



**CHRISTIAN SCHOOLS
INTERNATIONAL**

**CSI INSURANCE PLAN AND TRUST FUND
Medical Plan Options 2010/2011**

Schedule A: Trustmark PPO 90, PPO 80 \$500, and PPO 80 \$1,000

Schedule B: Trustmark PPO HSA 1 and PPO HSA 2

SCHEDULE A	TRUSTMARK PPO 90		TRUSTMARK PPO 80 \$500 and PPO 80 \$1,000			
	School chooses deductible level of \$500/\$1,000 or \$1,000/\$2,000		IN-NETWORK		OUT-OF-NETWORK	
MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK		OUT-OF-NETWORK	
Adoption (Adoption benefit is provided by CSI)	\$3,000 max per child under age 18 at adoption	\$3,000 max per child under age 18 at adoption	\$3,000 max per child under age 18 at adoption		\$3,000 max per child under age 18 at adoption	
HealthWise Wellness Program	Monthly Newsletter Annual Health Assessment Counseling for Specific Health Risks	Monthly Newsletter Annual Health Assessment Counseling for Specific Health Risks	Monthly Newsletter Annual Health Assessment Counseling for Specific Health Risks		Monthly Newsletter Annual Health Assessment Counseling for Specific Health Risks	
Contract Year Deductible	\$500/\$1,000	\$1,500/\$3,000	<u>PPO 80 \$500</u> \$500/\$1,000	<u>PPO 80 \$1,000</u> \$1,000/\$2,000	<u>PPO 80 \$500</u> \$1,500/\$3,000	<u>PPO 80 \$1,000</u> \$3,000/\$6,000
Out-of-Pocket Maximum	\$2,500/\$5,000	\$6,000/\$12,000	\$2,500/\$5,000	\$4,000/\$8,000	\$5,500/\$11,000	\$9,000/\$18,000
Lifetime Maximum	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Student Dependent Coverage	through Age 24	through Age 24	through Age 24	through Age 24	through Age 24	through Age 24
Primary Care Physician Services	Covered 100% (no deductible)	Covered 100% (no deductible)	Covered 100% (no deductible)		Covered 100% (no deductible)	
Preventive Care	<i>Adult</i> - \$500 plan year max	<i>Adult</i> - \$500 plan year max	<i>Adult</i> - \$500 plan year max		<i>Adult</i> - \$500 plan year max	
Well Child Care	<i>Child</i> - \$500 plan year max	<i>Child</i> - \$500 plan year max	<i>Child</i> - \$500 plan year max		<i>Child</i> - \$500 plan year max	
Routine Immunization	<i>Well Child</i> - \$500 plan year max	<i>Well Child</i> - \$500 plan year max	<i>Well Child</i> - \$500 plan year max		<i>Well Child</i> - \$500 plan year max	
Mammograms	Covered 100% every 12 months More often if medically necessary	Covered 100% every 12 months More often if medically necessary	Covered 100% every 12 months More often if medically necessary		Covered 100% every 12 months More often if medically necessary	
Primary Care & Specialty Physician Services	\$25 co-pay for office services. All other services covered 90%	Covered 70%	\$25 co-pay for office services. All other services covered 80%		Covered 60%	
Therapies in a physician's office: (Physical, Speech, Occupational, etc.)	Therapies limited to 60 days (visits) per year	Therapies limited to 60 days (visits) per year	Therapies limited to 60 days (visits) per year		Therapies limited to 60 days (visits) per year	
Urgent Care Center	\$35 Copay (facility charge only)	Covered at 70% subject to deductible	\$35 Copay (facility charge only)		Covered at 60% subject to deductible	
In-Store Health Care Clinics	\$20 co-pay	Covered at 70% subject to deductible	\$20 co-pay		Covered at 60% subject to deductible	
Prescription Drugs	\$10 generic, \$40 preferred brand, \$75 other brand at participating pharmacies	\$10 generic, \$40 preferred brand, \$75 other brand at participating pharmacies	\$10 generic, \$40 preferred brand, \$75 other brand at participating pharmacies		\$10 generic, \$40 preferred brand, \$75 other brand at participating pharmacies	
Inpatient Physician & Surgeon's Services	Covered 90%	Covered 70%	Covered 80%		Covered 60%	

All covered services have applicable deductibles, unless noted otherwise. In-Network deductibles and Out-of-Network deductibles accumulate separately. Out-of-Pocket Maximum totals include the deductible amount.



