

Health Republic Insurance of New York 2015 Individual Rate Filing - On Exchange Table of Contents	
Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT001	
Section	Page(s)
Rate Parameters	2
Rates - 2015	3a - 3c
Benefit Grid	
Standard Plans	4a - 4e
Non-Standard Plans	5a - 5i
Rating Regions	6
Commission Schedule	7
Expected Loss Ratios	8

Health Republic Insurance of New York
2015 Individual Rate Filing - On Exchange
Rate Setting Parameters

Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
Rider Numbers: FHSC-WMBT001

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 Opt	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

Index Rate (Adult) \$322.73

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**

Health Republic Insurance of New York
2015 Individual Rate Filing - On Exchange
Rates - 2015

Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
Rider Numbers: FHSC-WMBT001

	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
EssentialCare Platinum Age 29 Option	Region 2	\$405.61	\$811.19	\$689.52	\$689.52	\$689.52	\$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
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
EssentialCare Platinum Age 29 Option	Region 5	\$419.37	\$838.73	\$712.92	\$712.92	\$712.92	\$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
EssentialCare Platinum Age 29 Option	Region 7	\$430.92	\$861.82	\$732.55	\$732.55	\$732.55	\$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
EssentialCare Gold Age 29 Option	Region 1	\$387.61	\$775.20	\$658.92	\$658.92	\$658.92	\$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
EssentialCare Gold Age 29 Option	Region 3	\$435.41	\$870.81	\$740.18	\$740.18	\$740.18	\$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
EssentialCare Gold Age 29 Option	Region 5	\$356.68	\$713.33	\$606.33	\$606.33	\$606.33	\$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
EssentialCare Gold Age 29 Option	Region 7	\$366.50	\$732.97	\$623.02	\$623.02	\$623.02	\$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
EssentialCare Silver Age 29 Option	Region 1	\$331.71	\$663.40	\$563.89	\$563.89	\$563.89	\$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
EssentialCare Silver Age 29 Option	Region 3	\$372.62	\$745.22	\$633.44	\$633.44	\$633.44	\$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
EssentialCare Silver Age 29 Option	Region 5	\$305.24	\$610.46	\$518.89	\$518.89	\$518.89	\$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
EssentialCare Silver Age 29 Option	Region 7	\$313.64	\$627.26	\$533.17	\$533.17	\$533.17	\$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
EssentialCare Bronze Age 29 Option	Region 1	\$271.36	\$542.70	\$461.30	\$461.30	\$461.30	\$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
EssentialCare Bronze Age 29 Option	Region 3	\$304.83	\$609.64	\$518.19	\$518.19	\$518.19	\$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
EssentialCare Bronze Age 29 Option	Region 5	\$249.71	\$499.39	\$424.48	\$424.48	\$424.48	\$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
EssentialCare Bronze Age 29 Option	Region 7	\$256.58	\$513.14	\$436.17	\$436.17	\$436.17	\$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
Primary Select Platinum Age 29 Option	Region 1	\$436.81	\$873.61	\$742.73	\$742.73	\$742.73	\$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
Primary Select Platinum Age 29 Option	Region 3	\$490.80	\$981.58	\$834.34	\$834.34	\$834.34	\$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
Primary Select Platinum Age 29 Option	Region 5	\$402.05	\$804.07	\$683.46	\$683.46	\$683.46	\$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
Primary Select Platinum Age 29 Option	Region 7	\$413.11	\$826.21	\$702.28	\$702.28	\$702.28	\$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
Primary Select Gold Age 29 Option	Region 1	\$387.51	\$774.90	\$658.41	\$658.41	\$658.41	\$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
Primary Select Gold Age 29 Option	Region 3	\$435.08	\$870.13	\$739.61	\$739.61	\$739.61	\$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
Primary Select Gold Age 29 Option	Region 5	\$356.40	\$712.78	\$605.87	\$605.87	\$605.87	\$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
Primary Select Gold Age 29 Option	Region 7	\$366.21	\$732.41	\$622.54	\$622.54	\$622.54	\$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
Primary Select Silver Age 29 Option	Region 1	\$331.49	\$662.97	\$563.52	\$563.52	\$563.52	\$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
Primary Select Silver Age 29 Option	Region 3	\$372.38	\$744.73	\$633.02	\$633.02	\$633.02	\$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
Primary Select Silver Age 29 Option	Region 5	\$305.04	\$610.06	\$518.55	\$518.55	\$518.55	\$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
Primary Select Silver Age 29 Option	Region 7	\$313.44	\$626.85	\$532.82	\$532.82	\$532.82	\$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
Primary Select PCMH Age 29 Option	Region 1	\$312.77	\$625.52	\$531.69	\$531.69	\$531.69	\$891.36	\$891.36
Primary Select PCMH Age 29 Option	Region 2	\$278.36	\$556.70	\$473.20	\$473.20	\$473.20	\$783.30	\$783.30
Primary Select PCMH Age 29 Option	Region 3	\$351.24	\$702.47	\$597.27	\$597.27	\$597.27	\$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
Primary Select PCMH Age 29 Option	Region 5	\$287.81	\$575.60	\$489.26	\$489.26	\$489.26	\$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
Primary Select PCMH Age 29 Option	Region 7	\$295.73	\$591.45	\$502.73	\$502.73	\$502.73	\$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
TotalIndependence Advanced (Gold) Age 29 Option	Region 1	\$346.39	\$693.95	\$589.86	\$589.86	\$589.86	\$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
TotalIndependence Advanced (Gold) Age 29 Option	Region 3	\$388.78	\$777.54	\$662.61	\$662.61	\$662.61	\$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
TotalIndependence Advanced (Gold) Age 29 Option	Region 5	\$319.30	\$638.57	\$542.79	\$542.79	\$542.79	\$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
TotalIndependence Advanced (Gold) Age 29 Option	Region 7	\$328.09	\$656.15	\$557.73	\$557.73	\$557.73	\$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
TotalIndependence Plus (Silver) Age 29 Option	Region 1	\$294.10	\$588.18	\$499.95	\$499.95	\$499.95	\$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
TotalIndependence Plus (Silver) Age 29 Option	Region 3	\$330.37	\$660.72	\$561.62	\$561.62	\$561.62	\$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
TotalIndependence Plus (Silver) Age 29 Option	Region 5	\$270.63	\$541.24	\$460.06	\$460.06	\$460.06	\$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
TotalIndependence Plus (Silver) Age 29 Option	Region 7	\$278.08	\$556.14	\$472.72	\$472.72	\$472.72	\$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
TotalIndependence Basic (Bronze) Age 29 Option	Region 1	\$258.17	\$516.33	\$438.88	\$438.88	\$438.88	\$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
TotalIndependence Basic (Bronze) Age 29 Option	Region 3	\$290.01	\$580.01	\$493.01	\$493.01	\$493.01	\$826.51	\$826.51
TotalIndependence Basic (Bronze) Age 29 Option	Region 4	\$333.81	\$667.21	\$567.13	\$567.13	\$567.13	\$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
TotalIndependence Basic (Bronze) Age 29 Option	Region 6	\$222.06	\$444.11	\$377.49	\$377.49	\$377.49	\$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
TotalIndependence Basic (Bronze) Age 29 Option	Region 8	\$333.81	\$667.21	\$567.13	\$567.13	\$567.13	\$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
TotalIndependence Advanced (Gold) Child Only	Region 2	\$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
TotalIndependence Advanced (Gold) Child Only	Region 4	\$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
TotalIndependence Advanced (Gold) Child Only	Region 6	\$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
TotalIndependence Advanced (Gold) Child Only	Region 8	\$184.73	\$184.73	\$184.73	\$184.73	\$184.73	\$184.73	\$184.73

