IMPORTANT:
There is a provision for health & dental insurance through the University of Iowa after you leave. If you wish to utilize this option, complete the application on page 12. The continuation application must be made within 45 days of leaving the University of Iowa.
Contents
M E M O R A N D U M ................................................................................................................................. 4
CONTINUATION POLICY ............................................................................................................................ 5
HEALTH INSURANCE RATES ....................................................................................................................... 5
DENTAL INSURANCE RATES ..................................................................................................................... 5
OPEN ENROLLMENT PERIODS: ................................................................................................................... 5
ENROLLMENT INFORMATION: .................................................................................................................. 5
STUDENT HEALTH INSURANCE PLAN ..................................................................................................... 6
HOW AN INDIVIDUAL USES THE SHIP PLAN .......................................................................................... 6
IDENTIFICATION CARDS & POLICY INFORMATION .................................................................................. 6
BILLINGS ..................................................................................................................................................... 6
PRIVACY NOTICE AND RELEASE FORM .................................................................................................. 6
CANCELLATIONS .......................................................................................................................................... 7
COVERAGE TERMINOLOGY ............................................................................................................................. 7
Per-Service Co-payment: .............................................................................................................................. 7
Deductibles: .................................................................................................................................................. 7
Co-insurance: ................................................................................................................................................. 7
Out-of-Pocket Maximum (OPM): .................................................................................................................. 7
Medical Necessity Provision: ....................................................................................................................... 7
Pre-certification: ............................................................................................................................................. 8
Admission Review: ....................................................................................................................................... 8
BENEFIT SUMMARY ..................................................................................................................................... 8
OTHER FACTS YOU SHOULD KNOW ......................................................................................................... 8
REPATRIATION BENEFIT .............................................................................................................................. 8
MEDICAL EVACUATION BENEFIT ................................................................................................................. 9
OUT-OF-POCKET MAXIMUM (OPM) EXPENSES FOR INDIVIDUALS .......................................................... 9
HEALTH CARE FOR INDIVIDUALS WHO ARE AWAY FROM IOWA ............................................................ 9
HEALTH INSURANCE OVERVIEW ............................................................................................................... 10
DENTAL INSURANCE PLAN .......................................................................................................................... 12
HOW AN INDIVIDUAL USES THE DENTAL INSURANCE PLAN ................................................................. 12
HOW MUCH AN INDIVIDUAL PAYS FOR DENTAL SERVICES .................................................................. 12
VISION DISCOUNT PROGRAM ...................................................................................................................... 12
DEPARTING STUDENT INSURANCE PLANS ............................................................................................... 13
ENROLLMENT FORM ..................................................................................................................................... 13
The University of Iowa prohibits discrimination in employment, educational programs, and activities on the basis of race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associated preferences, or any other classification that deprives the person of consideration as an individual. The University also affirms its commitment to providing equal opportunities and equal access to University facilities. For additional information on nondiscrimination policies, contact the Director, Office of Equal Opportunity and Diversity, the University of Iowa, 202 Jessup Hall, Iowa City, Iowa 52242-1316. 319-335-0705 (voice), 319-335-0697 (TDD), diversity@uiowa.edu.
Dear University of Iowa Departing Students:

The University of Iowa is concerned about the potential threat the high cost of health and dental care may pose to your financial well-being. For this reason, the University offers health and dental insurance coverage to individuals who have recently ceased being an enrolled student through the University of Iowa.

The premium for a student-only health policy is $140.00 per month while the dental policy is $25.00 per month. After leaving the University of Iowa, you may continue coverage up to 12 months. You may seek care from any provider you choose. However, if you use an Iowa “Blue Cross & Blue Shield Provider” or Delta Dental provider, your costs will generally be much lower. The University of Iowa Hospitals and Clinics (UIHC), Mercy Hospital, and Family Practice Clinics are Blue Cross & Blue Shield Providers in Iowa City. The College of Dentistry is a Delta Dental provider in Iowa City.

Once you have enrolled in the plan you will be sent a membership card to present to care providers. The card includes phone numbers to call if you have questions or require pre-certification for certain procedures.

