Aspen Skiing Company: Their benefit period is from 6/1-5/31. Their enrollment level will determine their deductible and out of pocket amount. The network deductible and non-network deductible will cross accumulate. Once the non-network deductible is met, claims will be eligible at 60% of the maximum eligible expense. Once they meet their out of pocket maximum claims are eligible at 100% of the maximum eligible expense.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK	NON-NETWORK
ACUPUNCTURE TREATMENT		
	80% after Deductible	60% after Deductible
Benefit Limits: 20 visits Maximum Benefit per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		

COST SHARING PROVISIONS	NETWORK	NON-NETWORK
DEDUCTIBLE (Embedded)		
Employee with Single Coverage	$2,500	$2,500
Per Employee with Spouse OR Child		
Per Covered Person	$2,500	$2,500
Family Coverage	$3,750	$3,750
Per Employee with Children OR Spouse AND Child(ren)		
Per Covered Person	$2,500	$2,500
Family Coverage	$6,000	$6,000
Deductible applies to all benefits unless specifically indicated as waived. Network and Non-Network Deductibles cross accumulate.		
BENEFIT PERCENTAGE		
Before satisfaction of Out-of-Pocket Maximum	80%	60%
After satisfaction of Out-of-Pocket Maximum	100%	100%
Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise.		
OUT-OF-POCKET MAXIMUM (Embedded; Medical and Pharmacy Combined)		
Employee with Single Coverage	$7,000	$7,000
Per Employee with Spouse OR Child		
Per Covered Person	$7,000	$7,000
Family Coverage	$12,750	$12,750
Per Employee with Children OR Spouse AND Child(ren)		
Per Covered Person	$7,000	$7,000
Family Coverage	$14,000	$14,000
Out-of-Pocket Maximum, Medical and Pharmacy combined, includes the Deductible, Medical Benefit and Pharmacy Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Network and Non-Network Out-of-Pocket Maximums cross accumulate.		

City of Aspen: Their plan is a Calendar Year pan. They have two plan options either HDHP or HDHP with HRA, Non-Network deductible will apply, once that is met claims are eligible at 50% of the maximum eligible expense. Once the out of pocket maximum is met then claims are eligible at 100% of the maximum eligible expense. These accumulators do not cross accumulate.

HDHP with HRA:

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	NON-NETWORK
ACUPUNCTURE TREATMENT		
	100% after $50 Copayment, Deductible Waived	50% after Deductible
Benefit Limits: 12 visits per Benefit Period. The Copay applies to all charges provided and billed by the provider, including medications, treatments, vitamins and herbs. **Benefit limits are for services received from Network and Non-Network Providers.**		

COST SHARING PROVISIONS	IN-NETWORK	NON-NETWORK
DEDUCTIBLE (Embedded) Per Covered Person Per Benefit Period Per Family Per Benefit Period	 $2,500 $5,000	 $5,000 $10,000
The Deductible applies to all benefits unless specifically indicated as waived. In-Network and Non-Network Deductibles are completely separate and do not cross accumulate.		
BENEFIT PERCENTAGE	70%	50%
The Benefit Percentage applies after the Deductible is satisfied and applies to all benefits until the Combined Medical/Pharmacy Out-of-Pocket Maximum is met unless specifically stated otherwise. After satisfaction of Combined Medical/Pharmacy Out-of-Pocket Maximum, the Benefit Percentage will be 100%.		
COPAYMENTS Copayments are stated in this Schedule of Medical Benefits and apply to certain services such as office visits, emergency room visits, Urgent Care facility and are payable by the Covered Person. Copayments do not apply towards the Deductible but do apply towards the Combined Medical/Pharmacy Out-of-Pocket Maximum and after the Combined Medical/Pharmacy Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.		
COMBINED MEDICAL/PHARMACY OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person Per Benefit Period Per Family Per Benefit Period	 $5,000 $10,000	 $10,000 $20,000
Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments, Eligible Expenses in excess of the Benefit Percentage and Pharmacy Copayments. In-Network and Non-Network Out-of-Pocket Maximums are completely separate and do not cross accumulate.		

HDHP without HRA

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE IN-NETWORK	NON-NETWORK
ACUPUNCTURE TREATMENT		
	70% after Deductible	50% after Deductible
Benefit Limits: 12 visits per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		

COST SHARING PROVISIONS	IN-NETWORK	NON-NETWORK
COMBINED MEDICAL/PHARMACY DEDUCTIBLE (Non-Embedded)		
Single Coverage Deductible Per Benefit Period	$1,500	$2,000
Family Coverage Deductible Per Benefit Period	$3,000	$4,000
Single Coverage means only the Employee is covered under the Plan. Family Coverage means the Employee and one or more Dependent(s) are covered under the Plan. No benefits will be payable until satisfaction of the Family Coverage Deductible. The Deductible applies to all benefits unless specifically indicated as waived. In-Network and Non-Network Deductibles are completely separate and do not cross accumulate.		
BENEFIT PERCENTAGE	70%	50%
The Benefit Percentage applies after the Deductible is satisfied until the Combined Medical/Pharmacy Out-of-Pocket Maximum is met unless specifically stated otherwise. After satisfaction of Combined Medical/Pharmacy Out-of-Pocket Maximum the Benefit Percentage will be 100%.		
COMBINED MEDICAL/PHARMACY OUT-OF-POCKET MAXIMUM (Embedded)		
Per Covered Person Per Benefit Period	$4,450	$4,450
Per Family Per Benefit Period	$8,900	$8,900
Out-of-Pocket Maximum includes the Deductible and Eligible Expenses in excess of the Benefit Percentage. In-Network and Non-Network Out-of-Pocket Maximums are completely separate and do not cross accumulate.		

