Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
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Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

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Rate Setting Parameters
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Index Rate (Adult) $322.73

HIOS ID	Product	Market	Metal	Rate Factor
71644NY0010004	EssentialCare Platinum	On and Off Exchange	Platinum	1.6795
71644NY0010003	EssentialCare Gold	On and Off Exchange	Gold	1.4284
71644NY0010002	EssentialCare Silver	On and Off Exchange	Silver	1.2224
71644NY0010001	EssentialCare Bronze	On and Off Exchange	Bronze	1.0000
71644NY0010005	EssentialCare Catastrophic	On and Off Exchange	Catastrophic	0.5253
71644NY0030004	Primary Select Platinum	On and Off Exchange	Platinum	1.6101
71644NY0030003	Primary Select Gold	On and Off Exchange	Gold	1.4273
71644NY0030002	Primary Select Silver	On and Off Exchange	Silver	1.2216
71644NY0730001	TotalIndependence Advanced (Gold)	On and Off Exchange	Gold	1.2787
71644NY0700001	TotalIndependence Plus (Silver)	On and Off Exchange	Silver	1.0838
71644NY0670001	TotalIndependence Basic (Bronze)	On and Off Exchange	Bronze	0.9514
71644NY0040002	Primary Select PCMH	On and Off Exchange	Silver	1.1526
71644NY0020004	EssentialCare Platinum Child Only	On and Off Exchange	Platinum	1.6795
71644NY0020003	EssentialCare Gold Child Only	On and Off Exchange	Gold	1.4284
71644NY0020002	EssentialCare Silver Child Only	On and Off Exchange	Silver	1.2224
71644NY0020001	EssentialCare Bronze Child Only	On and Off Exchange	Bronze	1.0000
71644NY0090004	EssentialCare Platinum Age 29 Option	On and Off Exchange	Platinum	1.6795
71644NY0090003	EssentialCare Gold Age 29 Option	On and Off Exchange	Gold	1.4284
71644NY0090002	EssentialCare Silver Age 29 Option	On and Off Exchange	Silver	1.2224
71644NY0090001	EssentialCare Bronze Age 29 Option	On and Off Exchange	Bronze	1.0000
71644NY0130004	Primary Select Platinum Age 29 Option	On and Off Exchange	Platinum	1.6101
71644NY0130003	Primary Select Gold Age 29 Option	On and Off Exchange	Gold	1.4273
71644NY0130002	Primary Select Silver Age 29 Option	On and Off Exchange	Silver	1.2216
71644NY0150002	Primary Select PCMH Age 29 Option	On and Off Exchange	Silver	1.1526
71644NY0750001	TotalIndependence Advanced (Gold) Age 29 Option	On and Off Exchange	Gold	1.2787
71644NY0720001	TotalIndependence Plus (Silver) Age 29 Option	On and Off Exchange	Silver	1.0838
71644NY0690001	TotalIndependence Basic (Bronze) Age 29 Option	On and Off Exchange	Bronze	0.9514
71644NY0740001	TotalIndependence Advanced (Gold) Child Only	On and Off Exchange	Gold	1.2787
71644NY0710001	TotalIndependence Plus (Silver) Child Only	On and Off Exchange	Silver	1.0838
71644NY0680001	TotalIndependence Basic (Bronze) Child Only	On and Off Exchange	Bronze	0.9514
71644NY0840001	TotalIndependence Advanced (Platinum)	On and Off Exchange	Platinum	1.6314
71644NY0850001	TotalIndependence Advanced (Platinum) Age 29 Opti	On and Off Exchange	Platinum	1.6314
71644NY0030001	Primary Select Bronze	On and Off Exchange	Bronze	1.1218
71644NY0130001	Primary Select Bronze Age 29 Option	On and Off Exchange	Bronze	1.1218

Age Band	Rate Factor	Tobacco 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

Geographic Factors:

Area	Rate Factor
Region 1	0.8408
Region 2	0.7483
Region 3	0.9445
Region 4	1.0865
Region 5	0.7737
Region 6	0.7232
Region 7	0.7950
Region 8	1.0865

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
Child Only	0.412

Sample Rate Calculation:
EssentialCare Platinum in Region 1 for a Single Adult with Two Dependents =
Base Rate x EssentialCare Platinum Factor x Region 1 Factor x Single Adult and Two Dependents Factor =
$322.73 x 1.6795 x 0.8408 x 1.7000 = **$774.75**

