

**Available HSA-Qualified Plan Options for Individuals - Nevada  
For use with Summary of Benefits**

Plan Description *	Summary of Benefits Form #	In-network deductible	In-network coinsurance	In-network out-of-pocket maximum	Out-of-network deductible	Out-of-network coinsurance	Out-of-Network out-of-pocket maximum	Prescription Copayment
1500D/1500 - 100%	98844_1500D_1500_100_Y1_Y2	\$1,500	100%	\$1,500/\$3,000	\$3,000/\$6,000	70%	\$4,000/\$8,000	100%
2000D/2000 - 100%	98844_2000D_2000_100_Y3_Y4	\$2,000	100%	\$2,000/\$4,000	\$4,000/\$8,000	70%	\$6,000/\$12,000	100%
3000D/3000 - 100%	98844_3000D_3000_100_Y5_Y6	\$3,000	100%	\$3,000/\$6,000	\$6,000/\$12,000	70%	\$10,000/\$20,000	100%
4000D/4000 - 100%	98844_4000D_4000_100_Y7_Y8	\$4,000	100%	\$4,000/\$8,000	\$8,000/\$16,000	70%	\$12,000/\$24,000	100%
5000D/5000 - 100%	98844_5000D_5000_100_Z1_Z2	\$5,000	100%	\$5,000/\$10,000	\$10,000/\$20,000	70%	\$15,000/\$30,000	100%
1500D/5000 - 70%	98844_1500D_5000_70_Z3_Z4	\$1,500	70%	\$5,000/\$10,000	\$3,000/\$6,000	50%	\$10,000/\$20,000	70%
2000D/5000 - 70%	98844_2000D_5000_70_Z5_Z6	\$2,000	70%	\$5,000/\$10,000	\$4,000/\$8,000	50%	\$10,000/\$20,000	70%
3000D/5000 - 70%	98844_3000D_5000_70_Z7_Z8	\$3,000	70%	\$5,000/\$10,000	\$6,000/\$12,000	50%	\$10,000/\$20,000	70%

\* **Plan name structure:** Calendar year, self-only, in-network deductible (i.e., 1250D)---calendar year, self-only, in-network out-of-pocket maximum (i.e., 1250)---coinsurance (i.e., 100%). Family deductibles and out-of-pocket maximums are different from self-only deductibles and out-of-pocket maximums, even though the plan names are the same for both self-only and family coverage.



**HSA-Qualified Plan for Individuals - Nevada  
Prescription Drugs  
Summary of Benefits Schedule**

This summary provides you with the deductible, coinsurance, and a brief description of your benefits. For more complete information, see your certificate or call Anthem's customer service toll free at 800-992-6907.

**DEDUCTIBLE** applicable only to specified services (Per calendar year, aggregate deductible for family)

	<b>Preferred Providers:</b>		<b>Non-Preferred Providers:</b>	
	Individual:	Family:	Individual:	Family:
1500D/1500 – 100%	\$1,500	\$3,000	\$3,000	\$6,000
2000D/2000 – 100%	\$2,000	\$4,000	\$4,000	\$8,000
3000D/3000 – 100%	\$3,000	\$6,000	\$6,000	\$12,000
4000D/4000 – 100%	\$4,000	\$8,000	\$8,000	\$16,000
5000D/5000 – 100%	\$5,000	\$10,000	\$10,000	\$20,000
1500D/5000 – 70%	\$1,500	\$3,000	\$3,000	\$6,000
2000D/5000 – 70%	\$2,000	\$4,000	\$4,000	\$8,000
3000D/5000 – 70%	\$3,000	\$6,000	\$6,000	\$12,000

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Ambulance Services</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Benefits are paid for medically necessary ground or air ambulance transportation.  Ground Services are limited to a maximum benefit of \$700 per trip.  Air Services are limited to a maximum benefit of \$5,000 per trip.
<b>Alcohol and Drug Abuse</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are paid for medically necessary treatment for detoxification up to \$1,500; inpatient or outpatient rehabilitation \$9,000; and counseling \$2,500 per member per calendar year.

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Chemotherapy, Hemodialysis, and Radiation Therapy</b> Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	
<b>Diagnostic Services, Laboratory, Pathology, and X-ray</b> Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Services billed by a hospital are included in the hospital inpatient/outpatient benefits.
<b>Emergency Care</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Home Health Care</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are limited to 60 visits per calendar year.
<b>Hospice Care</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefit period of three months, up to maximum of two additional benefit periods, subject to a \$5,000 payment limit per benefit period, payable at \$55 per day.
<b>Hospital Care</b> Inpatient/Outpatient Surgery & Outpatient Nonemergency 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Maternity Care</b> Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are paid for complications of pregnancy only. Routine maternity care is not covered.
<b>Severe Mental Illness</b> Severe mental illness conditions are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are paid up to 40 inpatient days, 80 partial days (combined).  Outpatient services are paid up to 40 visits per calendar year.
<b>Physical Rehabilitation (physical, occupational, and speech therapy)</b> Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Inpatient benefits are paid up to 45 days per year.  Outpatient benefits are paid up to 12 visits for physical therapy, 12 visits for occupational therapy and 12 visits for speech therapy per calendar year.