The rates and terms of coverage described in this booklet are effective beginning September 1, 2015 through August 31, 2016.

If you decide this insurance is suitable for your situation, your signed and completed enrollment form must be returned to the University Benefits Office by the appropriate enrollment deadline (see page 1). For additional information, you may contact the University Benefits Office at 120 University Services Building or call 319-335-2676 or toll-free 877-830-4001.

The University of Iowa recommends that all departing students be covered under some type of health and dental insurance. We urge you to give the enclosed information your immediate attention.
HEALTH INSURANCE RATES
Effective September 1, 2015 through August 31, 2016

<table>
<thead>
<tr>
<th>TYPE OF CONTRACT</th>
<th>MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT</td>
<td>$140.00</td>
</tr>
<tr>
<td>STUDENT &amp; SPOUSE/DOMESTIC PARTNER</td>
<td>$604.00</td>
</tr>
<tr>
<td>STUDENT &amp; CHILDREN</td>
<td>$882.00</td>
</tr>
<tr>
<td>STUDENT, SPOUSE/DOMESTIC PARTNER &amp;</td>
<td>$1,163.00</td>
</tr>
<tr>
<td>CHILDREN</td>
<td></td>
</tr>
</tbody>
</table>

DENTAL INSURANCE RATES
Effective September 1, 2015 through August 31, 2016

<table>
<thead>
<tr>
<th>TYPE OF CONTRACT</th>
<th>MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT</td>
<td>$25.00</td>
</tr>
<tr>
<td>STUDENT &amp; SPOUSE/DOMESTIC PARTNER</td>
<td>$45.00</td>
</tr>
<tr>
<td>STUDENT &amp; CHILDREN</td>
<td>$62.00</td>
</tr>
<tr>
<td>STUDENT, SPOUSE/DOMESTIC PARTNER &amp;</td>
<td>$79.00</td>
</tr>
<tr>
<td>CHILDREN</td>
<td></td>
</tr>
</tbody>
</table>

OPEN ENROLLMENT PERIODS:
August 3, 2015 to October 5, 2015
December 2, 2015 to February 3, 2016
May 2, 2016 to July 1, 2016

To enroll, simply detach the continuation enrollment form in this brochure, complete it, and return the form to the University Benefits Office, 120 University Services Building, Iowa City, Iowa 52242-1911 during the appropriate enrollment period.

ENROLLMENT INFORMATION:
In order to apply for the student insurance continuation, you must apply within 45 days of leaving the University of Iowa.

- Coverage will begin the first day of the month following your departure from The University of Iowa.
- Rates are valid from September 1, 2015 until August 31, 2016.

Questions regarding premium charges should be directed to the University Benefits Office at 120 University Services Building or call (319) 335-2676 or toll-free 877-830-4001.
SHIP is available to students who have recently left the University of Iowa. SHIP is a Blue Cross & Blue Shield Classic Blue Plan, which provides coverage for preventive care, hospitalization, surgery, maternity, well-baby/well-child care, emergency care for accident or illness, medically-necessary physician care, prescription drugs, and mental health.

**HOW AN INDIVIDUAL USES THE SHIP PLAN**

Health care under this plan is provided by various groups of health care practitioners, suppliers, agencies, programs, and facilities called Blue Cross and Blue Shield Classic Blue Providers who have agreed to join with Wellmark Blue Cross and Blue Shield of Iowa to offer each student affordable health care.

To receive the greatest benefits from SHIP, we advise you to use the physicians from the Blue Cross & Blue Shield Classic Blue Provider list which can be accessed at the Wellmark website here.

**IDENTIFICATION CARDS & POLICY INFORMATION**

You will receive identification (ID) cards 10-21 business days after their application has been processed. A Coverage Manual that details complete information on benefits, definitions, terms, and exclusions is available from the University Benefits Office and on the University Benefits Office website at [http://hr.uiowa.edu/benefits](http://hr.uiowa.edu/benefits). A list of providers may be accessed at Wellmark’s website at [www.wellmark.com](http://www.wellmark.com).

