

Grand Valley Preferred Network

Community HOSPITAL

GRAND VALLEY PREFERRED \$500 PLAN

	GRAND VALLEY PREFERRED NETWORK	MULTIPLAN NETWORK	OUT OF NETWORK
CONDITIONS AND LIMITATIONS			
Lifetime Maximum Plan Payments		None	
Pre-Existing Conditions		None	
Benefit Accrual Period		Calendar Year	
MEDICAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM			
Deductible - Per Person/Family (per year)	\$500/\$1,000		\$10,000/\$20,000
Total Out-of-Pocket Maximum - Per Person/Family (per year)	\$3,000/\$6,000		\$20,000/\$40,000
INPATIENT SERVICES			
Inpatient Hospital, Surgical or Medical	\$500 Copay Per Day (2 Day Max Per Admission)	20% After Deductible	40% After Deductible
Maternity Physician Services	\$500 Copay Per Day (2 Day Max Per Admission)	20% After Deductible	40% After Deductible
Skilled Nursing / Rehab Facility - 60 day/year limit	10% After Deductible	20% After Deductible	40% After Deductible
Hospice Facility	10% After Deductible	20% After Deductible	40% After Deductible
Mental Health or Substance Abuse	\$500 Copay Per Day (2 Day Max Per Admission)	20% After Deductible	40% After Deductible
OUT PATIENT SERVICES			
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% After Deductible	40% After Deductible
Outpatient Surgical Services	\$500 Copay	20% After Deductible	40% After Deductible
Minor Diagnostic Tests	Covered 100%	20% After Deductible	40% After Deductible
Major Diagnostic Services	\$200 Copay	20% After Deductible	40% After Deductible
Allergy Treatment and Serum	\$75 Copay	20% After Deductible	40% After Deductible
Other Medical Services Performed at an Outpatient Facility	10% After Deductible	20% After Deductible	40% After Deductible
PREVENTIVE SERVICES			
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			
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			
Hospice Care Provided at Home	10% After Deductible	20% After Deductible	40% After Deductible
Home Health Care - Limited to 60 visits per year	10% After Deductible	20% After Deductible	40% After Deductible
Durable Medical Equipment (DME)	10% After Deductible	20% After Deductible	40% After Deductible
Medical Supplies	10% After Deductible	20% After Deductible	40% After Deductible
OTHER BENEFITS			
Chiropractic Services - Up to 12 visits pr year	10% After Deductible	20% After Deductible	40% After Deductible
Injectable Drugs and Specialty Medications	10% After Deductible	20% After Deductible	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 facilities. 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