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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
EssentialCare Platinum	Region 1	$455.74	$911.47	$774.75	$774.75	$774.75	$1,298.84	$1,298.84	$1,298.84
EssentialCare Platinum	Region 2	$405.61	$811.19	$689.52	$689.52	$689.52	$1,155.95	$1,155.95	$1,155.95
EssentialCare Platinum	Region 3	$511.95	$1,023.89	$870.30	$870.30	$870.30	$1,459.04	$1,459.04	$1,459.04
EssentialCare Platinum	Region 4	$588.92	$1,177.82	$1,001.15	$1,001.15	$1,001.15	$1,678.39	$1,678.39	$1,678.39
EssentialCare Platinum	Region 5	$419.37	$838.73	$712.92	$712.92	$712.92	$1,195.19	$1,195.19	$1,195.19
EssentialCare Platinum	Region 6	$392.00	$783.99	$666.39	$666.39	$666.39	$1,117.18	$1,117.18	$1,117.18
EssentialCare Platinum	Region 7	$430.92	$861.82	$732.55	$732.55	$732.55	$1,228.09	$1,228.09	$1,228.09
EssentialCare Platinum	Region 8	$588.92	$1,177.82	$1,001.15	$1,001.15	$1,001.15	$1,678.39	$1,678.39	$1,678.39
EssentialCare Gold	Region 1	$387.61	$775.20	$658.92	$658.92	$658.92	$1,104.66	$1,104.66	$1,104.66
EssentialCare Gold	Region 2	$344.97	$689.91	$586.43	$586.43	$586.43	$983.13	$983.13	$983.13
EssentialCare Gold	Region 3	$435.41	$870.81	$740.18	$740.18	$740.18	$1,240.90	$1,240.90	$1,240.90
EssentialCare Gold	Region 4	$500.87	$1,001.73	$851.47	$851.47	$851.47	$1,427.46	$1,427.46	$1,427.46
EssentialCare Gold	Region 5	$356.68	$713.33	$606.33	$606.33	$606.33	$1,016.50	$1,016.50	$1,016.50
EssentialCare Gold	Region 6	$333.40	$666.77	$566.76	$566.76	$566.76	$950.15	$950.15	$950.15
EssentialCare Gold	Region 7	$366.50	$732.97	$623.02	$623.02	$623.02	$1,044.48	$1,044.48	$1,044.48
EssentialCare Gold	Region 8	$500.87	$1,001.73	$851.47	$851.47	$851.47	$1,427.46	$1,427.46	$1,427.46
EssentialCare Silver	Region 1	$331.71	$663.40	$563.89	$563.89	$563.89	$945.34	$945.34	$945.34
EssentialCare Silver	Region 2	$295.22	$590.42	$501.85	$501.85	$501.85	$841.34	$841.34	$841.34
EssentialCare Silver	Region 3	$372.62	$745.22	$633.44	$633.44	$633.44	$1,061.94	$1,061.94	$1,061.94
EssentialCare Silver	Region 4	$428.64	$857.26	$728.67	$728.67	$728.67	$1,221.60	$1,221.60	$1,221.60
EssentialCare Silver	Region 5	$305.24	$610.46	$518.89	$518.89	$518.89	$869.90	$869.90	$869.90
EssentialCare Silver	Region 6	$285.32	$570.61	$485.02	$485.02	$485.02	$813.12	$813.12	$813.12
EssentialCare Silver	Region 7	$313.64	$627.26	$533.17	$533.17	$533.17	$893.85	$893.85	$893.85
EssentialCare Silver	Region 8	$428.64	$857.26	$728.67	$728.67	$728.67	$1,221.60	$1,221.60	$1,221.60
EssentialCare Bronze	Region 1	$271.36	$542.70	$461.30	$461.30	$461.30	$773.35	$773.35	$773.35
EssentialCare Bronze	Region 2	$241.51	$483.00	$410.55	$410.55	$410.55	$688.27	$688.27	$688.27
EssentialCare Bronze	Region 3	$304.83	$609.64	$518.19	$518.19	$518.19	$868.73	$868.73	$868.73
EssentialCare Bronze	Region 4	$350.66	$701.29	$596.10	$596.10	$596.10	$999.34	$999.34	$999.34
EssentialCare Bronze	Region 5	$249.71	$499.39	$424.48	$424.48	$424.48	$711.63	$711.63	$711.63
EssentialCare Bronze	Region 6	$233.41	$466.80	$396.78	$396.78	$396.78	$665.19	$665.19	$665.19
EssentialCare Bronze	Region 7	$256.58	$513.14	$436.17	$436.17	$436.17	$731.23	$731.23	$731.23
EssentialCare Bronze	Region 8	$350.66	$701.29	$596.10	$596.10	$596.10	$999.34	$999.34	$999.34
EssentialCare Catastrophic	Region 1	$142.55	$285.08	$242.32	$242.32	$242.32	$406.24	$406.24	$406.24
EssentialCare Catastrophic	Region 2	$126.87	$253.72	$215.66	$215.66	$215.66	$361.55	$361.55	$361.55
EssentialCare Catastrophic	Region 3	$160.13	$320.24	$272.21	$272.21	$272.21	$456.35	$456.35	$456.35
EssentialCare Catastrophic	Region 4	$184.20	$368.39	$313.13	$313.13	$313.13	$524.95	$524.95	$524.95
EssentialCare Catastrophic	Region 5	$131.17	$262.33	$222.98	$222.98	$222.98	$373.82	$373.82	$373.82
EssentialCare Catastrophic	Region 6	$122.61	$245.21	$208.43	$208.43	$208.43	$349.42	$349.42	$349.42
EssentialCare Catastrophic	Region 7	$134.78	$269.55	$229.12	$229.12	$229.12	$384.11	$384.11	$384.11
EssentialCare Catastrophic	Region 8	$184.20	$368.39	$313.13	$313.13	$313.13	$524.95	$524.95	$524.95
Primary Select Platinum	Region 1	$436.91	$873.81	$742.73	$742.73	$742.73	$1,245.17	$1,245.17	$1,245.17
Primary Select Platinum	Region 2	$388.85	$777.67	$661.02	$661.02	$661.02	$1,108.19	$1,108.19	$1,108.19
Primary Select Platinum	Region 3	$490.80	$981.58	$834.34	$834.34	$834.34	$1,398.75	$1,398.75	$1,398.75
Primary Select Platinum	Region 4	$564.59	$1,129.15	$959.78	$959.78	$959.78	$1,609.04	$1,609.04	$1,609.04
Primary Select Platinum	Region 5	$402.05	$804.07	$683.46	$683.46	$683.46	$1,145.80	$1,145.80	$1,145.80
Primary Select Platinum	Region 6	$375.80	$751.59	$638.85	$638.85	$638.85	$1,071.01	$1,071.01	$1,071.01
Primary Select Platinum	Region 7	$413.11	$826.21	$702.28	$702.28	$702.28	$1,177.35	$1,177.35	$1,177.35
Primary Select Platinum	Region 8	$564.59	$1,129.15	$959.78	$959.78	$959.78	$1,609.04	$1,609.04	$1,609.04
Primary Select Gold	Region 1	$387.31	$774.60	$658.41	$658.41	$658.41	$1,103.80	$1,103.80	$1,103.80
Primary Select Gold	Region 2	$344.70	$689.38	$585.98	$585.98	$585.98	$982.37	$982.37	$982.37
Primary Select Gold	Region 3	$435.08	$870.13	$739.61	$739.61	$739.61	$1,239.94	$1,239.94	$1,239.94
Primary Select Gold	Region 4	$500.49	$1,000.95	$850.81	$850.81	$850.81	$1,426.36	$1,426.36	$1,426.36
Primary Select Gold	Region 5	$356.40	$712.78	$605.87	$605.87	$605.87	$1,015.72	$1,015.72	$1,015.72
Primary Select Gold	Region 6	$333.14	$666.26	$566.32	$566.32	$566.32	$949.42	$949.42	$949.42
Primary Select Gold	Region 7	$366.21	$732.41	$622.54	$622.54	$622.54	$1,043.68	$1,043.68	$1,043.68
Primary Select Gold	Region 8	$500.49	$1,000.95	$850.81	$850.81	$850.81	$1,426.36	$1,426.36	$1,426.36
Primary Select Silver	Region 1	$331.49	$662.97	$563.52	$563.52	$563.52	$944.73	$944.73	$944.73
Primary Select Silver	Region 2	$295.03	$590.03	$501.53	$501.53	$501.53	$840.79	$840.79	$840.79
Primary Select Silver	Region 3	$372.38	$744.73	$633.02	$633.02	$633.02	$1,061.24	$1,061.24	$1,061.24
Primary Select Silver	Region 4	$428.36	$856.70	$728.19	$728.19	$728.19	$1,220.80	$1,220.80	$1,220.80
Primary Select Silver	Region 5	$305.04	$610.06	$518.55	$518.55	$518.55	$869.33	$869.33	$869.33
Primary Select Silver	Region 6	$285.13	$570.24	$484.70	$484.70	$484.70	$812.59	$812.59	$812.59
Primary Select Silver	Region 7	$313.44	$626.85	$532.82	$532.82	$532.82	$893.27	$893.27	$893.27
Primary Select Silver	Region 8	$428.36	$856.70	$728.19	$728.19	$728.19	$1,220.80	$1,220.80	$1,220.80
TotalIndependence Advanced (Gold)	Region 1	$346.99	$693.95	$589.86	$589.86	$589.86	$988.88	$988.88	$988.88
TotalIndependence Advanced (Gold)	Region 2	$308.81	$617.61	$524.97	$524.97	$524.97	$880.09	$880.09	$880.09
TotalIndependence Advanced (Gold)	Region 3	$389.78	$779.54	$662.61	$662.61	$662.61	$1,110.85	$1,110.85	$1,110.85
TotalIndependence Advanced (Gold)	Region 4	$448.38	$896.74	$762.23	$762.23	$762.23	$1,277.86	$1,277.86	$1,277.86
TotalIndependence Advanced (Gold)	Region 5	$319.30	$638.57	$542.79	$542.79	$542.79	$909.97	$909.97	$909.97
TotalIndependence Advanced (Gold)	Region 6	$298.46	$596.89	$507.36	$507.36	$507.36	$850.57	$850.57	$850.57
TotalIndependence Advanced (Gold)	Region 7	$328.09	$656.15	$557.73	$557.73	$557.73	$935.02	$935.02	$935.02
TotalIndependence Advanced (Gold)	Region 8	$448.38	$896.74	$762.23	$762.23	$762.23	$1,277.86	$1,277.86	$1,277.86
TotalIndependence Plus (Silver)	Region 1	$294.10	$588.18	$499.95	$499.95	$499.95	$838.16	$838.16	$838.16
TotalIndependence Plus (Silver)	Region 2	$261.75	$523.47	$444.95	$444.95	$444.95	$745.95	$745.95	$745.95
TotalIndependence Plus (Silver)	Region 3	$330.37	$660.72	$561.62	$561.62	$561.62	$941.53	$941.53	$941.53
TotalIndependence Plus (Silver)	Region 4	$380.04	$760.06	$646.05	$646.05	$646.05	$1,083.09	$1,083.09	$1,083.09
TotalIndependence Plus (Silver)	Region 5	$270.63	$541.24	$460.06	$460.06	$460.06	$771.27	$771.27	$771.27
TotalIndependence Plus (Silver)	Region 6	$252.97	$505.91	$430.03	$430.03	$430.03	$720.93	$720.93	$720.93
TotalIndependence Plus (Silver)	Region 7	$278.08	$556.14	$472.72	$472.72	$472.72	$792.50	$792.50	$792.50
TotalIndependence Plus (Silver)	Region 8	$380.04	$760.06	$646.05	$646.05	$646.05	$1,083.09	$1,083.09	$1,083.09
TotalIndependence Basic (Bronze)	Region 1	$258.17	$516.33	$438.88	$438.88	$438.88	$735.77	$735.77	$735.77
TotalIndependence Basic (Bronze)	Region 2	$229.77	$459.52	$390.60	$390.60	$390.60	$654.82	$654.82	$654.82
TotalIndependence Basic (Bronze)	Region 3	$290.01	$580.01	$493.01	$493.01	$493.01	$826.51	$826.51	$826.51
TotalIndependence Basic (Bronze)	Region 4	$333.61	$667.21	$567.13	$567.13	$567.13	$950.77	$950.77	$950.77
TotalIndependence Basic (Bronze)	Region 5	$237.57	$475.12	$403.85	$403.85	$403.85	$677.05	$677.05	$677.05
TotalIndependence Basic (Bronze)	Region 6	$222.06	$444.11	$377.49	$377.49	$377.49	$632.86	$632.86	$632.86
TotalIndependence Basic (Bronze)	Region 7	$244.11	$488.20	$414.97	$414.97	$414.97	$695.69	$695.69	$695.69
TotalIndependence Basic (Bronze)	Region 8	$333.61	$667.21	$567.13	$567.13	$567.13	$950.77	$950.77	$950.77
Primary Select PCMH	Region 1	$312.77	$625.52	$531.69	$531.69	$531.69	$891.36	$891.36	$891.36
Primary Select PCMH	Region 2	$278.36	$556.70	$473.20	$473.20	$473.20	$793.30	$793.30	$793.30
Primary Select PCMH	Region 3	$351.34	$702.67	$597.27	$597.27	$597.27	$1,001.30	$1,001.30	$1,001.30
Primary Select PCMH	Region 4	$404.16	$808.31	$687.06	$687.06	$687.06	$1,151.84	$1,151.84	$1,151.84
Primary Select PCMH	Region 5	$287.81	$575.60	$489.26	$489.26	$489.26	$820.23	$820.23	$820.23
Primary Select PCMH	Region 6	$269.02	$538.03	$457.33	$457.33	$457.33	$766.69	$766.69	$766.69
Primary Select PCMH	Region 7	$295.73	$591.45	$502.73	$502.73	$502.73	$842.81	$842.81	$842.81
Primary Select PCMH	Region 8	$404.16	$808.31	$687.06	$687.06	$687.06	$1,151.84	$1,151.84	$1,151.84
EssentialCare Platinum Child Only	Region 1	$187.76	$187.76	$187.76	$187.76	$187.76	$187.76	$187.76	$187.76
EssentialCare Platinum Child Only	Region 2	$167.10	$167.10	$167.10	$167.10	$167.10	$167.10	$167.10	$167.10
EssentialCare Platinum Child Only	Region 3	$210.92	$210.92	$210.92	$210.92	$210.92	$210.92	$210.92	$210.92
EssentialCare Platinum Child Only	Region 4	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63
EssentialCare Platinum Child Only	Region 5	$172.78	$172.78	$172.78	$172.78	$172.78	$172.78	$172.78	$172.78
EssentialCare Platinum Child Only	Region 6	$161.50	$161.50	$161.50	$161.50	$161.50	$161.50	$161.50	$161.50
EssentialCare Platinum Child Only	Region 7	$177.53	$177.53	$177.53	$177.53	$177.53	$177.53	$177.53	$177.53
EssentialCare Platinum Child Only	Region 8	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63	$242.63
EssentialCare Gold Child Only	Region 1	$159.69	$159.69	$159.69	$159.69	$159.69	$159.69	$159.69	$159.69
EssentialCare Gold Child Only	Region 2	$142.12	$142.12	$142.12	$142.12	$142.12	$142.12	$142.12	$142.12
EssentialCare Gold Child Only	Region 3	$179.38	$179.38	$179.38	$179.38	$179.38	$179.38	$179.38	$179.38
EssentialCare Gold Child Only	Region 4	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35
EssentialCare Gold Child Only	Region 5	$146.94	$146.94	$146.94	$146.94	$146.94	$146.94	$146.94	$146.94
EssentialCare Gold Child Only	Region 6	$137.36	$137.36	$137.36	$137.36	$137.36	$137.36	$137.36	$137.36
EssentialCare Gold Child Only	Region 7	$150.99	$150.99	$150.99	$150.99	$150.99	$150.99	$150.99	$150.99
EssentialCare Gold Child Only	Region 8	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35	$206.35
EssentialCare Silver Child Only	Region 1	$136.66	$136.66	$136.66	$136.66	$136.66	$136.66	$136.66	$136.66
EssentialCare Silver Child Only	Region 2	$121.63	$121.63	$121.63	$121.63	$121.63	$121.63	$121.63	$121.63
EssentialCare Silver Child Only	Region 3	$153.52	$153.52	$153.52	$153.52	$153.52	$153.52	$153.52	$153.52
EssentialCare Silver Child Only	Region 4	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60
EssentialCare Silver Child Only	Region 5	$125.75	$125.75	$125.75	$125.75	$125.75	$125.75	$125.75	$125.75
EssentialCare Silver Child Only	Region 6	$117.54	$117.54	$117.54	$117.54	$117.54	$117.54	$117.54	$117.54
EssentialCare Silver Child Only	Region 7	$129.21	$129.21	$129.21	$129.21	$129.21	$129.21	$129.21	$129.21
EssentialCare Silver Child Only	Region 8	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60	$176.60
EssentialCare Bronze Child Only	Region 1	$111.80	$111.80	$111.80	$111.80	$111.80	$111.80	$111.80	$111.80
EssentialCare Bronze Child Only	Region 2	$99.50	$99.50	$99.50	$99.50	$99.50	$99.50	$99.50	$99.50
EssentialCare Bronze Child Only	Region 3	$125.59	$125.59	$125.59	$125.59	$125.59	$125.59	$125.59	$125.59
EssentialCare Bronze Child Only	Region 4	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46
EssentialCare Bronze Child Only	Region 5	$102.87	$102.87	$102.87	$102.87	$102.87	$102.87	$102.87	$102.87
EssentialCare Bronze Child Only	Region 6	$96.16	$96.16	$96.16	$96.16	$96.16	$96.16	$96.16	$96.16
EssentialCare Bronze Child Only	Region 7	$105.70	$105.70	$105.70	$105.70	$105.70	$105.70	$105.70	$105.70
EssentialCare Bronze Child Only	Region 8	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46	$144.46

