)	(0.16)	(0.24)
$30	(0.10)	(0.25)	(0.18)	(0.29)	(0.19)	(0.20)	(0.31)
$35	(0.13)	(0.32)	(0.24)	(0.38)	(0.24)	(0.26)	(0.40)
$40	(0.14)	(0.34)	(0.26)	(0.41)	(0.26)	(0.28)	(0.43)
$45	(0.16)	(0.39)	(0.29)	(0.47)	(0.30)	(0.32)	(0.49)
$50	(0.17)	(0.42)	(0.31)	(0.49)	(0.32)	(0.34)	(0.52)
$55	(0.18)	(0.44)	(0.33)	(0.52)	(0.33)	(0.36)	(0.55)
$60	(0.20)	(0.49)	(0.37)	(0.58)	(0.37)	(0.40)	(0.61)
$65	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
$70	(0.23)	(0.56)	(0.42)	(0.67)	(0.43)	(0.46)	(0.70)
$75	(0.25)	(0.61)	(0.46)	(0.73)	(0.47)	(0.50)	(0.76)
minimum of [20%, $100], $500 annual maximum	(0.22)	(0.54)	(0.40)	(0.64)	(0.41)	(0.44)	(0.67)
			Diagnostic Testing (Professional) [std: $0]				
			Copay per procedure				
$0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
$5	(0.28)	(0.69)	(0.51)	(0.81)	(0.52)	(0.56)	(0.86)
$10	(0.56)	(1.37)	(1.02)	(1.63)	(1.04)	(1.12)	(1.71)
$15	(0.85)	(2.08)	(1.55)	(2.47)	(1.58)	(1.70)	(2.60)
$20	(1.15)	(2.82)	(2.10)	(3.34)	(2.14)	(2.30)	(3.52)
$25	(1.43)	(3.50)	(2.61)	(4.16)	(2.66)	(2.86)	(4.37)
$30	(1.71)	(4.19)	(3.12)	(4.97)	(3.18)	(3.42)	(5.23)
$35	(1.99)	(4.88)	(3.63)	(5.78)	(3.70)	(3.98)	(6.09)
$40	(2.28)	(5.59)	(4.16)	(6.63)	(4.24)	(4.56)	(6.97)
$45	(2.56)	(6.27)	(4.67)	(7.44)	(4.76)	(5.12)	(7.83)
$50	(2.86)	(7.01)	(5.22)	(8.31)	(5.32)	(5.72)	(8.75)
$55	(3.14)	(7.69)	(5.73)	(9.13)	(5.84)	(6.28)	(9.61)
$60	(3.43)	(8.40)	(6.26)	(9.97)	(6.38)	(6.86)	(10.49)
$65	(3.71)	(9.09)	(6.77)	(10.78)	(6.90)	(7.42)	(11.35)
$70	(3.99)	(9.78)	(7.29)	(11.60)	(7.42)	(7.98)	(12.21)
$75	(4.27)	(10.46)	(7.80)	(12.41)	(7.94)	(8.54)	(13.06)

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP RATE MANUAL

HIP HMO Access 1 LARGE GROUP COMMUNITY CONTRACT
DEPENDENT VARIABLES - APPLIED TO TOTAL HMO Access 1 PREMIUM
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

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

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

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

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

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

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

Dependent Coverage

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

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP COMMUNITY CONTRACT - MENTAL HEALTH
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Rider	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family
LARGE GROUP	**Inpatient Mental Health Care with Unlimited Bio and CSED Coverage [Copay same as Inpatient Facility]**						
# Days							
Unlimited	10.50	25.73	19.17	30.52	19.53	21.00	32.12
	Outpatient Mental Health Care with Unlimited Bio and CSED Coverage [Copay same or less than Primary Physician Office Visit]						
# Visits							
$0 Copay	13.10	32.10	23.92	38.08	24.37	26.20	40.07
$5 Copay	12.88	31.56	23.52	37.44	23.96	25.76	39.40
$10 Copay	12.64	30.97	23.08	36.74	23.51	25.28	38.67
$15 Copay	12.42	30.43	22.68	36.10	23.10	24.84	37.99
$20 Copay	12.20	29.89	22.28	35.47	22.69	24.40	37.32
$25 Copay	11.98	29.35	21.88	34.83	22.28	23.96	36.65
$30 Copay	11.75	28.79	21.46	34.16	21.86	23.50	35.94
$35 Copay	11.53	28.25	21.05	33.52	21.45	23.06	35.27
$40 Copay	11.30	27.69	20.63	32.85	21.02	22.60	34.57
$45 Copay	11.08	27.15	20.23	32.21	20.61	22.16	33.89
$50 Copay	10.85	26.58	19.81	31.54	20.18	21.70	33.19
$55 Copay	10.62	26.02	19.39	30.87	19.75	21.24	32.49
$60 Copay	10.40	25.48	18.99	30.23	19.34	20.80	31.81
$65 Copay	10.17	24.92	18.57	29.56	18.92	20.34	31.11
$70 Copay	9.94	24.35	18.15	28.90	18.49	19.88	30.41
$75 Copay	9.72	23.81	17.75	28.26	18.08	19.44	29.73