Health Republic Insurance of New York
2015 Individual Rate Filing - On Exchange
Rates - 2015

Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
Rider Numbers: FHSC-WMBT001

	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
Region 2	\$107.83	\$107.83	\$107.83	\$107.83	\$107.83	\$107.83	\$107.83	\$107.83
Region 3	\$136.10	\$136.10	\$136.10	\$136.10	\$136.10	\$136.10	\$136.10	\$136.10
Region 4	\$156.57	\$156.57	\$156.57	\$156.57	\$156.57	\$156.57	\$156.57	\$156.57
Region 5	\$111.50	\$111.50	\$111.50	\$111.50	\$111.50	\$111.50	\$111.50	\$111.50
Region 6	\$104.21	\$104.21	\$104.21	\$104.21	\$104.21	\$104.21	\$104.21	\$104.21
Region 7	\$114.56	\$114.56	\$114.56	\$114.56	\$114.56	\$114.56	\$114.56	\$114.56
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
Region 2	\$94.66	\$94.66	\$94.66	\$94.66	\$94.66	\$94.66	\$94.66	\$94.66
Region 3	\$119.48	\$119.48	\$119.48	\$119.48	\$119.48	\$119.48	\$119.48	\$119.48
Region 4	\$137.45	\$137.45	\$137.45	\$137.45	\$137.45	\$137.45	\$137.45	\$137.45
Region 5	\$97.87	\$97.87	\$97.87	\$97.87	\$97.87	\$97.87	\$97.87	\$97.87
Region 6	\$91.48	\$91.48	\$91.48	\$91.48	\$91.48	\$91.48	\$91.48	\$91.48
Region 7	\$100.57	\$100.57	\$100.57	\$100.57	\$100.57	\$100.57	\$100.57	\$100.57
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	\$895.37	\$752.56	\$752.56	\$752.56	\$1,261.65	\$1,261.65	\$1,261.65
Region 2	\$393.99	\$787.96	\$669.77	\$669.77	\$669.77	\$1,122.85	\$1,122.85	\$1,122.85
Region 3	\$497.29	\$994.56	\$845.38	\$845.38	\$845.38	\$1,417.25	\$1,417.25	\$1,417.25
Region 4	\$572.05	\$1,144.09	\$972.48	\$972.48	\$972.48	\$1,630.33	\$1,630.33	\$1,630.33
Region 5	\$407.36	\$814.71	\$692.50	\$692.50	\$692.50	\$1,160.96	\$1,160.96	\$1,160.96
Region 6	\$380.78	\$761.53	\$647.30	\$647.30	\$647.30	\$1,085.18	\$1,085.18	\$1,085.18
Region 7	\$418.58	\$837.14	\$711.57	\$711.57	\$711.57	\$1,192.92	\$1,192.92	\$1,192.92
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	\$895.37	\$752.56	\$752.56	\$752.56	\$1,261.65	\$1,261.65	\$1,261.65
Region 2	\$393.99	\$787.96	\$669.77	\$669.77	\$669.77	\$1,122.85	\$1,122.85	\$1,122.85
Region 3	\$497.29	\$994.56	\$845.38	\$845.38	\$845.38	\$1,417.25	\$1,417.25	\$1,417.25
Region 4	\$572.05	\$1,144.09	\$972.48	\$972.48	\$972.48	\$1,630.33	\$1,630.33	\$1,630.33
Region 5	\$407.36	\$814.71	\$692.50	\$692.50	\$692.50	\$1,160.96	\$1,160.96	\$1,160.96
Region 6	\$380.78	\$761.53	\$647.30	\$647.30	\$647.30	\$1,085.18	\$1,085.18	\$1,085.18
Region 7	\$418.58	\$837.14	\$711.57	\$711.57	\$711.57	\$1,192.92	\$1,192.92	\$1,192.92
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	\$967.55	\$967.55	\$967.55
Region 2	\$270.92	\$541.83	\$460.55	\$460.55	\$460.55	\$772.10	\$772.10	\$772.10
Region 3	\$341.96	\$683.89	\$581.31	\$581.31	\$581.31	\$974.54	\$974.54	\$974.54
Region 4	\$393.36	\$786.71	\$668.70	\$668.70	\$668.70	\$1,121.06	\$1,121.06	\$1,121.06
Region 5	\$280.12	\$560.22	\$476.19	\$476.19	\$476.19	\$798.31	\$798.31	\$798.31
Region 6	\$261.83	\$523.65	\$445.10	\$445.10	\$445.10	\$746.20	\$746.20	\$746.20
Region 7	\$287.83	\$575.64	\$489.30	\$489.30	\$489.30	\$820.29	\$820.29	\$820.29
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	\$967.55	\$967.55	\$967.55
Region 2	\$270.92	\$541.83	\$460.55	\$460.55	\$460.55	\$772.10	\$772.10	\$772.10
Region 3	\$341.96	\$683.89	\$581.31	\$581.31	\$581.31	\$974.54	\$974.54	\$974.54
Region 4	\$393.36	\$786.71	\$668.70	\$668.70	\$668.70	\$1,121.06	\$1,121.06	\$1,121.06
Region 5	\$280.12	\$560.22	\$476.19	\$476.19	\$476.19	\$798.31	\$798.31	\$798.31
Region 6	\$261.83	\$523.65	\$445.10	\$445.10	\$445.10	\$746.20	\$746.20	\$746.20
Region 7	\$287.83	\$575.64	\$489.30	\$489.30	\$489.30	\$820.29	\$820.29	\$820.29
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 - On Exchange Benefit Grid - STANDARD PLANS					
Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHLD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, 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	Out-of-Network
Deductible	\$0	Not Applicable	\$600	Not Applicable	Not Applicable
Coinsurance	100%	Not Applicable	100%	Not Applicable	Not Applicable
Out of Pocket Maximum	\$2,000	Not Applicable	\$4,000	Not Applicable	Not Applicable
Preventive Services					
