



## **Medical Benefits**

Sprout Jumpstart



A product of Trillium Community Health Plan®



# Contents

## **Definitions 1**

### **No Lifetime Maximum Benefit 8**

Questions Regarding Benefits and Coverage 8

### **Medical Deductible and Maximum Out-of-Pocket Expenses 8**

Medical Deductible 8

Your Maximum Out-of-Pocket Expenses 8

Summary of Maximum Out-of-Pocket Expenses 9

Medical Maximum Out-of-Pocket 9

Dental Maximum Out-of-Pocket 9

Prescription Drug Maximum Out-of-Pocket 9

### **Schedule of Benefits 10**

Alternative Services (Acupuncture, Chiropractic, and Naturopathic Care) 10

Ambulance Services 10

Biofeedback Therapy 10

Chemotherapy 11

Dental Benefits 11

Preventive 11

Maxillofacial Prosthetic Services 12

Restorative, Oral Surgery, and Endodontics 12

Periodontics 12

Prosthodontics (removable) 12

Orthodontics 13

Disease Management Program 13

Durable Medical Equipment, Supplies, and Appliances 13

Emergency Room Services 14

Emergency Copayments 14

Home or Office Visits 14

Home Health Care 15

Home Infusion Therapy 15

Hospice Care Benefits 17

Definitions 17

Palliative Hospice Care 17

Palliative Hospice Care Preauthorization 18

Hospital Care 19

Number of Inpatient Hospital Days Covered 20

Pre-Admission Testing 20

Hospital Inpatient Care 20

Hospital Outpatient Care 20

Imaging and Invasive Diagnostic Services 21

Inpatient Rehabilitation Hospital Care 21

Mastectomy Services 21

**Premium, copayments, coinsurance, and out-of-pocket expenses are waived for members who are American Indian/Alaska Natives.**

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**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

Maternity Care	22
Mental Health and Chemical Dependency Care	22
Definitions	23
Preauthorization	23
Newborn Nursery Care	24
Outpatient Diabetic Instruction	24
Outpatient Rehabilitation	24
Prescription Medication Benefit	25
Copayments for All Plans	25
Preventive Care Services	25
Adult Routine Physical Examinations	25
Colorectal Screenings	26
Men's Preventive Services	26
PKU Testing	26
Well-Baby Care	27
Well-Child Care	27
Immunizations	27
Women's Preventive Services	27
Professional Provider Visits in the Hospital	28
Skilled Nursing Facility Care	28
Smoking Cessation	29
Special Dental Care	29
Special Facility Care	29
Speech-Language Pathology, Audiology, and Hearing Aid Services	30
Temporomandibular Joint Services	30
Therapeutic Injections	30
Transplants	31
Vision Benefits	31
X-Rays and Laboratory Tests	32
<b>Benefit Limitations</b>	<b>33</b>
Breast Reconstruction	33
Growth Hormones	33
Home Health Care	33
Outpatient Prescription Limitations	34
Transplants	35
Definitions for the Transplant Benefit	35
Facility Benefits	37
Professional Provider Benefits	37
Donor Cost Benefits	37
Anti-Rejection Medication Benefits	37
Transplant Preauthorization Requirement	37

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

Transplant Preauthorization Procedure	38
<b>Benefit Exclusions</b>	<b>38</b>
Cosmetic/Reconstructive Surgery	38
Experimental or Investigational Services	38
General Exclusions	40
<b>Hospice Care Exclusions and Limitations</b>	<b>43</b>
<b>Mental Health and Chemical Dependency Exclusions</b>	<b>44</b>
Counseling or Treatment in the Absence of Illness	44
Developmental and Learning Disabilities	45
Mental Health Services for Certain Conditions	45
Sexual Dysfunction	45
Sexual Reassignment	45
<b>Outpatient Prescription Exclusions</b>	<b>46</b>
<b>Enrollee Grievance and Appeals Process</b>	<b>47</b>
Appeal Process	48
External Review	49
Expedited Appeal or Expedited Review	50
Appeal and Review Timelines	50
Appeals Forms (not required to file an appeal)	50
Other Appeals Resources	51
<b>Member Rights and Responsibilities</b>	<b>51</b>
Member Rights; Your Rights as a Member	51
Member Responsibilities; Your Responsibilities as a Member	52

**Premium, copayments, coinsurance, and out-of-pocket expenses are waived for members who are American Indian/Alaska Natives.**

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**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

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# Definitions

**Brand-name medication** means prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand-name medication based on manufacturer and price.

**Claim** means a request for payment under the terms of this plan.

**Coinsurance** means the amount of charges that you must pay on a claim, i.e., the portion of the claim that you pay after we pay the maximum amount for that benefit.

**Compound medication** means two or more medications that a pharmacist mixes together. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend medication or one state restricted medication. Copayment amounts are assessed on each covered prescription medication claim.

**Contracting agency** means any of the following with whom we have contracted to provide services and supplies under this contract: home health care agency, home infusion therapy agency, or hospice care plan.

**Contracting durable medical equipment supplier** means a supplier of durable medical equipment that has contracted to provide services and supplies to you under this plan.

**Copayment** means a fixed amount that you pay for covered medical services.

**Cosmetic** means services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem.

**Covered expenses** means the amounts that this plan pays for covered services.

**Durable medical equipment** means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness and/or injury and is appropriate for use in your home. Examples include oxygen equipment and wheelchairs.

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TTY: 1-866-279-9750

**Eligibility** means the requirements that you must meet in order to qualify for and remain in Trillium Sprout Healthy KidsConnect. See **When Coverage Begins** and **When Coverage Ends** sections.

**Emergency medical condition or medical emergency** means a medical condition with symptoms of sufficient severity for which a sensible person, who possesses an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would place your health, or the health of your fetus in the case of a pregnant woman, in serious jeopardy.

**Emergency medical screening exam** means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

**Emergency services** means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required to stabilize your condition.

**Exclusions** means specified conditions or circumstances, listed in this plan, for which we pay no benefits. Exclusions may apply to services that are medically necessary.

**Generic medication** means a prescription medication that is an equivalent medication to the brand-name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic has the same effectiveness as the brand-name medication.

**Home health care** means services and supplies that a licensed home health agency provides to a homebound patient.

**Hospice** means a program designed to provide comfort and supportive services to terminally ill patients and their families.

**Hospital** means a facility that provides diagnostic and treatment services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing services by registered nurses. Facilities that are primarily for rest, the aged or convalescence homes are not considered hospitals and neither are facilities operated by the state or federal government.

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**Illness** means a physical illness or mental illness. Physical illness is a disease or bodily disorder. Mental illness is an Axis 1 diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specifically excluded in the **General Exclusions** subsection in the **Benefit Exclusions** section.

**Injury** means a personal bodily injury to you caused directly and independently of all other causes by external, violent, and accidental means.

**In-network** means only the covered services that you receive from participating providers.

**Managed care** means Trillium Sprout Healthy KidsConnect.

**Maximum out-of-pocket** means the maximum amount you will incur in a calendar year before the plan begins paying at 100% for eligible medical expenses.

**Medical emergency** means a sudden and unexpected illness or injury, which requires immediate attention.

**Medically necessary** or **medical necessity** means health care services or supplies that a health care provider, exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing, or treating an illness, or injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury, or disease;
- Not primarily for the convenience of you, your physician, or other health care provider; and
- Not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, or disease.

For these purposes, **generally accepted standards of medical practice** means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of health care providers practicing in relevant clinical areas, and any other relevant factors.

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**Obesity** means a condition in which a person has a body mass index of at least 30.0 kg/m<sup>2</sup> but less than 40.0 kg/m<sup>2</sup>.