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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
EssentialCare Platinum Age 29 Option	Region 1	$455.74	$911.47	$774.75	$774.75	$774.75	$1,298.84	$1,298.84	$1,298.84
EssentialCare Platinum Age 29 Option	Region 2	$405.61	$811.19	$689.52	$689.52	$689.52	$1,155.95	$1,155.95	$1,155.95
EssentialCare Platinum Age 29 Option	Region 3	$511.95	$1,023.89	$870.30	$870.30	$870.30	$1,459.04	$1,459.04	$1,459.04
EssentialCare Platinum Age 29 Option	Region 4	$588.92	$1,177.82	$1,001.15	$1,001.15	$1,001.15	$1,678.39	$1,678.39	$1,678.39
EssentialCare Platinum Age 29 Option	Region 5	$419.37	$838.73	$712.92	$712.92	$712.92	$1,195.19	$1,195.19	$1,195.19
EssentialCare Platinum Age 29 Option	Region 6	$392.00	$783.99	$666.39	$666.39	$666.39	$1,117.18	$1,117.18	$1,117.18
EssentialCare Platinum Age 29 Option	Region 7	$430.92	$861.82	$732.55	$732.55	$732.55	$1,228.09	$1,228.09	$1,228.09
EssentialCare Platinum Age 29 Option	Region 8	$588.92	$1,177.82	$1,001.15	$1,001.15	$1,001.15	$1,678.39	$1,678.39	$1,678.39
EssentialCare Gold Age 29 Option	Region 1	$387.61	$775.20	$658.92	$658.92	$658.92	$1,104.66	$1,104.66	$1,104.66
EssentialCare Gold Age 29 Option	Region 2	$344.97	$689.91	$586.43	$586.43	$586.43	$983.13	$983.13	$983.13
EssentialCare Gold Age 29 Option	Region 3	$435.41	$870.81	$740.18	$740.18	$740.18	$1,240.90	$1,240.90	$1,240.90
EssentialCare Gold Age 29 Option	Region 4	$500.87	$1,001.73	$851.47	$851.47	$851.47	$1,427.46	$1,427.46	$1,427.46
EssentialCare Gold Age 29 Option	Region 5	$356.68	$713.33	$606.33	$606.33	$606.33	$1,016.50	$1,016.50	$1,016.50
EssentialCare Gold Age 29 Option	Region 6	$333.40	$666.77	$566.76	$566.76	$566.76	$950.15	$950.15	$950.15
EssentialCare Gold Age 29 Option	Region 7	$366.50	$732.97	$623.02	$623.02	$623.02	$1,044.48	$1,044.48	$1,044.48
EssentialCare Gold Age 29 Option	Region 8	$500.87	$1,001.73	$851.47	$851.47	$851.47	$1,427.46	$1,427.46	$1,427.46
EssentialCare Silver Age 29 Option	Region 1	$331.71	$663.40	$563.89	$563.89	$563.89	$945.34	$945.34	$945.34
EssentialCare Silver Age 29 Option	Region 2	$295.22	$590.42	$501.85	$501.85	$501.85	$841.34	$841.34	$841.34
EssentialCare Silver Age 29 Option	Region 3	$372.62	$745.22	$633.44	$633.44	$633.44	$1,061.94	$1,061.94	$1,061.94
EssentialCare Silver Age 29 Option	Region 4	$428.64	$857.26	$728.67	$728.67	$728.67	$1,221.60	$1,221.60	$1,221.60
EssentialCare Silver Age 29 Option	Region 5	$305.24	$610.46	$518.89	$518.89	$518.89	$869.90	$869.90	$869.90
EssentialCare Silver Age 29 Option	Region 6	$285.32	$570.61	$485.02	$485.02	$485.02	$813.12	$813.12	$813.12
EssentialCare Silver Age 29 Option	Region 7	$313.64	$627.26	$533.17	$533.17	$533.17	$893.85	$893.85	$893.85
EssentialCare Silver Age 29 Option	Region 8	$428.64	$857.26	$728.67	$728.67	$728.67	$1,221.60	$1,221.60	$1,221.60
EssentialCare Bronze Age 29 Option	Region 1	$271.36	$542.70	$461.30	$461.30	$461.30	$773.35	$773.35	$773.35
EssentialCare Bronze Age 29 Option	Region 2	$241.51	$483.00	$410.55	$410.55	$410.55	$688.27	$688.27	$688.27
EssentialCare Bronze Age 29 Option	Region 3	$304.83	$609.64	$518.19	$518.19	$518.19	$868.73	$868.73	$868.73
EssentialCare Bronze Age 29 Option	Region 4	$350.66	$701.29	$596.10	$596.10	$596.10	$999.34	$999.34	$999.34
EssentialCare Bronze Age 29 Option	Region 5	$249.71	$499.39	$424.48	$424.48	$424.48	$711.63	$711.63	$711.63
EssentialCare Bronze Age 29 Option	Region 6	$233.41	$466.80	$396.78	$396.78	$396.78	$665.19	$665.19	$665.19
EssentialCare Bronze Age 29 Option	Region 7	$256.58	$513.14	$436.17	$436.17	$436.17	$731.23	$731.23	$731.23
EssentialCare Bronze Age 29 Option	Region 8	$350.66	$701.29	$596.10	$596.10	$596.10	$999.34	$999.34	$999.34
Primary Select Platinum Age 29 Option	Region 1	$436.91	$873.81	$742.73	$742.73	$742.73	$1,245.17	$1,245.17	$1,245.17
Primary Select Platinum Age 29 Option	Region 2	$388.85	$777.67	$661.02	$661.02	$661.02	$1,108.19	$1,108.19	$1,108.19
Primary Select Platinum Age 29 Option	Region 3	$490.80	$981.58	$834.34	$834.34	$834.34	$1,398.75	$1,398.75	$1,398.75
Primary Select Platinum Age 29 Option	Region 4	$564.59	$1,129.15	$959.78	$959.78	$959.78	$1,609.04	$1,609.04	$1,609.04
Primary Select Platinum Age 29 Option	Region 5	$402.05	$804.07	$683.46	$683.46	$683.46	$1,145.80	$1,145.80	$1,145.80
Primary Select Platinum Age 29 Option	Region 6	$375.80	$751.59	$638.85	$638.85	$638.85	$1,071.01	$1,071.01	$1,071.01
Primary Select Platinum Age 29 Option	Region 7	$413.11	$826.21	$702.28	$702.28	$702.28	$1,177.35	$1,177.35	$1,177.35
Primary Select Platinum Age 29 Option	Region 8	$564.59	$1,129.15	$959.78	$959.78	$959.78	$1,609.04	$1,609.04	$1,609.04
Primary Select Gold Age 29 Option	Region 1	$387.31	$774.60	$658.41	$658.41	$658.41	$1,103.80	$1,103.80	$1,103.80
Primary Select Gold Age 29 Option	Region 2	$344.70	$689.38	$585.98	$585.98	$585.98	$982.37	$982.37	$982.37
Primary Select Gold Age 29 Option	Region 3	$435.08	$870.13	$739.61	$739.61	$739.61	$1,239.94	$1,239.94	$1,239.94
Primary Select Gold Age 29 Option	Region 4	$500.49	$1,000.95	$850.81	$850.81	$850.81	$1,426.36	$1,426.36	$1,426.36
Primary Select Gold Age 29 Option	Region 5	$356.40	$712.78	$605.87	$605.87	$605.87	$1,015.72	$1,015.72	$1,015.72
Primary Select Gold Age 29 Option	Region 6	$333.14	$666.26	$566.32	$566.32	$566.32	$949.42	$949.42	$949.42
Primary Select Gold Age 29 Option	Region 7	$366.21	$732.41	$622.54	$622.54	$622.54	$1,043.68	$1,043.68	$1,043.68
Primary Select Gold Age 29 Option	Region 8	$500.49	$1,000.95	$850.81	$850.81	$850.81	$1,426.36	$1,426.36	$1,426.36
Primary Select Silver Age 29 Option	Region 1	$331.49	$662.97	$563.52	$563.52	$563.52	$944.73	$944.73	$944.73
Primary Select Silver Age 29 Option	Region 2	$295.03	$590.03	$501.53	$501.53	$501.53	$840.79	$840.79	$840.79
Primary Select Silver Age 29 Option	Region 3	$372.38	$744.73	$633.02	$633.02	$633.02	$1,061.24	$1,061.24	$1,061.24
Primary Select Silver Age 29 Option	Region 4	$428.36	$856.70	$728.19	$728.19	$728.19	$1,220.80	$1,220.80	$1,220.80
Primary Select Silver Age 29 Option	Region 5	$305.04	$610.06	$518.55	$518.55	$518.55	$869.33	$869.33	$869.33
Primary Select Silver Age 29 Option	Region 6	$285.13	$570.24	$484.70	$484.70	$484.70	$812.59	$812.59	$812.59
Primary Select Silver Age 29 Option	Region 7	$313.44	$626.85	$532.82	$532.82	$532.82	$893.27	$893.27	$893.27
Primary Select Silver Age 29 Option	Region 8	$428.36	$856.70	$728.19	$728.19	$728.19	$1,220.80	$1,220.80	$1,220.80
Primary Select PCMH Age 29 Option	Region 1	$312.77	$625.52	$531.69	$531.69	$531.69	$891.36	$891.36	$891.36
Primary Select PCMH Age 29 Option	Region 2	$278.36	$556.70	$473.20	$473.20	$473.20	$793.30	$793.30	$793.30
Primary Select PCMH Age 29 Option	Region 3	$351.34	$702.67	$597.27	$597.27	$597.27	$1,001.30	$1,001.30	$1,001.30
Primary Select PCMH Age 29 Option	Region 4	$404.16	$808.31	$687.06	$687.06	$687.06	$1,151.84	$1,151.84	$1,151.84
Primary Select PCMH Age 29 Option	Region 5	$287.81	$575.60	$489.26	$489.26	$489.26	$820.23	$820.23	$820.23
Primary Select PCMH Age 29 Option	Region 6	$269.02	$538.03	$457.33	$457.33	$457.33	$766.69	$766.69	$766.69
Primary Select PCMH Age 29 Option	Region 7	$295.73	$591.45	$502.73	$502.73	$502.73	$842.81	$842.81	$842.81
Primary Select PCMH Age 29 Option	Region 8	$404.16	$808.31	$687.06	$687.06	$687.06	$1,151.84	$1,151.84	$1,151.84
TotalIndependence Advanced (Gold) Age 29 Option	Region 1	$346.99	$693.95	$589.86	$589.86	$589.86	$988.88	$988.88	$988.88
TotalIndependence Advanced (Gold) Age 29 Option	Region 2	$308.81	$617.61	$524.97	$524.97	$524.97	$880.09	$880.09	$880.09
TotalIndependence Advanced (Gold) Age 29 Option	Region 3	$389.78	$779.54	$662.61	$662.61	$662.61	$1,110.85	$1,110.85	$1,110.85
TotalIndependence Advanced (Gold) Age 29 Option	Region 4	$448.38	$896.74	$762.23	$762.23	$762.23	$1,277.86	$1,277.86	$1,277.86
TotalIndependence Advanced (Gold) Age 29 Option	Region 5	$319.30	$638.57	$542.79	$542.79	$542.79	$909.97	$909.97	$909.97
TotalIndependence Advanced (Gold) Age 29 Option	Region 6	$298.46	$596.89	$507.36	$507.36	$507.36	$850.57	$850.57	$850.57
TotalIndependence Advanced (Gold) Age 29 Option	Region 7	$328.09	$656.15	$557.73	$557.73	$557.73	$935.02	$935.02	$935.02
TotalIndependence Advanced (Gold) Age 29 Option	Region 8	$448.38	$896.74	$762.23	$762.23	$762.23	$1,277.86	$1,277.86	$1,277.86
TotalIndependence Plus (Silver) Age 29 Option	Region 1	$294.10	$588.18	$499.95	$499.95	$499.95	$838.16	$838.16	$838.16
TotalIndependence Plus (Silver) Age 29 Option	Region 2	$261.75	$523.47	$444.95	$444.95	$444.95	$745.95	$745.95	$745.95
TotalIndependence Plus (Silver) Age 29 Option	Region 3	$330.37	$660.72	$561.62	$561.62	$561.62	$941.53	$941.53	$941.53
TotalIndependence Plus (Silver) Age 29 Option	Region 4	$380.04	$760.06	$646.05	$646.05	$646.05	$1,083.09	$1,083.09	$1,083.09
TotalIndependence Plus (Silver) Age 29 Option	Region 5	$270.63	$541.24	$460.06	$460.06	$460.06	$771.27	$771.27	$771.27
TotalIndependence Plus (Silver) Age 29 Option	Region 6	$252.97	$505.91	$430.03	$430.03	$430.03	$720.93	$720.93	$720.93
TotalIndependence Plus (Silver) Age 29 Option	Region 7	$278.08	$556.14	$472.72	$472.72	$472.72	$792.50	$792.50	$792.50
TotalIndependence Plus (Silver) Age 29 Option	Region 8	$380.04	$760.06	$646.05	$646.05	$646.05	$1,083.09	$1,083.09	$1,083.09
TotalIndependence Basic (Bronze) Age 29 Option	Region 1	$258.17	$516.33	$438.88	$438.88	$438.88	$735.77	$735.77	$735.77
TotalIndependence Basic (Bronze) Age 29 Option	Region 2	$229.77	$459.52	$390.60	$390.60	$390.60	$654.82	$654.82	$654.82
TotalIndependence Basic (Bronze) Age 29 Option	Region 3	$290.01	$580.01	$493.01	$493.01	$493.01	$826.51	$826.51	$826.51
TotalIndependence Basic (Bronze) Age 29 Option	Region 4	$333.61	$667.21	$567.13	$567.13	$567.13	$950.77	$950.77	$950.77
TotalIndependence Basic (Bronze) Age 29 Option	Region 5	$237.57	$475.12	$403.85	$403.85	$403.85	$677.05	$677.05	$677.05
TotalIndependence Basic (Bronze) Age 29 Option	Region 6	$222.06	$444.11	$377.49	$377.49	$377.49	$632.86	$632.86	$632.86
TotalIndependence Basic (Bronze) Age 29 Option	Region 7	$244.11	$488.20	$414.97	$414.97	$414.97	$695.69	$695.69	$695.69
TotalIndependence Basic (Bronze) Age 29 Option	Region 8	$333.61	$667.21	$567.13	$567.13	$567.13	$950.77	$950.77	$950.77
TotalIndependence Advanced (Gold) Child Only	Region 1	$142.95	$142.95	$142.95	$142.95	$142.95	$142.95	$142.95	$142.95
TotalIndependence Advanced (Gold) Child Only	Region 2	$127.23	$127.23	$127.23	$127.23	$127.23	$127.23	$127.23	$127.23
TotalIndependence Advanced (Gold) Child Only	Region 3	$160.59	$160.59	$160.59	$160.59	$160.59	$160.59	$160.59	$160.59
TotalIndependence Advanced (Gold) Child Only	Region 4	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73
TotalIndependence Advanced (Gold) Child Only	Region 5	$131.55	$131.55	$131.55	$131.55	$131.55	$131.55	$131.55	$131.55
TotalIndependence Advanced (Gold) Child Only	Region 6	$122.96	$122.96	$122.96	$122.96	$122.96	$122.96	$122.96	$122.96
TotalIndependence Advanced (Gold) Child Only	Region 7	$135.16	$135.16	$135.16	$135.16	$135.16	$135.16	$135.16	$135.16
TotalIndependence Advanced (Gold) Child Only	Region 8	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73	$184.73