**BILLINGS**

All premiums will be charged on a monthly basis. You will receive a bill from the University of Iowa for your health insurance premium. You may choose to have premiums deducted from a savings or checking account by completing the appropriate section on the enrollment form or an Authorization for Automatic Withdrawal of Insurance Premiums form, available in the University Benefits Office or through the forms link via the University Benefits Office website.

**PRIVACY NOTICE AND RELEASE FORM**

Federal law requires individuals to sign a release form before any information can be released regarding their health benefit information. No information will be given to a spouse/domestic partner, parent, child, or other representative unless that form is on file in the University of Iowa Benefits Office. If you wish health information released to anyone, complete the Personal Health Information Release Form at the end of this booklet.
CANCELLATIONS
Coverage can be cancelled for the following reasons:

- You become ineligible for the continuation coverage under the policy twelve months after leaving the University (i.e., if a student leaves in May 2014 and begins their continuation policy effective June 1, 2014, their insurance coverage will terminate on May 31, 2015 as they have exhausted the continuation benefit of the health insurance plan).
- The student may cancel coverage by providing a written request to the University of Iowa Benefits Office. Coverage will terminate the last day of the month in which the request is made. The termination cannot be retroactive. No refund of premiums will be given.
- The University of Iowa Benefits Office will cancel coverage for non-payment of premium.

COVERAGE TERMINOLOGY
SHIP is designed for you to be responsible for some of the direct costs of your health care through per-service co-payments, deductibles and co-insurance provisions as explained below.

**Per-Service Co-payment:**
A per-service co-payment is an amount that you pay to your provider each time you receive care. Your cost will generally be less when you use a Blue Cross & Blue Shield Classic Blue facility or practitioner.

**Deductibles:**
A deductible is the amount you pay for covered services for each separate admission to a hospital or nursing facility. This amount is subject to the benefit maximums. Deductible amounts apply only to inpatient admissions.

**Co-insurance:**
Co-insurance is the amount calculated using a fixed percentage that you pay for covered services after you have met the deductible responsibility. Your cost will generally be less when you use a Blue Cross & Blue Shield Classic Blue facility or practitioner.

**Out-of-Pocket Maximum (OPM):**
The OPM is the highest dollar amount you would pay for covered services. Your OPM equals your per-service deductible plus the co-insurance amounts and any co-payments.

**Medical Necessity Provision:**
The benefits available through SHIP apply only to medically-necessary care. Only your medical condition is considered in determining the medical necessity of a covered service. Non-medical factors, such as your financial or family situation, are not considered. The fact that a physician may prescribe or recommend a service does not mean it will automatically meet the standards for medical necessity. You should discuss the medical necessity of services with Wellmark 1-800-535-6099 before treatment or services are performed.

The following is a description of the notification components with which you need to comply when you use Blue Cross & Blue Shield facilities or providers.
Pre-certification:
(Non-Emergency Admission) Before you are admitted to a hospital or nursing facility for a nonemergency procedure, or before you use home health care or hospice program services or services that require prior approval, you must contact Wellmark Blue Cross and Blue Shield of Iowa and receive pre-certification to determine if your care is medically-necessary. Participating practitioners and hospitals must do this for you; non-participating providers are not required to do so, so you must do it.

Admission Review:
(Emergency and Maternity Admissions) If you are admitted on an inpatient basis to the hospital for emergency or maternity services, your admission does not need to be pre-certified to receive the maximum benefits. However, Wellmark Blue Cross and Blue Shield of Iowa must be notified by you or your provider within 24 hours of your admission. The toll-free telephone number is printed towards the back of this brochure and on your identification card (ID).

If you or your provider does not notify Wellmark as required, you may have to pay as much as 25% of the cost of your care yourself in addition to the deductible and co-insurance amounts you are required to pay. You will be responsible for care that is determined not to be medically-necessary. These are excellent reasons to seek care from a Blue Cross & Blue Shield participating provider.

BENEFIT SUMMARY
More detailed information is provided in the Coverage Manual available online at the University Benefits Office website here or by contacting the University Benefits Office. The benefit summary in this booklet provides a brief description of the important features of your Coverage Manual. This booklet is not your Coverage Manual. Only the actual benefit provisions in your Coverage Manual will determine your benefits. Please read your Coverage Manual carefully.

