



HEALTH REPUBLIC

INSURANCE

INDIVIDUAL PRIME PLANS

A plan that encourages you to get to know your doctor.

	SILVER	BRONZE
DEDUCTIBLE	Individual: \$2000.00	Individual: \$2500.00
	Family: \$4000.00	Family: \$5000.00
OUT-OF-POCKET MAXIMUM	Individual: \$6350.00	Individual: \$6350.00
	Family: \$12700.00	Family: \$12700.00
PREVENTIVE CARE VISIT	No Charge	No Charge
PRIMARY CARE VISIT	First 4 visits - no charge - 30% Coinsurance after deductible thereafter	50% Coinsurance after deductible
SPECIALIST VISIT	30% Coinsurance after deductible	50% Coinsurance after deductible
PRESCRIPTIONS	Generic: No Charge	Generic: 50% Coinsurance after deductible
	Preferred: 30% Coinsurance after deductible	Preferred: 50% Coinsurance after deductible
	Non-preferred: 30% Coinsurance after deductible	Non-preferred: 50% Coinsurance after deductible
	Specialty: 30% Coinsurance after deductible	Specialty: 50% Coinsurance after deductible
URGENT CARE VISIT	30% Coinsurance after deductible	50% Coinsurance after deductible
EMERGENCY ROOM	30% Coinsurance after deductible	50% Coinsurance after deductible
VISION SERVICES	Adult: 30% Coinsurance after deductible	Adult: 50% Coinsurance after deductible
	Children: No Charge	Children: No Charge
INPATIENT	30% Coinsurance after deductible	50% Coinsurance after deductible
OUTPATIENT	30% Coinsurance after deductible	50% Coinsurance after deductible
DIAGNOSTIC IMAGING AND X-RAY SERVICES	Imaging: 30% Coinsurance after deductible	Imaging: 50% Coinsurance after deductible
	X-ray: 30% Coinsurance after deductible	X-ray: 50% Coinsurance after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient: 30% Coinsurance after deductible	Inpatient: 50% Coinsurance after deductible
	Outpatient: 30% Coinsurance after deductible	Outpatient: 50% Coinsurance after deductible
REHABILITATION SERVICES	Inpatient: 30% Coinsurance after deductible	Inpatient: 50% Coinsurance after deductible
	Outpatient: 30% Coinsurance after deductible	Outpatient: 50% Coinsurance after deductible
MEDICAL EQUIPMENT AND SUPPLIES	30% Coinsurance after deductible	50% Coinsurance after deductible



HEALTH REPUBLIC
INSURANCE

INDIVIDUAL SOLID PLANS

Deductible and Coinsurance based plans designed to work with an optional Health Savings Account Plus the added benefit of No Referrals Needed for Specialist Visits

	GOLD	SILVER	BRONZE
DEDUCTIBLE	Individual: \$1750.00	Individual: \$2500.00	Individual: \$2500.00
	Family: \$3500.00	Family: \$5000.00	Family: \$5000.00
OUT-OF-POCKET MAXIMUM	Individual: \$2000.00	Individual: \$4500.00	Individual: \$6350.00
	Family: \$4000.00	Family: \$9000.00	Family: \$12700.00
PREVENTIVE CARE VISIT	No Charge	No Charge	No Charge
PRIMARY CARE VISIT	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
SPECIALIST VISIT	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
PRESCRIPTIONS	Generic: 20% Coinsurance after deductible	Generic: 20% Coinsurance after deductible	Generic: 50% Coinsurance after deductible
	Preferred: 20% Coinsurance after deductible	Preferred: 20% Coinsurance after deductible	Preferred: 50% Coinsurance after deductible
	Non-preferred: 20% Coinsurance after deductible	Non-preferred: 20% Coinsurance after deductible	Non-preferred: 50% Coinsurance after deductible
	Specialty: 20% Coinsurance after deductible	Specialty: 20% Coinsurance after deductible	Specialty: 50% Coinsurance after deductible
URGENT CARE VISIT	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
EMERGENCY ROOM	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
VISION SERVICES	Adult: 20% Coinsurance after deductible	Adult: 20% Coinsurance after deductible	Adult: 50% Coinsurance after deductible
	Children: No Charge	Children: No Charge	Children: No Charge
INPATIENT	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
OUTPATIENT	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
DIAGNOSTIC IMAGING AND X-RAY SERVICES	Imaging: 20% Coinsurance after deductible	Imaging: 20% Coinsurance after deductible	Imaging: 50% Coinsurance after deductible
	X-ray: 20% Coinsurance after deductible	X-ray: 20% Coinsurance after deductible	X-ray: 50% Coinsurance after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient: 20% Coinsurance after deductible	Inpatient: 20% Coinsurance after deductible	Inpatient: 50% Coinsurance after deductible
	Outpatient: 20% Coinsurance after deductible	Outpatient: 20% Coinsurance after deductible	Outpatient: 50% Coinsurance after deductible
REHABILITATION SERVICES	Inpatient: 20% Coinsurance after deductible	Inpatient: 20% Coinsurance after deductible	Inpatient: 50% Coinsurance after deductible
	Outpatient: 20% Coinsurance after deductible	Outpatient: 20% Coinsurance after deductible	Outpatient: 50% Coinsurance after deductible
MEDICAL EQUIPMENT AND SUPPLIES	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible



