Health Direct

The Affordable Healthcare Advantage

Plan Comparison:
Summary of Benefits and Coverage

- $1.0 Million / $5.0 Million Plan with $250 Deductible
- $1.0 Million / $5.0 Million Plan with $500 Deductible
- **$1.0 Million / $5.0 Million Plan with $750 Deductible**

Summary of Benefits and Coverage: Plan Comparison

$1.0 Million / $5.0 Million Plans: $250 Deductible · $500 Deductible · $750 Deductible

PLAN	$1M/$5M - 250	$1M/$5M - 500	$1M/$5M - 750
Subject to plan allowable The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get copy of the complete terms of coverage, call M3 Benefits (888)711-4959. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, provider or other underlined terms see the Glossary. You can view the glossary at www.dol.gov/ebsa/, www.healthreform.com or www.cciio.cms.gov			
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)			
• Individual	$250	$500	$750
• Family Unit (Accumulated)	$500	$1,000	$1,500
Maximum Annual Benefit Amount			
• Yearly	$1,000,000	$1,000,000	$1,000,000
• Lifetime	$5,000,000	$5,000,000	$5,000,000

Copays Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.

Other Covered Services (Limitations may apply to these services. This may not be a complete list.)

- Annual Lab / X-Ray Tests
- Annual Pap Smear / Mammogram
- Cancer Screenings
- Colonoscopies
- Diabetic Supply
- Immunizations
- Other Preventative Screenings
- Symphony Rx (Prescriptions)
- Clever Health (including Mental Health Services)
- Urgent Care and Office Visits
- Well Baby Care
- Wellness Visits

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's Dental Check-Up
- Children's Glasses
- Children's Eye Exam
- Dialysis
- Biofeedback
- Mental Health Services
- Substance Abuse Services
- Organ Transplant Services

Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.

PRECERTIFICATION

Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. A 50% penalty will apply for not obtaining precertification.

This illustration describes the plan in an easily understood manner and is presented as a matter of general information

All Benefits Payable Under This Plan Are Subject To The Plan Allowable.

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Covered Services - Illness or Injury			
Physician Office Services • Primary care physician office visit - 10 visits per benefit period maximum is combined for PCP office visits, Specialist, Therapy and Urgent care visits. • Specialist Physician Office Visit - 10 visits per benefit period maximum is combined for PCP office visits, Specialist, Therapy and Urgent care visits. • Urgent Care Visit - 10 visits per benefit period maximum is combined for PCP office visits, Specialist, Therapy and Urgent care visits.	$50 Copay (after deductible)	$50 Copay (after deductible)	$50 Copay (after deductible)
Clever Health Virtual primary care, Virtual urgent care, Licensed mental wellness and more • Mental Health - Unlimited • Urgent Care - Unlimited • Mental Health - Unlimited	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible
Emergency Services • Emergency Room Care -2 visit limit per benefit period. **Freestanding ER and non-emergency visits not covered* • Emergency Medical Transportation -1 visit limit per benefit period .	$1000 Copay/Admission (after deductible) $1000 Copay/Admission (after deductible)	$1000 Copay/Admission (after deductible) $1000 Copay/Admission (after deductible)	$1000 Copay/Admission (after deductible) $1000 Copay/Admission (after deductible)
Outpatient Services • Outpatient Hospital/Ambulatory Surgical Center, All fees. - 2 surgeries per Plan Year. *Authorization required.*	$1000 Copay/Admission (after deductible)	$1000 Copay/Admission (after deductible)	$1000 Copay/Admission (after deductible)
Inpatient Services - Inpatient Hospital Services, Facility/Physician Fees - Paid at facility's semi-private room rate. Limit 1 hospital stays per benefit period, 10 day maximum hospitalization per benefit period. - Inpatient Hospital Surgical Services, All fees. - 1 surgeries per Plan Year.	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)
Testing • Diagnostic Test (Labs, EKG, ultrasound, and other in office procedures not included in Imaging) - 3 per Benefit Plan Year. *Authorization required, Quest only for Labs* • Diagnostic Imaging (CT/PET Scans, MRIs, MRAs) - 3 per Benefit Plan Year. *Authorization required, Green Imaging only*	$50 Copay (after deductible) $250 Copay (after deductible)	$50 Copay (after deductible) $250 Copay (after deductible)	$50 Copay (after deductible) $250 Copay (after deductible)