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP COMMUNITY CONTRACT - RIDERS
January 01, 2015 - December 31, 2015 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	5.28	12.94	9.64	15.35	9.82	10.56	16.15
$25	5.02	12.30	9.17	14.59	9.34	10.04	15.36
$50	4.68	11.47	8.55	13.60	8.70	9.36	14.32
$100	4.33	10.61	7.91	12.59	8.05	8.66	13.25
$500	2.04	5.00	3.73	5.93	3.79	4.08	6.24
Coinsurance							
80%	4.26	10.44	7.78	12.38	7.92	8.52	13.03
75%	3.95	9.68	7.21	11.48	7.35	7.90	12.08
70%	3.73	9.14	6.81	10.84	6.94	7.46	11.41
Deductible			**Orthotics Riders**				
$0	0.87	2.13	1.59	2.53	1.62	1.74	2.66
$25	0.84	2.06	1.53	2.44	1.56	1.68	2.57
$50	0.80	1.96	1.46	2.33	1.49	1.60	2.45
$100	0.74	1.81	1.35	2.15	1.38	1.48	2.26
$500	0.37	0.91	0.68	1.08	0.69	0.74	1.13
Coinsurance							
80%	0.74	1.81	1.35	2.15	1.38	1.48	2.26
75%	0.70	1.72	1.28	2.03	1.30	1.40	2.14
70%	0.66	1.62	1.21	1.92	1.23	1.32	2.02
			Optical Riders				
Eyeglasses Only with $45 copay							
24 Months	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Eyeglasses with $0 copay and Contacts with $70 copay							
24 Months	1.75	4.29	3.20	5.09	3.26	3.50	5.35
12 Months	2.76	6.76	5.04	8.02	5.13	5.52	8.44
Eyeglasses with $0 copay and Contacts with $25 copay							
24 Months	2.67	6.54	4.88	7.76	4.97	5.34	8.17
12 Months	4.32	10.58	7.89	12.56	8.04	8.64	13.21

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
HIPaccess 1 HMO LARGE GROUP COMMUNITY CONTRACT - RIDERS
January 01, 2015 - December 31, 2015 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	0.63	1.54	1.15	1.83	1.17	1.26	1.93
80% hrs 73-504	0.09	0.22	0.16	0.26	0.17	0.18	0.28
100% hrs 73-504	0.17	0.42	0.31	0.49	0.32	0.34	0.52
			Dental Network Access				
	0.55	1.35	1.00	1.60	1.02	1.10	1.68
Limit							
2 IVF	11.18	27.39	20.41	32.50	20.79	22.36	34.20
3 IVF	13.52	33.12	24.69	39.30	25.15	27.04	41.36
			Nurse Advice Line Rider				
	0.36	0.88	0.66	1.05	0.67	0.72	1.10
			Wellness Rider				
	0.92	2.25	1.68	2.67	1.71	1.84	2.81
			Maximum Out of Pocket				
MOOP	**Mandatory for all non grandfathered groups effective 1/1/2015**						
$6,600/$13,200*	0.00	0.00	0.00	0.00	0.00	0.00	0.00

** Amount is subject to change when amended by law*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP RATE MANUAL
LARGE GROUP HMO
VHLI - LGRP - 01
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

	Individual Subscriber	Family Subscriber
Large Group HMO Base Rates		
Base Rate (includes Women's Health & Autism Mandate Benefits)	656.40	1,708.15
Base Rate (Includes Autism - For Grandfathered Groups only)	654.45	1,703.07
Mental Health Coverage		
Inpatient Mental Health: 30 Days	2.45	5.99
Inpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.52	3.70
Outpatient Mental Health: 20 Visits	6.75	16.55
Outpatient Mental Health: Unlimited Biologically Based and Childhood Emotional Disturbances	1.22	3.00
Other Riders		
Durable Medical Equipment	1.80	4.23
Chiropractic: $5 Copay	4.76	12.52
Drug Rider (with WH): $7 Copay, $50 Deductible	166.82	432.64
Drug Rider (w/out WH): $7 Copay, $50 Deductible	166.14	431.96
Infertility Drug Coverage: $7 Brand Copay	3.86	10.16
Unmarried Dependents to 26 EOM & Unmarried Students to 26 EOY	N/A	24.85
Inpatient Substance Abuse Rehab: Unlimited days	5.13	12.53
Inpatient Alcohol/Substance Abuse Detoxification: Unlimited Days	0.72	1.76
Outpatient Substance Abuse Rehab: $5 Copay and Unlimited days	0.57	1.36

	Dependent Children [std: covered to 19 end of m	
Age	**End of Month**	
30	0.0%	7.2%