Allergy Testing					
Bone Density Testing					
Cervical Cytology					
Colonoscopy Screening					
Gynecological Screening					
Immunizations	\$0	Not Covered	\$0	Not Covered	Not Covered
Mammography					
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section 2713 of ACA					
Physician and Other Services					
Office Visit	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	Not Covered
Outpatient Surgical Procedures (in physician's office)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered	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	\$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	\$150 after deductible is met
Urgent Care Center	\$55 after deductible is met	Not Covered	\$60 after deductible is met	Not Covered	Not Covered
Hospital Services					
Inpatient Hospital	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered	Not Covered
Outpatient Surgical Procedures (Facility)	\$100 after deductible is met	Not Covered	\$100 after deductible is met	Not Covered	Not Covered
Skilled Nursing Facility	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered	Not Covered
Diagnostic Testing Services					
Laboratory Testing	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered	Not Covered
EKG	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered	Not Covered
Routine Radiology	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered	Not Covered
Advanced Radiology	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered	Not Covered
Maternity Services					
Inpatient Maternity	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered	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	Not Covered
Outpatient Mental Health	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	Not Covered
Inpatient Substance Abuse - Rehab	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered	Not Covered
Inpatient Substance Abuse - Detox	\$500 after deductible is met	Not Covered	\$1,000 after deductible is met	Not Covered	Not Covered
Outpatient Substance Abuse	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	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	Not Covered
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	Not Covered
Rehabilitation Services					
Chiropractic Services	\$35 after deductible is met	Not Covered	\$40 after deductible is met	Not Covered	Not Covered
Physical - Occupational - Speech Therapies	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	Not Covered
Cardiac Rehabilitation	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	Not Covered
Pulmonary Rehabilitation	\$25 after deductible is met	Not Covered	\$30 after deductible is met	Not Covered	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	Not Covered
Prosthetics and Appliances	90% cost sharing after deductible is met	Not Covered	80% cost sharing after deductible is met	Not Covered	Not Covered
Chemotherapy	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	Not Covered
Home Health Care	\$15 after deductible is met	Not Covered	\$25 after deductible is met	Not Covered	Not Covered
Prescription Drug Coverage					
Prescription Plan	\$10/\$30/\$60	Not Covered	\$10/\$35/\$70	Not Covered	Not Covered
Maintenance Medications	\$10/\$30/\$60	Not Covered	\$10/\$35/\$70	Not Covered	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	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	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	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	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 - On Exchange Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHLD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, 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	\$0	Not Covered	\$0	Not Covered
Mammography				
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	\$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
	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.		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.		All indicated benefits assume the member has appropriate authorization to receive services.	
	Certain benefits stated in this benefit summary are pending NYS approval.		Certain benefits stated in this benefit summary are pending NYS approval.	

