

The information on this document applies to January 1, 2009 – December 31, 2009 only

Plan Provisions	SHIP
Care Providers/Network	Alliance Select (Select) provider network; Life-threatening emergencies are covered in a hospital ER
Deductible Single/Family	Inpatient only: \$300 per covered admission for Select providers and \$600 per covered admission for non-Select providers
Out-of-Pocket Maximum (OPM) Single/Family	\$1,000 per hospital inpatient stay
Coinsurance	10% for Select inpatient hospital charges; 20% for non-Select inpatient hospital charges
Co-Payment	See plan details – does not apply toward OPM
Benefits Available from Non-Participating Providers	Co-payments, deductibles and co-insurance are higher and the individual is responsible for charges above usual and customary rates (UCR)
OUTPATIENT/AMBULATORY SERVICES	
Office Visits	\$10 copayment for Select provider; \$30 copayment for non-Select provider; *\$1,500 combined maximum benefit
Outpatient Mental Health Visits	\$10 copayment for Select provider; \$30 copayment for non-Select provider; *\$1,500 combined maximum benefit
Outpatient Substance Abuse Visits	\$10 copayment for Select provider; \$30 copayment for non-Select provider; *\$1,500 combined maximum benefit
Routine Physicals	Not covered
Well-Child Care	No cost for children to age 7 (includes required Immunizations)
X-ray and Lab	Diagnostic only - \$10 copayment at Physicians Office; \$50 copayment at Outpatient Facility; **\$1,500 combined maximum benefit
Outpatient Surgery	\$50 copayment for Select hospital; \$150 copayment for non-Select hospital
Allergy Treatments	\$10 copayment for Select physician; \$30 copayment for non-Select physician; *\$1,500 combined maximum benefit
Speech, Occupational, Respiratory and Physical Therapy Services	\$10 copayment for Select physician; \$30 copayment for non-Select physician; *\$1,500 combined maximum benefit
Immunizations	\$0 for Children under 7 years of age; no coverage for children over 7 years of age
Routine Eye Exam	Not covered
Eyeglasses	Not covered
Routine Hearing Exam	Not covered
Hearing Aid	Not covered
Chiropractor	\$10 copayment for Select provider; \$30 copayment for non-Select provider; *\$1,500 combined maximum benefit
Durable Medical Equipment	\$10 copayment for Select provider; \$30 copayment for non-Select provider *\$1,500 combined maximum benefit
Dental Accident Care	\$10 copayment for Select provider; \$30 copayment for non-Select provider; treatment must be completed within 6 mo of injury; *\$1,500 combined maximum benefit
INPATIENT/HOSPITAL SERVICES	
Emergency Room Care	\$50 copayment for Select hospital; \$150 copayment for non-Select hospital
Inpatient Hospital Room and Board for Medical and Mental Health care	10% coinsurance after \$300 deductible for Select hospital; 20% coinsurance after \$600 deductible for non-Select hospital
Inpatient Physician Services	Included in hospital deductible and coinsurance
Inpatient Supplies, Drugs, Medicines, etc.	10% coinsurance after \$300 deductible for Select hospital; 20% coinsurance after \$600 deductible for non-Select hospital
PRESCRIPTIONS	
Prescription Drugs and Contraceptives	Tier 1: Generic drugs 25% coinsurance Tier 2: Name brand formulary drugs 30% coinsurance Tier 3: Name brand non-formulary drugs 50% coinsurance \$500 maximum benefit for single contract \$750 for all other contracts

* Combined annual \$1,500 maximum benefit

** Combined annual \$1,500 maximum benefit