**Out-of-network** means covered services that you receive from providers that have no contract with us to serve Trillium Sprout Healthy KidsConnect.

**Participating pharmacy** means a pharmacy that has a contract with us to submit claims electronically and discount all prescription medications.

**Participating provider** means a provider that has a contract with us to serve the Program.

**Pharmacist** means an individual licensed to dispense prescription medication and counsel a patient about how the medication works and its possible adverse effects.

**Pharmacy** means any licensed outlet in which prescription medications are regularly compounded and dispensed.

**Plan** means our **Trillium Sprout Healthy KidsConnect Medical Benefits Plan, Dental Benefits Plan, Vision Benefits Plan,** and administrative procedures (such as procedures for claims submission, grievances, appeals, external review, coordination of benefits, and third-party liability), all as described in our member handbook.

**Preauthorization** means a determination by us prior to provision of services that we will provide reimbursement for the services.

**Prescription medication** means medications and biologicals that relate directly to the treatment of an illness or injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: Caution – federal law prohibits dispensing without prescription. For purposes of the outpatient prescription medication benefit, prescription medications also include covered insulin and diabetic supplies, self-injectable medications, and compound medications. We require a prescription order for insulin and diabetic supplies.

**Prescription order** means a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

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Local: 541-431-1990

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TTY: 1-866-279-9750

**Professional provider** means any of the following, for medically necessary services, which are within the scope of the professional provider's state license or registry:

- A physician (doctor of medicine or osteopathy);
- Podiatrist;
- Dentist (doctor of medical dentistry, doctor of dental surgery, or denturist);
- Pharmacist;
- Psychologist;
- Oregon-registered clinical social worker;
- Certified nurse practitioner;
- Registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;
- Physician assistant; or
- Registered physical, occupational, speech, or audiological therapist.

The term **professional provider** does not include any other class of provider not named previously, and no medical benefit of the plan will be paid for their services. For certain providers, coverage may exist under the **Dental Benefits** or **Vision Benefits** of the plan.

**Provider** or **health care provider** means a professional provider, or a facility, agency, supplier or program that provides health care services or supplies.

**Reconstructive** means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

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**Residential/partial hospitalization/day care** means care in a residential facility, hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the State of Oregon Addictions and Mental Health Division (or the equivalent agencies, if the services are provided outside Oregon).

**Self-injectable medications** mean outpatient injectable prescription medications intended for self-administration and approved by us for self-injection.

**Services** means health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a service.

**Service area** means statewide area or an area defined by region.

**Skilled nursing facility** means a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a day nursing services supervised by registered nurses.

**Spell of illness** means the duration of a particular illness that lasts for a period of consecutive days beginning with the first day not part of a previous illness on which you are admitted to a hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a hospital inpatient nor been confined in any other type of facility.

**Supplies** mean consumable goods to support health care services.

**Transplant** means a procedure or a series of procedures by which an organ or tissue is either removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient), or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term transplant includes any chemotherapy and related course of treatment, which the transplant supports.

**Trillium Sprout Healthy KidsConnect** means the Trillium Sprout Healthy KidsConnect of Trillium Community Health Plan, UO Riverfront Research Park, 1800 Millrace Drive, Eugene, OR 97403. Local 541-431-1990, Toll Free 1-877-401-KIDZ, TTY 1-866-279-9750.

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**Usual and customary or reasonable charge** means:

- Usual — not more than the provider’s, dispenser’s or vendor’s usual charge for a given service or supply; and
- Customary — an amount which falls within the range of usual charges for the service or supply billed by most professional providers, dispensers or vendors of the same or similar service or supply in the service area; or
- Reasonable — an amount, determined by us, according to our proprietary database on health care billings; or use of pharmacy or Medicare data, which is usual (not more than the provider’s normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in the service area).

**We, us, or our** refers to your Trillium Community Health Plan insurance company.

**When coverage begins** means:

- The first of the month after we have received your completed enrollment materials from Trillium Sprout Healthy KidsConnect.
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of Trillium Sprout Healthy KidsConnect.

**When coverage ends** is when you have:

- Become age 19 (except as provided under portability).
- Become eligible or entitled to Medicare.
- Become eligible for Medicaid/Oregon Health Plan (OHP).
- Not paid your premiums.
- Moved out of state.
- Moved out of our service area.
- Otherwise failed to satisfy the eligibility requirements of Trillium Sprout Healthy KidsConnect.

**You or your** means the person enrolled in Trillium Sprout Healthy KidsConnect.

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## No Lifetime Maximum Benefit

This plan has no maximum lifetime medical benefit.

## Questions Regarding Benefits and Coverage

This plan contains information about the benefits specific to the Trillium Sprout Healthy KidsConnect plan. Please be sure to read carefully for the terms, conditions, provisions, limitations, and exclusions of this plan.

## Medical Deductible and Maximum Out-of-Pocket Expenses

### Medical Deductible

This plan does not have an annual calendar year medical deductible.

### Your Maximum Out-of-Pocket Expenses

This plan has a maximum out-of-pocket expense of **\$900** for families with 1 child, or **\$1,800** for families with 2 or more children, each calendar year. The maximum out-of-pocket expense is the maximum set amount that you will incur in a calendar year, beginning in January, before we begin paying a 100% for in-network covered medical expenses.

There is **no** maximum out-of-pocket for your out-of-network services. Out-of-network expenses do not count towards your maximum out-of-pocket total. See **Summary of Maximum Out-of-Pocket Expenses**.

You are responsible for the coinsurance or copayment amount for each covered medical service listed in the following **Schedule of Benefits** until your medical out-of-pocket covered expenses reach your maximum out-of-pocket expense amount. The maximum out-of-pocket medical amount accumulates based on your own covered expenses.

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## **Summary of Maximum Out-of-Pocket Expenses**

### **Medical Maximum Out-of-Pocket**

- \$900 for families with 1 child
- \$1,800 for families with 2 or more children

The maximum out-of-pocket expense only applies when you use in-network providers.

### **Dental Maximum Out-of-Pocket**

- \$200 for families with 1 child
- \$400 for families with 2 or more children

The maximum out-of-pocket expense only applies when you use in-network providers.

### **Prescription Drug Maximum Out-of-Pocket**

- \$100 for families with 1 child
- \$200 for families with 2 or more children

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## Schedule of Benefits

To receive benefits, you must be enrolled with us. Listed below are your medical benefits, exclusions that apply to specific benefits, coinsurance and copayment amounts, and out-of-pocket expenses:

### Alternative Services (Acupuncture, Chiropractic, and Naturopathic Care)

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for services within the scope of the provider's license. Eligible providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists.

Coinsurance amounts you are responsible for do apply toward the annual out-of-pocket maximum amount.

**Exclusions:** Nutritional supplements are not covered. Diagnoses, which are considered plan exclusions such as obesity, smoking cessation, are ineligible for coverage.

In-network—\$10/Out-of-network—not covered

### Ambulance Services

We cover medically necessary ambulance services, including local ground transportation by a state-certified ambulance for transportation to the nearest hospital that has the facilities to give the necessary services. Certified air ambulance transportation will be covered if it is medically necessary.

In-network—\$100/Out-of-network—\$100

### Biofeedback Therapy

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches.

In-network—\$10/Out-of-network—not covered

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## Chemotherapy

Covered expenses include radium, radio isotopic, and X-ray therapy; treatment planning and simulation; professional services for administration and supervision; and treatments including the therapist, facility, and equipment charges.

In-network—\$10/Out-of-network—not covered

## Dental Benefits

**Capitol Dental Care, Inc. is your dental plan. Their toll free number is 1-800-525-6800, ext. 310 or ext. 315.** You can contact them to find out the names and phone numbers of dentists open to new patients in our area. They can also answer any questions you might have about Trillium Sprout Healthy KidsConnect dental coverage.