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Physician Visits</b> Inpatient/Outpatient and Outpatient - urgent 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<p><b>Preventive Care</b></p> <p>A. Children</p> <ul style="list-style-type: none"> <li>- routine child exam through age 12</li> <li>- immunizations through age 12</li> </ul> <p>1500D/1500 – 100%</p> <p>2000D/2000 – 100%</p> <p>3000D/3000 – 100%</p> <p>4000D/4000 – 100%</p> <p>5000D/5000 – 100%</p> <p>1500D/5000 – 70%</p> <p>2000D/5000 – 70%</p> <p>3000D/5000 – 70%</p> <p>B. Adults</p> <ul style="list-style-type: none"> <li>- routine exams and immunizations</li> <li>- routine pap smear</li> <li>- routine mammography</li> <li>- routine prostate screening</li> </ul> <p>1500D/1500 – 100%</p> <p>2000D/2000 – 100%</p> <p>3000D/3000 – 100%</p> <p>4000D/4000 – 100%</p> <p>5000D/5000 – 100%</p> <p>1500D/5000 – 70%</p> <p>2000D/5000 – 70%</p> <p>3000D/5000 – 70%</p>	<p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Not subject to deductible</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 100% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Except for routine mammography and prostate screening which are not subject to deductible and coinsurance.</p>	<p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 70% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Plan pays 50% coinsurance</p> <p>Except for routine mammography and prostate screening which are not subject to deductible and coinsurance.</p>	<p>Maximum annual benefit of \$500, this maximum payment is combined from In-Network and Out-of-network providers. Mammogram screening and prostate screening are not subject to the maximum payment, but do reduce the maximum payment of \$500. Annual pap smears for women 18 years or older. One screening mammogram for women between 35 and 40; and annual mammogram for women over 40 years of age. One yearly prostate screening for men 50 years of age and older, and in high-risk men 40 years of age and older.</p>

Services	What You Pay After Your Deductible For Preferred Providers	What You Pay After Your Deductible For Non-Preferred Providers	Additional Information
<b>Spinal Manipulations and Acupuncture</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are limited to a maximum of 12 visits per calendar year per member combined with acupuncture care.
<b>Supplies, Equipment, and Appliances (DME)</b> Inpatient/Outpatient 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	
<b>Temporal Mandibular Joint Syndrome (TMJ)</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	Benefits are paid up to a \$4,000 lifetime maximum.

<b>OUTPATIENT PRESCRIPTION DRUGS:</b> 1500D/1500 – 100% 2000D/2000 – 100% 3000D/3000 – 100% 4000D/4000 – 100% 5000D/5000 – 100% 1500D/5000 – 70% 2000D/5000 – 70% 3000D/5000 – 70%	Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 100% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance	Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 70% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance Plan pays 50% coinsurance	For more complete information, see the Prescription Drug amendment to your certificate. The member can fill prescriptions through a participating pharmacy or non-participating pharmacy. Prescriptions can also be ordered through the participating mail order service.
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<b>DENTAL INJURY:</b>	For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement, and the services are received within six months of the injury.	
<b>DEPENDENT ELIGIBILITY:</b>	The end of the month in which the employee's unmarried dependent child becomes age 19, or 24 if financially dependent upon the subscriber.	
<b>PRECERTIFICATION</b>	<b>Inpatient Services:</b> Hospital (medical and surgical care) and Hospice Care services are subject to precertification.	<b>Outpatient Services:</b> Outpatient surgeries in a Hospital are subject to precertification.

<b>MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT:</b> The maximum amount you will have to pay for covered expenses under this plan.				
	<b>Preferred Providers:</b>		<b>Non-Preferred Providers:</b>	
	Individual:	Family:	Individual:	Family:
1500D/1500 – 100%	\$1,500	\$3,000	\$4,000	\$8,000
2000D/2000 – 100%	\$2,000	\$4,000	\$6,000	\$12,000
3000D/3000 – 100%	\$3,000	\$6,000	\$10,000	\$20,000
4000D/4000 – 100%	\$4,000	\$8,000	\$12,000	\$24,000
5000D/5000 – 100%	\$5,000	\$10,000	\$15,000	\$30,000
1500D/5000 – 70%	\$5,000	\$10,000	\$10,000	\$20,000
2000D/5000 – 70%	\$5,000	\$10,000	\$10,000	\$20,000
3000D/5000 – 70%	\$5,000	\$10,000	\$10,000	\$20,000
	Includes deductible and coinsurance.	Includes deductible and coinsurance.	Includes deductible and coinsurance.	Includes deductible and coinsurance.
<b>LIFETIME MAXIMUM BENEFITS:</b> \$2,000,000 per member				

Reimbursement for covered services is based upon Allowable Charge as determined by Anthem Blue Cross and Blue Shield. Allowable Charge means the Contracted Amount for Preferred Providers or the Maximum Benefit Allowance for Non-Preferred Providers. Our determination of Allowable Charge is the maximum amount we approve for any particular service. Deductible, coinsurance, or other cost sharing amounts are based on this allowance and are the amounts you pay the provider.

**\*Emergency** – means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in: Serious jeopardy to the health of an insured; or, serious jeopardy to the health of an unborn child; or, serious impairment to bodily functions; or, serious and permanent dysfunction of any bodily organ or part.

**Medically Necessary** – benefits are payable only for covered services and supplies that are medically necessary which meet the following definition:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition, and
2. Provided for the diagnosis or direct care and treatment of the medical condition, and
3. Within standards of good medical practice within the organized medical community, and
4. Not primarily for the convenience of the Member, the Member's physician or another provider, and
5. The most appropriate supply or level of services which can safely be provided. For hospital stays this means acute care as an inpatient as necessary due to the kind of services you are receiving or the severity of your condition, and that safe and adequate care cannot be received as an outpatient or in a less acute medical setting. Claims for services that are not Medically Necessary may be denied either before or after payment of such services.