	Maximum Out of Pocket	
MOOP	**Mandatory for all non grandfathered groups effect 1/1**	
$6,600/$13,200*	0.00	0.00

**** Amount is subject to change when amended by law***

HEALTH INSURANCE PLAN OF GREATER NEW YORK

2015 LARGE GROUP COMMUNITY RATE MANUAL

HMO, POS, HIPaccess I HMO, HIPaccess II POS Factors
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

NETWORK AREA FACTORS

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

*** Based on member location**

HEALTH INSURANCE PLAN OF GREATER NEW YORK

1st - 4th Quarter 2015 LARGE GROUP COMMUNITY RATE MANUAL

Prime HMO, HIPaccess I Factors

January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

HMO RATING REGION FACTORS

Area *	Medical	RX
Downstate (excl. LI)	**0.980**	**1.000**
NYC, Westchester, Rockland		
Long Island	**1.072**	**1.000**
Nassau, Suffolk		
Mid-Hudson	**0.985**	**1.000**
Orange, Ulster, Dutchess, Sullivan, Putnam, Delaware		
Albany **	**0.985**	**1.000**
Greene, Rensselaer, Saratoga, Warren, Albany, Columbia, Fulton, Montgomery, Schenectady, Schoharie, Washington, Broome and Otsego		

* Based on employee location of residence

** Includes Broome County from the Syracuse Region and Ostego County from the Utica Region

HIP INSURANCE COMPANY OF NEW YORK
2015 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
January 01, 2015 - December 31, 2015 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

HIP INSURANCE COMPANY OF NEW YORK
2015 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

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*

HIP INSURANCE COMPANY OF NEW YORK
2015 LARGE GROUP RATE MANUAL
GROUP CONTRACT - DRUG RIDERS
January 01, 2015 - December 31, 2015 MONTHLY PREMIUMS

Table 4: Drug Rider Percentage Values

Drug Rider Variations	% Adjustment To Above Rates
[a] Exclude Contraceptives	-3.0%
[b] Annual Maximum to also include Generic Drugs:	
$1,000 (Brand & Generic)	-6.0%
$2,000 (Brand & Generic)	-4.0%
$2,500 (Brand & Generic)	-3.5%
$3,000 (Brand & Generic)	-3.0%
$4,000 (Brand & Generic)	-2.0%
$5,000 (Brand & Generic)	-1.0%
[c] Non Formulary Coverage, Generic Only Plans	5.0%
[d] PICA Adjustı Applies only to New York City account	-10.0%
[e] IC Adjustm Applies only to New York City account	-2.0%
[f] Product Fac HMO, Access I, and EPO	0.0%
POS, Access II, and PPO	0.0%
[g] Trend per Quarter	
2Q2010-2Q2011	2.5%
3Q2011	1.9%
4Q2011	2.5%
1Q2012 -4Q2012	1.9%
1Q2013	0.0%
2Q2013	1.22%
3Q2013	1.22%
4Q2013	1.22%
1Q14-4Q14	0.0%
1Q15	**10.15%**
2Q15-4Q15	**0.0%**
[h] Mandatory Women's Preventive Services	$0.62

Table 5: Tier Conversion Factors

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

Health Insurance Plan of Greater New York

Rating Region Definitions

County	Region
Albany	Albany
Columbia	Albany
Fulton	Albany
Greene	Albany
Montgomery	Albany
Rensselaer	Albany
Saratoga	Albany
Schenectady	Albany
Schoharie	Albany
Warren	Albany
Washington	Albany
Delaware	Mid-Hudson
Dutchess	Mid-Hudson
Orange	Mid-Hudson
Putnam	Mid-Hudson
Sullivan	Mid-Hudson
Ulster	Mid-Hudson
Bronx	Downstate (excl LI)
Kings	Downstate (excl LI)
Nassau	Long Island
New York	Downstate (excl LI)
Queens	Downstate (excl LI)
Richmond	Downstate (excl LI)
Rockland	Downstate (excl LI)
Suffolk	Long Island
Westchester	Downstate (excl LI)
Broome	Syracuse
Otsego	Utica

Commissions Schedule

Current Approved Schedule: SERFF Filing # HPHP-129561417

HEALTH INSURANCE PLAN OF GREATER NEW YORK
2015 LARGE GROUP COMMUNITY RATE MANUAL

Contents **Page #**

Manual Rate Calculation	1
Prime Large Group HMO	
Base Benefits	2
Base Variables	3 - 13
Dependent Variables	14 - 15
Mental Health	16
Riders	17 - 18
Prime Large Group HMO HIP*access* 1	
Base Benefits	19
Base Variables	20 - 36
Dependent Variables	37
Mental Health	38
Riders	39 - 40
VHLI-LRGP-01	41
Network Factors	42
Rating Region Factors	43
Drug Riders	44 - 46
Rating Regions and Commissions	47