Member's Name_____

NONGROUP ENROLLMENT/CHANGE REQUEST

HEALTH REPUBLIC INSURANCE

Health Republic Insurance of New Jersey

A. Type of Activity – to be completed by Subscriber. ***Refer to instructions page 5 before*** *completing this form. Print clearly*

	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
ADD	☐ Enrollment of a new Enrollee	_____/_____/_____	_____
	☐ Add Spouse/Civil Union Partner	_____/_____/_____	_____
	☐ Add Domestic Partner	_____/_____/_____	_____
	☐ Add Dependent Child	_____/_____/_____	_____
REMOVE	☐ Remove Subscriber	_____/_____/_____	_____
	☐ Remove Spouse/Civil Union Partner	_____/_____/_____	_____
	☐ Remove Domestic Partner	_____/_____/_____	_____
	☐ Remove Dependent Child	_____/_____/_____	_____
OTHER CHANGE	☐ Name Change	_____/_____/_____	_____
	☐ Change Plan	_____/_____/_____	_____
	☐ Special Enrollment Period (following a Triggering Event*)	_____/_____/_____	_____
	☐ Other	_____/_____/_____	_____
	*See list of Triggering Events in Instructions		

B. Subscriber Information Name (Last, First, MI):

SSN: | Birthdate (mm/dd/yyyy): | ☐ Male ☐ Female | Email:

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state or country? ☐ Yes ☐ No
Name of State/Country_____ Number of months you live there each year:_____

Primary residence:
Street/Apt:_____
City:_____ State:_____ Zip Code:_____
Phone (____)_____

Other residence:
Street/Apt:_____
City:_____ State:_____ Zip Code:_____
Phone (____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other (specify):

Are you eligible for Medicare? ☐ Yes ☐ No

Are you covered under any health coverage? ☐ Yes ☐ No
If yes, why are you applying for individual coverage?_____
_____

C. Plan Option – to be completed by the Subscriber - *Check one.*

Medical Plan options

Health Republic Full Access:

☐ PrimeBronze
Deductible – $2,500 (individual)/$5,000 (family)

☐ PrimeSilver
*Deductible – $2,000 (individual)/$4,000 (family)
*1st Four PCP visits $0 Cost Share

☐ SolidBronze (**HSA**)
Deductible – $2,500 (individual)/$5,000 (family)

☐ SolidSilver (**HSA**)
Deductible – $2,000 (individual)/$4,000 (family)

☐ SolidGold
Deductible – $1,500 (individual)/$3,000 (family)

☐ CoreSilver
Deductible – $2,000 (individual)/$5,000 (family)

☐ CoreGold
Deductible – $1,500 (individual)/$3,000 (family)

☐ CorePlatinum
Deductible – $750 (individual)/$1,500 (family)

Health Republic Full Access:

☐ PureBronze
Deductible – $2,500 (individual)/$5,000 (family)

☐ PureSilver
Deductible – $2,000 (individual)/$4,000 (family)

☐ PureGold
Deductible – $1,800 (individual)/$3,600 (family)

☐ PurePlatinum
Deductible – $0 (individual)/$0 (family)

☐ Vital (UNDER 30 Only)
Deductible – $6,500 (individual)/$13,000 (family)

Health Republic Monmouth County Community Plan:

☐ Bronze

Tier 1 Bronze: Deductible – $1,500 (individual)/$3,000 (family)

Tier 2 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

☐ Silver

Tier 1 Silver: Deductible – $0 (individual)/$0 (family)

Tier 2 Silver: Deductible – $2,500 (individual)/$5,000 (family)

☐ Gold

Tier 1 Gold: Deductible – $0 (individual)/$0 (family)

Tier 2 Gold: Deductible – $2,500 (individual)/$5,000 (family)

☐ Platinum

Tier 1 Platinum: Deductible – $0 (individual)/$0 (family)

Tier 2 Platinum: Deductible – $1,500 (individual)/$3,000 (family)

Health Republic Active Access Spotlight Plan:

☐ Bronze

Tier 1 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

Tier 2 Bronze: Deductible – $2,500 (individual)/$5,000 (family)

☐ Silver

Tier 1 Silver: Deductible – $2,000 (individual)/ $2,000(family)

Tier 2 Silver: Deductible – $2,000 (individual)/$4,000 (family)

☐ Gold

Tier 1 Gold: Deductible – $1,500 (individual)/$3,000 (family)

Tier 2 Gold: Deductible – $1,500 (individual)/$3,000 (family)

☐ Platinum

Tier 1 Platinum: Deductible – $0 (individual)/$0 (family)

