

2012 Summary of Benefits

Medical, Prescription Drug, Dental, and Vision

Sprout Jumpstart



 **Trillium sprout**[®]
Healthy KidsConnect

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.

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

Restrictions of this Summary of Benefits apply to children whose family's annual income is above 200% and up to 300% federal poverty level.

Medical Benefits Summary

Lifetime Maximum Benefit	None
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Pre-Existing Waiting Period, including Pregnancy	None
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Calendar Year Medical Deductible	None
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Medical Out-of-Pocket Maximum*	
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• Families with 1 child	\$900
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• Families with 2 or more children	\$1,800
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Drug Out-of-Pocket Maximum*	
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• Families with 1 child	\$100
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• Families with 2 or more children	\$200
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Member Pays

• Preventative Care and Services	
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• Women's Health Care Services and Men's Health Care Services	\$0
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• Routine Immunizations	\$0
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• Well-Baby Care (0-24 months) and Well-Child Care (2-18 years)	\$0
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• Outpatient Diabetic Instruction	\$0
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• Professional Office Visits	\$10
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• Hospital Inpatient Care – per admission	\$100
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• Outpatient Surgery	\$10
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• Skilled Nursing Care – limited to 60 days	\$10
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• Home Health Care – limited to 60 days	\$10
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• Emergency Room – waived if admitted**	\$100
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• Ambulance**	\$100
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• Maternity	
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• Prenatal and postnatal office	\$10
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• Labor and delivery hospital stay	\$100
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• Diagnostic X-Ray, Imaging, Lab, and Special Diagnostic Procedures	\$10
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• Transplants	\$100
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• Hospice Care	\$10
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• Rehabilitation Inpatient and Outpatient – limited to 60 days	\$10
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Medical Benefits, continued from previous page

Medical Benefits	Member Pays
• Durable Medical Equipment and Supplies	\$10
• Mental Health/Chemical Dependency	Same as hospital inpatient care
• Outpatient Treatment	\$10
• Alternative Services – Acupuncture, Chiropractic, and Naturopathic Care (Subject to referral by primary care physician)	\$10
• Speech-Language Pathology, Audiology, and Hearing Aid Services	\$10

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

** The emergency room copay, ambulance copay, out-of-pocket prescription drug payments, and disallowed charges do not apply to out-of-pocket maximum.

Prescription Drug Benefits Summary (Subject to plan's preferred drug list)	
Calendar Year Prescription Drug Deductible	None
Prescription Drug Out-of-Pocket Maximum	
• Families with 1 child	\$100
• Families with 2 or more children	\$200
Member Pays	
Generic Drug	\$0
Preferred Brand	\$10
Non-Preferred Brand*	Not covered

* 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.

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Dental Benefits Summary	Participating Provider
Calendar Year Maximum Benefit	\$1,750
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
Prostodontics (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.

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Vision Benefits Summary

	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

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