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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
TotalIndependence Plus (Silver) Child Only	Region 1	$121.17	$121.17	$121.17	$121.17	$121.17	$121.17	$121.17	$121.17
TotalIndependence Plus (Silver) Child Only	Region 2	$107.83	$107.83	$107.83	$107.83	$107.83	$107.83	$107.83	$107.83
TotalIndependence Plus (Silver) Child Only	Region 3	$136.10	$136.10	$136.10	$136.10	$136.10	$136.10	$136.10	$136.10
TotalIndependence Plus (Silver) Child Only	Region 4	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57
TotalIndependence Plus (Silver) Child Only	Region 5	$111.50	$111.50	$111.50	$111.50	$111.50	$111.50	$111.50	$111.50
TotalIndependence Plus (Silver) Child Only	Region 6	$104.21	$104.21	$104.21	$104.21	$104.21	$104.21	$104.21	$104.21
TotalIndependence Plus (Silver) Child Only	Region 7	$114.56	$114.56	$114.56	$114.56	$114.56	$114.56	$114.56	$114.56
TotalIndependence Plus (Silver) Child Only	Region 8	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57	$156.57
TotalIndependence Basic (Bronze) Child Only	Region 1	$106.36	$106.36	$106.36	$106.36	$106.36	$106.36	$106.36	$106.36
TotalIndependence Basic (Bronze) Child Only	Region 2	$94.66	$94.66	$94.66	$94.66	$94.66	$94.66	$94.66	$94.66
TotalIndependence Basic (Bronze) Child Only	Region 3	$119.48	$119.48	$119.48	$119.48	$119.48	$119.48	$119.48	$119.48
TotalIndependence Basic (Bronze) Child Only	Region 4	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45
TotalIndependence Basic (Bronze) Child Only	Region 5	$97.87	$97.87	$97.87	$97.87	$97.87	$97.87	$97.87	$97.87
TotalIndependence Basic (Bronze) Child Only	Region 6	$91.48	$91.48	$91.48	$91.48	$91.48	$91.48	$91.48	$91.48
TotalIndependence Basic (Bronze) Child Only	Region 7	$100.57	$100.57	$100.57	$100.57	$100.57	$100.57	$100.57	$100.57
TotalIndependence Basic (Bronze) Child Only	Region 8	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45	$137.45
TotalIndependence Advanced (Platinum)	Region 1	$442.69	$885.37	$752.56	$752.56	$752.56	$1,261.65	$1,261.65	$1,261.65
TotalIndependence Advanced (Platinum)	Region 2	$393.99	$787.96	$669.77	$669.77	$669.77	$1,122.85	$1,122.85	$1,122.85
TotalIndependence Advanced (Platinum)	Region 3	$497.29	$994.56	$845.38	$845.38	$845.38	$1,417.25	$1,417.25	$1,417.25
TotalIndependence Advanced (Platinum)	Region 4	$572.05	$1,144.09	$972.48	$972.48	$972.48	$1,630.33	$1,630.33	$1,630.33
TotalIndependence Advanced (Platinum)	Region 5	$407.36	$814.71	$692.50	$692.50	$692.50	$1,160.96	$1,160.96	$1,160.96
TotalIndependence Advanced (Platinum)	Region 6	$380.78	$761.53	$647.30	$647.30	$647.30	$1,085.18	$1,085.18	$1,085.18
TotalIndependence Advanced (Platinum)	Region 7	$418.58	$837.14	$711.57	$711.57	$711.57	$1,192.92	$1,192.92	$1,192.92
TotalIndependence Advanced (Platinum)	Region 8	$572.05	$1,144.09	$972.48	$972.48	$972.48	$1,630.33	$1,630.33	$1,630.33
TotalIndependence Advanced (Platinum) Age 29 Option	Region 1	$442.69	$885.37	$752.56	$752.56	$752.56	$1,261.65	$1,261.65	$1,261.65
TotalIndependence Advanced (Platinum) Age 29 Option	Region 2	$393.99	$787.96	$669.77	$669.77	$669.77	$1,122.85	$1,122.85	$1,122.85
TotalIndependence Advanced (Platinum) Age 29 Option	Region 3	$497.29	$994.56	$845.38	$845.38	$845.38	$1,417.25	$1,417.25	$1,417.25
TotalIndependence Advanced (Platinum) Age 29 Option	Region 4	$572.05	$1,144.09	$972.48	$972.48	$972.48	$1,630.33	$1,630.33	$1,630.33
TotalIndependence Advanced (Platinum) Age 29 Option	Region 5	$407.36	$814.71	$692.50	$692.50	$692.50	$1,160.96	$1,160.96	$1,160.96
TotalIndependence Advanced (Platinum) Age 29 Option	Region 6	$380.78	$761.53	$647.30	$647.30	$647.30	$1,085.18	$1,085.18	$1,085.18
TotalIndependence Advanced (Platinum) Age 29 Option	Region 7	$418.58	$837.14	$711.57	$711.57	$711.57	$1,192.92	$1,192.92	$1,192.92
TotalIndependence Advanced (Platinum) Age 29 Option	Region 8	$572.05	$1,144.09	$972.48	$972.48	$972.48	$1,630.33	$1,630.33	$1,630.33
Primary Select Bronze	Region 1	$304.41	$608.80	$517.48	$517.48	$517.48	$867.55	$867.55	$867.55
Primary Select Bronze	Region 2	$270.92	$541.83	$460.55	$460.55	$460.55	$772.10	$772.10	$772.10
Primary Select Bronze	Region 3	$341.96	$683.89	$581.31	$581.31	$581.31	$974.54	$974.54	$974.54
Primary Select Bronze	Region 4	$393.36	$786.71	$668.70	$668.70	$668.70	$1,121.06	$1,121.06	$1,121.06
Primary Select Bronze	Region 5	$280.12	$560.22	$476.19	$476.19	$476.19	$798.31	$798.31	$798.31
Primary Select Bronze	Region 6	$261.83	$523.65	$445.10	$445.10	$445.10	$746.20	$746.20	$746.20
Primary Select Bronze	Region 7	$287.83	$575.64	$489.30	$489.30	$489.30	$820.29	$820.29	$820.29
Primary Select Bronze	Region 8	$393.36	$786.71	$668.70	$668.70	$668.70	$1,121.06	$1,121.06	$1,121.06
Primary Select Bronze Age 29 Option	Region 1	$304.41	$608.80	$517.48	$517.48	$517.48	$867.55	$867.55	$867.55
Primary Select Bronze Age 29 Option	Region 2	$270.92	$541.83	$460.55	$460.55	$460.55	$772.10	$772.10	$772.10
Primary Select Bronze Age 29 Option	Region 3	$341.96	$683.89	$581.31	$581.31	$581.31	$974.54	$974.54	$974.54
Primary Select Bronze Age 29 Option	Region 4	$393.36	$786.71	$668.70	$668.70	$668.70	$1,121.06	$1,121.06	$1,121.06
Primary Select Bronze Age 29 Option	Region 5	$280.12	$560.22	$476.19	$476.19	$476.19	$798.31	$798.31	$798.31
Primary Select Bronze Age 29 Option	Region 6	$261.83	$523.65	$445.10	$445.10	$445.10	$746.20	$746.20	$746.20
Primary Select Bronze Age 29 Option	Region 7	$287.83	$575.64	$489.30	$489.30	$489.30	$820.29	$820.29	$820.29
Primary Select Bronze Age 29 Option	Region 8	$393.36	$786.71	$668.70	$668.70	$668.70	$1,121.06	$1,121.06	$1,121.06