Services are covered only when obtained from in-network providers, except in emergencies or when the participating plan provides an out-of-network preauthorization. In these circumstances, normal copay or coinsurance would apply.

- Calendar year maximum benefit—\$1,750
- Calendar year dental deductible—None
- Dental maximum out-of-pocket for families with 1 child—\$200\*
- Dental maximum out-of-pocket for families with 2 or more children—\$400\*

\*This is the maximum amount you will pay for covered dental benefits per family each calendar year, before your plan will begin paying 100% for covered services.

## Preventive

- Examinations—\$0
- X-rays—\$0
- Cleanings—\$0
- Fluoride treatment—\$0
- Sealants—\$0

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## Maxillofacial Prosthetic Services

We will cover services considered necessary for adjunctive treatment for restoration and management of head and facial structures and that cannot be replaced with living tissue and that are defective because of disease, trauma or birth, and developmental deformities when such restoration and management are performed for the purpose of:

- Controlling or eliminating infection;
- Controlling or eliminating pain; or
- Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

In-network—\$10/Out-of-network—not covered

## Restorative, Oral Surgery, and Endodontics

- Amalgams—\$10
- Composite resin restorations—\$10
- Extractions—\$10
- Root canal therapy—\$10
- Surgical extractions—\$10
- Crowns \$30 per crown

## Periodontics

- Space and periodontal maintenance—\$10
- Stabiliation of periodontal health—\$10

## Prosthodontics (removable)

- Complete and partial dentures—\$30
- Repairs to complete and partial dentures—\$15
- Denture rebase and reline procedures—\$15

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## Orthodontics

- Covered for patients who have a diagnosis of cleft palate with cleft lip—\$30

## Disease Management Program

If you have been diagnosed with select chronic disease condition(s), we can provide you with disease management programs. Those eligible for disease management are identified using a combination of methods, and referral, or you may self-enroll. The program addresses asthma, diabetes, overweight or obesity, high-risk maternity and smoking cessation.

## Durable Medical Equipment, Supplies, and Appliances

We cover the following medically necessary supplies and appliances when required by standard treatment practices for the treatment of an illness or injury:

- Blood or blood plasma
- Casts, trusses, limb or back braces, and crutches
- Colostomy
- Mastectomy supplies
- Medically necessary PKU formulas
- Nonprescription elemental enteral formula for home use when ordered by your authorized physician as long as:
  - The formula is medically necessary for the treatment of severe intestinal malabsorption; and
  - The formula comprises the sole or an essential source of your nutrition.
- Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders
- One contact lens for each eye undergoing cataract surgery
- Prosthetics, artificial limbs, artificial eyes and orthotic devices

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- Maxillofacial prosthetic devices that are medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function
- Rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other durable medical equipment unique to medical care or treatment

Covered durable medical equipment must be medically necessary and may not serve solely as a comfort or convenience item. The following items are not durable medical equipment and, therefore, are not covered: deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts; environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters, and portable whirlpool pumps.

We pay covered benefits at the usual and customary and reasonable charges.

In-network—\$10/Out-of-network—\$10

## Emergency Room Services

If you receive services for an emergency medical condition, you are responsible for the emergency room copayment. If you are admitted as an inpatient to the hospital while seeking emergency room services the copayment may be waived. Your emergency room copayment does not apply to your out-of-pocket maximum.

We will cover emergency services from an out-of-network provider if a prudent layperson possessing an average knowledge of health and medicine, would reasonably believe that the time required to go to an in-network provider would place your health; or the health of your fetus, in the case of a pregnant woman, in serious jeopardy.

## Emergency Copayments

In-network—\$100/Out-of-network—\$100

## Home or Office Visits

A visit means that a professional provider actually examined you. Covered expenses include physician consultations in addition to second opinion surgery consultations.

In-network—\$10/Out-of-network—not covered

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## Home Health Care

We cover up to 60 intermittent medically necessary home health care visits per calendar year. A visit must be for intermittent care of no more than two hours in duration. A physician must order the home health care services. Providers who deliver home health care must be registered or licensed practical nurses; physical, occupational, speech, or respiratory therapists; or licensed social workers.

This home health care benefit excludes home care services provided as part of a hospice treatment plan.

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.
- **Preauthorization.** Preauthorization is required for home health care.

Covered expenses for home health care exclude:

- More than one visit of any one kind of rehabilitation on any one day;
- Rehabilitative care provided in your home and covered under the inpatient or outpatient rehabilitation care benefit;
- Recreational or educational therapy;
- Self-help or training; or
- Treatment of psychotic or psychoneurotic conditions.

In-network—\$10/Out-of-network—not covered

## Home Infusion Therapy

We cover home infusion therapy services and supplies as described in this section that a physician orders and determines to be medically necessary, that an accredited home infusion therapy agency provides and that the therapy regimen requires.

Limited services. Home infusion therapy is limited to the following:

- Aerosolized pentamidine;
- Blood product administration;

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## 16

- Enteral nutrition (under certain circumstances);
- Hydration therapy;
- Intravenous medication therapy;
- Intravenous/subcutaneous pain management;
- SynchroMed pump management therapy;
- Terbutaline infusion therapy; or
- Total parenteral nutrition.

Covered expenses include only the following medically necessary services and supplies:

- Ancillary medical supplies;
- Collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy;
- Durable medical equipment;
- Nursing services associated with:
  - Administrative therapy;
  - Emergency care;
  - Patient and/or alternative care giver training;
  - Visits necessary to monitor intravenous therapy regimen.
- Pharmacy compounding and dispensing services; and
- Solutions, medications, and pharmaceutical additives.

Ask your physician to contact our Case Management Department for preauthorization before receiving such care.

In-network—\$10/Out-of-network—not covered

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**Trillium Community Health Plan**

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# Hospice Care Benefits

## Definitions

The following definitions apply only to this hospice care section:

- Approved hospice is a private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals.
- Homebound means that your condition is such that there exists a normal inability to leave home. If you do leave home, the absences must be infrequent, or short duration and mainly for the reason of receiving medical services.
- Home health aide is an employee of an approved hospice who provides intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist.
- Hospice treatment plan is a written plan of care established and periodically reviewed by your attending physician. The physician must certify in the plan that you are terminally ill. The plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.
- Palliative care is care primarily for the relief or control of distressing symptoms, not cure.
- Terminally ill means your condition has reached a point where recovery can no longer be expected and you are facing imminent death.

## Palliative Hospice Care

We cover palliative hospice care as described in this section when provided by a Medicare or state-certified hospice care provider. A hospice care program is a coordinated program for home and inpatient care, available 24 hours a day. It uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. The services include acute, respite, and home care to meet the physical, psychological, and special needs of a patient-family unit during the final stages of illness and dying.

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Palliative hospice care means medical services provided by a hospice care program that alleviates symptoms or affords temporary relief of pain but are not intended to affect a cure. If you elect palliative hospice care, then you are not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, your physician must certify that you are terminally ill with a life expectancy of six months or less if the illness runs its normal course.

- Palliative hospice care benefits are limited to the following levels of care:
  - Routine home care;
  - Continuous home care;
  - Inpatient respite care; and
  - Inpatient hospice care.

Additionally, covered expenses for palliative hospice care include the following when provided under any of the levels of care listed on the previous section:

- Durable medical equipment;
- Medications, including infusion therapy;
- Care by any enrollee of the hospice interdisciplinary team; and
- Any other supplies required for the palliative hospice care.

If you elect to discontinue palliative hospice care before this benefit has been exhausted, you will forfeit any remaining hospice benefit and we will not be obligated to pay for any additional palliative hospice care for you.