Tier 2 Platinum: Deductible – $0 (individual)/$0 (family)

D. Other Individuals Covered – *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.*

1. Spouse / Domestic / Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No
Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ Current Patient? ☐Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ Current Patient? ☐Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ Current Patient? ☐Yes ☐ No	Primary Care Provider: NPI#:_____ Address:_____ _____ _____ zip+4 _____ Current Patient? ☐Yes ☐ No
If last name is different from Subscriber's, please explain: _____ _____	If last name is different from Subscriber's, please explain: _____ _____	If last name is different from Subscriber's, please explain: _____ _____	If last name is different from [Subscriber's], please explain: _____ _____
Home or billing address same as Subscriber? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Subscriber? ☐ Yes ☐ No *If NO, complete Section F*	Living with Subscriber? ☐ Yes ☐ No *If NO, complete Section F*	Living with Subscriber? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Address Information for Spouse/Domestic Partner/Civil Union Partner– If *not applicable, please mark as "NA."*

Street/Apt:_____ City, State, Zip Code:_____	b. Please explain why the address is different: _____ _____

F. Additional Child Information – *Provide information below about children listed in Section D,* **if** *they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____	Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____

G. Race/Ethnicity – Response is appreciated but NOT *required!*	*Choose a category that most closely describes you:*	☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander	☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin	☐ Hispanic

H. Payment Information – *indicate how you would like to make payment*	☐ Check ☐ Money Order ☐ Automatic Bank Draft (attach voided check)	Card Type: ☐ Credit Card ☐ Debit Card Check One: ☐ MasterCard ☐ Visa No. :_____ Exp. Date ____/_____/_____ CVV_____ Cardholder Name:_____

I. Subscriber Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature: _____ Date: _____

J. Broker/General Agent Signature	Signature of Preparer	Date	NJ Producer License #
	General Agent		Agent ID #

Member's Name_____

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A and identify the applicable triggering event in the reason section "Other Change" section in A.
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a customer services representative at 1-888-990-5706 before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Health Republic Insurance of New Jersey. Coverage must be verified with Health Republic of New Jersey prior to visiting with a specialist or admission to a hospital.
- Triggering Events:

1. loss of eligibility for minimum essential coverage but not if lost due to non- payment of premium
2. dependent attained age 26 or 31 and lost coverage
3. Marketplace changed your subsidy determination
4. New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care
5. gained access to New Jersey plans as a result of permanent move to New Jersey
6. In 2014 only, non-renewal of current individual coverage; enrollment made be requested within the 30 days prior to the non-renewal of the current coverage. Check the "Other Change" section in A.

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
B. You MUST be a New Jersey resident which means your primary residence is in New Jersey
C. You must NOT be eligible for Medicare.
D. If application is made for the Catastrophic Plan the following additional requirements apply:
   1. You must be under 30 years old; OR
   2. You must have a Certificate of Exemption from the Marketplace. Attach a copy to your application.

   The **Annual Open Enrollment Period** for coverage to be effective in 2015 runs from November 15, 2014 through February 15, 2015. Your application must be received during this time period. During this Annual Open Enrollment Period you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. The effective date of coverage applied for by December 15, 2014 will be January 1, 2015. The effective date of coverage applied for from December 16, 2014, through February 15, 2015 will be the first or fifteenth of the month following the date of the application.
E. A **Special Enrollment Period** that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first or fifteenth of the month following receipt of the application.
F. NOTE: If you currently have coverage the plan for which you are applying must REPLACE the current coverage but you SHOULD NOT terminate it until the new coverage is effective

CONDITIONS OF ENROLLMENT -- SUBSCRIBER'S ACKNOWLEDGEMENTS AND AGREEMENTS
On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that: 1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Health Republic Insurance of New Jersey, or any consumer reporting agency acting on behalf of Health Republic Insurance of New Jersey information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date. 2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Health Republic Insurance of New Jersey has taken in reliance on the authorization. 3. I understand I may receive a copy of this authorization if I request one. 4. I agree Health Republic Insurance of New Jersey will provide coverage in accordance with the terms of the contract for the individual plan policy. 5. I understand that my enrollment and the enrollment of my listed dependents in Health Republic Insurance of New Jersey's individual plan policy is subject to acceptance by Health Republic Insurance of New Jersey. 6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan policy if premiums are not paid timely.
MISREPRESENTATION
Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to a criminal and civil penalties.

