



CHRISTIAN SCHOOLS  
INTERNATIONAL

## CSI INSURANCE PLAN AND TRUST FUND

### Priority Health Medical Plan Options 2008/2009 Health by Choice Incentives

MEDICAL BENEFITS	Health by Choice Incentives HMO 1		Health by Choice Incentives HMO 2		HSA
	Choice Benefits	Standard Benefits	Choice Benefits	Standard Benefits	Health Savings Account
<b>General Plan Information</b>					
Annual Deductible/Individual	N/A	\$750	\$250	\$1,000	\$1,100
Annual Deductible/Family	N/A	\$1,500	\$500	\$2,000	\$2,200 (If you have family coverage, the full family deductible must met before any benefits are paid.)
Employer Funding of Deductible	N/A	N/A	N/A	N/A	School Choice
Rollover	N/A	N/A	N/A	N/A	Yes
Coinsurance	100%	80%	90%	70%	80%
Office Visit/Exam	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	80% after deductible
Outpatient Specialist Visit	\$25 copay	\$35 copay	\$30 copay	\$40 copay	80% after deductible
Annual Out-of-Pocket Limit/Individual	Copays only	\$1,500 plus copays	\$750 plus copays	\$2,250 plus copays	\$2,100
Annual Out-of-Pocket Limit/Family	Copays only	\$3,000 plus copays	\$1,500 plus copays	\$4,500 plus copays	\$4,200
Deductible Included in Out-of-Pocket	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes	Yes	Yes
<b>Preventive Services (PCP Office/Outpatient)</b>					
Well-Child Care	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	Preventive care 100%
Immunizations	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	Preventive care 100%
Well Woman Exams	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	Preventive care 100%
Mammograms	100%	100%	100%	100%	Preventive care 100%
Adult Periodic Exams with Preventive Tests	\$10 copay PCP services	\$20 copay PCP services	\$15 copay PCP services	\$25 copay PCP services	Preventive care 100%
Diagnostic X-Ray and Lab Tests	100%	80%, after deductible	90%, after deductible	70%, after deductible	Preventive Care - 100% otherwise 80% 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	Physician 100%.
Inpatient Delivery	100%	80%, after deductible	90%, after deductible	70%, after deductible	80%, after deductible
<b>Inpatient Hospital Services</b>					
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	80%, after deductible	90%, after deductible	70%, after deductible	80%, after deductible



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<b>Surgical Services</b>					
Outpatient Facility Charge	100%	80%, after deductible	90%, after deductible	70%, after deductible	80%, after deductible
<b>Emergency Services</b>					
Emergency Room	\$100 copay	\$100 copay	\$100 copay	\$100 copay	80%, after deductible
Copay/Deductible Waived if Admitted	Copay Waived	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	Copay Waived, Deductible Still Applies	No
<b>Urgent Care</b>					
Urgent Care Facility	\$40 copay	\$50 copay	\$45 copay	\$55 copay	80%, after deductible
<b>Mental Health Benefits</b>					
Inpatient Care - 20 Days per Contract Year	100%	80%, after deductible	90%, after deductible	70%, after deductible	80%, after deductible
Outpatient Care - 20 Visits per Contract Year	\$20 copay	\$20 copay	\$20 copay	\$20 copay	80%, after deductible
<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	80%	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	80%	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 after deductible
Brand (Formulary/Preferred)	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay after deductible
Brand (Non-Formulary/Non-preferred)	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay w/approval	\$40 copay after deductible 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)



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<b>Mail Order</b>					
Generic	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay after deductible
Brand (Formulary/Preferred)	\$80 copay	\$80 copay	\$80 copay	\$80 copay	\$80 copay after deductible
Brand (Non-Formulary/Non-preferred)	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay w/approval	\$80 copay after deductible w/ approval
Number of Days Supply for Mail Order	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
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.	80%, after deductible
Home Health Care	100%	100%, after deductible	100%, after deductible	100%, after deductible	80%, after deductible
Skilled Nursing or Extended Care Facility - 45 days per Contract Year	100%	100%, after deductible	100%, after deductible	100%, after deductible	80%, after deductible
Hospice Care - 45 days per Contract Year	100%	100%, after deductible	100%, after deductible	100%, after deductible	80%, after deductible
Spinal Manipulation Services	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	Limited coverage up to 4 visits each contract year	Limited coverage up to 4 visits each contract year subject to 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
<b>Outpatient Rehabilitative Therapy Services</b>					
Includes physical, occupational, speech, cardiac & pulmonary therapies. Benefit is combined for all therapies.	\$10 copay. Up to 60 visits each Contract Year	\$20 copay. Up to 60 visits each Contract Year	\$15 copay. Up to 60 visits each Contract Year	\$25 copay. Up to 60 visits each Contract Year	80% after deductible. 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.

Revised 04/18/2008