## **Palliative Hospice Care Preauthorization**

If an agency other than a contracting agency provides palliative hospice care, you must contact our case management department before receiving such care. If palliative hospice care is provided by a provider that has not contracted with us, we strongly urge you to ask your provider to contact our Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity.

In-network—\$10/Out-of-network—not covered

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## Hospital Care

We pay for services provided in a hospital. A physician must authorize hospitalization and it must be medically necessary for acute care and services for illness or injury. All clinical decisions regarding length of stay in a health care facility, transfer between levels of care and follow-up care are the decision of the treating physician in consultation with you and subject to medical necessity as defined by us. The benefits are explained on the following page.

Covered expenses consist of the following:

- The charge for a semiprivate room or billed charges, whichever is less, up to the hospital's most common rate for a room with two beds.
- Isolation care when medically necessary to protect other patients from contagion or to protect you from contracting the illnesses of others.
- Use of an intensive care or coronary care unit. We establish our definition of an intensive care or coronary care unit by using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, but we reserve the right to decide whether the unit in a particular hospital is qualified for coverage.
- The use of the facility for surgery performed in a hospital outpatient department.
- Other hospital services and supplies that are necessary for diagnosis and treatment, and that the hospital ordinarily furnishes. These include, but are not limited to, operating and recovery rooms, traction equipment, and special diets.
- Covered services provided in a participating hospital.
- Inpatient mental health and chemical dependency services.

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## Number of Inpatient Hospital Days Covered

We will provide benefits for unlimited days of hospital inpatient care for most conditions. Inpatient services for some conditions may be limited to a lesser number of days. If benefits under this plan change while you are in the hospital, we will determine what the covered expenses are according to the benefits in effect when the stay began. The same rule applies to stays in other kinds of medical facilities.

## Pre-Admission Testing

We cover expenses for necessary pre-admission testing.

In-network—\$10/Out-of-network—not covered

## Hospital Inpatient Care

We cover hospital inpatient care, including intensive care, coronary care, and inpatient care for mental illness or chemical dependency.

- Number of days per stay—Unlimited, semiprivate room

In-network—\$100/Out-of-network—\$100 (for emergent and authorized services)

## Hospital Outpatient Care

We pay for medically necessary hospital outpatient care, including, but not limited to:

- Outpatient surgery

In-network—\$10/Out-of-network—not covered

- Outpatient rehabilitative hospital care (maximum of 60 days per calendar year)

In-network—\$10/Out-of-network—not covered

- Emergency room

In-network—\$100/Out-of-network—\$100

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## Imaging and Invasive Diagnostic Services

We cover imaging services such as MRI and CT scans, and diagnostic procedures that require entry into the body cavity, such as angiograms and endoscopy when they are medically necessary.

- X-ray/radium therapy, chemotherapy
- Diagnostic X-ray and laboratory for accident, illness, and pre-admission testing
- Imaging and invasive diagnostic

In-network—\$10/Out-of-network—not covered

## Inpatient Rehabilitation Hospital Care

We limit covered expenses for rehabilitative care up to 60 days for each calendar year for inpatient care in a hospital that has a specialized department for providing such care and services. These benefits are available only as long as you require the full rehabilitative team approach and services on an inpatient basis. This plan covers up to 60 days each calendar year for rehabilitative services that a professional provider delivers to you when not confined in a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy, necessary to restore or improve lost function caused by illness or injury. In order for this plan to cover expenses for these types of services and therapies, it must be medically necessary and part of a written treatment plan that a licensed physician prescribes. In order to be a covered expense, inpatient rehabilitative care must be preauthorized and be part of a licensed physician's formal written program to improve and restore lost function following illness or injury, and it must be consistent with the condition that is under treatment.

In-network—\$10/Out-of-network—not covered

## Mastectomy Services

The plan covers surgery, reconstruction, prosthesis, and treatment of physical complications of all stages of mastectomy. This benefit applies while enrolled in Trillium Sprout Healthy KidsConnect regardless of whether or not you were covered by us at the time of any previous treatment.

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**Trillium Sprout Healthy KidsConnect**

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If you received benefits in connection with a mastectomy following breast cancer and, in consultation with the attending physician, choose to have breast reconstruction while enrolled in the plan, we will provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas. Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., coinsurance and maximum out-of-pocket expenses). This benefit is limited to surgery related to breast reconstruction following a mastectomy necessary because of illness or injury.

In-network—\$0/Out-of-network—not covered

## Maternity Care

Pregnancy care, childbirth, termination of pregnancy, and related conditions are covered for you. We will not limit benefits for the mother and her newborn's length of inpatient stay to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. Such discharges do not need to be preauthorized.

- Prenatal and postnatal office visit: In-network—\$10/Out-of-network—not covered
- Labor and delivery hospital stay: In-network—\$100/Out-of-network—not covered

## Mental Health and Chemical Dependency Care

We will cover mental health and chemical dependency services under the plan the same as illness. We cover mental health and chemical dependency services that are residential care (care in a licensed residential facility, hospital, or other facility which provides an organized full-day or part-day program of treatment) for up to 45 days per year.

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## Definitions

The following definitions apply to treatment of mental health conditions and chemical dependency conditions:

**Chemical dependency conditions** are substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with your social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

**Mental health conditions** are mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this plan. Mental disorders that accompany an excluded diagnosis are covered.

**Mental health and chemical dependency services** are medically necessary outpatient, residential, partial hospital, or inpatient services provided by an approved licensed facility or licensed professionals who meet our credentialing requirements. Our mental health and chemical dependency benefit does not cover skilled nursing facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health care services, or court ordered services (unless the services are determined by us to be medically necessary). Mental health and chemical dependency services do not include:

- Educational programs for drinking drivers;
- Voluntary mutual support groups, such as Alcoholics Anonymous; and
- Family education or support groups.

## Preauthorization

Mental health and chemical dependency services require preauthorization. **Please call Mental Health Match to arrange services at 541-744-0828 or toll free 1-800-457-3798.**

- Inpatient treatment: In-network—\$100 per admission/  
Out-of-network—not covered
- Outpatient treatment: In-network—\$10/Out-of-network—not covered

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## Newborn Nursery Care

We cover routine nursery care of an enrolled newborn infant while the mother is confined in the hospital and receiving maternity benefits under this plan. However, we cover professional services for well-baby care under the well-baby care benefit. This plan does not provide coverage for pediatric standby charges for vaginal delivery. Please note: We cover an ill or injured newborn under the other medical provisions of this plan.

In-network—\$10/Out-of-network—not covered

## Outpatient Diabetic Instruction

This plan covers services and supplies used in outpatient diabetic instruction programs when they are provided by a health care professional or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. For the purposes of this benefit, a health care professional means a licensed physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietician with demonstrated expertise in diabetes. We will pay for one outpatient diabetic instruction program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medication and supplies that are not included in the charge for the outpatient diabetic instruction program are covered under the prescription medication benefit under this plan. Diabetic insulin and supplies are covered under the prescription medication benefit.

## Outpatient Rehabilitation

This plan covers up to 60 visits each calendar year for all outpatient rehabilitative services that a professional provider delivers to a patient who is not confined in a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by illness or injury. In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes and be submitted for preauthorization to Trillium Sprout Healthy KidsConnect. Covered expenses exclude the following: more than one session of any one kind of rehabilitation on any one day; rehabilitative care provided in your home are covered under the home health care benefit; recreational or educational therapy; self-help or training; or treatment of psychotic or psychoneurotic conditions.