Please mail completed form to:
Health Republic Insurance of New Jersey
PO Box 467965
Atlanta, GA 31146

HEALTH REPUBLIC
INSURANCE

2015 Individual Rates
Full Access Core, Full Access Prime, Full Access Solid and Vital

Age	Full Access Core Plans			Full Access Prime Plans		Full Access Solid Plans			Vital Plans
	SILVER	GOLD	PLATINUM	BRONZE	SILVER	BRONZE	SILVER	GOLD	CATASTROPHIC
0-20	$166.45	$224.20	$274.28	$159.39	$163.20	$159.39	$163.19	$229.58	$136.47
21	$262.14	$353.08	$431.95	$251.01	$257.01	$251.01	$257.01	$361.55	$214.92
22	$262.13	$353.07	$431.94	$251.00	$257.00	$251.00	$257.00	$361.54	$214.91
23	$262.13	$353.07	$431.94	$251.00	$257.00	$251.00	$257.00	$361.54	$214.91
24	$262.13	$353.07	$431.94	$251.00	$257.00	$251.00	$257.00	$361.54	$214.91
25	$263.18	$354.49	$433.67	$252.01	$258.03	$252.01	$258.02	$362.99	$215.77
26	$268.42	$361.55	$442.31	$257.03	$263.17	$257.03	$263.16	$370.22	$220.07
27	$274.71	$370.02	$452.67	$263.05	$269.34	$263.05	$269.33	$378.90	$225.23
28	$284.93	$383.79	$469.52	$272.84	$279.36	$272.84	$279.35	$393.00	$233.61
29	$293.32	$395.09	$483.34	$280.87	$287.59	$280.87	$287.58	$404.57	$240.49
30	$297.51	$400.74	$490.25	$284.89	$291.70	$284.89	$291.69	$410.35	$243.93
31	$303.81	$409.21	$500.62	$290.91	$297.87	$290.91	$297.86	$419.03	$249.09
32	$310.10	$417.69	$510.99	$296.93	$304.04	$296.94	$304.03	$427.71	$254.24
33	$314.03	$422.98	$517.47	$300.70	$307.89	$300.70	$307.88	$433.13	$257.47
34	$318.22	$428.63	$524.38	$304.72	$312.00	$304.72	$311.99	$438.92	$260.91
35	$320.32	$431.46	$527.83	$306.72	$314.06	$306.73	$314.05	$441.81	$262.62
36	$322.42	$434.28	$531.29	$308.73	$316.12	$308.74	$316.10	$444.70	$264.34
37	$324.51	$437.11	$534.74	$310.74	$318.17	$310.74	$318.16	$447.59	$266.06
38	$326.61	$439.93	$538.20	$312.75	$320.23	$312.75	$320.22	$450.48	$267.78
39	$330.80	$445.58	$545.11	$316.76	$324.34	$316.77	$324.33	$456.27	$271.22
40	$335.00	$451.23	$552.02	$320.78	$328.45	$320.78	$328.44	$462.05	$274.66
41	$341.29	$459.70	$562.39	$326.80	$334.62	$326.81	$334.61	$470.73	$279.82
42	$347.32	$467.82	$572.32	$332.58	$340.53	$332.58	$340.52	$479.05	$284.76
43	$355.71	$479.12	$586.14	$340.61	$348.76	$340.61	$348.74	$490.62	$291.64
44	$366.19	$493.24	$603.42	$350.65	$359.04	$350.65	$359.02	$505.08	$300.23
45	$378.51	$509.84	$623.72	$362.45	$371.11	$362.45	$371.10	$522.07	$310.34
46	$393.19	$529.61	$647.91	$376.50	$385.51	$376.51	$385.49	$542.32	$322.37
47	$409.70	$551.85	$675.12	$392.32	$401.70	$392.32	$401.68	$565.09	$335.91
48	$428.58	$577.28	$706.22	$410.39	$420.20	$410.39	$420.19	$591.13	$351.38
49	$447.19	$602.34	$736.89	$428.21	$438.45	$428.21	$438.43	$616.80	$366.64
50	$468.16	$630.59	$771.45	$448.29	$459.01	$448.29	$458.99	$645.72	$383.84
51	$488.87	$658.48	$805.57	$468.12	$479.31	$468.12	$479.30	$674.28	$400.81
52	$511.67	$689.20	$843.15	$489.95	$501.67	$489.96	$501.65	$705.74	$419.51
53	$534.74	$720.27	$881.16	$512.04	$524.29	$512.05	$524.27	$737.55	$438.42
54	$559.64	$753.81	$922.19	$535.89	$548.71	$535.89	$548.68	$771.90	$458.84
55	$584.54	$787.35	$963.23	$559.73	$573.12	$559.74	$573.10	$806.24	$479.26
56	$611.54	$823.72	$1,007.72	$585.59	$599.59	$585.59	$599.57	$843.48	$501.39
57	$638.80	$860.44	$1,052.64	$611.69	$626.32	$611.70	$626.30	$881.08	$523.75
58	$667.90	$899.63	$1,100.59	$639.55	$654.85	$639.56	$654.82	$921.22	$547.60
59	$682.32	$919.05	$1,124.34	$653.36	$668.98	$653.36	$668.96	$941.10	$559.42
60	$711.41	$958.24	$1,172.29	$681.22	$697.51	$681.23	$697.48	$981.23	$583.28
61	$736.58	$992.14	$1,213.75	$705.31	$722.18	$705.32	$722.16	$1,015.94	$603.91
62	$753.09	$1,014.38	$1,240.97	$721.13	$738.37	$721.14	$738.35	$1,038.72	$617.45
63	$773.80	$1,042.27	$1,275.09	$740.96	$758.68	$740.97	$758.65	$1,067.28	$634.43
64	$786.38	$1,059.22	$1,295.82	$753.00	$771.01	$753.01	$770.99	$1,084.63	$644.74
65+	$786.38	$1,059.22	$1,295.82	$753.00	$771.01	$753.01	$770.99	$1,084.63	$644.74