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	EssentialCare Platinum EssentialCare Platinum Child Only EssentialCare Platinum Age 29 Option		EssentialCare Gold EssentialCare Gold Child Only EssentialCare Gold Age 29 Option	
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	90% cost sharing after deductible is met	Not Covered	80% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	90% cost sharing after deductible is met	Not Covered	80% 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	Covered for children only: $15 after deductible is met	Not Covered	Covered for children only: $25 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 90% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 90% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 90% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	EssentialCare Silver EssentialCare Silver Child Only EssentialCare Silver Age 29 Option		EssentialCare Bronze EssentialCare Bronze Child Only EssentialCare Bronze Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$3,000	Not Applicable
Coinsurance	100%	Not Applicable	50%	Not Applicable
Out of Pocket Maximum	$5,500	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	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$100 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$150 after deductible is met	$150 after deductible is met	50% cost sharing after deductible is met	50% cost sharing after deductible is met
Ambulance	$150 after deductible is met	$150 after deductible is met	50% cost sharing after deductible is met	50% cost sharing after deductible is met
Urgent Care Center	$70 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$100 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Skilled Nursing Facility	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
EKG	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Routine Radiology	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Advanced Radiology	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Mental Health	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$1,500 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Outpatient Substance Abuse	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$50 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Cardiac Rehabilitation	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Pulmonary Rehabilitation	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	70% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	70% cost sharing after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Chemotherapy	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Home Health Care	$30 after deductible is met	Not Covered	50% cost sharing after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35/$70	Not Covered	$10 after ded /$35 after ded /$70 after ded	Not Covered
Maintenance Medications	$10/$35/$70	Not Covered	$10 after ded /$35 after ded /$70 after ded	Not Covered
Vision Services				
Medical Exam	Covered for children only: $30 after deductible is met	Not Covered	Covered for children only: 50% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 70% cost sharing after deductible is met	Not Covered	Covered for children only: 50% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 70% cost sharing after deductible is met	Not Covered	Covered for children only: 50% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 70% cost sharing after deductible is met	Not Covered	Covered for children only: 50% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - STANDARD PLANS
Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	EssentialCare Catastrophic	
Benefit Summary	**In-Network**	**Out-of-Network**
Deductible	$6,600	Not Applicable
Coinsurance	100%	Not Applicable
Out of Pocket Maximum	$6,600	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	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	No Charge after deductible	Not Covered
Emergency & Urgent Care Services		
Emergency Room	No Charge after deductible	Not Covered
Ambulance	No Charge after deductible	Not Covered
Urgent Care Center	No Charge after deductible	Not Covered
Hospital Services		
Inpatient Hospital	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	No Charge after deductible	Not Covered
Skilled Nursing Facility	No Charge after deductible	Not Covered
Diagnostic Testing Services		
Laboratory Testing	No Charge after deductible	Not Covered
EKG	No Charge after deductible	Not Covered
Routine Radiology	No Charge after deductible	Not Covered
Advanced Radiology	No Charge after deductible	Not Covered
Maternity Services		
Inpatient Maternity	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services		
Inpatient Mental Health	No Charge after deductible	Not Covered
Outpatient Mental Health	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	No Charge after deductible	Not Covered
Outpatient Substance Abuse	No Charge after deductible	Not Covered
Diabetic Supplies and Services		
Insulin and Other Oral Agents	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	No Charge after deductible	Not Covered
Rehabilitation Services		
Chiropractic Services	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	No Charge after deductible	Not Covered
Cardiac Rehabilitation	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	No Charge after deductible	Not Covered
Additional Services		
Durable Medical Equipment	No Charge after deductible	Not Covered
Prosthetics and Appliances	No Charge after deductible	Not Covered
Chemotherapy	No Charge after deductible	Not Covered
Home Health Care	No Charge after deductible	Not Covered
Prescription Drug Coverage		
Prescription Plan	No Charge after deductible	Not Covered
Maintenance Medications	No Charge after deductible	Not Covered
Vision Services		
Medical Exam	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Dental Services		
Preventive and Routine	Not Covered	Not Covered