- Maximum of 60 visits per calendar year for all rehabilitative care

In-network—\$10/Out-of-network—not covered

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## Prescription Medication Benefit

To obtain prescription medications, you must display your card at any pharmacy listed in our pharmacy provider directory. You may obtain a current directory by contacting us. Prescription medication must be medically necessary and must be the result of a prescription order. Any balances over the maximum amount available under this prescription medication benefit are not eligible for payment under any other provision of the plan.

Our preferred drug list shows the brand-name medications we cover. We will not exclude coverage of a prescription medication for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration, if the Oregon Health Resources Commission determines that the medication is recognized as effective for the treatment of that indication.

The chart below outlines your copayment costs:

### Copayments for All Plans

Generics—\$0

Preferred brands—\$10

Non-preferred brands—not covered\*

\* Non-preferred prescription drugs are covered only through an exception process and in such cases would be covered at the preferred brand copayment level.

Maximum out-of-pocket families with 1 child—\$100

Maximum out-of-pocket families with 2 or more children—\$200

## Preventive Care Services

### Adult Routine Physical Examinations

We cover the following physical examinations and related laboratory tests and X-ray examinations (as long as a third party is not liable for these charges) for adults age 18: Routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.

- Age 18—Once

In-network—\$0/Out-of-network—not covered

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## Colorectal Screenings

We cover the following services for colorectal cancer screening for any individual at high risk:

- One fecal occult blood test each calendar year;
- One flexible sigmoidoscopy every five years;
- One colonoscopy every ten years; or
- One double contrast barium enema every five years.

Those that are at high risk for colorectal cancer for the purpose of this plan are:

- Individuals who have a family history of colorectal cancer; or
- A prior occurrence of cancer or precursor neoplastic; polyps; or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis.

In-network—\$0/Out-of-network—not covered

## Men's Preventive Services

We will provide coverage for prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test (PSA) for males who are at high risk for prostate cancer as determined by the treating physician.

In-network—\$0/Out-of-network—not covered

## PKU Testing

We cover one PKU test to detect the presence of Phenylketonuria (PKU).

If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. **We cover necessary formulas for treatment under the supplies, appliances, and durable medical equipment section of this plan.**

In-network—\$0/Out-of-network—not covered

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## Well-Baby Care

Well-baby care covers physical examinations provided by a professional provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory services for an enrolled baby up to age 24 months.

In-network—\$0/Out-of-network—not covered

## Well-Child Care

We cover physical examinations and any related laboratory tests and X-ray examinations.

In-network—\$0/Out-of-network—not covered

## Immunizations

We cover immunizations recommended by the American Academy of Family Physicians for you up through age 18. Covered expenses do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.

In-network—\$0/Out-of-network—not covered

## Women’s Preventive Services

We cover women’s breast, pelvic, and Pap smear examinations once every calendar year. However, we cover more frequent examinations if they are medically necessary and the woman’s health care provider recommends them. By breast examination, we mean a complete and thorough exam of the breast for women age 18, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any coinsurance. We cover any covered expenses for laboratory, X-ray procedures, or mammography that accompany the examination according to the diagnostic X-rays and laboratory services.

In-network—\$0/Out-of-network—not covered

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## Professional Provider Visits in the Hospital

Covered expenses include professional provider visits to you during a covered hospital or skilled nursing facility stay. We do not cover separately, visits relating to surgery performed during a hospital stay because these visits are ordinarily included in the surgeon's fee. Covered expenses also include physician consultations with written reports during each hospital stay. We do not cover staff consultations required by hospital rules. These benefits apply only if you are eligible for hospital or skilled nursing facility benefits. For hospital inpatient treatment of mental health/chemical dependency, covered expenses are limited to durational visit limits. See **Benefit Limitations** section.

In-network—\$10/Out-of-network—not covered

## Skilled Nursing Facility Care

We cover care in a skilled nursing facility up to 60 days per spell of illness per calendar year. For benefits to renew after each stay, you must be discharged from the facility and 90-consecutive days must pass before readmission to a hospital or a skilled nursing facility. We limit payments for covered expenses to 80% of the in-network provider contract rate or the daily service rate, up to the maximum amount we would pay if you were in a semiprivate hospital room. Your attending physician must give us proof of medical necessity, that we find acceptable, showing that you would require hospitalization if care in a skilled nursing facility were not possible.

Covered expenses exclude routine nursing care, non-medical self-help or training, personal hygiene or custodial care. Covered expenses exclude an admission to a skilled nursing facility that began before you enrolled in Trillium Sprout Healthy KidsConnect or for a stay where care is provided principally for:

- Mental deficiency or retardation; or
- Mental illness.
- Number of days—Up to 60 days per spell of illness per calendar year

Semiprivate room plus medically necessary ancillary

In-network—\$10/Out-of-network—not covered

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## Smoking Cessation

You are eligible to enroll in a tobacco treatment program at no cost to you.

## Special Dental Care

We cover the treatment of accidental injury to natural teeth or a fractured jaw after you have paid any coinsurance. To qualify for coverage, you must receive the treatment from a physician or dentist while you are enrolled under this plan, and within 12 months after the injury except when completion is delayed due to healing time following medically necessary surgery.

For purposes of this special dental care benefit, injury does not include accidents that occur during eating, biting, or chewing. You have additional dental coverage under the **Dental Benefits** portion of this plan.

In-network— \$10/Out-of-network—not covered

## Special Facility Care

This plan includes care provided in a special facility. A special facility is an ambulatory surgical facility, surgical center, or birthing center. Covered expenses include use of the procedure room and other services and supplies that are medically necessary for treatment.

In-network—\$10/Out-of-network—not covered

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## Speech-Language Pathology, Audiology, and Hearing Aid Services

This plan includes speech-pathology, audiology and hearing aid services. The provision of speech therapy services must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner.

A written order is required for the initial evaluation. For therapy, must specify the ICD-9-CM diagnosis code, service, amount and duration required. Written orders must be submitted with the preauthorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months. Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.). Cochlear implants are covered.

In-network—\$10/Out-of-network—not covered

## Temporomandibular Joint Services

Temporomandibular joint disorders are covered under the plan the same as for other injuries or musculoskeletal disorders. All diagnostic and surgical procedures for TMJ services require preauthorization.

In-network—\$10/Out-of-network—not covered

## Therapeutic Injections

We cover therapeutic injections, such as allergy shots, when given in a professional provider's office, except when comparable results can be obtained safely with home self-care or thorough oral use of a prescription medication. Therapeutic injection benefits apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the provisions of the plan, subject to any coinsurance. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

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Local: 541-431-1990

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## Transplants

Benefits for services and supplies (including medications) rendered in connection with a transplant, including pre-transplant procedures such as ventricular assist devices (VADs), organ or tissue harvesting (donor costs), postoperative care (including anti-rejection medication treatment) and transplant-related chemotherapy for cancer are limited as described here.

We will cover expenses for certain medically necessary and non-experimental transplantation procedures. Eligible transplants must be preauthorized through a case manager.

In-network—\$100/Out-of-network—not covered

## Vision Benefits

Services are covered only when obtained from in-network providers except in emergencies or when the participating plan provides an out-of-network preauthorization. In these circumstances, normal copay or coinsurance would apply. **Vision exam and hardware benefits are allowed once every 12 months.**

- Examinations: one vision exam every 12 months—\$0
- Prescription contact lenses (as alternative to lenses and frames): when approved for medical reasons—\$0
- Ocular prosthetics, artificial eye: with documentation of medical necessity—\$0
- Vision therapy services: six sessions per calendar year—\$0
- Postsurgical care: optometrists post-operative care—\$0
- Radiological services: by optometrists or ophthalmologist—\$0

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**Trillium Sprout Healthy KidsConnect**

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Maximum Allowance: You pay any amount over the maximum allowance amounts listed below.