HEALTH REPUBLIC

INSURANCE

INDIVIDUAL CORE PLANS

Plans that offer the convenience of a co-pay for all your office visits.

	PLATINUM	GOLD	SILVER
DEDUCTIBLE	Individual: \$750.00	Individual: \$2000.00	Individual: \$2000.00
	Family: \$1500.00	Family: \$4000.00	Family: \$4000.00
OUT-OF-POCKET MAXIMUM	Individual: \$1250.00	Individual: \$3000.00	Individual: \$6350.00
	Family: \$2500.00	Family: \$6000.00	Family: \$12700.00
PREVENTIVE CARE VISIT	No Charge	No Charge	No Charge
PRIMARY CARE VISIT	\$10	\$10	\$20
SPECIALIST VISIT	\$25	\$25	\$35
PRESCRIPTIONS	Generic: \$5	Generic: \$10	Generic: \$10
	Preferred: \$25	Preferred: \$25	Preferred: \$30
	Non-preferred: 20% Coinsurance after deductible	Non-preferred: 20% Coinsurance after deductible	Non-preferred: 30% Coinsurance after deductible
	Specialty: 20% Coinsurance after deductible	Specialty: 20% Coinsurance after deductible	Specialty: 30% Coinsurance after deductible
URGENT CARE VISIT	\$50	\$50	\$50
EMERGENCY ROOM	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible
VISION SERVICES	Adult: \$10	Adult: \$10	Adult: \$20
	Children: No Charge	Children: No Charge	Children: No Charge
INPATIENT	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible
OUTPATIENT	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible
DIAGNOSTIC IMAGING AND X-RAY SERVICES	Imaging: \$100	Imaging: \$100	Imaging: \$100
	X-ray: \$25	X-ray: \$25	X-ray: \$35
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient: 20% Coinsurance after deductible	Inpatient: 20% Coinsurance after deductible	Inpatient: 30% Coinsurance after deductible
	Outpatient: \$10	Outpatient: \$10	Outpatient: \$20
REHABILITATION SERVICES	Inpatient: 20% Coinsurance after deductible	Inpatient: 20% Coinsurance after deductible	Inpatient: 30% Coinsurance after deductible
	Outpatient: 20% Coinsurance after deductible	Outpatient: 20% Coinsurance after deductible	Outpatient: 30% Coinsurance after deductible
MEDICAL EQUIPMENT AND SUPPLIES	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible



HEALTH REPUBLIC
INSURANCE

INDIVIDUAL CATASTROPHIC PLAN

*Designed for those under 30 years of age to protect them against
unexpected expenses*

DEDUCTIBLE	Individual: \$6350.00
	Family: \$12700.00
OUT-OF-POCKET MAXIMUM	Individual: \$6350.00
	Family: \$12700.00
PREVENTIVE CARE VISIT	No Charge
PRIMARY CARE VISIT	No Charge after deductible
SPECIALIST VISIT	No Charge after deductible
PRESCRIPTIONS	Generic: No Charge after deductible
	Preferred: No Charge after deductible
	Non-preferred: No Charge after deductible
	Specialty: No Charge after deductible
URGENT CARE VISIT	No Charge after deductible
EMERGENCY ROOM	No Charge after deductible
VISION SERVICES	Adults: No Charge after deductible
	Children: No Charge
INPATIENT	No Charge after deductible
OUTPATIENT	No Charge after deductible
DIAGNOSTIC IMAGING AND X-RAY SERVICES	Imaging: No Charge after deductible
	X-ray: No Charge after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	Inpatient: No Charge after deductible
	Outpatient: No charge after deductible
REHABILITATION SERVICES	Inpatient: No Charge after deductible
	Outpatient: No charge after deductible
MEDICAL EQUIPMENT AND SUPPLIES	No Charge after deductible