

THE UNIVERSITY OF IOWA

HEALTH INSURANCE OPTIONS

PLAN PROVISIONS	SHIP	UIGRADCare
Co-insurance Percentage	10% for Select inpatient hospital; 20% for non-Select inpatient hospital	10%
Out-of-Pocket Maximums Single/Family	\$1,000 per hospital stay	\$1,100/\$1,700 \$1,100/\$1,700 outpatient drugs
Pre-existing Condition Waiting Period	None	None
Pre-approval of Inpatient Admissions	Required	Required
Second Surgical Opinion	Voluntary	Voluntary
Prior Approval for Outpatient Surgery	None	Physician discretion
Benefits Available from Non-member Providers	Co-payment deductibles and co-insurance are higher plus individual is responsible for charges above UCR	Not available without approved referrals

OFFICE CARE

Office Calls	\$10 co-payment for Select provider; \$30 co-payment for non-Select provider; \$1,500 maximum benefit*	No cost
Routine Physicals	Not covered	No cost (10% co-insurance for lab and x-ray)
X-Ray and Lab	Diagnostic only; \$10 co-payment at Physicians Office \$50 co-payment at Outpatient Facility Maximum of \$1,500/year*	10% co-insurance
Well-Child Care	No cost for children to age 7 (includes required immunizations)	No cost to age 7 (includes required immunizations)
Routine Eye & Hearing Exam	Not covered	\$10 co-payment

HOSPITAL SERVICES

Room and Board	10% co-insurance after \$300 deductible for Select; hospital; 20% co-insurance after \$600 deductible for non-Select hospital; semi-private room	10% co-insurance after \$75 daily deductible; semi-private room
Physicians Services	Included in hospital deductible and co-insurance	10% co-insurance
Inpatient Surgery	10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital	10% co-insurance
Inpatient Supplies, Drugs	10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital	10% co-insurance

OUTPATIENT SERVICES Student Insurance**UIGRADCare**

Ambulance	\$10 co-payment for Select providers; \$30 co-payment for non-Select; \$1,500 maximum benefit*	10% co-insurance
Allergy Treatments	\$10 co-payment for Select physician; \$30 co-payment for non-Select physician; \$1,500 maximum benefit*	\$10 co-payment
Chiropractor	\$10 co-payment for Select provider; \$30 co-payment for non-Select; \$1,500 maximum benefit*	\$10 co-payment; referral for over 12 visits
Dental Accident Care	\$10 co-payment for Select; \$30 co-payment for non-Select; treatment must be completed within 6 months of injury; \$1,500 maximum benefit*	10% co-insurance; treatment must be completed within 6 months of injury
Durable Medical Equipment	\$10 co-payment for Select provider; \$30 co-payment for non-Select provider; \$1,500 maximum*	10% co-insurance
Speech, Occupational, Respiratory, and Physical Therapy	\$10 co-payment for Select provider; \$30 co-payment for non-Select; \$1,500 maximum benefit*	10% co-insurance
Prescription Drugs and Oral Contraceptives	3-tier plan \$500 maximum benefit for single contract \$750 for all other contracts (see page 5)	\$7 or 25%, whichever is greater \$1,100 OPM for single contract \$1,700 for all other contracts
Immunizations	Children to age 7 only	\$10 co-payment; no cost to age 7 for required immunizations
Home Health Care	Maximum of 30 days/calendar year	10% co-insurance
Emergency Services	\$50 co-payment for Select hospital; \$150 co-payment for non-Select hospital	10% co-insurance after \$25 co-payment
Outpatient Surgery	\$50 co-payment for Select hospital; \$150 co-payment for non-Select hospital;	10% co-insurance
Organ Transplants	Prior approval; cornea, kidney coverage only	Prior approval
Skilled Nursing Facility	Maximum of 30 days per calendar year	10% co-insurance after \$75 daily deductible
Hospice Care	Covered	10% co-insurance
Dependent Child Age Limit	18 or unlimited if full-time student	19 or unlimited if full-time student
Lifetime Maximum	\$250,000 per individual	None
Not Covered	Eyeglasses, Hearing Aid, Infertility Treatment, Routine Physicals	Eyeglasses, Hearing Aid, Infertility Treatment

MENTAL HEALTH/CHEMICAL DEPENDENCY

Inpatient Hospital Room and Board	10% co-insurance after \$300 for Select 20% co-insurance after \$600 for non-Select	10% co-insurance after \$75 daily deductible; pre-approval of admission required; semi-private room
Inpatient Physician Care	Included in hospital deductible and co-insurance	10% co-insurance
Outpatient	\$10 co-payment; maximum \$1,500 combined with other outpatient services*	\$0 for participating providers, otherwise 50%

*These services have a combined maximum of \$1,500