- Prescription lenses: one pair every 12 months
  - Single vision lenses—\$96
  - Bifocal lenses—\$134
  - Trifocal lenses—\$180
  - Frames: one frame every 12 months—\$96

## **X-Rays and Laboratory Tests**

Medically necessary diagnostic X-rays and laboratory tests are covered when a professional provider orders them. The X-rays for tests must be related to diagnosis or treatment of an illness or injury.

In-network—\$10/Out-of-network—not covered

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## Benefit Limitations

There are limitations on the benefits available under this plan of certain conditions and services. These limitations are explained in the following paragraphs.

### Breast Reconstruction

Limited to surgery following a mastectomy that was necessary due to illness or injury.

### Growth Hormones

Growth hormones are generally not an expense eligible for benefits under this plan. Benefits will be provided for the treatment of the following conditions when the use of growth hormones meets our medical criteria and the treatment has been preauthorized for the following conditions:

- Growth hormone deficiency
- Failure in children secondary to chronic renal insufficiency prior to transplant, or for the promotion of wound healing in patients with severe, active burns while hospitalized.
- Turner's syndrome
- Prader-Willi syndrome
- Neonatal hypoglycemia associated with growth hormone deficiency

### Home Health Care

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.

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**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- **Rehabilitative care.** This plan covers up to 60 days each calendar year for preauthorized rehabilitative services that a professional provider delivers to a patient who is not confined in a hospital. Rehabilitative services are physical, occupational, speech, or respiratory therapy services necessary to restore or improve lost function caused by illness or injury. In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes. Home health care provided by a licensed social worker is paid according to the home health care benefit. This plan covers services rendered by an Oregon-registered clinical social worker upon the written referral of a physician or psychologist.

Home health care benefits exclude:

- More than one visit of any one kind of rehabilitation on one day;
- Rehabilitative care provided in your home and covered under the home health care benefit;
- Recreational or educational therapy;
- Self-help or training; or
- Treatment of psychotic or psychoneurotic conditions.

## Outpatient Prescription Limitations

- **Maximum quantities.** The largest allowable quantity at one time for outpatient prescription medications purchased from a pharmacy, or mail order, is a 34-day supply. Your copayment is always based on each dispensing.

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TTY: 1-866-279-9750

- **Refills.** This plan allows refills from a pharmacy after 75 percent of the supply from the previous prescription order is used. You are responsible for the full cost of any prescription medications that are denied at the participating pharmacy because you have refilled them too soon.
- **Medication dispensing limits.** There are certain prescription medications that have medication dispensing limits. Medication dispensing limits (MDL) means the quantity or dispensing frequency of a prescription medication that we determine is medically necessary before it is dispensed. MDL apply to prescription medications that are used to treat a limited number of conditions or that have limited durations of therapy. Any prescription medications with MDL that are purchased without MDL authorization are not covered under this prescription medication plan, even if purchased from a participating pharmacy. Participating providers, including participating pharmacies, are notified which prescription medications have MDL. Only providers prescribing medications or pharmacies filling medications can request MDL authorization. The participating pharmacy will let you know if MDL authorization is necessary for the medication.

## Transplants

Benefits for services, supplies, and medications rendered in connection with a transplant, including pre-transplant procedures such as organ or tissue harvesting are limited as indicated on the following pages.

## Definitions for the Transplant Benefit

- **A contracting transplant facility** means a health care facility with which we have contracted or arranged to provide facility transplant services for you.
- **Contracted amount** means the amount that the contracting transplant facility has agreed to accept as payment in full for facility transplant services for a specific type of transplant.
- **Covered transplant** means medically appropriate transplant of one of the following organs or tissues only when determined by us to be medically necessary, and no others:

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- Allogenic or syngeneic hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
- Autologous hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
- Heart;
- Heart/lung;
- Lung;
- Pancreas;
- Liver;
- Pediatric small bowel; or
- Small bowel/liver/multivisceral.

Covered transplant does not include transplant of blood, blood derivatives (except peripheral stem cells), cornea, or any other organ or tissue not specifically listed.

- **Donor costs** mean all costs, direct and indirect (including program administration costs), incurred in connection with: medical services required to remove the organ or tissue from either the donor's or self-donor's body; preserving it; and transporting it to the site where the transplant is performed; and related and unrelated donor search cost.
- **Facility transplant services** means all medically necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and anti-rejection medications.
- **Medically appropriate for purposes of this transplant limitation** means the recipient or self-donor meets our medical necessity criteria for a transplant.
- **Professional provider transplant services** means all medically necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and anti-rejection medications.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## Facility Benefits

We will waive any otherwise applicable coinsurance of the plan and pay 100 percent of the contracted amount for facility transplant services for you if a covered transplant is performed at a contracting transplant facility.

**Note: Transplant services do not accumulate toward the maximum out-of-pocket amount under the plan.**

## Professional Provider Benefits

We will pay for professional provider transplant services according to the benefit under the **Medical Benefit Summary** in the **Summary of Benefits**.

## Donor Cost Benefits

We will pay donor costs incurred in connection with a covered transplant if the recipient is covered under this plan. We will not pay toward donor costs if the donor is covered under this plan and the recipient is not. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the plan only if the donor or self-donor is enrolled under the plan.

## Anti-Rejection Medication Benefits

We will pay according to the prescription medication benefit under the plan for anti-rejection medications following the covered transplant.

## Transplant Preauthorization Requirement

All transplant procedures must be preauthorized for type of transplant and must be medically appropriate according to our established criteria. Failure to preauthorize as described will result in a denial of benefits. Please ask your provider to contact the case management nurse who will work with you and your physician in selecting a transplant facility and negotiating for services.

The preauthorization requirement is a part of the benefit administration of the plan and is not a treatment recommendation. The actual course of medical treatment you choose remains strictly a matter between you and your physician.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## Transplant Preauthorization Procedure

To preauthorize, your physician must contact our Case Management Department before the transplant admission. Preauthorization should be obtained as soon as possible after you have been identified as a possible transplant candidate.

**Only our written approval of a proposed transplant will constitute preauthorization. Preauthorization can be obtained by submitting a preauthorization request to our Transplant Coordinator.**

## Benefit Exclusions

We will not pay for the following:

### Cosmetic/Reconstructive Surgery

We do not cover services and supplies for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery. However, we do provide coverage if the surgery is performed:

- To correct a functional disorder;
- To correct a disorder that results from accidental injury that occurs while a person is covered by this plan;
- To correct congenital anomalies; or
- For the reconstruction of the involved breast following a mastectomy necessary because of illness or injury and for all stages of reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after final reconstructive surgery on the diseased breast has been performed, or for prostheses and physical complications from all stages of mastectomy, including lymphoedemas.

### Experimental or Investigational Services

We do not cover services, which are, in our judgment, experimental or investigational for your specific illness or injury. Services, which support or are performed in connection with the experimental or investigational services, are also excluded.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services, which at the time they are rendered and for the purpose and in the manner they are being used:

- Have not yet received final Food and Drug Administration approval for other than experimental, investigational, or clinical testing; or;
- Are provided under a written protocol or are the same services provided to other patients under a written protocol for the diagnoses; or
- Are determined by us, in consultation with medical advisors, to be in a research status prior to general use in the medical community in Oregon. We will consider a service to be in a research status prior to general use in the medical community in Oregon, if two or more of the following indicators apply to a service at the time of preauthorization request or claim review:
  - The service is not performed in Oregon; or
  - The service is the subject of a Phase I, II or III trial; or
  - The service has not been the subject of a study published in peer reviewed medical literature. Peer reviewed medical literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical literature, the manuscript must actually have been reviewed by acknowledged experts before publication; or
  - Studies published in peer reviewed medical literature indicate the need for further investigation on dosage, means of administration, long term effects or other factors important to efficacy and patient safety; or
  - No federal government agency or national professional medical society or organization, which has done a formal evaluation, has declared the service to be appropriate medical practice.