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All indicated benefits assume the member has appropriate authorization to receive services.

Certain benefits stated in this benefit summary are pending NYS approval.

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Essential Care Silver CSR 200-250% FPL Essential Care Silver CSR 200-250% FPL Child Only Essential Care Silver CSR 200-250% FPL Age 29 Option		Essential Care Silver CSR 150-200% FPL Essential Care Silver CSR 150-200% FPL Child Only Essential Care Silver CSR 150-200% FPL Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$1,200	Not Applicable	$250	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$5,200	Not Applicable	$2,000	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	$15 after deductible is met	Not Covered
Outpatient Surgical Procedures (in physician's office)	$100 after deductible is met	Not Covered	$75 after deductible is met	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$150 after deductible is met	$150 after deductible is met	$75 after deductible is met	$75 after deductible is met
Ambulance	$150 after deductible is met	$150 after deductible is met	$75 after deductible is met	$75 after deductible is met
Urgent Care Center	$70 after deductible is met	Not Covered	$50 after deductible is met	Not Covered
Hospital Services				
Inpatient Hospital	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Outpatient Surgical Procedures (Facility)	$100 after deductible is met	Not Covered	$75 after deductible is met	Not Covered
Skilled Nursing Facility	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$50 after deductible is met	Not Covered	$35 after deductible is met	Not Covered
EKG	$50 after deductible is met	Not Covered	$35 after deductible is met	Not Covered
Routine Radiology	$50 after deductible is met	Not Covered	$35 after deductible is met	Not Covered
Advanced Radiology	$50 after deductible is met	Not Covered	$35 after deductible is met	Not Covered
Maternity Services				
Inpatient Maternity	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Outpatient Mental Health	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Inpatient Substance Abuse - Rehab	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Inpatient Substance Abuse - Detox	$1,500 after deductible is met	Not Covered	$250 after deductible is met	Not Covered
Outpatient Substance Abuse	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Rehabilitation Services				
Chiropractic Services	$50 after deductible is met	Not Covered	$35 after deductible is met	Not Covered
Physical - Occupational - Speech Therapies	$30 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Cardiac Rehabilitation	$30 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Pulmonary Rehabilitation	$30 after deductible is met	Not Covered	$25 after deductible is met	Not Covered
Additional Services				
Durable Medical Equipment	75% cost sharing after deductible is met	Not Covered	90% cost sharing after deductible is met	Not Covered
Prosthetics and Appliances	75% cost sharing after deductible is met	Not Covered	90% cost sharing after deductible is met	Not Covered
Chemotherapy	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Home Health Care	$30 after deductible is met	Not Covered	$15 after deductible is met	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35/$70	Not Covered	$9/$20/$40	Not Covered
Maintenance Medications	$10/$35/$70	Not Covered	$9/$20/$40	Not Covered
Vision Services				
Medical Exam	Covered for children only: $30 after deductible is met	Not Covered	Covered for children only: $15 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 75% cost sharing after deductible is met	Not Covered	Covered for children only: 90% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 75% cost sharing after deductible is met	Not Covered	Covered for children only: 90% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 75% cost sharing after deductible is met	Not Covered	Covered for children only: 90% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - STANDARD PLANS