00097 1114

HEALTH REPUBLIC
INSURANCE

2015 Individual Rates
Full Access Pure, Active Access Spotlight and Monmouth County Community

Age	Full Access Pure Plans				Active Access Spotlight Plans				Monmouth County Community Plans			
	BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
0-20	$152.11	$162.73	$229.26	$283.21	$146.05	$156.35	$210.14	$270.51	$146.05	$157.46	$206.79	$264.16
21	$239.55	$256.27	$361.05	$446.01	$230.01	$246.23	$330.94	$426.01	$230.01	$247.98	$325.66	$416.01
22	$239.54	$256.26	$361.04	$446.00	$230.00	$246.22	$330.93	$426.00	$230.00	$247.97	$325.65	$416.00
23	$239.54	$256.26	$361.04	$446.00	$230.00	$246.22	$330.93	$426.00	$230.00	$247.97	$325.65	$416.00
24	$239.54	$256.26	$361.04	$446.00	$230.00	$246.22	$330.93	$426.00	$230.00	$247.97	$325.65	$416.00
25	$240.50	$257.29	$362.48	$447.78	$230.92	$247.21	$332.25	$427.71	$230.92	$248.96	$326.95	$417.67
26	$245.29	$262.41	$369.70	$456.70	$235.52	$252.13	$338.87	$436.23	$235.53	$253.92	$333.47	$425.99
27	$251.04	$268.56	$378.37	$467.40	$241.04	$258.04	$346.81	$446.45	$241.05	$259.87	$341.28	$435.97
28	$260.38	$278.56	$392.45	$484.80	$250.01	$267.64	$359.72	$463.07	$250.02	$269.54	$353.98	$452.20
29	$268.05	$286.76	$404.00	$499.07	$257.37	$275.52	$370.31	$476.70	$257.38	$277.48	$364.40	$465.51
30	$271.88	$290.86	$409.78	$506.21	$261.05	$279.46	$375.61	$483.51	$261.06	$281.44	$369.62	$472.16
31	$277.63	$297.01	$418.44	$516.91	$266.57	$285.37	$383.55	$493.74	$266.58	$287.39	$377.43	$482.15
32	$283.38	$303.16	$427.11	$527.61	$272.09	$291.28	$391.49	$503.96	$272.10	$293.34	$385.25	$492.13
33	$286.97	$307.00	$432.53	$534.30	$275.54	$294.97	$396.45	$510.35	$275.55	$297.06	$390.13	$498.37
34	$290.80	$311.10	$438.30	$541.44	$279.22	$298.91	$401.75	$517.17	$279.23	$301.03	$395.34	$505.03
35	$292.72	$313.15	$441.19	$545.01	$281.06	$300.88	$404.40	$520.58	$281.07	$303.02	$397.95	$508.36
36	$294.64	$315.20	$444.08	$548.58	$282.90	$302.85	$407.04	$523.98	$282.91	$305.00	$400.55	$511.69
37	$296.55	$317.25	$446.97	$552.14	$284.74	$304.82	$409.69	$527.39	$284.75	$306.98	$403.16	$515.01
38	$298.47	$319.30	$449.85	$555.71	$286.58	$306.79	$412.34	$530.80	$286.59	$308.97	$405.76	$518.34
39	$302.30	$323.40	$455.63	$562.85	$290.26	$310.73	$417.63	$537.62	$290.27	$312.93	$410.97	$525.00
40	$306.13	$327.50	$461.41	$569.98	$293.94	$314.67	$422.93	$544.43	$293.95	$316.90	$416.18	$531.65
41	$311.88	$333.65	$470.07	$580.69	$299.46	$320.58	$430.87	$554.66	$299.47	$322.85	$424.00	$541.64
