

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	\$1,200/\$1,800 \$1,200/\$1,800 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 the maximum allowable fee	Not available without approved referrals
Dependent Child Age Limit	25 (if residing in the State of Iowa) or unlimited if full-time student	25 (if residing in the State of Iowa) or unlimited if full-time student
Lifetime Maximum	\$250,000 per individual	None

OFFICE CARE

Office Calls	\$10 co-payment for Select provider; \$30 co-payment for non-Select provider; \$1,500 maximum benefit*	\$10 co-payment
Routine Physicals	Not covered	\$0 co-pay (10% co-insurance for lab and imaging)
Gynecological pelvic examinations and Pap Smears	Covered (1 per calendar year unless medically-necessary)	Covered
Imaging 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 (routine eye exam \$0 co-pay at UIHC)

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 \$125 daily deductible; semi-private room
Physicians Services Inpatient Surgery	Included in hospital deductible and co-insurance 10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital	10% co-insurance 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
Dental Accident Care	\$10 co-payment for Select; \$30 co-payment for non-Select; treatment must be completed within 12 months of injury; \$1,500 maximum benefit*	10% co-insurance; treatment must be completed within 12 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 \$1,200 OPM for single contract \$1,800 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 \$50 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 Services	Maximum of 30 visits per calendar year	10% co-insurance after \$125 daily deductible
Hospice Care	Covered	10% co-insurance
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 \$125 daily deductible; pre-approval admission required; semi-private room
Inpatient Physician Care	Included in hospital deductible and co-insurance	10% co-insurance
Outpatient	\$10 co-payment for Select providers; \$30 co-payment for non-Select providers	\$10 co-payment for participating providers, otherwise 50% co-insurance

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

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