Benefit Summary	1,500 Classic	2,500 Classic	3,500 Classic
Benefits	In-Network	In-Network	In-Network
Deductible Individual / Family	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
Coinsurance Plan Pays /Member Pays	80% / 20%	80% / 20%	80% / 20%
Out-of-Pocket Maximum Individual / Family	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Lifetime Maximum	No Maximum	No Maximum	No Maximum
Co-Pay			
Primary Care Co-Pay	$30	$30	$45
Specialist Co-Pay	$60	$60	$90
Chiropractice Care Co-Pay Limited to 20 visits per benefit period	$20	$20	$20
Urgent Care	$80	$80	$90
Embedded No Cost Services			
Telemedicine	$0 Copay	$0 Copay	$0 Copay
Virtual Primary Care	Included	Included	Included
Advocacy Services	Included	Included	Included
Facility & Professional Services (Patient Responsibility)			
Inpatient Hospital (patient responsibility)	20% after deductible	20% after deductible	20% after deductible
Out Patient Services **Surgical Services** (Procedure & Anesthesia)	20% after deductible	20% after deductible	20% after deductible
Emergency Room	20% after deductible	20% after deductible	20% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)			
Free Standing Lab & Diagnostic Services (Lab & x-ray)	0% after deductible	0% after deductible	0% after deductible
Complex Diagnositc Services (CT, MRI, Ultra Sound, PET, Nuclear Med.)	20% after deductible	20% after deductible	20% after deductible
Professional Fees	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Benefit – **Non participating pharmacies are not covered**			
Prescription Drug	In-Network	In-Network	In-Network
Deductible	None	None	None
Speciality	See plan document for more information		
Retail (30 Day Supply)	$15/$45/$85	$15/$45/$85	$15/$65/$100
Generic	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay
Preferred Brand	Retail: $45 co-pay	Retail: $45 co-pay	Retail: $65 co-pay
Non-Preferred Brand	Retail: $85 co-pay	Retail: $85 co-pay	Retail: $100 co-pay
Mail Order (31-90 Day Supply)	$45/$90/$150	$45/$90/$150	$45/$90/$150
Generic	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay
Preferred Brand	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay
Non-Preferred Brand	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay
Non-Network Services (Patient Responsibility)			
Coinsurance Plan Pays/Member Pays	60% / 40%	60% / 40%	60% / 40%
Deductible Individual/Family	$3,000 / $6,000	$5,000 / $10,000	$7,000 / $14,000
Out of Pocket Maximum Individual/Family	$14,700 / $29,400	$14,700 / $29,400	$14,700 / $29,400

NOTE: Precerticiation is required for all in-hospital admissions, chemotherapy, diagnostic testing and outpatient surgery. Penalty may

This comparison describes the plan in an easy understood manner and presented as a matter of general information.
The contents are not to be accepted as a substitute for the provision of the plan, and are subject to change over time.

Benefit Summary	5,000 Classic	7,350 Value	5,000 HSA
Benefits	In-Network	In-Network	In-Network
Deductible Individual / Family	$5,000 / $10,000	$7,350 / $14,700	$5,000 / $10,000
Coinsurance Plan Pays /Member Pays	80% / 20%	100%	80% / 20%
Out-of-Pocket Maximum Individual / Family	$7,350 / $14,700	$7,350/$14,700	$7,350 / $14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Lifetime Maximum	No Maximum	No Maximum	No Maximum
Co-Pay			
Primary Care Co-Pay	$45	$50	20% after deductible
Specialist Co-Pay	$90	$100	20% after deductible
Chiropractice Care Co-Pay Limited to 20 visits per benefit period	$20	$20	20% after deductible
Urgent Care	$90	$100	20% after deductible
Embedded No Cost Services			
Telemedicine	$0 Copay	$0 Copay	$0 Copay
Virtual Primary Care	Included	Included	Included
Advocacy Services	Included	Included	Included
Facility & Professional Services (Patient Responsibility)			
Inpatient Hospital (patient responsibility)	20% after deductible	0% after deductible	20% after deductible
Out Patient Services **Surgical Services** (Procedure & Anesthesia)	20% after deductible	0% after deductible	20% after deductible
Emergency Room	20% after deductible	0% after deductible	20% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)			
Free Standing Lab & Diagnostic Services (Lab & x-ray)	0% after deductible	0% after deductible	0% after deductible
Complex Diagnositc Services (CT, MRI, Ultra Sound, PET, Nuclear Med.)	20% after deductible	0% after deductible	20% after deductible
Professional Fees	20% after deductible	0% after deductible	20% after deductible
Prescription Drug Benefit – **Non participating pharmacies are not covered**			
Prescription Drug	In-Network	In-Network	In-Network
Deductible	None	None	None
Speciality	See plan document for more information		
Retail (30 Day Supply)	$15/65/$100	$15/65/$100	$15/$65/$100
Generic	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay
Preferred Brand	Retail: $65 co-pay	Retail: $65 co-pay	Retail: $65 co-pay
Non-Preferred Brand	Retail: $100 co-pay	Retail: $100 co-pay	Retail: $100 co-pay
Mail Order (31-90 Day Supply)	$45/$90/$150	$45/$90/$150	$30/$130/$200
Generic	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $30 co-pay
Preferred Brand	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $130 co-pay
Non-Preferred Brand	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $200 co-pay
Non-Network Services (Patient Responsibility)			
Coinsurance Plan Pays/Member Pays	60% / 40%	50% / 50%	60% / 40%
Deductible Individual/Family	$7,000 / $14,000	$14,700 / $29,400	$10,000 / $20,000
Out of Pocket Maximum Individual/Family	$14,700 / $29,400	$14,700 / $29,400	$14,700 / $29,400

NOTE: Precerticiation is required for all in-hospital admissions,

This comparison describes the plan in an easy understood manner and presented as a matter of general information.
The contents are not to be accepted as a substitute for the provision of the plan, and are subject to change over time.

Cigna Network Choice Fund PPO

IHA HEALTH Monthly 1099 Average Plan Rates

CIGNA Plan Choices	Rates Between	Member Only	Member + Spouse	Member + Child(ren)	Member + Family
7350 VALUE Plan	Rates Between	**$487.08 to $703.54**	**$944.15 to $1,377.07**	**$852.73 to $1,242.37**	**$1,401.23 to $2,050.61**
5000 H.S.A. Plan	Rates Between	**$510.68 to $737.97**	**$990.61 to $1,445.17**	**$894.62 to $1,303.73**	**$1,470.54 to $2,152.39**
5000 Classic Plan	Rates Between	**$561.49 to $812.07**	**$1,090.61 to $1,591.77**	**$984.78 to $1,435.83**	**$1,619.73 to $2,371.48**
3500 Classic Plan	Rates Between	**$599.74 to $867.87**	**$1,165.90 to $1,702.14**	**$1,052.67 to $1,535.29**	**$1,732.06 to $2,536.43**
2500 Classic Plan	Rates Between	**$640.68 to $927.57**	**$1,246.46 to $1,820.24**	**$1,125.30 to $1,641.71**	**$1,852.26 to $2,712.93**
1500 Classic Plan	Rates Between	**$684.47 to $991.45**	**$1,332.66 to $1,946.61**	**$1,203.03 to $1,755.58**	**$1,980.87 to $2,901.79**

All of the above plan tiers are subject to underwriting and are based on health conditions disclosed on the submitted application. Some applications may be “Declined to Quote”. All rates are determined after underwriting is completed and can range between the above published rates. Above rate grid is valid through 5/31/2025.