Health Republic Insurance of New York 2015 Individual Rate Filing - On Exchange Benefit Grid - STANDARD PLANS Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHLD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, 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	\$0	Not Covered
Prenatal Maternity Care		
Prostate Cancer Screening		
Routine Exams		
Women's Preventive Health Services		
Other Services Noted in Section 2713 of ACA		
Physician and Other Services		
Office Visit	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
<p>This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Health Contract, attached Riders (if any), or Certificate of Coverage.</p> <p>All indicated benefits assume the member has appropriate authorization to receive services.</p> <p>Certain benefits stated in this benefit summary are pending NYS approval.</p>		

Health Republic Insurance of New York 2015 Individual Rate Filing - On Exchange Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHLD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, 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	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	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	\$0	Not Covered	\$0	Not Covered
Mammography				
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	\$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
	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.		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.		All indicated benefits assume the member has appropriate authorization to receive services.	
	Certain benefits stated in this benefit summary are pending NYS approval.		Certain benefits stated in this benefit summary are pending NYS approval.	

Health Republic Insurance of New York 2015 Individual Rate Filing - On Exchange Benefit Grid - STANDARD PLANS				
Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, 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	\$0	Not Covered	\$0	Not Covered
Mammography				
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	\$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.		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.		All indicated benefits assume the member has appropriate authorization to receive services.		
Certain benefits stated in this benefit summary are pending NYS approval.		Certain benefits stated in this benefit summary are pending NYS approval.		

