

SERFF Tracking #:

HNMN-129030684

State Tracking #:

2013050117

Company Tracking #:

State:

New York

Filing Company:

Freelancers Health Service Corporation

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005C Individual - Other

Product Name:

FHSC IND OFF Exchange

Project Name/Number:

/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual		New		FHSC Rate Manual (5-25-2013).pdf,

**Freelancers Health Service Corporation
2014 Individual Rate Filing
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FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers:
FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

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**Freelancers Health Service Corporation
2014 Individual Rate Filing
Rate Setting Parameters**

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

HIOS ID	Product	Market	Metal	Index Rate (Adult)	Age Band	Rate Factor	Tobacco Factor	Geographic Factors:
				Conversion Factor				
				214.578957				
				1.00				
				Rate				
				Factor				
					0-17	1.000	1.000	
					18	1.000	1.000	
					19	1.000	1.000	
					20	1.000	1.000	
					21	1.000	1.000	
					22	1.000	1.000	
					23	1.000	1.000	
					24	1.000	1.000	
					25	1.000	1.000	
					26	1.000	1.000	
					27	1.000	1.000	
					28	1.000	1.000	
					29	1.000	1.000	
					30	1.000	1.000	
					31	1.000	1.000	
					32	1.000	1.000	
					33	1.000	1.000	
					34	1.000	1.000	
					35	1.000	1.000	
					36	1.000	1.000	
					37	1.000	1.000	
					38	1.000	1.000	
					39	1.000	1.000	
					40	1.000	1.000	
					41	1.000	1.000	
					42	1.000	1.000	
					43	1.000	1.000	
					44	1.000	1.000	
					45	1.000	1.000	
					46	1.000	1.000	
					47	1.000	1.000	
					48	1.000	1.000	
					49	1.000	1.000	
					50	1.000	1.000	
					51	1.000	1.000	
					52	1.000	1.000	
					53	1.000	1.000	
					54	1.000	1.000	
					55	1.000	1.000	
					56	1.000	1.000	
					57	1.000	1.000	
					58	1.000	1.000	
					59	1.000	1.000	
					60	1.000	1.000	
					61	1.000	1.000	
					62	1.000	1.000	
					63	1.000	1.000	
					64+	1.000	1.000	

Area	Rate Factor
Region 1	1.086664
Region 2	1.017235
Region 3	1.220650
Region 4	1.431276
Region 5	1.000000
Region 6	1.056058
Region 7	1.027582
Region 8	1.431276

Four Tier Family Factors:		
	Individual	1.000
	Couple	2.000
	Primary Subscriber and One Dependent	1.700
	Primary Subscriber and Two Dependents	1.700
	Primary Subscriber and Three or More Dependents	1.700
	Couple and One Dependent	2.850
	Couple and Two Dependents	2.850
	Couple and Three or More Dependents	2.850

Sample Rate Calculation:
 Platinum Select in Region 2 for a Couple with Two Dependents =
 Base Rate x Conversion Factor x Platinum Select Factor x Region 2 Factor x Couple and Two Dependents Factor =
 \$214.58 x 1.00 x 1.610092 x 1.017235 x 2.85 = \$1,001.62

**Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates**

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Essential Care Platinum	Region 1	\$391.62	\$783.23	\$665.75	\$665.75	\$665.75	\$1,116.11	\$1,116.11	\$1,116.11
	Region 2	\$366.60	\$733.19	\$623.21	\$623.21	\$623.21	\$1,044.80	\$1,044.80	\$1,044.80
	Region 3	\$439.90	\$879.81	\$747.84	\$747.84	\$747.84	\$1,253.73	\$1,253.73	\$1,253.73
	Region 4	\$515.81	\$1,031.62	\$876.88	\$876.88	\$876.88	\$1,470.06	\$1,470.06	\$1,470.06
	Region 5	\$360.38	\$720.77	\$612.65	\$612.65	\$612.65	\$1,027.10	\$1,027.10	\$1,027.10
	Region 6	\$380.59	\$761.17	\$647.00	\$647.00	\$647.00	\$1,084.67	\$1,084.67	\$1,084.67
	Region 7	\$370.32	\$740.65	\$629.55	\$629.55	\$629.55	\$1,055.43	\$1,055.43	\$1,055.43
	Region 8	\$515.81	\$1,031.62	\$876.88	\$876.88	\$876.88	\$1,470.06	\$1,470.06	\$1,470.06
Essential Care Gold	Region 1	\$333.06	\$666.13	\$566.21	\$566.21	\$566.21	\$949.23	\$949.23	\$949.23
	Region 2	\$311.78	\$623.57	\$530.03	\$530.03	\$530.03	\$888.58	\$888.58	\$888.58
	Region 3	\$374.13	\$748.26	\$636.02	\$636.02	\$636.02	\$1,066.27	\$1,066.27	\$1,066.27
	Region 4	\$438.69	\$877.38	\$745.77	\$745.77	\$745.77	\$1,250.26	\$1,250.26	\$1,250.26
	Region 5	\$306.50	\$613.00	\$521.05	\$521.05	\$521.05	\$873.53	\$873.53	\$873.53
	Region 6	\$323.68	\$647.37	\$550.26	\$550.26	\$550.26	\$922.50	\$922.50	\$922.50
	Region 7	\$314.98	\$629.91	\$535.42	\$535.42	\$535.42	\$887.62	\$887.62	\$887.62
	Region 8	\$438.69	\$877.38	\$745.77	\$745.77	\$745.77	\$1,250.26	\$1,250.26	\$1,250.26
Essential Care Silver	Region 1	\$294.14	\$588.28	\$500.04	\$500.04	\$500.04	\$838.30	\$838.30	\$838.30
	Region 2	\$275.35	\$550.70	\$468.09	\$468.09	\$468.09	\$784.74	\$784.74	\$784.74
	Region 3	\$330.41	\$660.82	\$561.70	\$561.70	\$561.70	\$941.67	\$941.67	\$941.67
	Region 4	\$387.42	\$774.85	\$658.62	\$658.62	\$658.62	\$1,104.15	\$1,104.15	\$1,104.15
	Region 5	\$270.68	\$541.37	\$460.16	\$460.16	\$460.16	\$771.45	\$771.45	\$771.45
	Region 6	\$285.86	\$571.71	\$485.96	\$485.96	\$485.96	\$814.69	\$814.69	\$814.69
	Region 7	\$278.15	\$556.30	\$472.85	\$472.85	\$472.85	\$792.73	\$792.73	\$792.73
	Region 8	\$387.42	\$774.85	\$658.62	\$658.62	\$658.62	\$1,104.15	\$1,104.15	\$1,104.15
Essential Care Bronze	Region 1	\$233.18	\$466.35	\$396.40	\$396.40	\$396.40	\$664.55	\$664.55	\$664.55
	Region 2	\$218.28	\$436.56	\$371.07	\$371.07	\$371.07	\$622.09	\$622.09	\$622.09
	Region 3	\$261.93	\$523.85	\$445.27	\$445.27	\$445.27	\$746.49	\$746.49	\$746.49
	Region 4	\$307.12	\$614.24	\$522.11	\$522.11	\$522.11	\$875.30	\$875.30	\$875.30
	Region 5	\$214.58	\$429.16	\$364.78	\$364.78	\$364.78	\$611.55	\$611.55	\$611.55
	Region 6	\$226.61	\$453.22	\$385.23	\$385.23	\$385.23	\$645.83	\$645.83	\$645.83
	Region 7	\$220.50	\$441.00	\$374.85	\$374.85	\$374.85	\$628.42	\$628.42	\$628.42
	Region 8	\$307.12	\$614.24	\$522.11	\$522.11	\$522.11	\$875.30	\$875.30	\$875.30
Essential Care Catastrophic	Region 1	\$161.51	\$323.02	\$274.57	\$274.57	\$274.57	\$460.31	\$460.31	\$460.31
	Region 2	\$151.19	\$302.39	\$257.03	\$257.03	\$257.03	\$430.90	\$430.90	\$430.90
	Region 3	\$181.43	\$362.85	\$308.43	\$308.43	\$308.43	\$517.07	\$517.07	\$517.07
	Region 4	\$212.73	\$425.47	\$361.65	\$361.65	\$361.65	\$606.29	\$606.29	\$606.29
	Region 5	\$148.63	\$297.26	\$252.67	\$252.67	\$252.67	\$423.60	\$423.60	\$423.60
	Region 6	\$156.96	\$313.93	\$266.84	\$266.84	\$266.84	\$447.35	\$447.35	\$447.35
	Region 7	\$152.73	\$305.46	\$259.64	\$259.64	\$259.64	\$435.28	\$435.28	\$435.28
	Region 8	\$212.73	\$425.47	\$361.65	\$361.65	\$361.65	\$606.29	\$606.29	\$606.29
Primary Select Platinum	Region 1	\$375.43	\$750.87	\$638.24	\$638.24	\$638.24	\$1,069.99	\$1,069.99	\$1,069.99
	Region 2	\$351.45	\$702.89	\$597.46	\$597.46	\$597.46	\$1,001.62	\$1,001.62	\$1,001.62
	Region 3	\$421.72	\$843.45	\$716.93	\$716.93	\$716.93	\$1,201.92	\$1,201.92	\$1,201.92
	Region 4	\$494.49	\$988.99	\$840.64	\$840.64	\$840.64	\$1,409.31	\$1,409.31	\$1,409.31
	Region 5	\$345.49	\$690.98	\$587.34	\$587.34	\$587.34	\$984.65	\$984.65	\$984.65
	Region 6	\$364.86	\$729.72	\$620.26	\$620.26	\$620.26	\$1,039.85	\$1,039.85	\$1,039.85
	Region 7	\$355.02	\$710.04	\$603.54	\$603.54	\$603.54	\$1,011.81	\$1,011.81	\$1,011.81
	Region 8	\$494.49	\$988.99	\$840.64	\$840.64	\$840.64	\$1,409.31	\$1,409.31	\$1,409.31
Primary Select Gold	Region 1	\$332.80	\$665.60	\$565.76	\$565.76	\$565.76	\$948.48	\$948.48	\$948.48
	Region 2	\$311.54	\$623.07	\$529.61	\$529.61	\$529.61	\$887.88	\$887.88	\$887.88
	Region 3	\$373.83	\$747.67	\$635.52	\$635.52	\$635.52	\$1,065.43	\$1,065.43	\$1,065.43
	Region 4	\$438.34	\$876.68	\$745.18	\$745.18	\$745.18	\$1,249.27	\$1,249.27	\$1,249.27
	Region 5	\$306.26	\$612.52	\$520.64	\$520.64	\$520.64	\$872.84	\$872.84	\$872.84
	Region 6	\$323.43	\$646.85	\$549.83	\$549.83	\$549.83	\$921.77	\$921.77	\$921.77
	Region 7	\$314.71	\$629.41	\$535.00	\$535.00	\$535.00	\$896.91	\$896.91	\$896.91
	Region 8	\$438.34	\$876.68	\$745.18	\$745.18	\$745.18	\$1,249.27	\$1,249.27	\$1,249.27
Primary Select Silver	Region 1	\$293.93	\$587.86	\$499.68	\$499.68	\$499.68	\$837.70	\$837.70	\$837.70
	Region 2	\$275.15	\$550.30	\$467.76	\$467.76	\$467.76	\$784.18	\$784.18	\$784.18
	Region 3	\$330.17	\$660.34	\$561.29	\$561.29	\$561.29	\$940.99	\$940.99	\$940.99
	Region 4	\$387.14	\$774.29	\$658.14	\$658.14	\$658.14	\$1,103.36	\$1,103.36	\$1,103.36
	Region 5	\$270.49	\$540.98	\$459.83	\$459.83	\$459.83	\$770.89	\$770.89	\$770.89
	Region 6	\$285.65	\$571.30	\$485.61	\$485.61	\$485.61	\$814.11	\$814.11	\$814.11
	Region 7	\$277.95	\$555.90	\$472.51	\$472.51	\$472.51	\$792.15	\$792.15	\$792.15
	Region 8	\$387.14	\$774.29	\$658.14	\$658.14	\$658.14	\$1,103.36	\$1,103.36	\$1,103.36
Primary Select Silver EPO	Region 1	\$277.33	\$554.67	\$471.47	\$471.47	\$471.47	\$790.40	\$790.40	\$790.40
	Region 2	\$259.61	\$519.23	\$441.34	\$441.34	\$441.34	\$739.90	\$739.90	\$739.90
	Region 3	\$311.53	\$623.06	\$529.60	\$529.60	\$529.60	\$887.86	\$887.86	\$887.86
	Region 4	\$365.28	\$730.57	\$620.98	\$620.98	\$620.98	\$1,041.06	\$1,041.06	\$1,041.06
	Region 5	\$255.21	\$510.43	\$433.87	\$433.87	\$433.87	\$727.36	\$727.36	\$727.36
	Region 6	\$269.52	\$539.04	\$458.19	\$458.19	\$458.19	\$768.14	\$768.14	\$768.14
	Region 7	\$262.25	\$524.51	\$445.83	\$445.83	\$445.83	\$747.42	\$747.42	\$747.42
	Region 8	\$365.28	\$730.57	\$620.98	\$620.98	\$620.98	\$1,041.06	\$1,041.06	\$1,041.06
Primary Select Bronze	Region 1	\$202.13	\$404.26	\$343.62	\$343.62	\$343.62	\$576.07	\$576.07	\$576.07
	Region 2	\$189.21	\$378.43	\$321.66	\$321.66	\$321.66	\$539.26	\$539.26	\$539.26
	Region 3	\$227.05	\$454.10	\$385.99	\$385.99	\$385.99	\$647.09	\$647.09	\$647.09
	Region 4	\$266.23	\$532.46	\$452.59	\$452.59	\$452.59	\$758.75	\$758.75	\$758.75
	Region 5	\$186.01	\$372.02	\$316.21	\$316.21	\$316.21	\$530.12	\$530.12	\$530.12
	Region 6	\$196.44	\$392.87	\$333.94	\$333.94	\$333.94	\$559.84	\$559.84	\$559.84
	Region 7	\$191.14	\$382.28	\$324.94	\$324.94	\$324.94	\$544.74	\$544.74	\$544.74
	Region 8	\$266.23	\$532.46	\$452.59	\$452.59	\$452.59	\$758.75	\$758.75	\$758.75
EssentialCare Platinum Dental	Region 1	\$397.25	\$794.51	\$675.33	\$675.33	\$675.33	\$1,132.17	\$1,132.17	\$1,132.17
	Region 2	\$371.87	\$743.74	\$632.18	\$632.18	\$632.18	\$1,059.83	\$1,059.83	\$1,059.83
	Region 3	\$446.23	\$892.47	\$758.60	\$758.60	\$758.60	\$1,271.77	\$1,271.77	\$1,271.77
	Region 4	\$523.23	\$1,046.47	\$889.50	\$889.50	\$889.50	\$1,491.21	\$1,491.21	\$1,491.21
	Region 5	\$365.57	\$731.14	\$621.47	\$621.47	\$621.47	\$1,041.88	\$1,041.88	\$1,041.88
	Region 6	\$386.06	\$772.13	\$656.31	\$656.31	\$656.31	\$1,100.28	\$1,100.28	\$1,100.28
	Region 7	\$375.65	\$751.31	\$638.61	\$638.61	\$638.61	\$1,070.61	\$1,070.61	\$1,070.61
	Region 8	\$523.23	\$1,046.47	\$889.50	\$889.50	\$889.50	\$1,491.21	\$1,491.21	\$1,491.21
EssentialCare Gold Dental	Region 1	\$338.56	\$677.12	\$575.56	\$575.56	\$575.56	\$964.90	\$964.90	\$964.90
	Region 2	\$316.93	\$633.86	\$538.78	\$538.78	\$538.78	\$903.25	\$903.25	\$903.25
	Region 3	\$380.31	\$760.61	\$646.52	\$646.52	\$646.52	\$1,083.87	\$1,083.87	\$1,083.87
	Region 4	\$445.93	\$891.86	\$758.08	\$758.08	\$758.08	\$1,270.90	\$1,270.90	\$1,270.90
	Region 5	\$311.56	\$623.12	\$529.65	\$529.65	\$529.65	\$887.95	\$887.95	\$887.95
	Region 6	\$329.03	\$658.05	\$559.34	\$559.34	\$559.34	\$937.73	\$937.73	\$937.73
	Region 7	\$320.15	\$640.31	\$544.26	\$544.26	\$544.26	\$912.44	\$912.44	\$912.44
	Region 8	\$445.93	\$891.86	\$758.08	\$758.08	\$758.08	\$1,270.90	\$1,270.90	\$1,270.90
EssentialCare Silver Dental	Region 1	\$299.57	\$599.15	\$509.27	\$509.27	\$509.27	\$853.78	\$853.78	\$853.78
	Region 2	\$280.43	\$560.87	\$476.74	\$476.74	\$476.74	\$799.23	\$799.23	\$799.23
	Region 3	\$336.51	\$673.02	\$572.07	\$572.07	\$572.07	\$959.06	\$959.06	\$959.06
	Region 4	\$394.58	\$789.15	\$670.78	\$670.78	\$670.78	\$1,124.54	\$1,124.54	\$1,124.54
	Region 5	\$275.68	\$551.36	\$468.66	\$468.66	\$468.66	\$785.69	\$785.69	\$785.69
	Region 6	\$291.14	\$582.27	\$494.93	\$494.93	\$494.93	\$829.74	\$829.74	\$829.74
	Region 7	\$283.29	\$566.57	\$481.59	\$481.59	\$481.59	\$80		

**Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates**

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		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
PrimarySelect Platinum Dental	Region 1	\$381.07	\$762.14	\$647.82	\$647.82	\$647.82	\$1,086.05	\$1,086.05	\$1,086.05
	Region 2	\$356.72	\$713.44	\$606.43	\$606.43	\$606.43	\$1,016.66	\$1,016.66	\$1,016.66
	Region 3	\$428.05	\$856.11	\$727.69	\$727.69	\$727.69	\$1,219.96	\$1,219.96	\$1,219.96
	Region 4	\$501.92	\$1,003.83	\$853.26	\$853.26	\$853.26	\$1,430.46	\$1,430.46	\$1,430.46
	Region 5	\$350.68	\$701.36	\$596.15	\$596.15	\$596.15	\$999.43	\$999.43	\$999.43
	Region 6	\$370.34	\$740.67	\$629.57	\$629.57	\$629.57	\$1,055.46	\$1,055.46	\$1,055.46
	Region 7	\$360.35	\$720.70	\$612.60	\$612.60	\$612.60	\$1,027.00	\$1,027.00	\$1,027.00
	Region 8	\$501.92	\$1,003.83	\$853.26	\$853.26	\$853.26	\$1,430.46	\$1,430.46	\$1,430.46
PrimarySelect Gold Dental	Region 1	\$338.30	\$676.60	\$575.11	\$575.11	\$575.11	\$964.15	\$964.15	\$964.15
	Region 2	\$316.68	\$633.37	\$538.36	\$538.36	\$538.36	\$902.55	\$902.55	\$902.55
	Region 3	\$380.01	\$760.02	\$646.02	\$646.02	\$646.02	\$1,083.03	\$1,083.03	\$1,083.03
	Region 4	\$445.58	\$891.16	\$757.49	\$757.49	\$757.49	\$1,269.91	\$1,269.91	\$1,269.91
	Region 5	\$311.32	\$622.64	\$529.24	\$529.24	\$529.24	\$887.26	\$887.26	\$887.26
	Region 6	\$328.77	\$657.54	\$558.91	\$558.91	\$558.91	\$936.99	\$936.99	\$936.99
	Region 7	\$3639.81	\$7279.62	\$5813.84	\$5813.84	\$5813.84	\$9111.73	\$9111.73	\$9111.73
	Region 8	\$445.58	\$891.16	\$757.49	\$757.49	\$757.49	\$1,269.91	\$1,269.91	\$1,269.91
PrimarySelect Silver Dental	Region 1	\$299.36	\$598.72	\$508.91	\$508.91	\$508.91	\$853.18	\$853.18	\$853.18
	Region 2	\$280.23	\$560.47	\$476.40	\$476.40	\$476.40	\$798.67	\$798.67	\$798.67
	Region 3	\$336.27	\$672.55	\$571.66	\$571.66	\$571.66	\$958.38	\$958.38	\$958.38
	Region 4	\$394.30	\$788.60	\$670.31	\$670.31	\$670.31	\$1,123.75	\$1,123.75	\$1,123.75
	Region 5	\$275.49	\$550.97	\$468.33	\$468.33	\$468.33	\$785.14	\$785.14	\$785.14
	Region 6	\$290.93	\$581.86	\$494.58	\$494.58	\$494.58	\$829.15	\$829.15	\$829.15
	Region 7	\$283.09	\$566.17	\$481.24	\$481.24	\$481.24	\$806.79	\$806.79	\$806.79
	Region 8	\$394.30	\$788.60	\$670.31	\$670.31	\$670.31	\$1,123.75	\$1,123.75	\$1,123.75
PrimarySelect Silver EPO Dental	Region 1	\$282.76	\$565.53	\$480.70	\$480.70	\$480.70	\$805.88	\$805.88	\$805.88
	Region 2	\$264.70	\$529.40	\$449.99	\$449.99	\$449.99	\$754.39	\$754.39	\$754.39
	Region 3	\$317.63	\$635.26	\$539.97	\$539.97	\$539.97	\$905.24	\$905.24	\$905.24
	Region 4	\$372.44	\$744.87	\$633.14	\$633.14	\$633.14	\$1,061.45	\$1,061.45	\$1,061.45
	Region 5	\$260.21	\$520.43	\$442.36	\$442.36	\$442.36	\$741.61	\$741.61	\$741.61
	Region 6	\$274.80	\$549.60	\$467.16	\$467.16	\$467.16	\$783.18	\$783.18	\$783.18
	Region 7	\$267.39	\$534.78	\$454.56	\$454.56	\$454.56	\$762.06	\$762.06	\$762.06
	Region 8	\$372.44	\$744.87	\$633.14	\$633.14	\$633.14	\$1,061.45	\$1,061.45	\$1,061.45
PrimarySelect Bronze Dental	Region 1	\$205.66	\$411.32	\$349.62	\$349.62	\$349.62	\$586.12	\$586.12	\$586.12
	Region 2	\$192.52	\$385.04	\$327.28	\$327.28	\$327.28	\$548.68	\$548.68	\$548.68
	Region 3	\$231.02	\$462.03	\$392.73	\$392.73	\$392.73	\$658.39	\$658.39	\$658.39
	Region 4	\$270.88	\$541.76	\$460.49	\$460.49	\$460.49	\$772.00	\$772.00	\$772.00
	Region 5	\$189.26	\$378.51	\$321.74	\$321.74	\$321.74	\$539.38	\$539.38	\$539.38
	Region 6	\$199.87	\$399.73	\$339.77	\$339.77	\$339.77	\$569.62	\$569.62	\$569.62
	Region 7	\$194.48	\$388.95	\$330.61	\$330.61	\$330.61	\$554.26	\$554.26	\$554.26
	Region 8	\$270.88	\$541.76	\$460.49	\$460.49	\$460.49	\$772.00	\$772.00	\$772.00
Essential Care Platinum Child-Only	Region 1	\$161.35	\$161.35	\$161.35	\$161.35	\$161.35	\$161.35	\$161.35	\$161.35
	Region 2	\$151.04	\$151.04	\$151.04	\$151.04	\$151.04	\$151.04	\$151.04	\$151.04
	Region 3	\$181.24	\$181.24	\$181.24	\$181.24	\$181.24	\$181.24	\$181.24	\$181.24
	Region 4	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51
	Region 5	\$148.48	\$148.48	\$148.48	\$148.48	\$148.48	\$148.48	\$148.48	\$148.48
	Region 6	\$156.80	\$156.80	\$156.80	\$156.80	\$156.80	\$156.80	\$156.80	\$156.80
	Region 7	\$152.57	\$152.57	\$152.57	\$152.57	\$152.57	\$152.57	\$152.57	\$152.57
	Region 8	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51	\$212.51
Essential Care Gold Child-Only	Region 1	\$137.22	\$137.22	\$137.22	\$137.22	\$137.22	\$137.22	\$137.22	\$137.22
	Region 2	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45
	Region 3	\$154.14	\$154.14	\$154.14	\$154.14	\$154.14	\$154.14	\$154.14	\$154.14
	Region 4	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74
	Region 5	\$126.28	\$126.28	\$126.28	\$126.28	\$126.28	\$126.28	\$126.28	\$126.28
	Region 6	\$133.36	\$133.36	\$133.36	\$133.36	\$133.36	\$133.36	\$133.36	\$133.36
	Region 7	\$129.76	\$129.76	\$129.76	\$129.76	\$129.76	\$129.76	\$129.76	\$129.76
	Region 8	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74	\$180.74
Essential Care Silver Child-Only	Region 1	\$121.19	\$121.19	\$121.19	\$121.19	\$121.19	\$121.19	\$121.19	\$121.19
	Region 2	\$113.44	\$113.44	\$113.44	\$113.44	\$113.44	\$113.44	\$113.44	\$113.44
	Region 3	\$136.13	\$136.13	\$136.13	\$136.13	\$136.13	\$136.13	\$136.13	\$136.13
	Region 4	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62
	Region 5	\$111.52	\$111.52	\$111.52	\$111.52	\$111.52	\$111.52	\$111.52	\$111.52
	Region 6	\$117.77	\$117.77	\$117.77	\$117.77	\$117.77	\$117.77	\$117.77	\$117.77
	Region 7	\$114.60	\$114.60	\$114.60	\$114.60	\$114.60	\$114.60	\$114.60	\$114.60
	Region 8	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62	\$159.62
Essential Care Bronze Child-Only	Region 1	\$98.07	\$98.07	\$98.07	\$98.07	\$98.07	\$98.07	\$98.07	\$98.07
	Region 2	\$89.93	\$89.93	\$89.93	\$89.93	\$89.93	\$89.93	\$89.93	\$89.93
	Region 3	\$107.91	\$107.91	\$107.91	\$107.91	\$107.91	\$107.91	\$107.91	\$107.91
	Region 4	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53
	Region 5	\$88.41	\$88.41	\$88.41	\$88.41	\$88.41	\$88.41	\$88.41	\$88.41
	Region 6	\$93.36	\$93.36	\$93.36	\$93.36	\$93.36	\$93.36	\$93.36	\$93.36
	Region 7	\$90.84	\$90.84	\$90.84	\$90.84	\$90.84	\$90.84	\$90.84	\$90.84
	Region 8	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53	\$126.53
EssentialCare Platinum Dental Child-Only	Region 1	\$163.67	\$163.67	\$163.67	\$163.67	\$163.67	\$163.67	\$163.67	\$163.67
	Region 2	\$153.21	\$153.21	\$153.21	\$153.21	\$153.21	\$153.21	\$153.21	\$153.21
	Region 3	\$183.85	\$183.85	\$183.85	\$183.85	\$183.85	\$183.85	\$183.85	\$183.85
	Region 4	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57
	Region 5	\$150.62	\$150.62	\$150.62	\$150.62	\$150.62	\$150.62	\$150.62	\$150.62
	Region 6	\$159.06	\$159.06	\$159.06	\$159.06	\$159.06	\$159.06	\$159.06	\$159.06
	Region 7	\$154.77	\$154.77	\$154.77	\$154.77	\$154.77	\$154.77	\$154.77	\$154.77
	Region 8	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57	\$215.57
EssentialCare Gold Dental Child-Only	Region 1	\$139.49	\$139.49	\$139.49	\$139.49	\$139.49	\$139.49	\$139.49	\$139.49
	Region 2	\$130.58	\$130.58	\$130.58	\$130.58	\$130.58	\$130.58	\$130.58	\$130.58
	Region 3	\$156.69	\$156.69	\$156.69	\$156.69	\$156.69	\$156.69	\$156.69	\$156.69
	Region 4	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72
	Region 5	\$128.36	\$128.36	\$128.36	\$128.36	\$128.36	\$128.36	\$128.36	\$128.36
	Region 6	\$135.56	\$135.56	\$135.56	\$135.56	\$135.56	\$135.56	\$135.56	\$135.56
	Region 7	\$131.90	\$131.90	\$131.90	\$131.90	\$131.90	\$131.90	\$131.90	\$131.90
	Region 8	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72	\$183.72
EssentialCare Silver Dental Child-Only	Region 1	\$123.42	\$123.42	\$123.42	\$123.42	\$123.42	\$123.42	\$123.42	\$123.42
	Region 2	\$115.54	\$115.54	\$115.54	\$115.54	\$115.54	\$115.54	\$115.54	\$115.54
	Region 3	\$138.64	\$138.64	\$138.64	\$138.64	\$138.64	\$138.64	\$138.64	\$138.64
	Region 4	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57
	Region 5	\$113.58	\$113.58	\$113.58	\$113.58	\$113.58	\$113.58	\$113.58	\$113.58
	Region 6	\$119.95	\$119.95	\$119.95	\$119.95	\$119.95	\$119.95	\$119.95	\$119.95
	Region 7	\$116.71	\$116.71	\$116.71	\$116.71	\$116.71	\$116.71	\$116.71	\$116.71
	Region 8	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57	\$162.57
EssentialCare Bronze Dental Child-Only	Region 1	\$97.52	\$97.52	\$97.52	\$97.52	\$97.52	\$97.52	\$97.52	\$97.52
	Region 2	\$91.29	\$91.29	\$91.29	\$91.29	\$91.29	\$91.29	\$91.29	\$91.29
	Region 3	\$109.55	\$109.55	\$109.55	\$109.55	\$109.55	\$109.55	\$109.55	\$109.55
	Region 4	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45
	Region 5	\$89.74	\$89.74	\$89.74	\$89.74	\$89.74	\$89.74	\$89.74	\$89.74
	Region 6	\$94.78	\$94.78	\$94.78	\$94.78	\$94.78	\$94.78	\$94.78	\$94.78
	Region 7	\$92.22	\$92.22	\$92.22	\$92.22	\$92.22	\$92.22	\$92.22	\$92.22
	Region 8	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45	\$128.45
Essential Care Platinum Age 29 Option	Region 1	\$391.62	\$78						

**Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates**

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BDON, FHSC – CAT001, FHSC – CHLD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD-D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHLD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

		Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Essential Care Silver Age 29 Option	Region 1	\$294.14	\$588.28	\$500.04	\$500.04	\$500.04	\$638.30	\$838.30	\$838.30
	Region 2	\$275.35	\$550.70	\$468.09	\$468.09	\$468.09	\$581.67	\$781.67	\$781.67
	Region 3	\$330.41	\$660.82	\$561.70	\$561.70	\$561.70	\$694.67	\$894.67	\$894.67
	Region 4	\$387.42	\$774.85	\$658.62	\$658.62	\$658.62	\$814.15	\$1,104.15	\$1,104.15
	Region 5	\$270.68	\$541.37	\$460.16	\$460.16	\$460.16	\$577.45	\$777.45	\$777.45
	Region 6	\$285.86	\$571.71	\$485.96	\$485.96	\$485.96	\$614.69	\$814.69	\$814.69
	Region 7	\$278.15	\$556.30	\$472.85	\$472.85	\$472.85	\$592.73	\$792.73	\$792.73
	Region 8	\$387.42	\$774.85	\$658.62	\$658.62	\$658.62	\$814.15	\$1,104.15	\$1,104.15
Essential Care Bronze Age 29 Option	Region 1	\$233.18	\$466.35	\$396.40	\$396.40	\$396.40	\$496.55	\$646.55	\$646.55
	Region 2	\$218.28	\$436.55	\$371.07	\$371.07	\$371.07	\$462.09	\$592.09	\$592.09
	Region 3	\$261.93	\$523.85	\$445.27	\$445.27	\$445.27	\$564.49	\$714.49	\$714.49
	Region 4	\$307.12	\$614.24	\$522.11	\$522.11	\$522.11	\$653.30	\$803.30	\$803.30
	Region 5	\$214.58	\$429.16	\$364.78	\$364.78	\$364.78	\$451.55	\$581.55	\$581.55
	Region 6	\$226.61	\$453.22	\$385.23	\$385.23	\$385.23	\$481.83	\$611.83	\$611.83
	Region 7	\$224.50	\$449.00	\$374.85	\$374.85	\$374.85	\$462.42	\$592.42	\$592.42
	Region 8	\$307.12	\$614.24	\$522.11	\$522.11	\$522.11	\$653.30	\$803.30	\$803.30
Essential Care Platinum Dental Age 29 Option	Region 1	\$397.25	\$794.51	\$675.33	\$675.33	\$675.33	\$844.17	\$1,093.17	\$1,093.17
	Region 2	\$371.87	\$743.74	\$632.18	\$632.18	\$632.18	\$792.73	\$1,041.73	\$1,041.73
	Region 3	\$446.23	\$892.47	\$758.60	\$758.60	\$758.60	\$953.26	\$1,202.26	\$1,202.26
	Region 4	\$523.23	\$1,046.47	\$889.50	\$889.50	\$889.50	\$1,114.21	\$1,421.21	\$1,421.21
	Region 5	\$365.57	\$731.14	\$621.47	\$621.47	\$621.47	\$777.45	\$1,001.45	\$1,001.45
	Region 6	\$386.06	\$772.13	\$656.31	\$656.31	\$656.31	\$820.28	\$1,061.28	\$1,061.28
	Region 7	\$375.65	\$751.31	\$638.61	\$638.61	\$638.61	\$792.73	\$1,041.73	\$1,041.73
	Region 8	\$523.23	\$1,046.47	\$889.50	\$889.50	\$889.50	\$1,114.21	\$1,421.21	\$1,421.21
Essential Care Gold Dental Age 29 Option	Region 1	\$338.56	\$677.12	\$575.56	\$575.56	\$575.56	\$714.69	\$914.69	\$914.69
	Region 2	\$316.93	\$633.86	\$538.78	\$538.78	\$538.78	\$664.55	\$864.55	\$864.55
	Region 3	\$380.51	\$760.99	\$646.52	\$646.52	\$646.52	\$792.73	\$1,041.73	\$1,041.73
	Region 4	\$445.93	\$891.86	\$758.08	\$758.08	\$758.08	\$944.15	\$1,204.15	\$1,204.15
	Region 5	\$311.56	\$623.12	\$529.65	\$529.65	\$529.65	\$653.30	\$803.30	\$803.30
	Region 6	\$329.03	\$658.05	\$559.34	\$559.34	\$559.34	\$692.73	\$892.73	\$892.73
	Region 7	\$320.15	\$640.31	\$544.26	\$544.26	\$544.26	\$677.45	\$877.45	\$877.45
	Region 8	\$445.93	\$891.86	\$758.08	\$758.08	\$758.08	\$944.15	\$1,204.15	\$1,204.15
Essential Care Silver Dental Age 29 Option	Region 1	\$299.57	\$599.15	\$509.27	\$509.27	\$509.27	\$638.30	\$838.30	\$838.30
	Region 2	\$280.43	\$560.87	\$476.74	\$476.74	\$476.74	\$592.73	\$792.73	\$792.73
	Region 3	\$336.51	\$673.02	\$572.07	\$572.07	\$572.07	\$714.69	\$914.69	\$914.69
	Region 4	\$394.58	\$789.15	\$670.78	\$670.78	\$670.78	\$844.17	\$1,093.17	\$1,093.17
	Region 5	\$275.68	\$551.36	\$468.66	\$468.66	\$468.66	\$581.67	\$781.67	\$781.67
	Region 6	\$291.14	\$582.27	\$494.93	\$494.93	\$494.93	\$614.69	\$814.69	\$814.69
	Region 7	\$283.29	\$566.57	\$481.59	\$481.59	\$481.59	\$592.73	\$792.73	\$792.73
	Region 8	\$394.58	\$789.15	\$670.78	\$670.78	\$670.78	\$844.17	\$1,093.17	\$1,093.17
Essential Care Bronze Dental Age 29 Option	Region 1	\$236.70	\$473.41	\$402.40	\$402.40	\$402.40	\$501.45	\$651.45	\$651.45
	Region 2	\$221.58	\$443.16	\$376.69	\$376.69	\$376.69	\$462.42	\$592.42	\$592.42
	Region 3	\$265.89	\$531.78	\$452.01	\$452.01	\$452.01	\$564.49	\$714.49	\$714.49
	Region 4	\$311.77	\$623.54	\$530.01	\$530.01	\$530.01	\$653.30	\$803.30	\$803.30
	Region 5	\$217.83	\$435.65	\$370.31	\$370.31	\$370.31	\$462.42	\$592.42	\$592.42
	Region 6	\$230.04	\$460.08	\$391.06	\$391.06	\$391.06	\$481.83	\$611.83	\$611.83
	Region 7	\$223.84	\$447.67	\$380.52	\$380.52	\$380.52	\$462.42	\$592.42	\$592.42
	Region 8	\$311.77	\$623.54	\$530.01	\$530.01	\$530.01	\$653.30	\$803.30	\$803.30
Primary Select Platinum Age 29 Option	Region 1	\$375.43	\$750.87	\$638.24	\$638.24	\$638.24	\$792.73	\$1,041.73	\$1,041.73
	Region 2	\$351.45	\$702.89	\$597.46	\$597.46	\$597.46	\$744.15	\$944.15	\$944.15
	Region 3	\$421.72	\$843.45	\$716.93	\$716.93	\$716.93	\$881.67	\$1,131.67	\$1,131.67
	Region 4	\$494.49	\$988.98	\$840.64	\$840.64	\$840.64	\$1,041.73	\$1,341.73	\$1,341.73
	Region 5	\$345.49	\$690.98	\$587.34	\$587.34	\$587.34	\$731.14	\$931.14	\$931.14
	Region 6	\$364.86	\$729.72	\$620.26	\$620.26	\$620.26	\$777.45	\$977.45	\$977.45
	Region 7	\$355.02	\$710.04	\$603.54	\$603.54	\$603.54	\$751.31	\$951.31	\$951.31
	Region 8	\$494.49	\$988.98	\$840.64	\$840.64	\$840.64	\$1,041.73	\$1,341.73	\$1,341.73
Primary Select Gold Age 29 Option	Region 1	\$332.80	\$665.60	\$565.76	\$565.76	\$565.76	\$694.67	\$894.67	\$894.67
	Region 2	\$311.54	\$623.07	\$529.61	\$529.61	\$529.61	\$653.30	\$803.30	\$803.30
	Region 3	\$373.83	\$747.67	\$635.52	\$635.52	\$635.52	\$781.67	\$981.67	\$981.67
	Region 4	\$438.34	\$876.68	\$745.18	\$745.18	\$745.18	\$914.69	\$1,164.69	\$1,164.69
	Region 5	\$306.26	\$612.52	\$520.64	\$520.64	\$520.64	\$646.52	\$846.52	\$846.52
	Region 6	\$323.43	\$646.85	\$549.83	\$549.83	\$549.83	\$681.67	\$881.67	\$881.67
	Region 7	\$314.71	\$629.41	\$535.00	\$535.00	\$535.00	\$653.30	\$803.30	\$803.30
	Region 8	\$438.34	\$876.68	\$745.18	\$745.18	\$745.18	\$914.69	\$1,164.69	\$1,164.69
Primary Select Silver Age 29 Option	Region 1	\$293.93	\$587.86	\$499.68	\$499.68	\$499.68	\$614.69	\$814.69	\$814.69
	Region 2	\$275.15	\$550.30	\$467.78	\$467.78	\$467.78	\$581.67	\$781.67	\$781.67
	Region 3	\$330.17	\$660.34	\$561.29	\$561.29	\$561.29	\$694.67	\$894.67	\$894.67
	Region 4	\$387.14	\$774.29	\$658.14	\$658.14	\$658.14	\$814.69	\$1,014.69	\$1,014.69
	Region 5	\$270.49	\$540.98	\$459.83	\$459.83	\$459.83	\$577.45	\$777.45	\$777.45
	Region 6	\$285.65	\$571.30	\$485.61	\$485.61	\$485.61	\$601.45	\$801.45	\$801.45
	Region 7	\$277.95	\$555.90	\$472.51	\$472.51	\$472.51	\$581.67	\$781.67	\$781.67
	Region 8	\$387.14	\$774.29	\$658.14	\$658.14	\$658.14	\$814.69	\$1,014.69	\$1,014.69
Primary Select Silver EPO Age 29 Option	Region 1	\$277.33	\$554.67	\$471.47	\$471.47	\$471.47	\$581.67	\$781.67	\$781.67
	Region 2	\$259.61	\$519.23	\$441.34	\$441.34	\$441.34	\$541.69	\$741.69	\$741.69
	Region 3	\$311.53	\$623.06	\$529.60	\$529.60	\$529.60	\$653.30	\$803.30	\$803.30
	Region 4	\$365.28	\$730.57	\$620.98	\$620.98	\$620.98	\$777.45	\$977.45	\$977.45
	Region 5	\$255.21	\$510.43	\$433.97	\$433.97	\$433.97	\$531.14	\$731.14	\$731.14
	Region 6	\$259.04	\$518.08	\$438.19	\$438.19	\$438.19	\$531.14	\$731.14	\$731.14
	Region 7	\$262.25	\$524.51	\$445.83	\$445.83	\$445.83	\$541.69	\$741.69	\$741.69
	Region 8	\$365.28	\$730.57	\$620.98	\$620.98	\$620.98	\$777.45	\$977.45	\$977.45
Primary Select Bronze Age 29 Option	Region 1	\$202.13	\$404.26	\$343.62	\$343.62	\$343.62	\$421.69	\$541.69	\$541.69
	Region 2	\$189.21	\$378.43	\$321.66	\$321.66	\$321.66	\$392.73	\$492.73	\$492.73
	Region 3	\$227.05	\$454.10	\$385.99	\$385.99	\$385.99	\$477.45	\$597.45	\$597.45
	Region 4	\$266.23	\$532.46	\$452.59	\$452.59	\$452.59	\$551.31	\$691.31	\$691.31
	Region 5	\$186.01	\$372.02	\$316.21	\$316.21	\$316.21	\$392.73	\$492.73	\$492.73
	Region 6	\$196.44	\$392.87	\$333.94	\$333.94	\$333.94	\$414.69	\$514.69	\$514.69
	Region 7	\$191.14	\$382.28	\$324.94	\$324.94	\$324.94	\$392.73	\$492.73	\$492.73
	Region 8	\$266.23	\$532.46	\$452.59	\$452.59	\$452.59	\$551.31	\$691.31	\$691.31
Primary Select Platinum Dental Age 29 Option	Region 1	\$381.07	\$762.14	\$647.82	\$647.82	\$647.82	\$803.30	\$1,053.30	\$1,053.30
	Region 2	\$358.72	\$717.44	\$606.43	\$606.43	\$606.43	\$751.31	\$981.31	\$981.31
	Region 3	\$428.05	\$856.11	\$727.69	\$727.69	\$727.69	\$894.67	\$1,144.67	\$1,144.67
	Region 4	\$501.92	\$1,003.83	\$853.26	\$853.26	\$853.26	\$1,053.30	\$1,303.30	\$1,303.30
	Region 5	\$350.68	\$701.36	\$596.15	\$596.15	\$596.15	\$731.14	\$931.14	\$931.14
	Region 6	\$370.34	\$740.67	\$629.57	\$629.57	\$629.57	\$777.45	\$977.45	\$977.45
	Region 7	\$360.35	\$720.70	\$612.60	\$612.60	\$612.60	\$751.31	\$951.31	\$951.31
	Region 8	\$501.92	\$1,003.83	\$853.26	\$853.26	\$853.26	\$1,053.30	\$1,303.30	\$1,303.30
Primary Select Gold Dental Age 29 Option	Region 1	\$338.30	\$676.60	\$575.11	\$575.11	\$575.11	\$714.69	\$914.69	\$914.69
	Region 2	\$316.68	\$633.37	\$538.36	\$538.36	\$538.36	\$664.55	\$864.55	\$864.55
	Region 3	\$380.01	\$760.02	\$646.02	\$646.02	\$646.02	\$792.73	\$1,041.73	\$1,041.73
	Region 4	\$445.58	\$891.16	\$757.49	\$757.49	\$757.49	\$944.15	\$1,204.15	\$1,204.15
	Region 5	\$311.32	\$622.64	\$529.24	\$529.24	\$529.24	\$653.30	\$803.30	\$803.30
	Region 6	\$328.77	\$657.54	\$558.91	\$558.91	\$558.91	\$692.73	\$892.73	\$892.73
	Region 7	\$319.00	\$638.00	\$543.84	\$543.84	\$543.84	\$677.45	\$877.45	\$877.45

