Grand Valley Preferred Network
Community HOSPITAL

GRAND VALLEY PREFERRED $0 PLAN

	GRAND VALLEY PREFERRED NETWORK	MULTIPLAN NETWORK	OUT OF NETWORK
CONDITIONS AND LIMITATIONS			
Lifetime Maximum Plan Payments		None	
Pre-Exisiting Conditions		None	
Benefit Accrual Period		Calendar Year	
MEDICAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Deductible - Per Person/Family (per year)	$0/$0		$10,000/$20,000
Total Out-of-Pocket Maximum - Per Person/Family (per year)	$2,500/$5,000		$20,000/$40,000
INPATIENT SERVICES	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Inpatient Hosptial, Surgical or Medical	$750 Copay	20%	40% After Deductible
Maternity Physician Services	$750 Copay	20%	40% After Deductible
Skilled Nursing / Rehab Facility - 60 day/year limit	10%	20%	40% After Deductible
Hospice Facility	10%	20%	40% After Deductible
Mental Health or Substance Abuse	$750 Copay	20%	40% After Deductible
OUT PATIENT SERVICES	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Primary Care Office Visit	$25 Copay	$75 Copay	40% After Deductible
Specialist Office Visit	$75 Copay	$95 Copay	40% After Deductible
After Hours Urgent Care Visit	$75 Copay	$100 Copay	40% After Deductible
Mental Health or Substance Abuse Office Visit	$25 Copay	$75 Copay	40% After Deductible
Rehabilitation or Habilitation Services - Limited to 40 visits	$75 Copay	20%	40% After Deductible
Outpatient Surgical Services	$300 Copay	20%	40% After Deductible
Minor Diagnostic Tests	Covered 100%	20%	40% After Deductible
Major Diagnostic Services	$175 Copay	20%	40% After Deductible
Allergy Treatment and Serum	$75 Copay	20%	40% After Deductible
Other Medical Services Performed at an Outpatient Facility	10%	20%	40% After Deductible
PREVENTIVE SERVICES	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Primary Care Office Visit	Covered 100%	Covered 100%	40% After Deductible
Specialist Office Visit	Covered 100%	Covered 100%	40% After Deductible
Adult and Pediatric Immunizations	Covered 100%	Covered 100%	40% After Deductible
Elective Immunizations	Covered 100%	Covered 100%	40% After Deductible
Minor Diagnostic Tests	Covered 100%	Covered 100%	40% After Deductible
Other Preventive Services	Covered 100%	Covered 100%	40% After Deductible
EMERGENCY SERVICES	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Ambulance - Emergencies Only	$300 Copay	$300 Copay	$300 Copay
Emergency Room - Copay waived if admitted to hospital	$300 Copay	$300 Copay	$300 Copay
HOME HEALTH CARE SERVICES AND SUPPLIES	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Hospice Care Provided at Home	10%	20%	40% After Deductible
Home Health Care - Limited to 60 visits per year	10%	20%	40% After Deductible
Durable Medical Equipment (DME)	10%	20%	40% After Deductible
Medical Supplies	10%	20%	40% After Deductible
OTHER BENEFITS	**GRAND VALLEY PREFERRED**	**MULTIPLAN**	**OUT OF NETWORK**
Chiropractic Services - Up to 12 visits pr year	10%	20%	40% After Deductible
Injectable Drugs and Specialty Medications	10%	20%	40% After Deductible
Travel Benefit: For some services members may be eligible for a travel benefit to receive care at the University of Utah Hospital, Huntsman Cancer Institute, or Primary Children's Medical Center in Utah at the Grand Valley Preferred benefits. Preauthorization is required.			
PRESCRIPTIONS			
Prescriptions Administered by SimpleSave **Questions Call: 844-728-3479** **www.simplesaverx.com**			

All deductible, copay and coinsurance are based on the allowed amounts and not the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and faciliteis. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliance with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change.
- Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn.
- Frequency and/or quantity limitations apply to some preventive care and medical supplies
- All covered services obtained outside the United States, except for urgent or emergent conditions, will be paid at the Out-of-Network benefit.
- Preauthorization may be required for certain medical services and medications

HEALTH PLANS
UNIVERSITY OF UTAH