42	$317.39	$339.55	$478.38	$590.94	$304.75	$326.24	$438.48	$564.45	$304.76	$328.56	$431.49	$551.21
43	$325.06	$347.75	$489.93	$605.22	$312.11	$334.12	$449.07	$578.09	$312.12	$336.49	$441.91	$564.52
44	$334.64	$358.00	$504.37	$623.06	$321.31	$343.97	$462.31	$595.13	$321.32	$346.41	$454.94	$581.16
45	$345.90	$370.04	$521.34	$644.02	$332.12	$355.55	$477.86	$615.15	$332.13	$358.06	$470.24	$600.71
46	$359.31	$384.39	$541.56	$668.99	$345.00	$369.33	$496.40	$639.00	$345.01	$371.95	$488.48	$624.01
47	$374.40	$400.54	$564.30	$697.09	$359.49	$384.85	$517.24	$665.84	$359.50	$387.57	$508.99	$650.21
48	$391.65	$418.99	$590.30	$729.20	$376.05	$402.57	$541.07	$696.51	$376.06	$405.43	$532.44	$680.17
49	$408.66	$437.19	$615.93	$760.87	$392.38	$420.06	$564.57	$726.76	$392.39	$423.03	$555.56	$709.70
50	$427.82	$457.69	$644.82	$796.55	$410.78	$439.75	$591.04	$760.84	$410.79	$442.87	$581.61	$742.98
51	$446.75	$477.93	$673.34	$831.78	$428.95	$459.21	$617.18	$794.50	$428.96	$462.46	$607.34	$775.85
52	$467.59	$500.23	$704.75	$870.58	$448.96	$480.63	$645.98	$831.56	$448.97	$484.03	$635.67	$812.04
53	$488.67	$522.78	$736.52	$909.83	$469.21	$502.29	$675.10	$869.05	$469.21	$505.85	$664.33	$848.65
54	$511.42	$547.12	$770.82	$952.20	$491.06	$525.69	$706.54	$909.52	$491.06	$529.41	$695.27	$888.17
55	$534.18	$571.47	$805.12	$994.57	$512.91	$549.08	$737.97	$949.99	$512.91	$552.97	$726.20	$927.69
56	$558.85	$597.86	$842.30	$1,040.51	$536.60	$574.44	$772.06	$993.86	$536.60	$578.51	$759.75	$970.54
57	$583.76	$624.51	$879.85	$1,086.89	$560.52	$600.04	$806.48	$1,038.17	$560.52	$604.30	$793.61	$1,013.80
58	$610.35	$652.96	$919.93	$1,136.40	$586.05	$627.38	$843.21	$1,085.46	$586.05	$631.82	$829.76	$1,059.98
59	$623.53	$667.05	$939.79	$1,160.93	$598.70	$640.92	$861.41	$1,108.89	$598.70	$645.46	$847.67	$1,082.86
60	$650.12	$695.50	$979.86	$1,210.43	$624.23	$668.25	$898.14	$1,156.17	$624.23	$672.98	$883.82	$1,129.04
61	$673.11	$720.10	$1,014.52	$1,253.25	$646.31	$691.89	$929.91	$1,197.07	$646.31	$696.79	$915.08	$1,168.97
62	$688.20	$736.24	$1,037.27	$1,281.35	$660.80	$707.40	$950.76	$1,223.91	$660.80	$712.41	$935.60	$1,195.18
63	$707.13	$756.49	$1,065.79	$1,316.58	$678.97	$726.85	$976.91	$1,257.56	$678.97	$732.00	$961.33	$1,228.04
64	$718.63	$768.79	$1,083.12	$1,337.99	$690.01	$738.67	$992.79	$1,278.01	$690.01	$743.90	$976.96	$1,248.01
65+	$718.63	$768.79	$1,083.12	$1,337.99	$690.01	$738.67	$992.79	$1,278.01	$690.01	$743.90	$976.96	$1,248.01

