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# THE UNIVERSITY OF IOWA

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## HEALTH INSURANCE OPTIONS

PLAN PROVISIONS	SHIP
Co-insurance Percentage	10% for Select inpatient hospital; 20% for non-Select inpatient hospital
Out-of-Pocket Maximums	\$1,000 per hospital stay
Pre-existing Condition Waiting Period	None
Pre-approval of Inpatient Admissions	Required
Second Surgical Opinion	Voluntary
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

PREVENTIVE CARE	
Immunizations	Children to age 7 only
Well-Child Care	No cost for children to age 7
Gynecological Pelvic Exams and Pap Smears	Covered (1 per calendar year unless medically necessary)
Not Covered	Routine Physicals Routine Eye Exam Hearing Exam

HOSPITAL SERVICES	
Room and Board Semi-private Room	10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital;
Physicians Services	Included in hospital deductible and co-insurance
Inpatient Surgery	10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital
Outpatient Surgery	\$50 co-payment for Select hospital; \$150 co-payment for non-Select hospital;
Inpatient Supplies, Drugs, Tests, ICU, Operating Room, and Specialized Care	10% co-insurance after \$300 deductible for Select hospital; 20% co-insurance after \$600 deductible for non-Select hospital

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## OUTPATIENT SERVICES

The following services have a \$10 co-payment for Select providers; \$30 co-payment for non-Select providers; and a **total combined maximum benefit of \$1,500 per year**.

Allergy Treatments	Chiropractor
Ambulance	Durable Medical Equipment
Office Calls	Speech, Occupational and Respiratory Therapy
Physical Therapy	Dental Accident Care (completed within 6 months)
Outpatient Mental Health/Chemical Dependency	\$10 co-payment for Select providers \$30 co-payment for non-Select providers
Imaging and Lab	Diagnostic only; \$10 co-payment at Physicians Office \$50 co-payment at Outpatient Facility Maximum of \$1,500/year
Prescription Drugs/Oral Contraceptives	\$500 maximum for single/\$750 maximum for all other contracts (see page 3)
Emergency Room Services	\$50 co-payment \$150 co-payment for non-Select hospital
Home Health Care	Maximum of 30 visits per calendar year
Organ Transplants	Prior approval; cornea, kidney coverage only
Skilled Nursing Services	Maximum of 30 days per calendar year
Blood	10% co-insurance after \$300 deductible for Select hospital 20% co-insurance after \$600 deductible for non-Select hospital
Hospice Care	Covered
Domestic Partner	Yes, same sex or opposite sex
Dependent Child Age Limit	25 (if residing in the State of Iowa) or unlimited if full-time student
Lifetime Maximum	\$250,000 per individual
Not Covered	Eyeglasses Hearing Aid Infertility Treatment Routine Physicals