



**CSI INSURANCE PLAN AND TRUST FUND
Priority Health Medical Plan Options 2011/2012
Health by Choice Achievement Plans**

MEDICAL BENEFITS	Health by Choice Achievement HMO 1		Health by Choice Achievement HMO 2	
	Choice Benefits	Standard Benefits	Choice Benefits	Standard Benefits
General Plan Information				
Annual Deductible/Individual	\$250	\$1,000	\$500	\$1,500
Annual Deductible/Family	\$500	\$2,000	\$1,000	\$3,000
Employer Funding of Deductible	N/A	N/A	N/A	N/A
Rollover	N/A	N/A	N/A	N/A
Coinsurance	90%	70%	80%	70%
Office Visit/Exam	\$20 copay PCP services	\$30 copay PCP services	\$25 copay PCP services	\$35 copay PCP services
Outpatient Specialist Visit	\$35 copay	\$45 copay	\$40 copay	\$50 copay
Annual Out-of-Pocket Limit/Individual	\$1,250 plus copays	\$2,500 plus copays	\$2,500 plus copays	\$4,500 plus copays
Annual Out-of-Pocket Limit/Family	\$2,500 plus copays	\$5,000 plus copays	\$5,000 plus copays	\$9,000 plus copays
Deductible Included in Out-of-Pocket	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes
Preventive Services (PCP Office/Outpatient)				
Well-Child Care	100%	100%	100%	100%
Immunizations	100%	100%	100%	\$100%
Well Woman Exams	100%	100%	100%	100%
Mammograms	100%	100%	100%	100%
Adult Exams with Preventive Tests	100%	100%	100%	100%
Diagnostic X-Ray and Lab Tests	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Maternity Care				
Routine Pregnancy and Maternity Care (Pre-Natal Care)	\$20 copay, Maximum of 4 copays per pregnancy	\$30 copay, Maximum of 4 copays per pregnancy	\$25 copay, Maximum of 4 copays per pregnancy	\$35 copay, Maximum of 4 copays per pregnancy
Inpatient Delivery	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Inpatient Hospital Services				
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible



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Surgical Services				
Outpatient Facility Charge	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Emergency Services				
Emergency Room	\$150, after deductible	\$150, after deductible	\$150, after deductible	\$150, after deductible
Copay/Deductible Waived if Admitted	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies
Ambulance	\$150, after deductible	\$150, after deductible	\$150, after deductible	\$150, after deductible
Urgent Care				
Urgent Care Facility	\$75	\$75	\$75	\$75
Mental Health Benefits Alcohol & Substance Abuse				
Inpatient Care	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Outpatient Care	\$20 copay	\$30 copay	\$25 copay	\$35 copay
Prescription Drug Benefits				
Generic	\$10 copay	\$10 copay	\$15 copay	\$15 copay
Brand (Formulary/Preferred)	\$40 copay	\$40 copay	\$50 copay	\$50 copay
Brand (Non-Formulary/Non-preferred)	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval
Specialty Drugs Brand Preferred	20% copay, with max out of pocket of \$100 per script/annual \$2,400	20% copay, with max out of pocket of \$100 per script/annual \$2,400	20% copay, with max out of pocket of \$150 per script/annual \$3,600	20% copay, with max out of pocket of \$150 per script/annual \$3,600
Specialty Drugs Brand Non-Preferred	20% copay, with max out of pocket of \$200 per script/annual \$2,400	20% copay, with max out of pocket of \$200 per script/annual \$2,400	20% copay, with max out of pocket of \$300 per script/annual \$3,600	20% copay, with max out of pocket of \$200 per script/annual 3,600
Number of Days Supply	30 days (90 day supply available from your local pharmacy for three copays)	30 days (90 day supply available from your local pharmacy for three copays)	30 days (90 day supply available from your local pharmacy for three copays)	30 days (90 day supply available from your local pharmacy for three copays)



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Mail Order				
Generic	\$20 copay	\$20 copay	\$30 copay	\$30 copay
Brand (Formulary/Preferred)	\$80 copay	\$80 copay	\$100 copay	\$100 copay
Brand (Non-Formulary/Non-preferred)	\$160 copay w/approval	\$160 copay w/approval	\$160 copay w/approval	\$160 copay w/approval
Specialty Drugs Coinsurance for Brand Preferred and Brand Non-Preferred	Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible
Advanced Diagnostic Services (CT, CTA, MRI, Nuclear Cardiology Studies and PET Scan in an office, Outpatient or emergency setting)	\$150, after deductible Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150, after deductible Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150, after deductible Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150, after deductible Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.
Home Health Care	100%, after deductible	100%, after deductible	100%, after deductible	100%, after deductible
Skilled Nursing or Extended Care Facility - 45 days per Contract Year	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Hospice Care - 45 days per Contract Year	90%, after deductible	70%, after deductible	80%, after deductible	70%, after deductible
Infertility				
Diagnosis and treatment of underlying cause of infertility	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible
Rehabilitative Medicine Services				
Physical and Occupational Therapy (including spinal manipulation)	\$20 copay. Up to 30 visits/Contract Year	\$30 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$35 copay. Up to 30 visits/Contract Year
Speech Therapy	\$20 copay. Up to 30 visits/Contract Year	\$30 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$35 copay. Up to 30 visits/Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$20 copay. Up to 30 visits/Contract Year	\$30 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$35 copay. Up to 30 visits/Contract Year

This is a summary of the benefits available to you through the CSI Insurance Plan. All of the provisions of the plan are contained in the Group Agreement between Priority Health and the Plan. Since the Group Agreement is complete in detail, the final interpretation of any specific provision is governed by it.

Revised 01/25/2011