Experimental or investigational dental or vision services are excluded under the same standards. An experimental or investigational service is not made eligible for coverage even if your doctor considers that other services will be ineffective or not as effective as the service or that the service is the one most likely to prolong life.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## General Exclusions

We will not cover:

- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps or tanning lights.
- Custodial care including routine nursing care and rest cures, and hospitalization for environmental change.
- Dental services, except as specifically provided in the **Special Dental Care** subsection in the **Schedule of Benefits** section and in our **Dental Benefits Plan**. The dental services excluded from the medical benefit plan are services to prevent, diagnose or treat disease of the teeth, gingiva, the periodontal tissue and the alveolus, including services to repair defects, which have developed because of tooth loss, and/or to restore the ability to chew.
- Educational programs for which drivers are referred by the judicial system, or for volunteer mutual support groups.
- Eye examinations and routine eye exercises, except as specifically provided in the **Vision Benefits Plan**.
- Family planning services and supplies for infertility (except sterilization), artificial insemination, invitro fertilization, or to surgically to correct voluntary sterilization.
- Fitting, provision, or replacement of hearing aids, including implantable hearing aids and the surgical procedure to implant them except as specifically covered in plan.
- Inpatient hospital staff consultations that the hospital rules require.
- Inpatient services after your termination from this plan. The only exception occurs if you are in the hospital on the day the coverage ends. This plan will continue to provide benefits for that hospitalization until your discharge from the hospital.
- Instruction or training programs, except as covered under the disease management benefit. Examples of instruction or training programs excluded from coverage are:
  - Instruction to learn to self-administer medications or nutrition, except as provided in the outpatient diabetic instruction benefit;
  - Self-management education courses;

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- Training to control weight or provide general fitness, except under our disease management program;
  - Programs that teach you how to use durable medical equipment, except for prosthetics or orthotics; or
  - Training how to care for your family.
- Massage or massage therapy.
  - Treatment of sexual dysfunction or inadequacy or services and supplies related to sex change procedures.
  - Off the shelf orthopedic shoes and orthopedic inserts.
  - Orthognathic surgery, which includes services and supplies to change the position of a bone of the upper or lower jaw (except when necessary due to an accidental injury that occurred while enrolled under this plan or when performed on a person who has been covered by our plan since birth).
  - Personal items, such as telephones, televisions and guest meals, in a hospital or skilled nursing facility.
  - Physical exercise programs, even though they may be prescribed for a specific condition.
  - Private nursing service for hospital or skilled nursing facility inpatients.
  - Routine tests and screening procedures not specified by this plan, except that routine preadmission testing is covered.
  - Services and supplies you received while in the custody of any law enforcement authority or while in jail or prison.
  - Services or supplies that are not medically necessary for the diagnosis or treatment of an illness or injury.
  - Services and supplies provided by your immediate family.
  - Skilled nursing care for mental illness, mental deficiency, or retardation.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- Surgical procedures, which alter the refractive character of the eye, except as, covered under our **Vision Benefits Plan**. Examples of surgical procedures excluded from medical benefits are:
  - Radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism.
  - Reversals or revisions of surgical procedures, which alter the refractive character of the eye and complications of all of these procedures.
- Telephone consultations, missed appointments, completion of claim forms or completion of reports requested by us in order to process claims.
- The fitting, provision, or replacement of eyeglasses, except as specifically provided in the **Vision Benefits Plan**.
- Services for corns, calluses, removal of nails (except complete removal), and other routine foot care.
- Services for weight control or obesity. This includes surgery and/or any other services provided for weight control or obesity and/or any complications arising out of or related to such services. These services are not covered whether or not you have other medical conditions related to or caused by overweight or obesity, or the treatment of those conditions. However, disease management programs for overweight or obesity are covered.
- Treatment of any condition caused by or arising out of service in the armed forces of any country or from war or insurrection.
- Services you received before the effective date of your enrollment in this plan or after the date of your termination from this plan.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

# Hospice Care Exclusions and Limitations

In addition to other exclusions listed in the **Benefit Exclusions** section, we will not pay for the following hospice services and supplies:

- Care that is not palliative;
- More than one visit of any one kind of rehabilitation on any one day;
- Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts;
- Environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters and portable whirlpool pumps;
- Food services, such as Meals on Wheels;
- Homemaker or housekeeping services, except those that home health aids provide as ordered in the hospice treatment plan;
- Legal and financial counseling services;
- Normal necessities of living, including but not limited to food, clothing, and household supplies;
- Pastoral and spiritual counseling;
- Recreational or educational therapy; self-help or training;
- Rehabilitative care provided in your home and covered under the home health care benefit;
- Separate charges for reports, records or transportation;
- Services provided to other than the terminally ill patient, including bereavement counseling;
- Services that your family or volunteer workers provide;
- Services in excess of the benefit limitations;
- Services not included in the hospice treatment plan or not specifically set forth in a hospice benefit;

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- Services provided more than six months after the initial date of covered hospice care, unless specifically approved by us;
- Supportive environmental materials, including but not limited to hand rails, ramps, air conditioners and telephones; or
- Treatment of psychotic or psychoneurotic conditions.

## **Mental Health and Chemical Dependency Exclusions**

We will not cover the following when administering benefits under the plan for treatment of mental health conditions and chemical dependency conditions:

### **Counseling or Treatment in the Absence of Illness**

Services in the absence of illness are excluded. For example, we will not cover:

- Educational, social, image, behavioral or recreational therapy;
- Sensory movement groups;
- Marathon group therapy;
- Sensitivity training;
- Employee assistance plan services;
- Wilderness programs;
- Premarital or marital counseling; or
- Family counseling (However, family counseling will be covered when you have a covered diagnosis and the family counseling is part of the treatment.)

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## Developmental and Learning Disabilities

We will not cover services for developmental and/or learning disabilities in the absence of an illness or when it is not medically necessary.

## Mental Health Services for Certain Conditions

We will not cover services for Paraphilias no matter your age. Additionally, we will not cover any **V Code** diagnoses except the following when medically necessary for a child five years of age or younger:

- Parent-child relational problems;
- Neglect or abuse; or
- Bereavement.

By **V Code**, we mean diagnosis codes as described in the most recent edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV TR) that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment, such as occupational or academic problems.

## Sexual Dysfunction

Services and supplies for sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.

## Sexual Reassignment

Treatment, surgery or counseling services for sexual reassignment.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## Outpatient Prescription Exclusions

We will not cover:

- Administration or injection of prescription or nonprescription medications.
- Any medication not specifically described as a benefit under the prescription medication benefit.
- Devices or appliances of any type, even if they may require a prescription order. Some devices and appliances may be covered under the other provisions of this plan.
- Fertility medications.
- Immunization agents, biological sera, blood or blood plasma.
- Injectable prescription medications, except those defined as self-injectable. Excluded are all injectable medications administered in a physician's office, hospital, outpatient facility, or skilled nursing facility.
- Newly approved prescription medications. This plan may exclude, for up to 18 months from the federal Food and Drug Administration (FDA) approval date, prescription medications that the FDA newly approves. The list of newly approved prescription medications currently excluded is provided to participating pharmacies and is available on our Web site and in paper form.
- Nonprescription medications, which are medications that by law do not require a prescription order and which are not, included in the outpatient prescription medications that this plan covers.
- Medications dispensed in a facility to you while a patient in a hospital, skilled nursing facility, nursing home or other health care facility.
- Prescription medications for cosmetic purposes, including but not limited to: Tretinoin (i.e. Retin-A); Renova; topical Minoxidil or other medications used to treat baldness; and medications used to treat nail fungus, such as Sporanox and Lamisil.
- Prescription medications for weight loss or treatment of obesity.
- Prescription medications for which claims are submitted 12 months or more after the date of purchase.
- Prescription medications that are not medically necessary.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- Prescription medications with no proven therapeutic indication.
- Refills needed for stolen, lost, spilled or destroyed prescription medications.
- Vitamins and fluoride, except those that by law require a prescription order.
- Insulin and diabetic supplies without a prescription order.