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	MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
Inpatient Hospital Services S/P Room & Board Operating & Recovering Room Lab & X-Ray Drugs, Medications Hemodialysis Radiation & Chemotherapy Internal Prosthetics Rehabilitation Therapy	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Outpatient Surgical Charges Operating & Recovery Room Lab & X-Ray	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Outpatient Treatments Hemodialysis Radiation & Chemotherapy	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Outpatient Professional Fees (includes anesthesiologist, surgeons, co-surgeons, pathology interpretations, etc.)	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Outpatient X-Ray & Lab (including preadmission testing)	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Other Health Care Facilities (Skilled Nursing & Rehabilitation)	Covered for 45 days Subject to deductible and coinsurance	Covered for 45 days Subject to deductible and coinsurance	Covered for 45 days Subject to deductible and coinsurance	Covered for 45 days Subject to deductible and coinsurance
Home Health Care	Covered 90% 60 visits per year	Covered 70% 60 visits per year	Covered 80% 60 visits per year	Covered 60% 60 visits per year
Durable Medical Equipment	Covered 50% after deductible	Covered 50% after deductible	Covered 50% after deductible	Covered 50% after deductible
External Prosthetic Appliances	Covered 50%	Covered 50%	Covered 50%	Covered 50%

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	MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
Family Planning Vasectomy Tubal Ligation	Covered 90% Covered 90%	Covered 70% Covered 70%	Covered 80% Covered 80%	Covered 60% Covered 60%
Infertility Diagnosis & Treatment Abortions	Covered 90% \$20,000 Lifetime Max	Covered 70% \$20,000 Lifetime Max	Covered 80% \$20,000 Lifetime Max	Covered 60% \$20,000 Lifetime Max
Emergency Care Doctor's Office Hospital Emergency Room or other Urgent Care Facility	Not Covered	Not Covered	Not Covered	Not Covered
Ambulance	\$25 Co-pay	Covered 70%	\$25 Co-pay	Covered 60%
Mental Health Inpatient	Covered 90% after \$75 Access fee	Covered 70% after \$75 Access Fee	Covered 80% after \$75 Access Fee	Covered 60% after \$75 Access Fee
Outpatient	Covered 90%	Covered 70%	Covered 80%	Covered 60%
Substance Abuse Inpatient & Outpatient	Covered 90% Covered up to 30 visits per year	Covered 70% Covered up to 30 visits per year	Covered 80% Covered up to 30 visits per year	Covered 60% Covered up to 30 visits per year
Hospital, Surgical, Mental Health, Pre-Certification	Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more than \$3,905 outpatient per year \$25,000 Lifetime Max combined	Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more than \$3,905 outpatient per year \$25,000 Lifetime Max combined	Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more than \$3,905 outpatient per year \$25,000 Lifetime Max combined	Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more than \$3,905 outpatient per year \$25,000 Lifetime Max combined
Pre-Existing Condition Limitations	Employee must pre-certify \$500 non-compliance penalty	Employee must pre-certify \$500 non-compliance penalty	Employee must pre-certify \$500 non-compliance penalty	Employee must pre-certify \$500 non-compliance penalty
Chiropractic Coverage	Treatment or 12 months insured	Treatment or 12 months insured	Treatment or 12 months insured	Treatment or 12 months insured
	\$25 Co-pay, \$1,500 per year	Covered 70%, \$1,500 per year	\$25 Co-pay, \$1,500 per year	Covered 60%, \$1,500 per year

**Note on PPO HSA 1 and HSA 2: Schools may offer a choice of one of the PPO HSAs and one of the following plans: PPO 90,
PPO 80 \$500,
PPO 80 \$1,000**

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Out-of-Pocket Maximum totals include the deductible amount.