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Full Access Core

		SILVER	GOLD	PLATINUM
DEDUCTIBLE	Individual	$2,000	$1,500	$750
	Family	$4,000	$3,000	$1,500
OUT-OF-POCKET MAXIMUM	Individual	$4,500	$3,500	$1,500
	Family	$9,000	$7,000	$3,000
PRIMARY CARE VISIT		$25 Copay	$10 Copay	$5 Copay
SPECIALIST VISIT No referrals required		$50 Copay	$25 Copay	$10 Copay
PREVENTIVE CARE VISIT		Plan pays 100%		
PRENATAL AND POSTNATAL CARE				
PEDIATRIC VISION SERVICES				
PRESCRIPTION DRUGS	Select Generic	$25 Copay	$10 Copay	$5 Copay
	Select Preferred	$50 Copay	$25 Copay	$10 Copay
	Non-preferred	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance after Deductible
	Specialty			
EMERGENCY ROOM		$100 Copay, then Deductible and 40% Coinsurance	$100 Copay, then Deductible and 30% Coinsurance	$100 Copay
URGENT CARE VISIT		$50 Copay	$25 Copay	$10 Copay
INPATIENT HOSPITAL SERVICES	Facility Fee	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance after Deductible
	Physician/ Surgeon Fee			
OUTPATIENT SURGERY	Facility Fee	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance after Deductible
	Physician/ Surgeon Fee			
LAB SERVICES		$50 Copay	$25 Copay	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance after Deductible
	Outpatient	$50 Copay	$25 Copay	$10 Copay

00092 1014

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Full Access Prime

		BRONZE	SILVER	GOLD
DEDUCTIBLE	Individual	$2,500	$2,000	$1,750
	Family	$5,000	$4,000	$3,500
OUT-OF-POCKET MAXIMUM	Individual	$6,600	$4,500	$2,500
	Family	$13,200	$9,000	$5,000
PRIMARY CARE VISIT		50% Coinsurance after Deductible	First 4 visits covered 100% 40% Coinsurance after deductible for subsequent visits	Plan pays 100%
SPECIALIST VISIT No referrals required		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
PREVENTIVE CARE VISIT		Plan pays 100%		
PRENATAL AND POSTNATAL CARE				
PEDIATRIC VISION SERVICES				
PRESCRIPTION DRUGS	Select Generic	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Select Preferred			
	Non-preferred			
	Specialty			
EMERGENCY ROOM		Deductible, then $100 Copay and 50% Coinsurance	Deductible, then $100 Copay and 40% Coinsurance	Deductible, then $100 Copay and 30% Coinsurance
URGENT CARE VISIT		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
INPATIENT HOSPITAL SERVICES	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Physician/ Surgeon Fee			
OUTPATIENT SURGERY	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Physician/ Surgeon Fee			
LAB SERVICES		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Outpatient			

Full Access Prime Gold is only available for small groups

00089 1014

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Full Access Solid

		BRONZE HSA	SILVER HSA	GOLD
DEDUCTIBLE	Individual	$2,500	$2,000	$1,500
	Family	$5,000	$4,000	$3,000
OUT-OF-POCKET MAXIMUM	Individual	$6,450	$4,000	$2,500
	Family	$12,900	$8,000	$5,000
PRIMARY CARE VISIT		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance
SPECIALIST VISIT No referrals required		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance
PREVENTIVE CARE VISIT		Plan pays 100%		
PRENATAL AND POSTNATAL CARE				
PEDIATRIC VISION SERVICES				
PRESCRIPTION DRUGS	Select Generic	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Select Preferred			
	Non-preferred			
	Specialty			
EMERGENCY ROOM		Deductible, then $100 Copay and 50% Coinsurance	Deductible, then $100 Copay and 40% Coinsurance	Deductible, then $100 Copay and 30% Coinsurance
URGENT CARE VISIT		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance
INPATIENT HOSPITAL SERVICES	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Physician/ Surgeon Fee			
OUTPATIENT SURGERY	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Physician/ Surgeon Fee			
LAB SERVICES		50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible
	Outpatient			30% Coinsurance

