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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | EPO Platinum 2016

PLAN NAME	PLATINUM EPO1	PLATINUM EPO 2	PLATINUM EPO 3
Network	Core Network/Extended Network	Core Network/Extended Network	Core Network/Extended Network
Deductible (Single/Family) **Deductible Structure** **Max Out of Pocket** (Single/Family)	No deductible N/A $3,000/$6,000	No deductible N/A $2,500/$5,000	No deductible N/A $2,000/$4,000
MEDICAL			
Primary Care **Specialist Visit** **Outpatient Surgery – Hospital Setting** (Facility) **Hospital Inpatient Charges** (Medical/Surgical/Maternity) **Emergency Room** **Urgent Care**	$0 copay/$25 copay $25 copay/$50 copay $250 copay/$300 copay $500 copay per admit/ $750 copay per admit $200 copay/$200 copay $0 copay/$25 copay	$0 copay/$30 copay $30 copay/$50 copay $250 copay/$300 copay $500 copay per admit/ $750 copay per admit $200 copay/$200 copay $0 copay/$30 copay	$0 copay/$35 copay $35 copay/$75 copay 10% coinsurance/ 20% coinsurance 10% coinsurance/ 20% coinsurance $200 copay/$200 copay $0 copay/$35 copay
PHARMACY			
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$50**/$80**	$0/$30**/$60**	$0/$30**/$60**

**Cost shares are subject to $100 Rx deductible.

RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($18.39 per dependent - max . 3)

Single	$526.85	$537.37	$531.97
Single + Spouse	$1,053.71	$1,074.75	$1,063.95
Single + Children	$895.65	$913.54	$904.36
Family	$1,501.53	$1,531.52	$1,516.13

All plans include dependent care to Age 26.

For full plan details or to request a custom quote, please call Everett Patterson, Jr, Vice President of Marketing and Sales at 845-703-6422 x14515 or visit **CrystalRunHP.com/Brokers**.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | EPO Gold 2016

PLAN NAME	GOLD EPO 1	GOLD EPO 2	GOLD EPO 3	GOLD EPO 4	GOLD EPO 5 HDHP HSA QUALIFIED
Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network
Deductible (Single/Family) **Deductible Structure** **Max Out of Pocket** (Single/Family)	$1,000/$2,000 Embedded $4,000/$8,000	$1,500/$3,000 Embedded $4,000/$8,000	$1,000/$2,000 Embedded $4,000/$8,000	$500/$1,000 Embedded $6,850/$13,700	$1,500/$3,000 Aggregate $5,000/$10,000
MEDICAL					
Primary Care **Specialist Visit**	$0 copay/$30 copay $40 copay/$70 copay	$0 copay/$30 copay $40 copay/$70 copay	$30 copay/$60 copay $50 copay/$75 copay	$0 copay*/$40 copay* $50 copay*/$75 copay*	$0 copay*/$20 copay* $20 copay*/$40 copay*
Outpatient Surgery – Hospital Setting (Facility)	$250 copay*/$300 copay*	$250 copay*/$300 copay*	$250 copay*/$300 copay*	$300 copay*/$400 copay*	$200 copay*/$250 copay*
Hospital Inpatient Charges (Medical/Surgical/Maternity)	10% coinsurance*/ 20% coinsurance*	10% coinsurance*/ 20% coinsurance*	$250 per day*/$400 per day* (Max 10 days copay per contract year)	$1,000 copay*/ $1,500 copay*	$200 copay per admit*/ $300 copay per admit*
Emergency Room **Urgent Care**	$300 copay*/$300 copay* $0 copay/$30 copay	$350 copay/$350 copay $0 copay/$30 copay	$300 copay/$300 copay $30 copay/$60 copay	$350 copay*/$350 copay* $0 copay*/$40 copay*	$200 copay*/$200 copay* $0 copay*/$20 copay*

*Cost shares are subject to plan deductible.

PHARMACY					
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$50 **/$80 **	$15/$50/$80	$10/$50 **/$80 **	$10/$50*/$80*	$0*/$30*/$60*

*Cost shares are subject to plan deductible. **Cost shares are subject to $100 Rx deductible.

RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($18.39 per dependent - max . 3)					
Single	$465.06	$480.10	$462.50	$449.95	$435.16
Single + Spouse	$930.11	$960.20	$924.99	$899.91	$870.32
Single + Children	$790.60	$816.17	$786.24	$764.92	$739.77
Family	$1,325.41	$1,368.29	$1,318.11	$1,282.37	$1,240.21

All plans include dependent care to Age 26.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | EPO Silver 2016

PLAN NAME	SILVER EPO 1	SILVER EPO 2	SILVER EPO 3	SILVER EPO 4	SILVER EPO 5	SILVER EPO 6 HDHP HSA QUALIFIED	SILVER EPO 7 HDHP HSA QUALIFIED
Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network
Deductible (Single/Family)	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000
Deductible Structure	Embedded	Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
Max Out of Pocket (Single/Family)	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$6,550/$13,100	$6,550/$13,100
MEDICAL							
Primary Care	$0 copay*/$30 copay*	20% coinsurance*/ 30% coinsurance*	$40 copay/$60 copay	$20 copay/$50 copay	$0 copay*/$40 copay*	$0 copay*/$40 copay*	20% coinsurance*/ 30% coinsurance*
Specialist Visit	$40 copay*/$70 copay*	20% coinsurance*/ 30% coinsurance*	$60 copay/$75 copay	$50 copay/$75 copay	$50 copay*/$75 copay*	$50 copay*/$75 copay*	20% coinsurance*/ 30% coinsurance*
Outpatient Surgery – Hospital Setting (Facility)	$300 copay*/$400 copay*	$300 copay*/$400 copay*	25% coinsurance*/ 35% coinsurance*	25% coinsurance*/ 35% coinsurance*	$300 copay*/$400 copay*	$300 copay*/$400 copay*	$300 copay*/$400 copay*
Hospital Inpatient Charges (Medical/Surgical/Maternity)	20% coinsurance*/ 30% coinsurance*	20% coinsurance*/ 30% coinsurance*	25% coinsurance*/ 35% coinsurance*	25% coinsurance*/ 35% coinsurance*	20% coinsurance*/ 30% coinsurance*	$500 copay per admit*/ $750 copay per admit*	20% coinsurance*/ 30% coinsurance*
Emergency Room	$350 copay*/$350 copay*	$350 copay*/$350 copay*	$350 copay*/$350 copay*	$350 copay/$350 copay	$350 copay*/$350 copay*	$350 copay*/$350 copay*	$350 copay*/$350 copay*
Urgent Care	$0 copay*/$30 copay*	20% coinsurance*/ 30% coinsurance*	$40 copay/$60 copay	$20 copay/$50 copay	$0 copay*/$40 copay*	$0 copay*/$40 copay*	20% coinsurance*/ 30% coinsurance*

*Cost shares are subject to plan deductible.

PHARMACY							
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$50*/$80*	$10/$50*/$80*	$10*/$50*/$80*	$15/$50/$80	$10*/$50*/$80*	$10*/$50*/$80*	$10*/$50*/$80*

*Cost shares are subject to plan deductible.

RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($18.39 per dependent - max . 3)							
Single	$374.13	$360.62	$394.46	$410.65	$384.21	$379.36	$370.08
Single + Spouse	$748.27	$721.24	$788.93	$821.30	$768.41	$758.72	$740.15
Single + Children	$636.03	$613.06	$670.59	$698.10	$653.15	$644.91	$629.13
Family	$1,066.28	$1,027.77	$1,124.22	$1,170.35	$1,094.99	$1,081.18	$1,054.72

All plans include dependent care to Age 26.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | EPO Bronze 2016

PLAN NAME	BRONZE EPO 1 HDHP HSA QUALIFIED	BRONZE EPO 2 HDHP HSA QUALIFIED	BRONZE EPO 3 HDHP HSA QUALIFIED	BRONZE EPO 4 HDHP HSA QUALIFIED	BRONZE EPO 5
Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network	Core Network/ Extended Network
Deductible (Single/Family) **Deductible Structure** **Max Out of Pocket** (Single/Family)	$4,000/$8,000 Embedded $6,550/$13,100	$4,000/$8,000 Embedded $6,550/$13,100	$5,000/$10,000 Embedded $6,550/$13,100	$5,000/$10,000 Embedded $6,550/$13,100	$6,000/$12,000 Embedded $6,850/$13,700
MEDICAL					
Primary Care	$0 copay*/$30 copay*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*	$0 copay*/ 50% coinsurance*	1st 2 at $50 copay/ 20% after-deductible*
Specialist Visit	$50 copay*/$75 copay*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*
Outpatient Surgery – Hospital Setting (Facility)	40% coinsurance*/ 50% coinsurance*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*
Hospital Inpatient Charges (Medical/Surgical/Maternity)	40% coinsurance*/ 50% coinsurance*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*
Emergency Room	50% coinsurance*/ 50% coinsurance*	50% coinsurance*/ 50% coinsurance*	20% coinsurance*/ 20% coinsurance*	50% coinsurance*/ 50% coinsurance*	20% coinsurance*/ 20% coinsurance
Urgent Care	$0 copay*/$30 copay*	40% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*	0% coinsurance*/ 50% coinsurance*	10% coinsurance*/ 20% coinsurance*
PHARMACY					
Retail (Tier 1/Tier 2/Tier 3 copays)	$10*/$50*/$80*	$10*/$50*/$80*	$10*/$50*/$80*	$10*/$50*/$80*	$10*/$50*/$80*

*Cost shares are subject to plan deductible.