OTHER FACTS YOU SHOULD KNOW
- We may terminate your coverage without advance notice for fraudulent use of your policy.
- You become ineligible for continuation coverage under the policy twelve months after leaving the University.
- Wellmark Blue Cross and Blue Shield of Iowa will coordinate benefits with other group health carriers when duplicate coverage exists. Total payment from this coverage and all other group health coverages under which you are enrolled shall not exceed 100 percent of the cost of the covered services.

This is a general description of your coverage. It is not a statement of contract. Your actual coverage is subject to the terms and conditions specified in the policy between the University of Iowa and Wellmark Blue Cross and Blue Shield of Iowa.

REPATRIATION BENEFIT
A repatriation benefit applies to the student, spouse/domestic partner, or child covered under the policy. This must be applied toward those expenses incurred in returning the body to the person’s place of residence in his or her home country including, but not limited to, the cost of embalming, coffin, and transportation of the body.
MEDICAL EVACUATION BENEFIT

Medical evacuation services will be covered in the event of illness or injury to participants if necessary and adequate medical care cannot be provided at the location where the illness or injury occurs.

Medical evacuation benefits cover expenses to the nearest appropriate medical facility and/or to the participant’s home country. Pre-certification of medical evacuation services is required.

OUT-OF-POCKET MAXIMUM (OPM) EXPENSES FOR INDIVIDUALS

SHIP provides an OPM of $1,700 for Single and $3,400 for Family. There is also a separate OPM of $1,000 for Single and $2,000 for Family for prescription drugs. The OPM equals the per-service deductible plus the co-insurance and co-payment amounts. The OPM refers to the maximum amount you will pay for most covered services during an inpatient stay.

When the amount paid by the insured equals the OPM, the plan pays 100% of the maximum allowable fee for covered charges incurred for that admission. The maximum allowable fee is the amount established by Wellmark using various methodologies for covered services and supplies.

HEALTH CARE FOR INDIVIDUALS WHO ARE AWAY FROM IOWA

SHIP provides coverage worldwide. Choosing a Blue Cross & Blue Shield provider can be an advantage when receiving treatment.

The insured is responsible for telephoning the Blue Cross and Blue Shield of Iowa toll-free number before being admitted to a hospital for non-emergency care and within 24 hours of emergency and maternity admissions.

PRESCRIPTION DRUGS (3-TIER PLAN)

Preferred name brand drugs are drugs that are on Wellmark’s preferred list available on their website at www.wellmark.com.

If you purchase a brand name drug when an FDA-approved “A”-rated generic equivalent is available, you are responsible for your co-payment or co-insurance, plus any difference between the billed charge for the brand name drug and the billed charge for the generic. This can result in you paying substantially higher costs than if you had chosen the generic drug.

If your physician feels it is important for you to have the brand name drug, they can write the prescription for the brand name drug with the direction “Dispense As Written” on the prescription. In this situation you will not be responsible for the difference between the billed charge for the brand name drug and the billed charge for the generic drug.

Self-administered, self-injectable drugs are covered under your medical insurance with 10% co-insurance.
# UNIVERSITY OF IOWA