Freelancers Health Service Corporation
2014 Individual Rate Filing
Rates

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD-D002, FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

	Individual	Couple	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Couple and One Dependent	Couple and Two Dependents	Couple and Three or More Dependents
Region 3	\$231.02	\$462.03	\$392.73	\$392.73	\$392.73	\$658.39	\$658.39	\$658.39
Region 4	\$270.88	\$541.76	\$460.49	\$460.49	\$460.49	\$772.00	\$772.00	\$772.00
Region 5	\$189.26	\$378.51	\$321.74	\$321.74	\$321.74	\$539.38	\$539.38	\$539.38
Region 6	\$199.87	\$399.73	\$339.77	\$339.77	\$339.77	\$569.62	\$569.62	\$569.62
Region 7	\$194.48	\$388.95	\$330.61	\$330.61	\$330.61	\$554.26	\$554.26	\$554.26
Region 8	\$270.88	\$541.76	\$460.49	\$460.49	\$460.49	\$772.00	\$772.00	\$772.00

Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002, Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003				
Plans:	Essential Care Platinum EssentialCare Platinum Dental Essential Care Platinum Child-Only EssentialCare Platinum Child-Only Dental Essential Care Platinum Age 29 Option EssentialCare Platinum Dental Age 29 Option	Out-of-Network	Essential Care Gold EssentialCare Gold Dental Essential Care Gold Child-Only EssentialCare Gold Child-Only Dental Essential Care Gold Age 29 Option EssentialCare Gold Dental Age 29 Option	Out-of-Network
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	Not Applicable	\$600	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	\$2,000	Not Applicable	\$4,000	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	\$0	Not Covered	\$0	Not Covered
Physician and Other Services				
Office Visit	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	\$100 after deductible is met	\$100 after deductible is met	\$150 after deductible is met	\$150 after deductible is met
Ambulance	\$100 after deductible is met	\$100 after deductible is met	\$150 after deductible is met	\$150 after deductible is met
Urgent Care Center	\$55 after deductible is met	Not Covered	\$60 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Skilled Nursing Facility	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered
EKG	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered
Routine Radiology	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered
Advanced Radiology	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Outpatient Mental Health	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered
Outpatient Substance Abuse	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered
Cardiac Rehabilitation	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered
Pulmonary Rehabilitation	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Chemotherapy	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Home Health Care	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	\$10/\$30/\$60	Not Covered	\$10/\$35/\$70	Not Covered
Maintenance Medications	\$10/\$30/\$60	Not Covered	\$10/\$35/\$70	Not Covered
Vision Services				
Medical Exam	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Standard Plastic Lenses	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Frames	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	10% cost sharing after deductible is met	Not Covered	20% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.				
All indicated benefits assume the member has appropriate authorization to receive services.				
Certain benefits stated in this benefit summary are pending NYS approval.				

		Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS			
		Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	Essential Care Silver EssentialCare Silver Dental Essential Care Silver Child-Only EssentialCare Silver Child-Only Dental Essential Care Silver Age 29 Option EssentialCare Silver Dental Age 20 Option	Essential Care Silver CSR 200-250% FPL EssentialCare Silver CSR 200-250% FPL Dental Essential Care Silver CSR 200-250% FPL Child-Only EssentialCare Silver CSR 200-250% FPL Child-Only Dental Essential Care Silver CSR 200-250% FPL Age 29 Option EssentialCare Silver CSR 200-250% FPL Dental Age 20 Option			
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible	\$2,000	Not Applicable	\$1,750	Not Applicable	
Coinsurance	100%	Not Applicable	100%	Not Applicable	
Out of Pocket Maximum	\$5,500	Not Applicable	\$4,000	Not Applicable	
Preventive Services					
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	\$0	Not Covered	\$0	Not Covered	
Physician and Other Services					
Office Visit	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Outpatient Surgical Procedures (in physician's office)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered	
Emergency & Urgent Care Services					
Emergency Room	\$150 after deductible is met	\$150 after deductible is met	\$150 after deductible is met	\$150 after deductible is met	
Ambulance	\$150 after deductible is met	\$150 after deductible is met	\$150 after deductible is met	\$150 after deductible is met	
Urgent Care Center	\$70 after deductible is met	Not Covered	\$70 after deductible is met	Not Covered	
Hospital Services					
Inpatient Hospital	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Outpatient Surgical Procedures (Facility)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered	
Skilled Nursing Facility	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Diagnostic Testing Services					
Laboratory Testing	\$50 after deductible is met	Not Covered	\$50 after deductible is met	Not Covered	
EKG	\$50 after deductible is met	Not Covered	\$50 after deductible is met	Not Covered	
Routine Radiology	\$50 after deductible is met	Not Covered	\$50 after deductible is met	Not Covered	
Advanced Radiology	\$50 after deductible is met	Not Covered	\$50 after deductible is met	Not Covered	
Maternity Services					
Inpatient Maternity	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Mental Health & Substance Abuse Services					
Inpatient Mental Health	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Outpatient Mental Health	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Inpatient Substance Abuse - Rehab	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Inpatient Substance Abuse - Detox	\$1,500 after deductible is met	Not Covered	\$1,500 after deductible is met	Not Covered	
Outpatient Substance Abuse	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Diabetic Supplies and Services					
Insulin and Other Oral Agents	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Rehabilitation Services					
Chiropractic Services	\$50 after deductible is met	Not Covered	\$50 after deductible is met	Not Covered	
Physical - Occupational - Speech Therapies	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Cardiac Rehabilitation	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Pulmonary Rehabilitation	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Additional Services					
Durable Medical Equipment	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered	
Prosthetics and Appliances	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered	
Chemotherapy	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Home Health Care	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Prescription Drug Coverage					
Prescription Plan	\$10/\$35/\$70	Not Covered	\$10/\$35/\$70	Not Covered	
Maintenance Medications	\$10/\$35/\$70	Not Covered	\$10/\$35/\$70	Not Covered	
Vision Services					
Medical Exam	\$30 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	
Standard Plastic Lenses	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered	
Frames	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered	
Conventional Contact Lenses	30% cost sharing after deductible is met	Not Covered	25% cost sharing after deductible is met	Not Covered	
Dental Services					
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered	
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.					
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Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003				
Plans:	Essential Care Silver CSR 150-200% FPL EssentialCare Silver CSR 150-200% FPL Dental Essential Care Silver CSR 150-200% FPL Child-Only EssentialCare Silver CSR 150-200% FPL Child-Only Dental Essential Care Silver CSR 150-200% FPL Age 29 Option EssentialCare Silver CSR 150-200% FPL Dental Age 20 Option	Essential Care Silver CSR 100-150% FPL EssentialCare Silver CSR 100-150% FPL Dental Essential Care Silver CSR 100-150% FPL Child-Only EssentialCare Silver CSR 100-150% FPL Child-Only Dental Essential Care Silver CSR 100-150% FPL Age 29 Option EssentialCare Silver CSR 100-150% FPL Dental Age 20 Option		
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$250	Not Applicable	\$0	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	\$2,000	Not Applicable	\$1,000	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	\$0	Not Covered	\$0	Not Covered
Physician and Other Services				
Office Visit	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	\$75 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	\$75 after deductible is met	\$75 after deductible is met	\$50 after deductible is met	\$50 after deductible is met
Ambulance	\$75 after deductible is met	\$75 after deductible is met	\$50 after deductible is met	\$50 after deductible is met
Urgent Care Center	\$50 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	\$75 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered
Skilled Nursing Facility	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	\$35 after deductible is met	Not Covered	\$20 after deductible is met	Not Covered
EKG	\$35 after deductible is met	Not Covered	\$20 after deductible is met	Not Covered
Routine Radiology	\$35 after deductible is met	Not Covered	\$20 after deductible is met	Not Covered
Advanced Radiology	\$35 after deductible is met	Not Covered	\$20 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Outpatient Mental Health	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	\$250 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered
Outpatient Substance Abuse	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	\$35 after deductible is met	Not Covered	\$20 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	\$25 after deductible is met	Not Covered	\$15 after deductible is met	Not Covered
Cardiac Rehabilitation	\$25 after deductible is met	Not Covered	\$15 after deductible is met	Not Covered
Pulmonary Rehabilitation	\$25 after deductible is met	Not Covered	\$15 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Chemotherapy	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Home Health Care	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	\$9/\$20/\$40	Not Covered	\$6/\$15/\$30	Not Covered
Maintenance Medications	\$9/\$20/\$40	Not Covered	\$6/\$15/\$30	Not Covered
Vision Services				
Medical Exam	\$15 after deductible is met	Not Covered	\$10 after deductible is met	Not Covered
Standard Plastic Lenses	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Frames	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	10% cost sharing after deductible is met	Not Covered	5% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.				
All indicated benefits assume the member has appropriate authorization to receive services.				
Certain benefits stated in this benefit summary are pending NYS approval.				

Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILDD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILDD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003				
Plans:	Essential Care Bronze EssentialCare Bronze Dental Essential Care Bronze Child-Only EssentialCare Bronze Child-Only Dental Essential Care Bronze Age 29 Option EssentialCare Bronze Dental Age 29 Option		Essential Care Catastrophic EssentialCare Catastrophic Dental Essential Care Bronze Age 29 Option EssentialCare Bronze Dental Age 29 Option	
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$3,000	Not Applicable	\$6,350	Not Applicable
Coinsurance	50%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	\$6,350	Not Applicable	\$6,350	Not Applicable
Preventive Services				
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	\$0	Not Covered	\$0	Not Covered
Physician and Other Services				
Office Visit	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	50% cost sharing after deductible is met	50% cost sharing after deductible is met	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Ambulance	50% cost sharing after deductible is met	50% cost sharing after deductible is met	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Urgent Care Center	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
EKG	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Routine Radiology	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Advanced Radiology	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Chemotherapy	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Home Health Care	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	\$10/\$35/\$70	Not Covered	0% cost sharing after deductible is met	Not Covered
Maintenance Medications	\$10/\$35/\$70	Not Covered	0% cost sharing after deductible is met	Not Covered
Vision Services				
Medical Exam	\$10 after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Frames	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	50% cost sharing after deductible is met	Not Covered	0% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.				
All indicated benefits assume the member has appropriate authorization to receive services.				
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Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - STANDARD PLANS		
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILDD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILDD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003		
Plans:	Essential Care American Indian/Alaska Native = or < 300% FPL EssentialCare American Indian/Alaska Native = or < 300% FPLDental Essential Care American Indian/Alaska Native = or < 300% FPLChild-Only EssentialCare American Indian/Alaska Native = or < 300% FPLChild-Only Dental Essential Care American Indian/Alaska Native = or < 300% FPLAge 29 Option EssentialCare American Indian/Alaska Native = or < 300% FPLDental Age 20 Option	
Benefit Summary	In-Network	Out-of-Network
Deductible	\$0	Not Applicable
Coinsurance	100%	Not Applicable
Out of Pocket Maximum	\$0	Not Applicable
Preventive Services		
Allergy Testing Bone Density Testing Cervical Cytology Colonoscopy Screening Gynecological Screening Immunizations Mammography Prenatal Maternity Care Prostate Cancer Screening Routine Exams Women's Preventive Health Services Other Services Noted in Section 2713 of ACA	\$0	Not Covered
Physician and Other Services		
Office Visit	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	0% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services		
Emergency Room	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Ambulance	0% cost sharing after deductible is met	0% cost sharing after deductible is met
Urgent Care Center	0% cost sharing after deductible is met	Not Covered
Hospital Services		
Inpatient Hospital	0% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	0% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	0% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services		
Laboratory Testing	0% cost sharing after deductible is met	Not Covered
EKG	0% cost sharing after deductible is met	Not Covered
Routine Radiology	0% cost sharing after deductible is met	Not Covered
Advanced Radiology	0% cost sharing after deductible is met	Not Covered
Maternity Services		
Inpatient Maternity	0% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services		
Inpatient Mental Health	0% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	0% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	0% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	0% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services		
Insulin and Other Oral Agents	0% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	0% cost sharing after deductible is met	Not Covered
Rehabilitation Services		
Chiropractic Services	0% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	0% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	0% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	0% cost sharing after deductible is met	Not Covered
Additional Services		
Durable Medical Equipment	0% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	0% cost sharing after deductible is met	Not Covered
Chemotherapy	0% cost sharing after deductible is met	Not Covered
Home Health Care	0% cost sharing after deductible is met	Not Covered
Prescription Drug Coverage		
Prescription Plan	0% cost sharing after deductible is met	Not Covered
Maintenance Medications	0% cost sharing after deductible is met	Not Covered
Vision Services		
Medical Exam	0% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	0% cost sharing after deductible is met	Not Covered
Frames	0% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	0% cost sharing after deductible is met	Not Covered
Dental Services		
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered
<p>This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.</p> <p>All indicated benefits assume the member has appropriate authorization to receive services.</p> <p>Certain benefits stated in this benefit summary are pending NYS approval.</p>		

		Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
		Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:		Primary Select Platinum PrimarySelect Platinum Dental Primary Select Platinum Age 29 Option PrimarySelect Platinum Dental Age 29 Option		Primary Select Gold PrimarySelect Gold Dental Primary Select Gold Age 29 Option PrimarySelect Gold Dental Age 29 Option	
Benefit Summary		In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible		\$0	Not Applicable	\$250	Not Applicable
Coinsurance		20%	Not Applicable	20%	Not Applicable
Out of Pocket Maximum		\$1,400	Not Applicable	\$3,500	Not Applicable
Preventive Services					
Allergy Testing					
Bone Density Testing					
Cervical Cytology					
Colonoscopy Screening					
Gynecological Screening					
Immunizations					
Mammography		\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section 2713 of ACA					
Physician and Other Services					
Office Visit		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Emergency & Urgent Care Services					
Emergency Room		\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance		\$100 Copay	\$100 Copay	\$150 Copay	\$150 Copay
Urgent Care Center		\$100 Copay	Not Covered	\$100 Copay	Not Covered
Hospital Services					
Inpatient Hospital		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Surgical Procedures (Facility)		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Skilled Nursing Facility		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Diagnostic Testing Services					
Laboratory Testing		\$75 Copay	Not Covered	\$75 Copay	Not Covered
EKG		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Routine Radiology		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Advanced Radiology		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Maternity Services					
Inpatient Maternity		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Mental Health		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Inpatient Substance Abuse - Detox		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Substance Abuse		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Diabetic Supplies and Services					
Insulin and Other Oral Agents		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Rehabilitation Services					
Chiropractic Services		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Cardiac Rehabilitation		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Pulmonary Rehabilitation		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Additional Services					
Durable Medical Equipment		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Prosthetics and Appliances		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Chemotherapy		\$15 Copay	Not Covered	\$25 Copay	Not Covered
Home Health Care		\$15 Copay	Not Covered	\$25 Copay	Not Covered
Prescription Drug Coverage					
Prescription Plan		\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications		\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services					
Medical Exam		\$15 Copay	Not Covered	\$25 Copay after deductible is met	Not Covered
Standard Plastic Lenses		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Frames		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Conventional Contact Lenses		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Dental Services					
Preventive and Routine		Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
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Certain benefits stated in this benefit summary are pending NYS approval.					

		Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
		Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:		Primary Select Silver PrimarySelect Silver Dental Primary Select Silver Age 29 Option PrimarySelect Silver Dental Age 29 Option		Primary Select Silver CSR 200-250% FPL PrimarySelect Silver CSR 200-250% FPL Dental Primary Select Silver CSR 200-250% FPL Age 29 Option PrimarySelect Silver CSR 200-250% FPL Dental Age 29 Option	
Benefit Summary		In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible		\$2,000	Not Applicable	\$2,000	Not Applicable
Coinsurance		20%	Not Applicable	20%	Not Applicable
Out of Pocket Maximum		\$6,350	Not Applicable	\$5,200	Not Applicable
Preventive Services					
Allergy Testing					
Bone Density Testing					
Cervical Cytology					
Colonoscopy Screening					
Gynecological Screening					
Immunizations					
Mammography		\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section 2713 of ACA					
Physician and Other Services					
Office Visit		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Emergency & Urgent Care Services					
Emergency Room		\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance		\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Urgent Care Center		\$100 Copay	Not Covered	\$100 Copay	Not Covered
Hospital Services					
Inpatient Hospital		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Surgical Procedures (Facility)		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Skilled Nursing Facility		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Diagnostic Testing Services					
Laboratory Testing		\$75 Copay	Not Covered	\$75 Copay	Not Covered
EKG		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Routine Radiology		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Advanced Radiology		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Maternity Services					
Inpatient Maternity		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Mental Health		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Inpatient Substance Abuse - Detox		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Outpatient Substance Abuse		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Diabetic Supplies and Services					
Insulin and Other Oral Agents		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)		\$0 Copay	Not Covered	\$0 Copay	Not Covered
Rehabilitation Services					
Chiropractic Services		\$75 Copay	Not Covered	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Cardiac Rehabilitation		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Pulmonary Rehabilitation		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Additional Services					
Durable Medical Equipment		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Prosthetics and Appliances		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Chemotherapy		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Home Health Care		\$30 Copay	Not Covered	\$30 Copay	Not Covered
Prescription Drug Coverage					
Prescription Plan		\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications		\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services					
Medical Exam		\$30 Copay after deductible is met	Not Covered	\$30 Copay after deductible is met	Not Covered
Standard Plastic Lenses		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Frames		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Conventional Contact Lenses		20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered
Dental Services					
Preventive and Routine		Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered
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		Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
		Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	Primary Select Silver CSR 150-200% FPL PrimarySelect Silver CSR 150-200% FPL Dental Primary Select Silver CSR 150-200% FPL Age 29 Option PrimarySelect Silver CSR 150-200% FPL Dental Age 29 Option	Primary Select Silver CSR 100-150% FPL PrimarySelect Silver CSR 100-150% FPL Dental Primary Select Silver CSR 100-150% FPL Age 29 Option PrimarySelect Silver CSR 100-150% FPL Dental Age 29 Option			
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible	\$0	Not Applicable	\$0	Not Applicable	
Coinsurance	20%	Not Applicable	20%	Not Applicable	
Out of Pocket Maximum	\$2,000	Not Applicable	\$500	Not Applicable	
Preventive Services					
Allergy Testing					
Bone Density Testing					
Cervical Cytology					
Colonoscopy Screening					
Gynecological Screening					
Immunizations					
Mammography	\$0	Not Covered	\$0	Not Covered	
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section 2713 of ACA					
Physician and Other Services					
Office Visit	\$0 Copay	Not Covered	\$0 Copay	Not Covered	
Outpatient Surgical Procedures (in physician's office)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Emergency & Urgent Care Services					
Emergency Room	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible	
Ambulance	\$75 Copay	\$75 Copay	\$50 Copay	\$50 Copay	
Urgent Care Center	\$100 Copay	Not Covered	\$100 Copay	Not Covered	
Hospital Services					
Inpatient Hospital	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Outpatient Surgical Procedures (Facility)	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Skilled Nursing Facility	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Diagnostic Testing Services					
Laboratory Testing	\$75 Copay	Not Covered	\$75 Copay	Not Covered	
EKG	\$75 Copay	Not Covered	\$75 Copay	Not Covered	
Routine Radiology	\$75 Copay	Not Covered	\$75 Copay	Not Covered	
Advanced Radiology	\$75 Copay	Not Covered	\$75 Copay	Not Covered	
Maternity Services					
Inpatient Maternity	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Mental Health & Substance Abuse Services					
Inpatient Mental Health	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Outpatient Mental Health	\$0 Copay	Not Covered	\$0 Copay	Not Covered	
Inpatient Substance Abuse - Rehab	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Inpatient Substance Abuse - Detox	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Outpatient Substance Abuse	\$0 Copay	Not Covered	\$0 Copay	Not Covered	
Diabetic Supplies and Services					
Insulin and Other Oral Agents	\$0 Copay	Not Covered	\$0 Copay	Not Covered	
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$0 Copay	Not Covered	\$0 Copay	Not Covered	
Rehabilitation Services					
Chiropractic Services	\$75 Copay	Not Covered	\$75 Copay	Not Covered	
Physical - Occupational - Speech Therapies	\$30 Copay	Not Covered	\$30 Copay	Not Covered	
Cardiac Rehabilitation	\$30 Copay	Not Covered	\$30 Copay	Not Covered	
Pulmonary Rehabilitation	\$30 Copay	Not Covered	\$30 Copay	Not Covered	
Additional Services					
Durable Medical Equipment	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Prosthetics and Appliances	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Chemotherapy	\$15 Copay	Not Covered	\$10 Copay	Not Covered	
Home Health Care	\$15 Copay	Not Covered	\$10 Copay	Not Covered	
Prescription Drug Coverage					
Prescription Plan	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	
Maintenance Medications	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered	
Vision Services					
Medical Exam	\$15 Copay	Not Covered	\$10 Copay	Not Covered	
Standard Plastic Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Frames	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Conventional Contact Lenses	20% Cost Sharing	Not Covered	20% Cost Sharing	Not Covered	
Dental Services					
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Not Covered	
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.					
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Freelancers Health Services Corporation
2014 Individual Rate Filing
Benefit Grid - NON-STANDARD PLANS

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Plans:	Primary Select Bronze PrimarySelect Bronze Dental Primary Select Bronze Age 29 Option PrimarySelect Bronze Dental Age 29 Option		Primary Select EPO Silver PrimarySelect EPO Silver Dental Primary Select EPO Silver Age 29 Option PrimarySelect EPO Silver Dental Age 29 Option		
	In-Network	Out-of-Network	In-Network (Preferred)	In-Network (Participating)	Out-of-Network
Benefit Summary					
Deductible	\$6,350	Not Applicable	\$2,000	\$2,000	Not Applicable
Coinsurance	100%	Not Applicable	20%	20%	Not Applicable
Out of Pocket Maximum	\$6,350	Not Applicable	\$6,350	\$6,350	Not Applicable
Preventive Services					
Allergy Testing					
Bone Density Testing					
Cervical Cytology					
Colonoscopy Screening					
Gynecological Screening					
Immunizations					
Mammography	\$0	Not Covered	\$0	\$0	Not Covered
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section 2713 of ACA					
Physician and Other Services					
Office Visit	\$0 Copay	Not Covered	\$0 Copay if using selected Doctor	\$30 Copay after Deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services					
Emergency Room	Subject To Deductible	Subject To Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance	Subject To Deductible	Subject To Deductible	\$150 Copay after Deductible	\$150 Copay after Deductible	\$150 Copay after Deductible
Urgent Care Center	Subject To Deductible	Not Covered	\$100 Copay after Deductible	\$100 Copay after Deductible	Not Covered
Hospital Services					
Inpatient Hospital	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services					
Laboratory Testing	Subject To Deductible	Not Covered	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
EKG	Subject To Deductible	Not Covered	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Routine Radiology	Subject To Deductible	Not Covered	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Advanced Radiology	Subject To Deductible	Not Covered	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Maternity Services					
Inpatient Maternity	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	\$0 Copay	Not Covered	\$0 Copay	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	\$0 Copay	Not Covered	\$0 Copay	\$0 Copay	Not Covered
Diabetic Supplies and Services					
Insulin and Other Oral Agents	\$0 Copay	Not Covered	\$0 Copay	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$0 Copay	Not Covered	\$0 Copay	\$0 Copay	Not Covered
Rehabilitation Services					
Chiropractic Services	Subject To Deductible	Not Covered	\$75 Copay	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	Subject To Deductible	Not Covered	\$30 Copay	\$30 Copay	Not Covered
Cardiac Rehabilitation	Subject To Deductible	Not Covered	\$30 Copay	\$30 Copay	Not Covered
Pulmonary Rehabilitation	Subject To Deductible	Not Covered	\$30 Copay	\$30 Copay	Not Covered
Additional Services					
Durable Medical Equipment	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Chemotherapy	Subject To Deductible	Not Covered	\$30 Copay after Deductible	\$30 Copay after Deductible	Not Covered
Home Health Care	Subject To Deductible	Not Covered	\$30 Copay after Deductible	\$30 Copay after Deductible	Not Covered
Prescription Drug Coverage					
Prescription Plan	\$0/Subject To Deductible/Subject To Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications	\$0/Subject To Deductible/Subject To Deductible	Not Covered	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services					
Medical Exam	Subject To Deductible	Not Covered	\$30 Copay after Deductible	\$30 Copay after Deductible	Not Covered
Standard Plastic Lenses	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	Subject To Deductible	Not Covered	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services					
Preventive and Routine	Pediatric Coverage with Dental Option	Not Covered	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered
<p>This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.</p> <p>All indicated benefits assume the member has appropriate authorization to receive services.</p> <p>Certain benefits stated in this benefit summary are pending NYS approval.</p>					

Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	Primary Select EPO Silver CSR 200-250% FPL PrimarySelect EPO Silver CSR 200-250% FPL Dental Primary Select EPO Silver CSR 200-250% FPL Age 29 Option PrimarySelect EPO Silver CSR 200-250% FPL Dental Age 29 Option		
Benefit Summary	In-Network (Preferred)	In-Network (Participating)	Out-of-Network
Deductible	\$2,000	\$2,000	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	\$5,200	\$5,200	Not Applicable
Preventive Services			
Allergy Testing			
Bone Density Testing			
Cervical Cytology			
Colonoscopy Screening			
Gynecological Screening			
Immunizations			
Mammography	\$0	\$0	Not Covered
Prenatal Maternity Care			
Prostate Cancer Screening			
Routine Exams			
Women's Preventive Health Services			
Other Services Noted in Section 2713 of ACA			
Physician and Other Services			
Office Visit	\$0 Copayment with Selected Doctor	\$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services			
Emergency Room	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance	\$150 Copay after Deductible	\$150 Copay after Deductible	\$150 Copay after Deductible
Urgent Care Center	\$100 Copay after Deductible	\$100 Copay after Deductible	Not Covered
Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services			
Laboratory Testing	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
EKG	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Routine Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Advanced Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Maternity Services			
Inpatient Maternity	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services			
Inpatient Mental Health	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	\$0 Copay	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	\$0 Copay	\$0 Copay	Not Covered
Diabetic Supplies and Services			
Insulin and Other Oral Agents	\$0 Copay	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$0 Copay	\$0 Copay	Not Covered
Rehabilitation Services			
Chiropractic Services	\$75 Copay	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	\$30 Copay	\$30 Copay	Not Covered
Cardiac Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Pulmonary Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	\$30 Copay	\$30 Copay	Not Covered
Home Health Care	\$30 Copay after Deductible	\$30 Copay after Deductible	Not Covered
Prescription Drug Coverage			
Prescription Plan	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services			
Medical Exam	\$30 Copay after Deductible	\$30 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.			
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Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	Primary Select EPO Silver CSR 150-200% FPL PrimarySelect EPO Silver CSR 150-200% FPL Dental Primary Select EPO Silver CSR 150-200% FPL Age 29 Option PrimarySelect EPO Silver CSR 150-200% FPL Dental Age 29 Option		
Benefit Summary	In-Network (Preferred)	In-Network (Participating)	Out-of-Network
Deductible	\$0	\$0	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	\$2,000	\$2,000	Not Applicable
Preventive Services			
Allergy Testing			
Bone Density Testing			
Cervical Cytology			
Colonoscopy Screening			
Gynecological Screening			
Immunizations			
Mammography	\$0	\$0	Not Covered
Prenatal Maternity Care			
Prostate Cancer Screening			
Routine Exams			
Women's Preventive Health Services			
Other Services Noted in Section 2713 of ACA			
Physician and Other Services			
Office Visit	\$0 Copayment with Selected Doctor	\$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services			
Emergency Room	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance	\$100 Copay after Deductible	\$100 Copay after Deductible	\$100 Copay after Deductible
Urgent Care Center	\$100 Copay after Deductible	\$100 Copay after Deductible	Not Covered
Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services			
Laboratory Testing	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
EKG	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Routine Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Advanced Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Maternity Services			
Inpatient Maternity	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services			
Inpatient Mental Health	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	\$0 Copay	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	\$0 Copay	\$0 Copay	Not Covered
Diabetic Supplies and Services			
Insulin and Other Oral Agents	\$0 Copay	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$0 Copay	\$0 Copay	Not Covered
Rehabilitation Services			
Chiropractic Services	\$75 Copay	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	\$30 Copay	\$30 Copay	Not Covered
Cardiac Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Pulmonary Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	\$15 Copay	\$15 Copay	Not Covered
Home Health Care	\$15 Copay	\$15 Copay	Not Covered
Prescription Drug Coverage			
Prescription Plan	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services			
Medical Exam	\$15 Copay after Deductible	\$15 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered
This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.			
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Freelancers Health Services Corporation 2014 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS			
Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003			
Plans:	Primary Select EPO Silver CSR 100-150% FPL PrimarySelect EPO Silver CSR 100-150% FPL Dental Primary Select EPO Silver CSR 100-150% FPL Age 29 Option PrimarySelect EPO Silver CSR 100-150% FPL Dental Age 29 Option		
Benefit Summary	In-Network (Preferred)	In-Network (Participating)	Out-of-Network
Deductible	\$0	\$0	Not Applicable
Coinsurance	20%	20%	Not Applicable
Out of Pocket Maximum	\$500	\$500	Not Applicable
Preventive Services			
Allergy Testing			
Bone Density Testing			
Cervical Cytology			
Colonoscopy Screening			
Gynecological Screening			
Immunizations			
Mammography	\$0	\$0	Not Covered
Prenatal Maternity Care			
Prostate Cancer Screening			
Routine Exams			
Women's Preventive Health Services			
Other Services Noted in Section 2713 of ACA			
Physician and Other Services			
Office Visit	\$0 Copayment with Selected Doctor	\$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services			
Emergency Room	\$250 Copay after Deductible	\$250 Copay after Deductible	\$250 Copay after Deductible
Ambulance	\$100 Copay after Deductible	\$100 Copay after Deductible	\$100 Copay after Deductible
Urgent Care Center	\$100 Copay after Deductible	\$100 Copay after Deductible	Not Covered
Hospital Services			
Inpatient Hospital	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services			
Laboratory Testing	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
EKG	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Routine Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Advanced Radiology	\$75 Copay after Deductible	\$75 Copay after Deductible	Not Covered
Maternity Services			
Inpatient Maternity	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services			
Inpatient Mental Health	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	\$0 Copay	\$0 Copay	Not Covered
Inpatient Substance Abuse - Rehab	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	\$0 Copay	\$0 Copay	Not Covered
Diabetic Supplies and Services			
Insulin and Other Oral Agents	\$0 Copay	\$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$0 Copay	\$0 Copay	Not Covered
Rehabilitation Services			
Chiropractic Services	\$75 Copay	\$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	\$30 Copay	\$30 Copay	Not Covered
Cardiac Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Pulmonary Rehabilitation	\$30 Copay	\$30 Copay	Not Covered
Additional Services			
Durable Medical Equipment	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	20 % Cost Sharing after Deductible	20 % Cost Sharing after Deductible	Not Covered
Chemotherapy	\$10 Copay	\$10 Copay	Not Covered
Home Health Care	\$10 Copay	\$10 Copay	Not Covered
Prescription Drug Coverage			
Prescription Plan	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Maintenance Medications	\$0/\$35 after Deductible /\$70 after Deductible	\$0/\$35 after Deductible /\$70 after Deductible	Not Covered
Vision Services			
Medical Exam	\$10 Copay after Deductible	\$10 Copay after Deductible	Not Covered
Standard Plastic Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Frames	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Conventional Contact Lenses	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	Not Covered
Dental Services			
Preventive and Routine	Pediatric Coverage with Dental Option	Pediatric Coverage with Dental Option	Not Covered
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**Freelancers Health Service Corporation
2014 Individual Rate Filing
Rating Region Composition**

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002, FHSC – IND29NDOFF, FHSC – IND29BDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Albany County Columbia County Fulton County Greene County Montgomery County Rensselaer County Saratoga County Schenectady County Schoharie County Warren County Washington County	Allegany County Cattaraugus County Chautauqua County Erie County Genesee County Niagara County Orleans County Wyoming County	Delaware County Dutchess County Orange County Putnam County Sullivan County Ulster County	Bronx County Kings County New York County Queens County Richmond County Rockland County Westchester County	Livingston County Monroe County Ontario County Seneca County Wayne County Yates County	Broome County Cayuga County Chemung County Cortland County Onondaga County Schuyler County Steuben County Tioga County Tompkins County	Chenango County Clinton County Essex County Franklin County Hamilton County Herkimer County Jefferson County Lewis County Madison County Oneida County Oswego County Otsego County St. Lawrence County	Nassau County Suffolk County

**Freelancers Health Service Corporation
2014 Individual Rate Filing
Commission Schedule**

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHIL001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Individual Schedule:

1% of Premium

Freelancers Health Service Corporation
2014 Individual Rate Filing
Expected Loss Ratio

Form Numbers: FHSC – IND29DON, FHSC – IND29BDON, FHSC – CAT-D001, FHSC – CHILD-D001, FHSC – IND29NDON, FHSC – IND29BNDON, FHSC – CAT001, FHSC – CHILD001, FHSC – IND29DOFF, FHSC – IND29BDOFF, FHSC – CAT – D002, FHSC – CHILD – D002 , FHSC – IND29NDOFF, FHSC – IND29BNDOFF, FHSC – CAT002, FHSC – CHILD002. Rider Numbers: FHSC-WMBT001, FHSC-WMBT002, FHSC-WMBT003

Federal ACA Loss Ratio 88.4%

ACA MLR = (Incurred Claims + Quality Initiatives - Gross Reinsurance Recoveries) / (Earned Premium - Taxes and Fees)

New York State Loss Ratio 82.4%

NY MLR = (Incurred Claims + HCRA Surcharge + Covered Lives Assessment (GME) - Gross Reinsurance Recoveries) / Earned Premium