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Essential Care Silver CSR 100-150% FPL Essential Care Silver CSR 100-150% FPL Child Only Essential Care Silver CSR 100-150% FPL Age 29 Option		Essential Care American Indian/Alaska Native = or < 300% FPL Essential Care American Indian/Alaska Native = or < 300% FPL Child Only Essential Care American Indian/Alaska Native = or < 300% FPL Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$0	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$1,000	Not Applicable	$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	$0	Not Covered
Physician and Other Services				
Office Visit	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	$25 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$50 after deductible is met	$50 after deductible is met	No Charge after deductible	No Charge after deductible
Ambulance	$50 after deductible is met	$50 after deductible is met	No Charge after deductible	No Charge after deductible
Urgent Care Center	$30 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Hospital Services				
Inpatient Hospital	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	$25 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Skilled Nursing Facility	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$20 after deductible is met	Not Covered	No Charge after deductible	Not Covered
EKG	$20 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Routine Radiology	$20 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Advanced Radiology	$20 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Maternity Services				
Inpatient Maternity	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Outpatient Mental Health	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	$100 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Outpatient Substance Abuse	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Rehabilitation Services				
Chiropractic Services	$20 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	$15 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Cardiac Rehabilitation	$15 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	$15 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Additional Services				
Durable Medical Equipment	95% cost sharing after deductible is met	Not Covered	No Charge after deductible	Not Covered
Prosthetics and Appliances	95% cost sharing after deductible is met	Not Covered	No Charge after deductible	Not Covered
Chemotherapy	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Home Health Care	$10 after deductible is met	Not Covered	No Charge after deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$6/$15/$30	Not Covered	No Charge after deductible	Not Covered
Maintenance Medications	$6/$15/$30	Not Covered	No Charge after deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: $10 after deductible is met	Not Covered	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 95% cost sharing after deductible is met	Not Covered	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 95% cost sharing after deductible is met	Not Covered	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 95% cost sharing after deductible is met	Not Covered	Covered for children only: 100% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	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.		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.	

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX1,FHSCGCHILD002 OFF1,FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select Platinum Primary Select Platinum Age 29 Option		Primary Select Gold Primary Select Gold Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$250	Not Applicable
Coinsurance	80%	Not Applicable	80%	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 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	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	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 after Deductible	$100 Copay after Deductible	$150 Copay after Deductible	$150 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	Not Covered	$100 Copay after Deductible	Not Covered
Hospital Services				
Inpatient Hospital	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	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	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	No Charge	Not Covered	No Charge	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	No Charge	Not Covered	No Charge	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 after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Additional Services				
Durable Medical Equipment	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$15 Copay after Deductible	Not Covered	$25 Copay after Deductible	Not Covered
Home Health Care	$15 Copay after Deductible	Not Covered	$25 Copay after Deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$0/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$0/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: $15 after deductible is met	Not Covered	Covered for children only: $25 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	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.		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.	

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX, FHSCGCHILD002 OFF, FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select Silver Primary Select Silver Age 29 Option		Primary Select PCMH Primary Select PCMH Age 29 Option		
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$2,000	Not Applicable	$2,000	$2,000	Not Applicable
Coinsurance	80%	Not Applicable	80%	80%	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 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	$0	Not Covered
Physician and Other Services					
Office Visit	$0 Copay	Not Covered	$0 Copayment with Selected Doctor	$30 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services					
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$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	$150 Copay after Deductible	$150 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	Not Covered	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered
Hospital Services					
Inpatient Hospital	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services					
Laboratory Testing	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
EKG	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Routine Radiology	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Maternity Services					
Inpatient Maternity	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	No Charge	Not Covered	No Charge	No Charge	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	No Charge	Not Covered	No Charge	No Charge	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	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Additional Services					
Durable Medical Equipment	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Home Health Care	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Prescription Drug Coverage					
Prescription Plan	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	$10/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	$10/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services					
Medical Exam	Covered for children only: $30 after deductible is met	Not Covered	Covered for children only: $30 after deductible is met	Covered for children only: $30 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services					
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered	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.		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.		

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX1,FHSCFCHILD002 OFF,FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select PCMH CSR 200-250% FPL Primary Select PCMH CSR 200-250% FPL Age 29 Option			Primary Select PCMH CSR 150-200% FPL Primary Select PCMH CSR 150-200% FPL Age 29 Option		
Benefit Summary	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**
Deductible	$2,000	$2,000	Not Applicable	$0	$0	Not Applicable
Coinsurance	80%	80%	Not Applicable	80%	80%	Not Applicable
Out of Pocket Maximum	$4,500	$4,500	Not Applicable	$1,750	$1,750	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	$0	Not Covered	$0	$0	Not Covered
Physician and Other Services						
Office Visit	$0 Copayment with Selected Doctor	$30 Copay after Deductible any other PCP	Not Covered	$0 Copayment with Selected Doctor	$15 Copay after Deductible any other PCP	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services						
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$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	$75 Copay after Deductible	$75 Copay after Deductible	$75 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered
Hospital Services						
Inpatient Hospital	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services						
Laboratory Testing	$75 Copay	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
EKG	$75 Copay	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Routine Radiology	$75 Copay	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Maternity Services						
Inpatient Maternity	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services						
Inpatient Mental Health	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	No Charge	No Charge	Not Covered	No Charge	No Charge	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	No Charge	No Charge	Not Covered	No Charge	No Charge	Not Covered
Diabetic Supplies and Services						
Insulin and Other Oral Agents	$0 Copay	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	$0 Copay	Not Covered	$0 Copay	$0 Copay	Not Covered
Rehabilitation Services						
Chiropractic Services	$75 Copay	$75 Copay	Not Covered	$75 Copay	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered
Additional Services						
Durable Medical Equipment	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$25 Copay after Deductible	$25 Copay after Deductible	Not Covered
Home Health Care	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$25 Copay after Deductible	$25 Copay after Deductible	Not Covered
Prescription Drug Coverage						
Prescription Plan	$10/$35 after Deductible /$70 after Deductible	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$10/$35 after Deductible /$70 after Deductible	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	Not Covered
Vision Services						
Medical Exam	Covered for children only: $30 after deductible is met	Covered for children only: $30 after deductible is met	Not Covered	Covered for children only: $25 after deductible is met	Covered for children only: $25 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services						
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	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.			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.		

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX, FHSCCHILD002 OFF, FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select PCMH CSR 100-150% FPL Primary Select PCMH CSR 100-150% FPL Age 29 Option			Primary Select Silver CSR 200-250% FPL Primary Select Silver CSR 200-250% FPL Age 29 Option	
Benefit Summary	**In-Network (Preferred)**	**In-Network (Participating)**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	$0	Not Applicable	$2,000	Not Applicable
Coinsurance	80%	80%	Not Applicable	80%	Not Applicable
Out of Pocket Maximum	$500	$500	Not Applicable	$4,750	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	$0	Not Covered	$0	Not Covered
Physician and Other Services					
Office Visit	$0 Copayment with Selected Doctor	$10 Copay after Deductible any other PCP	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Emergency & Urgent Care Services					
Emergency Room	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible	$250 Copay after Deductible
Ambulance	$50 Copay after Deductible	$50 Copay after Deductible	$50 Copay after Deductible	$150 Copay after Deductible	$150 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	$100 Copay after Deductible	Not Covered	$100 Copay after Deductible	Not Covered
Hospital Services					
Inpatient Hospital	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Diagnostic Testing Services					
Laboratory Testing	$75 Copay	$75 Copay	Not Covered	$75 Copay	Not Covered
EKG	$75 Copay	$75 Copay	Not Covered	$75 Copay	Not Covered
Routine Radiology	$75 Copay	$75 Copay	Not Covered	$75 Copay	Not Covered
Advanced Radiology	$75 Copay	$75 Copay	Not Covered	$75 Copay	Not Covered
Maternity Services					
Inpatient Maternity	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services					
Inpatient Mental Health	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	No Charge	No Charge	Not Covered	No Charge	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	No Charge	No Charge	Not Covered	No Charge	Not Covered
Diabetic Supplies and Services					
Insulin and Other Oral Agents	$0 Copay	$0 Copay	Not Covered	$0 Copay	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	$0 Copay	Not Covered	$0 Copay	Not Covered
Rehabilitation Services					
Chiropractic Services	$75 Copay	$75 Copay	Not Covered	$75 Copay	Not Covered
Physical - Occupational - Speech Therapies	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay after Deductible	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Additional Services					
Durable Medical Equipment	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$10 Copay after Deductible	$10 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Home Health Care	$10 Copay after Deductible	$10 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Prescription Drug Coverage					
Prescription Plan	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	$10 /$35 after Deductible /$70 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services					
Medical Exam	Covered for children only: $10 after deductible is met	Covered for children only: $10 after deductible is met	Not Covered	Covered for children only: $30 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services					
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered	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.			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.	