00090 1014

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Full Access Pure

		BRONZE	SILVER	GOLD	PLATINUM
DEDUCTIBLE	Individual	$2,500	$2,000	$1,800	$0
	Family	$5,000	$4,000	$3,600	$0
OUT-OF-POCKET MAXIMUM	Individual	$6,450	$5,000	$3,000	$2,000
	Family	$12,900	$10,000	$6,000	$4,000
PRIMARY CARE VISIT		$50 Copay after Deductible	$25 Copay	$15 Copay	$10 Copay
SPECIALIST VISIT No referrals required		$75 Copay after Deductible	$75 Copay	$50 Copay	$25 Copay
PREVENTIVE CARE VISIT		Plan pays 100%			
PRENATAL AND POSTNATAL CARE					
PEDIATRIC VISION SERVICES					
PRESCRIPTION DRUGS	Select Generic	50% Coinsurance after Deductible, up to $100 maximum	40% Coinsurance after Deductible, up to $100 maximum	$10 Copay	$5 Copay
	Select Preferred	50% Coinsurance after Deductible, up to $250 maximum	40% Coinsurance after Deductible, up to $250 maximum	$25 Copay	$10 Copay
	Non-preferred	50% Coinsurance after Deductible, up to $500 maximum	40% Coinsurance after Deductible, up to $500 maximum	$50 Copay	$25 Copay
	Specialty	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance
EMERGENCY ROOM		$100 Copay after Deductible	$100 Copay		
URGENT CARE VISIT		$75 Copay after Deductible	$75 Copay	$50 Copay	$25 Copay
INPATIENT HOSPITAL SERVICES	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance
	Physician/ Surgeon				
OUTPATIENT SURGERY	Facility Fee	50% Coinsurance after Deductible	40% Coinsurance after Deductible	$50 Copay	$25 Copay
	Physician/ Surgeon			30% Coinsurance after Deductible	20% Coinsurance
LAB SERVICES		50% Coinsurance after Deductible	$75 Copay	$50 Copay	$25 Copay
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	50% Coinsurance after Deductible	40% Coinsurance after Deductible	30% Coinsurance after Deductible	20% Coinsurance
	Outpatient	$75 Copay after Deductible	$75 Copay	$50 Copay	$25 Copay

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Active Access Spotlight

		BRONZE		SILVER		GOLD		PLATINUM	
		Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2
DEDUCTIBLE	Individual	$2,500		$2,000		$1,500		$0	
	Family	$5,000		$4,000		$3,000		$0	
OUT-OF-POCKET MAXIMUM	Individual	$6,600		$6,000		$3,000		$1,250	
	Family	$13,200		$12,000		$6,000		$2,500	
PRIMARY CARE VISIT		$10 Copay, then Deductible	50% Coinsurance after Deductible	$10 Copay	40% Coinsurance	$10 Copay	30% Coinsurance	$10 Copay	20% Coinsurance
SPECIALIST VISIT No referrals required		$75 Copay after Deductible		$50 Copay		$25 Copay		$10 Copay	
PREVENTIVE CARE VISIT		Plan pays 100%							
PRENATAL AND POSTNATAL CARE									
PEDIATRIC VISION SERVICES									
PRESCRIPTION DRUGS	Select Generic	$25 Copay				$10 Copay		$5 Copay	
	Select Preferred	50% Coinsurance after Deductible		$50 Copay		$25 Copay		$10 Copay	
	Non-preferred			$75 Copay		$50 Copay		$15 Copay	
	Specialty			40% Coinsurance after Deductible		30% Coinsurance		20% Coinsurance	
EMERGENCY ROOM		$100 Copay, then Deductible and 50% Coinsurance		Deductible, then $100 Copay and 40% Coinsurance		Deductible, then $100 Copay and 30% Coinsurance		$100 Copay and 20% Coinsurance	
URGENT CARE VISIT		$75 Copay after Deductible		$50 Copay		$25 Copay		$10 Copay	
INPATIENT HOSPITAL SERVICES	Facility Fee	50% Coinsurance after Deductible		$500/day, up to 5 days		$250/day, up to 5 days		$100/day, up to 5 days	
	Physician/ Surgeon Fee			40% Coinsurance after Deductible		30% Coinsurance after Deductible		20% Coinsurance	
OUTPATIENT SURGERY	Facility Fee	50% Coinsurance after Deductible		$50 Copay		$25 Copay		$10 Copay	
	Physician/ Surgeon Fee			40% Coinsurance after Deductible		30% Coinsurance after Deductible		20% Coinsurance	
LAB SERVICES		50% Coinsurance after Deductible		40% Coinsurance after Deductible		30% Coinsurance after Deductible		$75 Copay	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	50% Coinsurance after Deductible		$500/day, up to 5 days		$250/day, up to 5 days		$100/day, up to 5 days	
	Outpatient	$75 Copay after Deductible		$50 Copay		$25 Copay		$10 Copay	

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Monmouth County Community Plan

