INDIVIDUAL SAVER PLANS - TENNESSEE

In-Network Benefits	Saver $1,500	Saver $2,000	Saver $2,500	Saver $3,500	Saver $5,000
Benefit year deductible must be satisfied before coinsurance applies.					
Coinsurance	100%				
Deductible (combined family deductible equal to 2x the single)	$1,500	$2,000	$2,500	$3,500	$5,000
Annual Out of Pocket Maximum (per contract year; combined family out-of-pocket maximum is equal to 2x the single)	$1,500	$2,000	$2,500	$3,500	$5,000
Maximum Lifetime Benefit (per member)	Unlimited				
Preventive Services Includes Mammogram, Pap Smears, PSA Testing, Colorectal Cancer Screening, Routine Child Well-Care Exams	Covered in full.				
Routine Lab and X-ray	Covered in full.				
Primary Care and Specialist Visit	100% after deductible				
Urgent Care Facility Services	100% after deductible				
Emergency Room Services (waived if admitted to the hospital)	100% after deductible				
Inpatient Hospital Care/Outpatient Hospital Services and Professional Services, Home Health Care, Hospice Care, Ambulance Services, Outpatient Facility Services and Diagnostic Imaging	100% after deductible				
Short Term Rehabilitative Therapy, Durable Medical Equipment and Skilled Nursing Facility Services	100% after deductible				
Chiropractic Services	100% after deductible				
Mental Health and Substance Abuse (Optional Benefit) Outpatient limited to 25 visits / Inpatient limited to 20 days per contract year	100% after deductible				
Prescription Drug Coverage	*Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.*				
Prescription Deductible	100% after deductible				
Tier 1: Preferred Generic (not subject to brand name deductible)	100% after deductible				
Tier 2: Formulary Brand	100% after deductible				
Tier 3: Non-Formulary	100% after deductible				
Out-of-Network Benefits	**Saver $1,500**	**Saver $2,000**	**Saver $2,500**	**Saver $3,500**	**Saver $5,000**
Coinsurance	80/20				
Deductible (per member, maximum three per family)	$3,000	$4,000	$5,000	$7,000	$10,000
Annual Out of Pocket Maximum	$5,000	$6,000	$7,000	$9,000	$12,000
Physician Office Services, Urgent Care Facility Services and Emergency Room Services	Office Visit, Urgent Care, ER Visit is 80% after Deductible.				
Inpatient and Outpatient Hospital Services	Subject to deductible and coinsurance				

This summary is only a partial description of coverage and does not detail all benefits, limitations and exclusions. The complete terms of coverage are contained in the official coverage documents which are the Individual Membership Agreement, the Schedule of Benefits and any applicable riders, amendments, supplemental benefits or endorsements. In the event of any differences between this brochure and the official coverage documents, the coverage documents will control. All plans are subject to a 12 month period for pre-existing conditions except when a condition is disclosed at the time of medical underwriting and the policy is approved. Please note that routine maternity, infertility, custodial care, dental service and sexual dysfunction are items excluded from this product.