



CHRISTIAN SCHOOLS
INTERNATIONAL

CSI INSURANCE PLAN AND TRUST FUND
Medical Plan Options 2008/2009
Priority Health Plans POS, HMO 100, HMO 80, HSA, and HRA

MEDICAL BENEFITS	POS (Point-of-Service)		HMO 100	HMO 80	HSA Health Savings Account	HRA Health Advantage HMO
	In-Network	Out-of-Network				
General Plan Information						
Annual Deductible/Individual	\$250	\$1,000	\$250	\$500	\$1,100	\$1,000
Annual Deductible/Family	\$500	\$2,000	\$500	\$1,000	\$2,200 (If you have family coverage, the full family deductible must met before any benefits are paid.)	\$2,000
Employer Funding of Deductible	N/A	N/A	N/A	N/A	School Choice	School Choice: First 90% of deductible, or 50% up to the deductible
Rollover	N/A	N/A	N/A	N/A	Yes	No
Coinsurance	100%	70% of R&C	100%	80%	80%	100%
Office Visit/Exam	\$15 copay PCP services	70% of R&C after deductible	\$15 copay PCP services	\$20 copay PCP services	80% after deductible (preventive care covered 100%)	\$15 copay PCP services
Outpatient Specialist Visit	\$30 copay	70% of R&C after deductible	\$30 copay	\$35 copay	80% after deductible	\$30 copay
Annual Out-of-Pocket Limit/Individual	\$250 plus copays	\$2,000	\$250 plus copays	\$1,300 plus copays	\$2,100	\$1,000 plus copays
Annual Out-of-Pocket Limit/Family	\$500 plus copays	\$4,000	\$500 plus copays	\$3,400 plus copays	\$4,200	\$2,000 plus copays
Deductible Included in Out-of-Pocket	Yes	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	\$1,000,000	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Required	Yes	No	Yes	Yes	Yes	Yes
Preventive Services (Outpatient)						
Well-Child Care	\$15 copay PCP services	70% of R&C after deductible	\$15 copay PCP services	\$20 copay PCP services	Preventive care 100%	\$15 copay PCP services
Immunizations	\$15 copay PCP services	70% of R&C after deductible	\$15 copay PCP services	\$20 copay PCP services	Preventive care 100%	\$15 copay PCP services
Well Woman Exams	\$15 copay PCP services	70% of R&C after deductible	\$15 copay PCP services	\$20 copay PCP services	Preventive care 100%	\$15 copay PCP services
Mammograms	100%	70% of R&C after deductible	100%	80%	Preventive care 100%	100%
Adult Periodic Exams with Preventive Tests	\$15 copay PCP services	70% of R&C after deductible	\$20 copay PCP services	\$20 copay PCP services	Preventive care 100%	\$15 copay PCP services
Diagnostic X-Ray and Lab Tests	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	Preventive Care - 100% otherwise 80% after deductible	100%, after deductible
Maternity Care						
Routine Pregnancy and Maternity Care (Pre-Natal Care)	\$15 copay, Maximum of 4 copays per pregnancy	70% of R&C after deductible	\$15 copay, Maximum of 4 copays per pregnancy	\$20 copay, Maximum of 4 copays per pregnancy	Physician 100%.	\$15 copay, Maximum of 4 copays per pregnancy
Inpatient Delivery	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible
Inpatient Hospital Services						
Pre-Authorization of Services Required	Yes by PCP	Yes by member. 20% penalty for non-precertification.	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible



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Surgical Services						
Outpatient Facility Charge	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible
Emergency Services						
Emergency Room	\$100 copay	\$100 copay	\$100 copay	\$100 copay	80%, after deductible	\$100 copay
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	No	Copay Waived, Deductible Still Applies
Urgent Care						
Urgent Care Facility	\$45 copay	70% of R&C after deductible	\$45 copay	\$50 copay	80%, after deductible	\$45 copay
Mental Health Benefits						
Inpatient Care - 20 Days per Contract Year	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible
Outpatient Care - 20 Visits per Contract Year	\$20 copay	70% of R&C after deductible	\$20 copay	\$20 copay	80%, after deductible	\$20 copay
Alcohol & Substance Abuse						
Inpatient Care						
Inpatient Hospitalization: To minimum annual benefit as determined by the State of Michigan per contract year	80%, after deductible	70% of R&C after deductible. 20% Penalty for non-pre-certification	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible
Outpatient Care						
Outpatient Services - To minimum annual benefit as determined by the State of Michigan per contract year	80%, after deductible	70% of R&C after deductible	80%, after deductible	80%, after deductible	80%, after deductible	80%, after deductible
Prescription Drug Benefits						
Generic	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay after deductible	\$10 copay
Brand (Formulary/Preferred)	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay after deductible	\$40 copay
Brand (Non-Formulary/Non-preferred)	\$40 copay with approval	\$40 copay with approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay after deductible 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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Mail Order						
Generic	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay after deductible	\$20 copay
Brand (Formulary/Preferred)	\$80 copay	\$80 copay	\$80 copay	\$80 copay	\$80 copay after deductible	\$80 copay
Brand (Non-Formulary/Non-preferred)	\$80 copay with approval	\$80 copay with approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay after deductible 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
Other Services and Supplies						
Durable Medical Equipment & Prosthetic Devices	50%, after deductible	50% of R&C 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	70% of R&C after deductible	\$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.	80%, after deductible	\$150 copay Annual maximum of 10 copays per individual. Copay waived if performed while confined in hospital
Home Health Care	100%, after deductible	70% of R&C after deductible	100%, after deductible	100%, after deductible	80%, after deductible	100%, after deductible
Skilled Nursing or Extended Care Facility - 45 days per Contract Year	100%, after deductible	70% of R&C after deductible 20% penalty for non-precertification	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible
Hospice Care - 45 days per Contract Year	100%, after deductible	70% of R&C after deductible	100%, after deductible	80%, after deductible	80%, after deductible	100%, after deductible
Spinal Manipulation Services	Limited coverage up to 4 visits each contract year	50% of R&C. Maximum of \$300 per Contract Year	Limited coverage up to 4 visits each contract year	Limited coverage up to 4 visits each contract year	Limited coverage up to 4 visits each contract year subject to deductible	Limited coverage up to 4 visits each contract year
Infertility						
Diagnosis and treatment of underlying cause of infertility	50%, after deductible	Not covered	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible
Outpatient Rehabilitative Therapy Services						
Includes physical, occupational, speech, cardiac & pulmonary therapies. Benefit is combined for all therapies.	\$15 copay. Up to 60 visits each contract year	70% of R&C after deductible Maximum of 60 visits each contract year	\$15 copay. Up to 60 visits each contract year	\$20 copay. Up to 60 visits each contract year	80%, after deductible up to 60 visits each contract year.	\$15 copay. Up to 60 visits each 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.