



**CSI INSURANCE PLAN AND TRUST FUND**  
**Medical Plan Options 2010/2011**  
**Schedule A: Trustmark PPO Plans**  
**Schedule B: Trustmark Plans PPO HSA 1 and PPO HSA 2**

<b>SCHEDULE B</b>	<b>TRUSTMARK PPO HSA 1</b>		<b>TRUSTMARK PPO HSA 2</b>	
	<b>MEDICAL BENEFITS</b>			
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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	\$1,200/\$2,400	\$1,200/\$2,400	\$3,050/\$6,150	\$3,050/\$6,150
Out-of-Pocket Maximum	\$3,200/\$6,400	\$5,200/\$10,400	\$6,150/\$11,900	\$8,500/\$17,000
Lifetime Maximum	\$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
Primary Care Physician Services	Covered 100% (no deductible)	Covered 100% (no deductible)	Covered 100% (no deductible)	Covered 100% (no deductible)
Preventive Care				
Well Child Care	<i>Adult</i> - \$500 plan year max <i>Child</i> - \$500 plan year max	<i>Adult</i> - \$500 plan year max <i>Child</i> - \$500 plan year max	<i>Adult</i> - \$500 plan year max <i>Child</i> - \$500 plan year max	<i>Adult</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 80% every 12 months More often if medically necessary	Covered 60% every 12 months More often if medically necessary
Primary Care & Specialty Physician Services	Covered 80%	Covered 60%	Covered 80%	Covered 60%
Therapies in a physician's office : (Physical, Speech, Occupational, etc.)	Limited to 60 days (visits) per year	Limited to 60 days (visits) per year	Limited to 60 days (visits) per year	Limited to 60 days (visits) per year
Prescription Drugs	Covered at in-network deductible and 80% coinsurance	Covered at in-network deductible and 80% coinsurance	Covered at in-network deductible and 80% coinsurance	Covered at in-network deductible and 80% coinsurance
Inpatient Hospital Services	Covered 80%	Covered 60%	Covered 80%	Covered 60%
S/P Room & Board				
Operating & Recovering Room				
Lab & X-Ray				
Drugs, Medications				
Hemodialysis				
Radiation & Chemotherapy				
Internal Prosthetics				
Rehabilitation Therapy				
Inpatient Physician & Surgeon's Services	Covered 80%	Covered 60%	Covered 80%	Covered 60%

All covered services have applicable deductibles, unless noted otherwise. If you have family coverage, the full family deductible must be met before any benefits are paid. In-Network deductibles and Out-of-Network deductibles accumulate separately. The Out-of-Pocket Maximum totals include deductible amounts.



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	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Outpatient Surgical Charges Operating & Recovery Room, Lab & X-Ray	Covered 80%	Covered 60%	Covered 80%	Covered 60%
Outpatient Treatments Hemodialysis Radiation & Chemotherapy	Covered 80%	Covered 60%	Covered 80%	Covered 60%
Outpatient Professional Fees (includes anesthesiologist, surgeons, co- surgeons, pathology interpretations, etc.)	Covered 80%	Covered 60%	Covered 80%	Covered 60%
Outpatient X-Ray & Lab (including preadmission testing)	Covered 80%	Covered 60%	Covered 80%	Covered 60%
Other Health Care Facilities (Skilled Nursing & Rehabilitation)	Covered 80% for 45 days per year Subject to deductible and coinsurance	Covered 60% for 45 days per year Subject to deductible and coinsurance	Covered 80% for 45 days per year Subject to deductible and coinsurance	Covered 60% for 45 days per year Subject to deductible and coinsurance
Home Health Care	Covered 80% 60 visits per year	Covered 80% 60 visits per year	Covered 80% 60 visits per year	Covered 60% 60 visits per year
Family Planning Vasectomy Tubal Ligation Infertility Diagnosis & Treatment Abortions	Covered 80% Covered 80%  Covered 80% \$20,000 Lifetime Max Not Covered	Covered 60% Covered 60%  Covered 60% \$20,000 Lifetime Max Not Covered	Covered 80% Covered 80%  Covered 80% \$20,000 Lifetime Max Not Covered	Covered 60% Covered 60%  Covered 60% \$20,000 Lifetime Max Not Covered
Durable Medical Equipment	Covered 50% Subject to deductible and coinsurance	Covered 50% Subject to deductible and coinsurance	Covered 50% Subject to deductible and coinsurance	Covered 50% Subject to deductible and coinsurance
External Prosthetic Appliances	Covered 50%	Covered 50%	Covered 50%	Covered 50%
Emergency Care Doctor's Office Hospital Emergency Room or other Urgent Care Facility Ambulance	Covered 80% Covered 80% after \$75 Access Fee  Covered 80%	Covered 60% Covered 60% after \$75 Access Fee  Covered 60%	Covered 80% Covered 80% after \$75 Access Fee  Covered 80%	Covered 60% Covered 60% after \$75 Access Fee  Covered 60%

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	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Mental Health Inpatient	Covered 80% 30 days per year	Covered 60% 30 days per year	Covered 80% 30 days per year	Covered 60% 30 days per year
Outpatient	Covered 80% Covered up to 30 visits per year	Covered 60% 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
Substance Abuse Inpatient & Outpatient	Covered 80% Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more that \$3,905 outpatient per year. \$25,000 Lifetime Max combined	Covered 60% Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more that \$3,905 outpatient per year \$25,000 Lifetime Max combined	Covered 80% Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more that \$3,905 outpatient per year. \$25,000 Lifetime Max combined	Covered 60% Limited to 1 outpatient visit per 7 days. \$10,000 Plan year Max with no more that \$3,905 outpatient per year \$25,000 Lifetime Max combined
Hospital, Surgical, Mental Health, Pre- Certification	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
Pre-Existing Condition Limitations	Treatment or 12 months insured	Treatment or 12 months insured	Treatment or 12 months insured	Treatment or 12 months insured
Chiropractic Coverage	Covered 80% for a maximum of \$1,500 per year	Covered 60% for a maximum of \$1,500 per year	Covered 80% for a maximum of \$1,500 per year	Covered 60% for a maximum of \$1,500 per year

In this schedule, we have attempted to summarize as clearly as possible the benefits available to you under the CSI Group Insurance Plan. All the provisions of the Plan are contained in the master policy issued by Trustmark Life Insurance Company. Since the master policy is complete in detail, the final interpretation of any specific provision is governed by it.

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