



**CHRISTIAN SCHOOLS  
INTERNATIONAL**

**CSI INSURANCE PLAN AND TRUST FUND  
Priority Health Medical Plan Options 2010/2011  
Health by Choice Incentives**

MEDICAL BENEFITS	Health by Choice Incentives HMO 1		Health by Choice Incentives HMO 2		Health by Choice Incentives HMO 3	
	Choice Benefits	Standard Benefits	Choice Benefits	Standard Benefits	Choice Benefits	Standard Benefits
<b>General Plan Information</b>						
Annual Deductible/Individual	N/A	\$750	\$250	\$1,000	\$500	\$1,250
Annual Deductible/Family	N/A	\$1,500	\$500	\$2,000	\$1,000	\$2,500
Employer Funding of Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Rollover	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance	100%	80%	90%	70%	90%	70%
Office Visit/Exam	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	\$15 copay PCP services	\$25 copay PCP services
Outpatient Specialist Visit	\$25 copay	\$35 copay	\$30 copay	\$40 copay	\$30 copay	\$40 copay
Annual Out-of-Pocket Limit/Individual	Copays only	\$1,500 plus copays	\$750 plus copays	\$2,250 plus copays	\$1,500 plus copays	\$3,000 plus copays
Annual Out-of-Pocket Limit/Family	Copays only	\$3,000 plus copays	\$1,500 plus copays	\$4,500 plus copays	\$3,000 plus copays	\$6,000 plus copays
Deductible Included in Out-of-Pocket	N/A	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes	Yes	Yes
<b>Preventive Services (PCP Office/Outpatient)</b>						
Well-Child Care	\$10 copay PCP	\$20 copay PCP	\$15 copay PCP	\$25 copay PCP	\$15 copay PCP	\$25 copay PCP
Immunizations	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	\$15 copay PCP services	\$25 copay PCP services
Well Woman Exams	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	\$15 copay PCP services	\$25 copay PCP services
Mammograms	100%	80%	90%	70%	90%	70%
Adult Periodic Exams with Preventive Tests	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	\$15 copay PCP services	\$25 copay PCP services
Diagnostic X-Ray and Lab Tests	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
<b>Maternity Care</b>						
Routine Pregnancy and Maternity Care (Pre-Natal Care)	\$10 copay, Maximum of 4 copays per pregnancy	\$20 copay, Maximum of 4 copays per pregnancy	\$15 copay, Maximum of 4 copays per pregnancy	\$25 copay, Maximum of 4 copays per pregnancy	\$15 copay, Maximum of 4 copays per pregnancy	\$25 copay, Maximum of 4 copays per pregnancy
Inpatient Delivery	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
<b>Inpatient Hospital Services</b>						
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible



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<b>Surgical Services</b>						
Outpatient Facility Charge	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
<b>Emergency Services</b>						
Emergency Room	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Copay/Deductible Waived if Admitted	Copay Waived	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies
<b>Urgent Care</b>						
Urgent Care Facility	\$40 copay	\$50 copay	\$45 copay	\$55 copay	\$45 copay	\$55 copay
<b>Mental Health Benefits</b>						
Inpatient Care - 20 Days per Contract Year	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
Outpatient Care - 20 Visits per Contract Year	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
<b>Alcohol &amp; Substance Abuse</b>						
<b>Inpatient Care</b>						
Inpatient Hospitalization: To minimum annual benefit as determined by the State of Michigan per contract year	100%	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible
<b>Outpatient Care</b>						
Outpatient Services - To minimum annual benefit as determined by the State of Michigan per contract year	100%	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible
<b>Prescription Drug Benefits</b>						
Generic	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay
Brand (Non-Formulary/Non-preferred)	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval
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)	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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<b>Mail Order</b>						
Generic	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Brand (Formulary/Preferred)	\$80 copay	\$80 copay	\$80 copay	\$80 copay	\$80 copay	\$80 copay
Brand (Non-Formulary/Non-preferred)	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	90 days	90 days
<b>Other Services and Supplies</b>						
Durable Medical Equipment & Prosthetic Devices	50%	50%, after deductible	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 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital.
Home Health Care	100%	100%, after deductible	100%, after deductible	100%, after deductible	100%, after deductible	100%, after deductible
Skilled Nursing or Extended Care Facility - 45 days per Contract Year	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
Hospice Care - 45 days per Contract Year	100%	80%, after deductible	90%, after deductible	70%, after deductible	90%, after deductible	70%, after deductible
<b>Infertility</b>						
Diagnosis and treatment of underlying cause of infertility	50%	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible
<b>Rehabilitative Medicine Services</b>						
Physical and Occupational Therapy (including spinal manipulation)	\$10 copay. Up to 30 visits/Contract Year	\$20 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year
Speech Therapy	\$10 copay. Up to 30 visits/Contract Year	\$20 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$10 copay. Up to 30 visits/Contract Year	\$20 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 copay. Up to 30 visits/Contract Year	\$15 copay. Up to 30 visits/Contract Year	\$25 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 01/22/2010