Health Republic Insurance of New York 2015 Individual Rate Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT001				
Plans:	Primary Select Platinum Primary Select Platinum Ase 29 Option		Primary Select Gold Primary Select Gold Ase 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	\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	\$0 Copay	Not Covered	\$0 Copay	Not Covered
Outpatient Surgical Procedures (in physician's office)	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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT01					
Plans:	Primary Select Silver Primary Select Silver Ase 29 Option		Primary Select PCMH Primary Select PCMH Ase 29 Option		
	In-Network	Out-of-Network	In-Network (Preferred)	In-Network (Participating)	Out-of-Network
Benefit Summary					
Deductible	\$2,000	Not Applicable	\$2,000	\$2,000	Not Applicable
Coinsurance	80%	Not Applicable	80%	80%	Not Applicable
Out of Pocket Maximum	\$8,350	Not Applicable	\$8,350	\$8,350	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 Z713 of ACA					
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
Huma 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 if met	Not Covered	Covered for children only; \$30 after deductible if met	Covered for children only; \$30 after deductible if 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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT01						
Plans:	Primary Select PCMH CSR 200-250% FPL Primary Select PCMH CSR 200-250% FPL Ase 29 Option			Primary Select PCMH CSR 150-200% FPL Primary Select PCMH CSR 150-200% FPL Ase 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	\$0	\$0	Not Covered	\$0	\$0	Not Covered
Mammography						
Prenatal Maternity Care						
Prostate Cancer Screening						
Routine Exams						
Women's Preventive Health Services						
Other Services Noted in Section Z713 of ACA						
Physician and Other Services						
Office Visit	\$0 Copayment with Selected Doctor 80 % Cost Sharing after Deductible	\$30 Copay after Deductible any other PCP 80 % Cost Sharing after Deductible	Not Covered Not Covered	\$0 Copayment with Selected Doctor 80 % Cost Sharing after Deductible	\$15 Copay after Deductible any other PCP 80 % Cost Sharing after Deductible	Not Covered 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
Heme 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	\$10 /\$35 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	\$10 /\$35 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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHLD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT01					
Plans:	Primary Select PCMH CSR 100-150% FPL Primary Select PCMH CSR 100-150% FPL Aoe 29 Option			Primary Select Silver CSR 200-250% FPL Primary Select Silver CSR 200-250% FPL Aoe 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	\$0	\$0	Not Covered	\$0	Not Covered
Mammography					
Prenatal Maternity Care					
Prostate Cancer Screening					
Routine Exams					
Women's Preventive Health Services					
Other Services Noted in Section Z713 of ACA					
Physician and Other Services					
Office Visit	\$0 Copay 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.			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.			All indicated benefits assume the member has appropriate authorization to receive services.		
Certain benefits stated in this benefit summary are pending NYS approval.			Certain benefits stated in this benefit summary are pending NYS approval.		

Health Republic Insurance of New York 2015 Individual Rate Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT001				
Plans:	Primary Select Silver CSR 150-200%, FPL Primary Select Silver CSR 150-200% FPL Aoe 29 Option	Out-of-Network	Primary Select Silver CSR 100-150%, FPL Primary Select Silver CSR 100-150% FPL Aoe 29 Option	Out-of-Network
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	\$0	Not Covered	\$0	Not Covered
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				
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
	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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT001				
Plans:	Primary Select Bronze Ase 29 Option Primary Select Bronze Ase 29 Option Ase 29 Option		TotalIndependence Advanced (Platinum) TotalIndependence Advanced (Platinum) Ase 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	\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	\$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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMBT001				
Plans:	TotalIndependence Advanced (Gold) TotalIndependence Advanced (Gold) Aoe 29 Option TotalIndependence Advanced (Gold) Child Only		TotalIndependence Plus (Silver) TotalIndependence Plus (Silver) Aoe 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	\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	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
	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 Filings - On Exchange Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMB1001				
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	\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	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 2018 Individual Rate Filings Benefit Grid - NON-STANDARD PLANS Form Numbers: FHSC-CAY001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW, Rider Numbers: FHSC-WMB1001				
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	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	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	\$0	Not Covered	\$0	Not Covered
Prenatal Maternity Care				
Prostate Cancer Screening				
Routine Exams				
Women's Preventive Health Services				
Other Services Noted in Section 2713 of ACA				
Physician and Other Services				
Office Visit	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
	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 - On Exchange
Rating Region Composition**

**Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
Rider Numbers: FHSC-WMBT001**

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

Health Republic Insurance of New York
2015 Individual Rate Filing - On Exchange
Commission Schedule

Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
Rider Numbers: FHSC-WMBT001

Individual Schedule:

1% of Premium

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

Form Numbers: FHSC-CAT001, FHSC-IND26NDX, FHSC-CHILD001, FHSC-IND26ND, FHSC-IND26BND, FHSC-IND26NDXW,
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