*Cost shares are subject to plan deductible.

RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($18.39 per dependent - max . 3)

Single	$316.88	$315.10	$313.57	$307.28	$303.11
Single + Spouse	$633.76	$630.20	$627.13	$614.56	$606.23
Single + Children	$538.69	$535.67	$533.06	$522.38	$515.29
Family	$903.10	$898.03	$893.66	$875.75	$863.88

All plans include dependent care to Age 26.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | PPO 2016

PLAN NAME	PLATINUM PPO 1		GOLD PPO 1		GOLD PPO 3 HDHP HSA QUALIFIED		GOLD PPO UCR		SILVER PPO 1		SILVER PPO 2 HDHP HSA QUALIFIED	
Network	Core Network/ Extended Network	Out-Of-Network	Core Network/ Extended Network	Out-Of-Network	Core Network/ Extended Network	Out-Of-Network	Core Network/ Extended Network	Out-Of-Network	Core Network/ Extended Network	Out-Of-Network	Core Network/ Extended Network	Out-Of-Network
Deductible (Single/Family)	No Deductible	$2,000/$4,000	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000	$500/$1,000	$3,000/$6,000	$2,500/$5,000	$4,000/$8,000	$2,000/$4,000	$5,000/$10,000
Deductible Structure	N/A	Embedded	Embedded	Embedded	Aggregate	Aggregate	Embedded	Embedded	Embedded	Embedded	Aggregate	Aggregate
Max Out of Pocket (Single/Family)	$3,000/$6,000	$5,000/$10,000	$4,000/$8,000	$6,000/$12,000	$5,000/$10,000	$7,500/$15,000	$6,850/$13,700	$7,500/$15,000	$6,850/$13,700	$10,000/$20,000	$6,550/$13,100	$12,500/$25,000
MEDICAL												
Primary Care	$0 copay/ $25 copay	30% coinsurance*	$30 copay/ $60 copay	40% coinsurance*	$0 copay*/ $20 copay*	40% coinsurance*	$0 copay*/ $40 copay*	20% coinsurance*	$40 copay/ $60 copay	40% coinsurance*	$0 copay*/ $40 copay*	40% coinsurance*
Specialist Visit	$25 copay/ $50 copay	30% coinsurance*	$50 copay/ $75 copay	40% coinsurance*	$20 copay*/ $40 copay*	40% coinsurance*	$50 copay*/ $75 copay*	20% coinsurance*	$60 copay/ $75 copay	40% coinsurance*	$50 copay*/ $75 copay*	40% coinsurance*
Outpatient Surgery – Hospital Setting (Facility)	$250 copay/ $300 copay	30% coinsurance*	$250 copay*/ $300 copay*	40% coinsurance*	$200 copay*/ $250 copay*	40% coinsurance*	$300 copay*/ $400 copay	20% coinsurance*	25% coinsurance* 35% coinsurance*	40% coinsurance*	$300 copay*/ $400 copay*	40% coinsurance*
Hospital Inpatient Charges (Medical/Surgical/Maternity)	$500 copay per admit/$750 copay per admit	30% coinsurance*	$250 copay per day*/ $400 copay per day* (Max 10 days copay per contract year)	40% coinsurance*	$200 copay per admit*/$300 copay per admit*	40% coinsurance*	$1,000 copay*/ $1,500 copay*	20% coinsurance*	25% coinsurance* 35% coinsurance*	40% coinsurance*	$500 copay per admit*/$750 copay per admit*	40% coinsurance*
Emergency Room	$200 copay/ $200 copay	$200 copay*	$300 copay/ $300 copay	$300 copay	$200 copay*/ $200 copay*	$200 copay*	$350 copay*/ $350 copay*	$350 copay*	$350 copay*/ $350 copay*	$350 copay*	$350 copay*/ $350 copay*	$350 copay*
Urgent Care	$0 copay/ $25 copay	30% coinsurance*	$30 copay/ $60 copay	40% coinsurance*	$0 copay*/ $20 copay*	40% coinsurance*	$0 copay*/ $40 copay*	20% coinsurance*	$40 copay/ $60 copay	40% coinsurance*	$0 copay*/ $40 copay*	40% coinsurance*

*Cost shares are subject to plan deductible.