		BRONZE		SILVER		GOLD		PLATINUM	
		Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2
DEDUCTIBLE	Individual	$1,500	$2,500	$0	$2,500	$0	$2,500	$0	$1,500
	Family	$3,000	$5,000	$0	$5,000	$0	$5,000	$0	$3,000
OUT-OF-POCKET MAXIMUM	Individual	$6,450	$6,600	$5,000	$6,600	$3,000	$6,600	$1,000	$2,000
	Family	$12,900	$13,200	$10,000	$13,200	$6,000	$13,200	$2,000	$4,000
PRIMARY CARE VISIT		$50 Copay after Deductible	50% Coinsurance after Deductible	$25 Copay	40% Coinsurance after Deductible	$10 Copay	30% Coinsurance after Deductible	$10 Copay	Deductible only, 0% Coinsurance
SPECIALIST VISIT No referrals required		$75 Copay after Deductible	50% Coinsurance after Deductible	$50 Copay	40% Coinsurance after Deductible	$20 Copay	30% Coinsurance after Deductible	$20 Copay	Deductible only, 0% Coinsurance
PREVENTIVE CARE VISIT PRENATAL AND POSTNATAL CARE PEDIATRIC VISION SERVICES		Plan pays 100%							
PRESCRIPTION DRUGS	Select Generic	$25 Copay after Deductible		$25 Copay		$0 Copay			
	Select Preferred	50% Coinsurance after Deductible		$50 Copay				$25 Copay	
	Non-preferred			$75 Copay				$50 Copay	
	Specialty			40% Coinsurance after Deductible		30% Coinsurance after Deductible		20% Coinsurance after Deductible	
EMERGENCY ROOM		50% Coinsurance after Deductible		$100 Copay	$100 Copay, then Deductible and 40% Coinsurance	$100 Copay			
URGENT CARE VISIT		$75 Copay after Deductible		$50 Copay	40% Coinsurance after Deductible	$20 Copay	30% Coinsurance after Deductible	$20 Copay	Deductible only, 0% Coinsurance
INPATIENT HOSPITAL SERVICES	Facility Fee	50% Coinsurance after Deductible		$500/admit	40% Coinsurance after Deductible	$500/admit			
	Physician/ Surgeon Fee			40% Coinsurance		30% Coinsurance	30% Coinsurance after Deductible	20% Coinsurance	20% Coinsurance after Deductible
OUTPATIENT SURGERY	Facility Fee	50% Coinsurance after Deductible		40% Coinsurance	40% Coinsurance after Deductible	$50 Copay	30% Coinsurance after Deductible	$50 Copay	
	Physician/ Surgeon Fee					30% Coinsurance		20% Coinsurance	20% Coinsurance after Deductible
LAB SERVICES		$100 Copay after Deductible	50% Coinsurance after Deductible	$75 Copay	40% Coinsurance after Deductible	$75 Copay	30% Coinsurance after Deductible	$75 Copay	20% Coinsurance after Deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	50% Coinsurance after Deductible		$500/admit	40% Coinsurance after Deductible	$500/admit			
	Outpatient	$75 Copay after Deductible	50% Coinsurance after Deductible	$50 Copay	40% Coinsurance after Deductible	$20 Copay	30% Coinsurance after Deductible	$20 Copay	Deductible only, 0% Coinsurance

00088 1014

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

2015 Vital Plan

		CATASTROPHIC
DEDUCTIBLE	Individual	$6,500
	Family	$13,000
OUT-OF-POCKET MAXIMUM	Individual	$6,500
	Family	$13,000
PRIMARY CARE VISIT		First 3 visits covered 100% Subsequent visits covered 100% after deductible
SPECIALIST VISIT No referrals required		Covered 100% after deductible
PREVENTIVE CARE VISIT		Plan pays 100%
PRENATAL AND POSTNATAL CARE		
PEDIATRIC VISION SERVICES		
PRESCRIPTION DRUGS	Select Generic	Covered 100% after deductible
	Select Preferred	
	Non-preferred	
	Specialty	
EMERGENCY ROOM		Covered 100% after deductible
URGENT CARE VISIT		Covered 100% after deductible
INPATIENT HOSPITAL SERVICES	Facility Fee	Covered 100% after deductible
	Physician/ Surgeon Fee	
OUTPATIENT SURGERY	Facility Fee	Covered 100% after deductible
	Physician/ Surgeon Fee	
LAB SERVICES		Covered 100% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient	Covered 100% after deductible
	Outpatient	

Vital is only available for individuals

00093 1014

570 Broad Street, Suite 1100, Newark, NJ 07102 | Tel: 888 990 5706 | newjersey.healthrepublic.us