Aspen Valley Hospital: This plan is a calendar year plan. Their benefit is combined with Chiropractic Care so if they are utilizing both benefits their visits with you may be lower. For the first 20 visits deductible is waived and claims are eligible at 70% of the maximum eligible expense. Once the out of pocket maximum is met claims are eligible at 100% of the maximum eligible expense. If they use more than 20 visits then the Tier 3 deductible will apply, once that is met claims are eligible at 70% of the maximum eligible expense and once the out of pocket maximum is met claims are eligible at 100% of the maximum eligible expense.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT			
	TIER 1 AND TIER 2	TIER 3	TIER 4	TIER 5
ACUPUNCTURE TREATMENT				
	Not Available	70%, Deductible Waived first 20 visits 70% after Tier 3 Deductible thereafter		
Benefit Limits: Deductible Waived for first 20 visits, combined for Acupuncture Treatment and Chiropractic Care, then Tier 3 Deductible applies. **Benefit limits are for services received from all Tier 3, Tier 4 and Tier 5 Providers.**				

COST SHARING PROVISIONS PER BENEFIT PERIOD	TIER 1 AND TIER 2		TIER 3	TIER 4	TIER 5
	ASPEN VALLEY HOSPITAL	VALLEY VIEW HOSPITAL AND VHA PROVIDERS (When Services are NOT Available at AVH)	CIGNA OAP (When Services are NOT Available at AVH)	CIGNA OAP and Valley View Hospital (When Services Otherwise Available at AVH)	NON-NETWORK
DEDUCTIBLE Per Covered Person Per Family	$2,000 $4,000		$3,000 $6,000	$6,000 $12,000	
The Deductible applies to all benefits except as specifically indicated as waived. Tier 1, Tier 2 and Tier 3 Deductibles will only cross accumulate between Tier 1, Tier 2 and Tier 3. Tier 4 and Tier 5 Deductibles will only cross accumulate between Tier 4 and Tier 5.					
BENEFIT PERCENTAGE Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	85% 100%		70% 100%	60% 100%	50% 100%
The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise. The Benefit Percentage is the percentage payable by the Plan.					

COST SHARING PROVISIONS PER BENEFIT PERIOD	TIER 1 AND TIER 2		TIER 3	TIER 4	TIER 5
	ASPEN VALLEY HOSPITAL	VALLEY VIEW HOSPITAL AND VHA PROVIDERS (When Services are NOT Available at AVH)	CIGNA OAP (When Services are NOT Available at AVH)	CIGNA OAP and Valley View Hospital (When Services Otherwise Available at AVH)	NON-NETWORK
OUT-OF-POCKET MAXIMUM (Combined with Pharmacy Benefit) Per Covered Person Per Family	$5,500 $11,000		$7,350 $14,700	$10,250 $20,500	
The Out-of-Pocket Maximum, combined with Pharmacy Benefit, includes the Deductible, Medical Benefits Copayments, Pharmacy Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Tier 1, Tier 2 and Tier 3 Out-of-Pocket Maximums will only cross accumulate between Tier 1, Tier 2 and Tier 3. Tier 4 and Tier 5 Out-of-Pocket Maximums will only cross accumulate between Tier 4 and Tier 5.					

Pitkin County: Their deductible and out of pocket will be dependent on their enrollment level. This plan is a calendar year plan. The non-network deductible will apply; once that is met claims are eligible at 80% of the maximum eligible expense. Once the out of pocket maximum is met claims are eligible at 100% of the maximum eligible expense.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE NETWORK	NON-NETWORK
ACUPUNCTURE TREATMENT		
	80% after Deductible	80% after Deductible
Benefit Limits: 12 visits per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		

COST SHARING PROVISIONS	NETWORK	NON-NETWORK
DEDUCTIBLE PER BENEFIT PERIOD **(Non-Embedded)**[2]		
Single Coverage Deductible	$1,400	$3,000
Family Coverage Deductible	$2,800	$6,000
"Single Coverage" means only the Employee is covered under the Plan. No benefits will be payable until satisfaction of the Single Coverage Deductible.		
"Family Coverage" means the Employee and one or more Dependent(s) are covered under the Plan. No benefits will be payable until satisfaction of the Family Coverage Deductible.		
The Deductible is combined for Medical Benefits and Pharmacy Benefits and applies to all benefits unless specifically indicated as waived.		
Charges for Network services will cross accumulate between the Network Deductible and Non-Network Deductible. However, charges for Non-Network services will only apply toward satisfaction of the Non-Network Deductible but will not apply toward satisfaction of the Network Deductible.		
BENEFIT PERCENTAGE		
Before satisfaction of Out-of-Pocket Maximum	80%	50%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise.		
OUT-OF-POCKET MAXIMUM PER BENEFIT PERIOD **(Non-Embedded**		
Single Coverage Out-of-Pocket Maximum	$4,500	$12,000
Family Coverage Out-of-Pocket Maximum	$6,850	$24,000
"Single Coverage" means only the Employee is covered under the Plan. No benefits will be payable at 100% until satisfaction of the Single Coverage Out-of-Pocket Maximum.		
"Family Coverage" means the Employee and one or more Dependent(s) are covered under the Plan. No benefits will be payable at 100% until satisfaction of the Family Coverage Out-of-Pocket Maximum.		
The Out-of-Pocket Maximum is combined for Medical Benefits and Pharmacy Benefits and includes the Deductible, Eligible Expenses in excess of the Benefit Percentage, any applicable Medical Copayments and Pharmacy Copayments.		
Charges for Network services will cross accumulate between the Network Out-of-Pocket Maximum and Non-Network Out-of-Pocket Maximum. However, charges for Non-Network services will only apply toward satisfaction of the Non-Network Out-of-Pocket Maximum but will not apply toward satisfaction of the Network Out-of-Pocket Maximum.		