PHARMACY												
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$50 **/$80 **	Not Covered	$10/$50 **/$80 **	Not Covered	$0*/$30*/$60*	Not Covered	$10/$50*/$80*	Not Covered	$10*/$50*/$80*	Not Covered	$10*/$50*/$80*	Not Covered

*Cost shares are subject to plan deductible. **Cost shares are subject to $100 Rx deductible.

RATES

Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($18.39 per dependent - max . 3)

Single	$531.56	$470.68	$439.42	$526.57	$396.72	$380.40
Single + Spouse	$1,063.12	$941.35	$878.84	$1,053.15	$793.45	$760.80
Single + Children	$903.65	$800.15	$747.01	$895.18	$674.43	$646.68
Family	$1,514.94	$1,341.43	$1,252.34	$1,500.74	$1,130.66	$1,084.14

All plans include dependent care to Age 26.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | HMO Standard 2016

PLAN NAME	PLATINUM HMO STD	GOLD HMO STD	SILVER HMO STD	BRONZE HMO STD
Network	Core Network Only	Core Network Only	Core Network Only	Core Network Only
Deductible (Single/Family) **Deductible Structure** **Max Out of Pocket** (Single/Family)	$0/$0 Embedded $2,000/$4,000	$600/$1,200 Embedded $4,000/$8,000	$2,000/$4,000 Embedded $5,500/$11,000	$3,500/$7,000 Embedded $6,850/$13,700
MEDICAL				
Primary Care **Specialist Visit** **Outpatient Surgery – Hospital Setting** (Facility) **Hospital Inpatient Charges** (Medical/Surgical/Maternity) **Emergency Room** **Urgent Care**	$15 copay $35 copay $100 copay $500/admission $100 copay $55 copay	$25 copay* $40 copay* $100 copay* $1,000/admission* $150 copay* $60 copay*	$30 copay* $50 copay* $100 copay* $1,500/admission* $150 copay* $70 copay*	50% coinsurance* 50% coinsurance* 50% coinsurance* 50% coinsurance* 50% coinsurance* 50% coinsurance*
				*Cost shares are subject to plan deductible.
PHARMACY				
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$30/$60	$10/$35/$70	$10/$35/$70	$10*/$35*/$70*
				*Cost shares are subject to plan deductible.
RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($14.45 per dependent)				
Single **Single + Spouse** **Single + Children** **Family**	$459.46 $918.92 $781.08 $1,309.46	$393.75 $787.51 $669.38 $1,122.20	$342.55 $685.10 $582.34 $976.27	$264.04 $528.07 $448.86 $752.50

All plans include dependent care to Age 26.

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PLAN SUMMARIES

Small Group Plans Q3 Age 26 | HMO Nonstandard 2016

PLAN NAME	PLATINUM HMO NS	GOLD HMO NS	SILVER HMO NS	BRONZE HMO NS
Network	Core Network Only	Core Network Only	Core Network Only	Core Network Only
Deductible (Single/Family) **Deductible Structure** **Max Out of Pocket** (Single/Family)	$0/$0 Embedded $2,000/$4,000	$0/$0 Embedded $4,000/$8,000	$2,000/$4,000 Embedded $6,850/$13,700	$6,000/$12,000 Embedded $6,850/$13,700
MEDICAL				
Primary Care **Specialist Visit** **Outpatient Surgery – Hospital Setting** (Facility) **Hospital Inpatient Charges** (Medical/Surgical/Maternity) **Emergency Room** **Urgent Care**	$0 copay $50 copay 20% coinsurance 20% coinsurance 20% coinsurance $0 copay	$0 copay $50 copay 50% coinsurance 50% coinsurance 50% coinsurance $0 copay	$0 copay* $75 copay* 50% coinsurance* 50% coinsurance* 50% coinsurance* $0 copay*	$0 copay* $75 copay* 50% coinsurance* 50% coinsurance* 50% coinsurance* $0 copay*
PHARMACY				
Retail (Tier 1/Tier 2/Tier 3 copays)	$10/$50/$80	$10/$50/$80	$10/$50*/$80*	$10*/$50*/$80*

*Cost shares are subject to plan deductible.

*Cost shares are subject to plan deductible.

RATES Effective 07/01/2016 - 09/30/2016. Rates do not include pediatric dental ($14.45 per dependent)

Single	$451.63	$392.56	$302.80	$248.06
Single + Spouse	$903.26	$785.13	$605.59	$496.12
Single + Children	$767.77	$667.36	$514.75	$421.70
Family	$1,287.15	$1,118.81	$862.97	$706.97

All plans include dependent care to Age 26.

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