## Enrollee Grievance and Appeals Process

As an enrollee you or your authorized representative has the right to express your dissatisfaction with services that you received or to appeal any of our decisions not to pay for a medical treatment or if you feel we have not paid enough.

You may call us or write to express any dissatisfaction with the availability of services, the delivery of services, the quality of health care services you receive, or the service you receive from us. You may write to request an appeal of any decision we make to deny a request for referral, a prior authorization request for a service, deny a claim, or to question our handling or payment for health care services. If you call us to express dissatisfaction or request an appeal you will be asked to provide the request in writing so that we can proceed with the review of your request. The following paragraphs give more information on the process that we follow.

### If You Are Not Happy with a Service You Received

If you are not satisfied with any aspect of the health care you receive through a Trillium Sprout Healthy KidsConnect provider, we want to know about it. Help begins with a phone call to one of our Customer Service Representatives.

Trillium Sprout Healthy KidsConnect Customer Service is available from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays.

Call 1-877-401-5439 (toll free) or 541-431-1990. If you are hearing impaired, call TTY services at 1-866-279-9750.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

You can also contact us in writing. Our mailing address is:

Trillium Sprout Healthy KidsConnect  
P.O. Box 11756  
Eugene, OR 97440-3956

If you call and we are not able to immediately resolve your concern, we will ask if you would like to submit a written grievance. If you indicate that you want to submit a written grievance, we will send you a form to complete and return to us. Within 5 business days of receiving your written grievance, we will send a letter confirming that we have received your written grievance. We will send you our written decision regarding your grievance within 30 calendar days of our receipt of your written grievance.

## **If You Are Not Happy about a Denial for a Request for Service or with How We Handled Your Claim**

Whenever we deny a request for service or a claim we will send you written explanation of the denial. If you are not satisfied with the denial you, your provider, or your authorized representative may submit a written request to appeal the denial decision. Any request to appeal a denial must be submitted within 60 calendar days of our denial decision.

If you need assistance in completing a written appeal request, give us a call.

## **Appeal Process**

We will send you a written acknowledgement within 5 working days of receiving your written appeal and will also initiate our internal appeal process.

Our appeal process includes up to two levels of review for each appeal. The first level is by the person involved in making the original decision. If the result of the first level of review is to continue to uphold the initial denial, we will automatically forward to the second level of review which will be by an appropriate healthcare professional not involved in the initial decision or in the first level appeal process.

We will send you written notice of our final appeal decision within 30 calendar days of receiving your appeal request.

If after the second level review we continue to uphold our initial denial you may have the right to request an external review.

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Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

## External Review

If you disagree with our final appeal decision you may submit a written request to us for an external review. You are not responsible for the expenses of the external review. Your request must be received within 180 days of our final decision.

To qualify, your appeal must be:

- An adverse decision based on medical necessity; or
- An adverse decision for treatment determined to be experimental or investigational; or
- For the purpose of continuity of care (no interruption of an active course of treatment) under ORS 743.854.

To apply for an external review you must submit your request to us at the following address:

Trillium Sprout Healthy KidsConnect  
 Appeals  
 P.O. Box 11756  
 Eugene, OR 97440-3956

As a member, you should know that in order to have your appeal submitted for external review, you, or your authorized representative must sign a waiver granting the independent review organization access to your medical records. A waiver may be a written letter or an Appeals Request form. If the request is being submitted by your authorized representative, the waiver must also include your signature and the name and signature of the individual you are authorizing to represent you.

When we receive your request for an external review, either expedited or standard, we must complete an External Review Request form. We must forward your request and the completed External Review Request form to the Director of the Department of Consumer and Business Services within two days of receiving your request. If you have submitted an expedited request, we must forward your request immediately.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

We are bound by the decision made by the Independent Review Organization (IRO). Trillium Sprout Healthy KidsConnect agrees to be bound by the decisions made by the IRO.

A written decision by the IRO will be sent to you or your authorized representative within 30 days of our receiving your written appeal request for External Review. If you made an expedited request, a written decision will be sent to you or your authorized representative within 3 days of our receiving your written appeal request.

If you want more information regarding External Review, please contact our Customer Service Department at 541-431-1990 or toll free at 1-877-401-5439 or TTY 1-866-279-9750.

You may also learn more about external reviews by visiting:

[http://insurance.oregon.gov/consumer/exreview/external\\_review\\_overview.html](http://insurance.oregon.gov/consumer/exreview/external_review_overview.html)

## **Expedited Appeal or Expedited Review**

An expedited appeal or review is warranted when any health care professional who has a clinical relationship with you states that you may experience serious danger or a deterioration in quality of life if you are required to wait 30 days for a decision, the length of time for a standard appeal or review decision.

## **Appeal and Review Timelines**

Trillium Sprout Health KidsConnect and the IRO have the following timeframes for making decisions on appeals and external review requests:

- 3 days for expedited requests
- 30 days for standard requests

## **Appeals Forms (not required to file an appeal)**

You may use a written letter or an Appeals Request form to submit your request for appeal or for external review. If you call to request an appeal, we will send you a letter which confirms our understanding of your reason for appeal. You will be asked to indicate whether or not we understand your request correctly and to sign and return the letter along with any additional documentation you would like to submit for our consideration. We will initiate the appeal process and will provide you with a response within 30 calendar days of receipt of your written confirmation.

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Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

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## Other Appeals Resources

Complaint and Appeals: If I am not satisfied with my health plan or provider, what can I do to file a complaint or get outside assistance?

You also have the right to file a complaint and seek assistance from the Director of the Department of Consumer and Business Services (DCBS). You can write to the Director of the DCBS at:

Department of Consumer and Business Services  
350 Winter Street NE  
P.O. Box 14480  
Salem, OR 97309-0405

You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:

- By calling 503-947-7984 or the toll free message line at 1-888-877-4894;
- By writing to the Oregon agency: Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
- Through the Internet at <http://www.cbs.state.or.us/external/ins/>; and
- By email at [dcbs.inmail@state.or.us](mailto:dcbs.inmail@state.or.us).

## Member Rights and Responsibilities

In accordance with Oregon law (Senate Bill 21, known as the Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform you and your covered dependents about benefits and policies of this health insurance plan

### Member Rights; Your Rights as a Member

- You have the right to receive information about Trillium Sprout, our services, our providers, and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your diversity and right to privacy.
- You have a right to participate with your healthcare provider in decision making regarding your care.

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**Trillium Community Health Plan**

**Trillium Sprout Healthy KidsConnect**

Local: 541-431-1990

Toll Free: 1-877-401-KIDZ

TTY: 1-866-279-9750

- You have a right to honest discussions of appropriate or medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to confidential protection of your medical information and records.
- You have a right to voice complaints about Trillium Sprout or the care you receive, and to appeal decisions you believe are wrong.
- You have the right to continue care from an individual provider for a limited period of time after the medical services contract terminates.

## **Member Responsibilities; Your Responsibilities as a Member**

- You are responsible for providing Trillium Sprout and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your health care providers.
- You are responsible for payment of copays at the time of service and be on time for that service.
- You are responsible for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.
- You are responsible for making sure that services are prior authorized when required by this plan before receiving medical care.

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