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Preventive Care			
Preventive Care / Screening / Immunization (You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Services are limited to those covered by the Affordable Care Act. **All services must be conducted in office,** hospital services are not covered.)	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible
Mental Health, Behavioral Health and/or Substance Use Disorder Services			
Inpatient Services Inpatient Services	Not Covered	Not Covered	Not Covered
Outpatient Services • Outpatient Services	See Clever Health	See Clever Health	See Clever Health
Other Covered Services - Illness or Injury			
Pregnancy, Maternity Global Maternity Services, All fees. (Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc. Capped at $15,000 Per Plan Year. Excludes Genetic testing unless medically necessary).			
• Routine Vaginal Delivery	$1000 Copay/**Day** (after deductible)	$1000 Copay/**Day** (after deductible)	$1000 Copay/**Day** (after deductible)
• Routine C-Section Delivery	$1000 Copay/**Day** (after deductible)	$1000 Copay/**Day** (after deductible)	$1000 Copay/**Day** (after deductible)
• All Other Maternity Services	100% Covered	100% Covered	100% Covered
Home Health Care $500 Maximun per Benefit Year	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Skilled Nursing Care $5,000 Maximun per Benefit Year	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Hospice Services $5,000 Maximun per Benefit Year	$0 Copay (after deductible)	$0 Copay (after deductible)	$0 Copay (after deductible)
Therapy -10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certification Required) • Chiropractic • PT / OT / ST • Cardiac	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Durable Medical Equipment $500 Maximun per Benefit Year. Copay is applied per item received	$50 Copay/Item (after deductible)	$50 Copay/Item (after deductible)	$50 Copay/Item (after deductible)
Infusion / Injection Drugs See Specialty Medications	Not Covered	Not Covered	Not Covered
Chemotherapy / Radiation $50,000 Maximum benefit	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)

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Other Covered Services - Illness or Injury (Continued)			
Diabetic Services • Diabetic Nutritional Counseling - 1 Visit per Plan Year. • Diabetic Supplies / Equipment	$0 Copay (after deductible) Call the Care Team for more details	$0 Copay (after deductible) Call the Care Team for more details	$0 Copay (after deductible) Call the Care Team for more details
Prosthetics ($2,500 Maximum per Benefit Year. Copayment is applied per item received.)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Dialysis	Not Covered	Not Covered	Not Covered
Organ Transplant Services	Not Covered	Not Covered	Not Covered
Child Dentistry and Eye Care • Child Eye Exam • Child Glasses / Contacts • Child Dental Check-Up	Not Covered	Not Covered	Not Covered

TELEMEDICINE PLATFORM Highlights

- Virtual Primary Care $0 copay
- Virtual Urgent Care $0 copay
- Virtual Mental Health $0 copay

Prescription Drugs			
Prescription Drugs (If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at Symphony Rx			
• Generic Drugs	$0 Copay	$0 Copay	$0 Copay
• Non-Preferred Brand Name Drugs*	*PAP Available	*PAP Available	*PAP Available
• Specialty Drugs*	*PAP Available	*PAP Available	*PAP Available

***Specialty Medications**

Specialty Medications are not covered by your plan, however, medications may be separately available through Patient Assistance Program **(PAP)**. Health Direct will assist members with these applications.

Company: Symphony RX

- (833)870-2945

NO Rx Copayments:

- Retail Pharmacy Acute Meds **No Copay**
- Mail Order Chronic Meds (90 Day Supply) **No Copay**

Formulary Drug List:

- Covered medications

Symphony RX has **over 1,000 Generic Drugs available at no cost**. Please see formulary for more details.

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Coverage: 01/01/2026-12/31/2026

PREMIUMS EFFECTIVE AS OF JANUARY 1, 2026

PLAN	$1M/$5M - 250	$1M/$5M - 500	$1M/$5M - 750
AGES 18-29			
Employee	$429.00	$409.00	$389.00
Employee + Spouse	$764.00	$744.00	$724.00
Employee + Child(ren)	$744.00	$724.00	$704.00
Family	$1099.00	$1059.00	$1049.00
AGES 30-44			
Employee	$479.00	$449.00	$429.00
Employee + Spouse	$824.00	$784.00	$764.00
Employee + Child(ren)	$794.00	$764.00	$734.00
Family	$1159.00	$1129.00	$1089.00
AGES 45-54			
Employee	$529.00	$509.00	$489.00
Employee + Spouse	$844.00	$824.00	$804.00
Employee + Child(ren)	$824.00	$794.00	$774.00
Family	$1179.00	$1149.00	$1139.00
AGES 55-64			
Employee	$629.00	$609.00	$589.00
Employee + Spouse	$919.00	$899.00	$879.00
Employee + Child(ren)	$899.00	$869.00	$849.00
Family	$1249.00	$1229.00	$1209.00