

2012 Summary of Benefits

Medical, Prescription Drug, Dental, and Vision

Sprout Beginnings



A product of Trillium Community Health Plan®

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

Note: This benefit summary does not fully describe the benefit coverage with Trillium Sprout Healthy KidsConnect.

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 300% federal poverty level.

Medical Benefits Summary

Lifetime Maximum Benefit	Unlimited
Pre-Existing Waiting Period, including Pregnancy	None
Calendar Year Medical Deductible	\$1,000
Calendar Year Maximum Per Member	\$6,000 (including deductible)

Member Pays	
• Preventative Care and Services (Per PPACA)	None
• Professional Office Visits	20% (after deductible)
• Hospital Inpatient Care – per admission	20% (after deductible)
• Outpatient Surgery	20% (after deductible)
• Skilled Nursing Care – limited to 60 days	20% (after deductible)
• Home Health Care – limited to 60 days	20% (after deductible)
• Emergency Room	20% (after deductible)
• Ambulance	20% (after deductible)
• Hospital Maternity	20% (after deductible)
• Diagnostic X-Ray, Imaging, Lab, and Special Diagnostic Procedures	20% (after deductible)
• Transplants	20% (after deductible)
• Hospice Care	20% (after deductible)
• Rehabilitation Inpatient and Outpatient – limited to 60 days	20% (after deductible)
• Durable Medical Equipment and Supplies	20% (after deductible)
• Mental Health/Chemical Dependency	
• Inpatient Psychiatric Care	Same as hospital inpatient care
Residential/Day Treatment - Same as inpatient care for up to 60 days per year; day treatment same as office visit cost.	
• Outpatient Treatment	20% (after deductible)
• Alternative Services – Acupuncture, Chiropractic, and Naturopathic Care (Subject to referral by primary care physician)	20% (after deductible)
• Speech-Language Pathology, Audiology, and Hearing Aid Services	20% (after deductible)

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 300% federal poverty level.

Prescription Drug Benefits Summary (Subject to plan's preferred drug list)

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 cases the normal copay or coinsurance would apply.

Prescription Drug is a separate benefit and out-of-pocket expenses by the member are not applied towards the medical out-of-pocket expense.

Calendar Year Prescription Drug Deductible	None
Prescription Drug Out-of-Pocket Maximum	
• Individual	Unlimited
	Member Pays
Generic Drug	\$5
Preferred Brand	\$50 or 50%, whichever is less
Non-Preferred Brand*	\$50 or 50%, whichever is less

* Non-preferred prescription drugs are covered only when an exception process exists with the insurance carrier and in such cases would be covered at the preferred brand copay level.

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 300% federal poverty level.

Dental Benefits Summary

Participating Provider

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 cases the normal copay or coinsurance would apply.

Calendar Year Maximum Benefit	\$1,000
Calendar Year Dental Deductible	None
Dental Out-of-Pocket Maximum*	
• Families with 1 child	\$200
• Families with 2 or more children	\$400

Member Pays

Diagnostic and Preventative

• Examinations	\$0
• X-Rays	\$0
• Cleanings	\$0
• Fluoride Treatment	\$0
• Sealants	\$0

Restorative, Oral Surgery, and Endodontics

• Amalgams	\$10
• Composite Resin Restorations	\$10
• Crowns	\$30 per crown
• Extractions	\$10
• Root Canal Therapy	\$10
• Surgical Extractions	\$10

Periodontics

• Space and Periodontal Maintenance	\$10
• Stabilization of Periodontal Health	\$10

Prosthodontics (Removable)

• Complete and Partial Dentures	\$30
• Repairs to Complete and Partial Dentures	\$15
• Denture Rebase and Reline Procedures	\$15

Orthodontics

• Covered for Patients Who Have a Diagnosis of Cleft Palate with Cleft Lip	\$30
--	------

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

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 300% federal poverty level.

Vision Benefits Summary

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 cases the normal copay or coinsurance would apply.

	Member Pays
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
	Maximum Allowance
Prescription Lenses	
• One Pair Every 12 Months You pay any amount over the maximum allowance.	
• Single Vision Lenses	\$96
• Bifocal Lenses	\$134
• Trifocal Lenses	\$180
Frames	
• One Frame Every 12 Months You pay any amount over the maximum allowance.	\$96

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 300% federal poverty level.