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX1,FHSCGCHILD002,OFF1,FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select Silver CSR 150-200% FPL Primary Select Silver CSR 150-200% FPL Age 29 Option		Primary Select Silver CSR 100-150% FPL Primary Select Silver CSR 100-150% FPL Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0	Not Applicable	$0	Not Applicable
Coinsurance	80%	Not Applicable	80%	Not Applicable
Out of Pocket Maximum	$1,750	Not Applicable	$500	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	$0 Copay	Not Covered	$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	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 after Deductible	$75 Copay after Deductible	$50 Copay after Deductible	$50 Copay after Deductible
Urgent Care Center	$100 Copay after Deductible	Not Covered	$100 Copay after Deductible	Not Covered
Hospital Services				
Inpatient Hospital	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	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	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Mental Health	No Charge	Not Covered	No Charge	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Outpatient Substance Abuse	No Charge	Not Covered	No Charge	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 after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Cardiac Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Pulmonary Rehabilitation	$30 Copay after Deductible	Not Covered	$30 Copay after Deductible	Not Covered
Additional Services				
Durable Medical Equipment	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	Not Covered	80 % Cost Sharing after Deductible	Not Covered
Chemotherapy	$25 Copay after Deductible	Not Covered	$10 Copay after Deductible	Not Covered
Home Health Care	$25 Copay after Deductible	Not Covered	$10 Copay after Deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Maintenance Medications	$10/$35 after Deductible /$70 after Deductible	Not Covered	$10/$35 after Deductible /$70 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: $25 after deductible is met	Not Covered	Covered for children only: $10 after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: 80% cost sharing after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDXI, FHSCGCHILD002 OFF, FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	Primary Select Bronze Age 29 Option Primary Select Bronze Age 29 Option Age 29 Option		TotalIndependence Advanced (Platinum) TotalIndependence Advanced (Platinum) Age 29 Option	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$5,500	Not Applicable	$200	Not Applicable
Coinsurance	80%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$6,350	Not Applicable	$1,100	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	$75 Copay	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$300 Copay after Deductible	$250 Copay after Deductible	$250	$250
Ambulance	$150 Copay after Deductible	$150 Copay after Deductible	$250	$250
Urgent Care Center	$100 Copay after Deductible	Not Covered	$50	Not Covered
Hospital Services				
Inpatient Hospital	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Skilled Nursing Facility	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$75 Copay	Not Covered	$20	Not Covered
EKG	$75 Copay	Not Covered	$20	Not Covered
Routine Radiology	$75 Copay	Not Covered	$20	Not Covered
Advanced Radiology	$75 Copay	Not Covered	$20	Not Covered
Maternity Services				
Inpatient Maternity	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Mental Health	$75 Copay	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Substance Abuse	$75 Copay	Not Covered	No Charge after deductible	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	$0 Copay	Not Covered	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 Copay	Not Covered	No Charge after deductible	Not Covered
Rehabilitation Services				
Chiropractic Services	$75 Copay after Deductible	Not Covered	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	$75 Copay after Deductible	Not Covered	No Charge after deductible	Not Covered
Cardiac Rehabilitation	$75 Copay after Deductible	Not Covered	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	$75 Copay after Deductible	Not Covered	No Charge after deductible	Not Covered
Additional Services				
Durable Medical Equipment	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Prosthetics and Appliances	80 % Cost Sharing after Deductible	Not Covered	No Charge after deductible	Not Covered
Chemotherapy	$75 Copay	Not Covered	No Charge after deductible	Not Covered
Home Health Care	$75 Copay	Not Covered	No Charge after deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$10/$35 after Deductible /$70 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Maintenance Medications	$10/$35 after Deductible /$70 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: $75 Copay	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Frames	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: 80% cost sharing after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	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.		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.	

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX1,FHSCGCHILD002,OFF1,FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	TotalIndependence Advanced (Gold) TotalIndependence Advanced (Gold) Age 29 Option TotalIndependence Advanced (Gold) Child Only		TotalIndependence Plus (Silver) TotalIndependence Plus (Silver) Age 29 Option TotalIndependence Plus (Silver) Child Only	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$1,950	Not Applicable	$3,800	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$2,500	Not Applicable	$4,300	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	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250	$250	$250	$250
Ambulance	$250	$250	$250	$250
Urgent Care Center	$50	Not Covered	$75	Not Covered
Hospital Services				
Inpatient Hospital	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Skilled Nursing Facility	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$20	Not Covered	$20	Not Covered
EKG	$20	Not Covered	$20	Not Covered
Routine Radiology	$20	Not Covered	$20	Not Covered
Advanced Radiology	$20	Not Covered	$20	Not Covered
Maternity Services				
Inpatient Maternity	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Substance Abuse	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Rehabilitation Services				
Chiropractic Services	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Cardiac Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Additional Services				
Durable Medical Equipment	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prosthetics and Appliances	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Chemotherapy	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Home Health Care	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$20/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Maintenance Medications	$20/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Frames	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Benefit Grid - NON-STANDARD PLANS
Form Numbers: FHSC-IND29NDX1,FHSCGCHILD002 OFF1,FHSCIND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Plans:	TotalIndependence Basic (Bronze) TotalIndependence Basic (Bronze) Age 29 Option TotalIndependence Basic (Bronze) Child Only		TotalIndependence Plus (Silver) CSR 200-250% FPL TotalIndependence Plus (Silver) CSR 200-250% FPL Age 29 Option TotalIndependence Plus (Silver) CSR 200-250% FPL Child Only	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$6,000	Not Applicable	$3,000	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$6,500	Not Applicable	$3,600	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	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	No Charge after deductible	No Charge after deductible	$250	$250
Ambulance	No Charge after deductible	No Charge after deductible	$250	$250
Urgent Care Center	$75	Not Covered	$75	Not Covered
Hospital Services				
Inpatient Hospital	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Skilled Nursing Facility	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	No Charge after deductible	Not Covered	$20	Not Covered
EKG	No Charge after deductible	Not Covered	$20	Not Covered
Routine Radiology	No Charge after deductible	Not Covered	$20	Not Covered
Advanced Radiology	No Charge after deductible	Not Covered	$20	Not Covered
Maternity Services				
Inpatient Maternity	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Substance Abuse	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Rehabilitation Services				
Chiropractic Services	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Cardiac Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Additional Services				
Durable Medical Equipment	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prosthetics and Appliances	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Chemotherapy	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Home Health Care	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$30/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Maintenance Medications	$30/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Frames	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	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.		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.	

	Health Republic Insurance of New York 2015 Individual Rate Filing Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-IND29NDX, FHSCCHILD002OFF, FHSCIND29NDOFF, FHSC-IND29BNDOFF Rider Numbers: FHSC-WMBT001			
Plans:	**TotalIndependence Plus (Silver) CSR 150-200% FPL TotalIndependence Plus (Silver) CSR 150-200% FPL Age 29 Option TotalIndependence Plus (Silver) CSR 150-200% FPL Child Only**		**TotalIndependence Plus (Silver) CSR 100-150% FPL TotalIndependence Plus (Silver) CSR 100-150% FPL Age 29 Option TotalIndependence Plus (Silver) CSR 100-150% FPL Child Only**	
Benefit Summary	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$700	Not Applicable	$0	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable
Out of Pocket Maximum	$1,300	Not Applicable	$500	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	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (in physician's office)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Emergency & Urgent Care Services				
Emergency Room	$250	$250	$250	$250
Ambulance	$250	$250	$250	$250
Urgent Care Center	$75	Not Covered	$75	Not Covered
Hospital Services				
Inpatient Hospital	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Surgical Procedures (Facility)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Skilled Nursing Facility	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diagnostic Testing Services				
Laboratory Testing	$20	Not Covered	$20	Not Covered
EKG	$20	Not Covered	$20	Not Covered
Routine Radiology	$20	Not Covered	$20	Not Covered
Advanced Radiology	$20	Not Covered	$20	Not Covered
Maternity Services				
Inpatient Maternity	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Mental Health & Substance Abuse Services				
Inpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Mental Health	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Rehab	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Inpatient Substance Abuse - Detox	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Outpatient Substance Abuse	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Supplies and Services				
Insulin and Other Oral Agents	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Rehabilitation Services				
Chiropractic Services	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Physical - Occupational - Speech Therapies	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Cardiac Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Pulmonary Rehabilitation	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Additional Services				
Durable Medical Equipment	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prosthetics and Appliances	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Chemotherapy	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Home Health Care	No Charge after deductible	Not Covered	No Charge after deductible	Not Covered
Prescription Drug Coverage				
Prescription Plan	$20/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Maintenance Medications	$20/$0 after Deductible/$0 after Deductible	Not Covered	$20/$0 after Deductible/$0 after Deductible	Not Covered
Vision Services				
Medical Exam	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Standard Plastic Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Frames	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Conventional Contact Lenses	Covered for children only: No charge after deductible is met	Not Covered	Covered for children only: No charge after deductible is met	Not Covered
Dental Services				
Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
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Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Rating Region Composition

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

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

Health Republic Insurance of New York 2015 Individual Rate Filing - Off Exchange Commission Schedule	
Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF Rider Numbers: FHSC-WMBT001	
Individual Schedule:	1% of Premium

Health Republic Insurance of New York
2015 Individual Rate Filing - Off Exchange
Expected Loss Ratio

Form Numbers: FHSC-IND29NDX, FHSC-CHILD002 OFF, FHSC-IND29NDOFF, FHSC-IND29BNDOFF
Rider Numbers: FHSC-WMBT001

Federal ACA Loss Ratio *	90.7%

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

New York State Loss Ratio	88.9%

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