## HEALTH INSURANCE OVERVIEW

**EFFECTIVE JANUARY 1, 2016**

<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>SHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-insurance Percentage</td>
<td>10%; participating / non-participating providers</td>
</tr>
<tr>
<td>Out-of-Pocket Maximums</td>
<td>$1,700 for single / $3,400 for family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drugs:</td>
</tr>
<tr>
<td></td>
<td>$1,000 for single and $2,000 for family</td>
</tr>
<tr>
<td>Pre-approval of Inpatient Admissions</td>
<td>Required</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Benefits Available from Non-member</td>
<td>Individual is responsible for charges above the maximum allowable fee</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>Yes, same sex or opposite sex</td>
</tr>
<tr>
<td>Dependent Child Age Limit</td>
<td>End of calendar year in which the individual turns 26 or unlimited if full-time student</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVENTIVE CARE</th>
<th>SHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>Covered; $0 co-pay</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>Covered; $0 co-pay</td>
</tr>
<tr>
<td>Gynecological Pelvic Exams and Pap Smears</td>
<td>Covered; $0 co-pay (1 per calendar year unless medically necessary)</td>
</tr>
<tr>
<td>Routine Physicals</td>
<td>Covered; $0 co-pay (1 per calendar year unless medically necessary);</td>
</tr>
<tr>
<td>Not Covered</td>
<td>Routine Eye Exam</td>
</tr>
<tr>
<td></td>
<td>Hearing Exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES</th>
<th>SHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Semi-private Room</td>
<td>10% co-insurance after $300 deductible</td>
</tr>
<tr>
<td>Physicians Services</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Inpatient / Outpatient Surgery &amp; Supplies</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>OUTPATIENT SERVICES</td>
<td>SHIP</td>
</tr>
<tr>
<td>---------------------</td>
<td>------</td>
</tr>
<tr>
<td>Allergy Treatments</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Speech Occupational and Respiratory Therapy</td>
<td></td>
</tr>
<tr>
<td>Dental Accident Care (completed within 12 months)</td>
<td></td>
</tr>
<tr>
<td>Imaging and Lab</td>
<td>$15 co-payment</td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
</tr>
<tr>
<td>Chiropractic visits</td>
<td></td>
</tr>
<tr>
<td>Mental Health visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Tier and what you pay per tier: 1. Generic drugs; 25% 2. Preferred name brand drugs; 30% 3. Non-preferred name brand drugs; 50%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$50 co-payment</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Maximum of 30 visits per calendar year</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Prior approval; cornea, kidney coverage only</td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>Maximum of 30 days per calendar year</td>
</tr>
<tr>
<td>Not Covered</td>
<td>Eyeglasses Hearing Aid Infertility Treatment Travel Vaccines</td>
</tr>
</tbody>
</table>
DENTAL INSURANCE PLAN

HOW AN INDIVIDUAL USES THE DENTAL INSURANCE PLAN
Dental care under this plan can be obtained from any provider; however, there are advantages to using participating providers who have contracts with Delta Dental of Iowa, the dental insurance plan administrator. A list of plan providers may be accessed via the web at the University Benefits Office website here. You will receive an ID card from Delta Dental of Iowa which you should present to your provider when you receive care.

Participating providers will accept payment arrangements and file claims for you. Payment is made directly to these providers.

Non-participating providers have not agreed to accept Delta Dental’s payment arrangements. This means you are responsible for any difference between your dentist’s covered charges and the Delta allowance. These dentists are not responsible for filing your claims. Claims are settled directly with you and you are then responsible for making payment to your provider.

HOW MUCH AN INDIVIDUAL PAYS FOR DENTAL SERVICES
Insureds will pay nothing out-of-pocket for diagnostic and preventive services, which includes dental cleaning, oral evaluation, imaging, diagnostic tests, fluoride applications (under age 19), sealant applications (under age 19), space maintainer (under age 14), and biopsy of oral tissue.

There is a $25 deductible per person, with a maximum deductible of $75 for a family, for restorative services (cavity repair, tooth extraction, root canals, treatment of gum and bone disease). In addition, the insured pays 20% of the remaining covered services.

For high cost restorations, such as crowns, inlays, dentures, and bridges there is a $25 deductible per person, with a maximum of $75 for a family. In addition, you pay 50% co-insurance for the remainder of covered services.

There are no benefits for orthodontics.

This plan will pay maximum of $1,000 per covered individual per year.

VISION DISCOUNT PROGRAM
Through Delta Dental vision partnership with EyeMed Vision Care, Delta Dental offers all members access to a vision discount program at no cost. The vision discount program provides the following features:

- Discounts on eye exams
- Discounted pricing for lenses and lens options
- Savings on eyeglass frames and conventional contact lenses
- Unlimited use
- Discounts on LASIK and PRK
- Competitive pricing on contact lenses through Contact Lens by Mail
- Access to a large, diverse network of providers

Using Your EyeMed Discount Program:
- Locate an EyeMed provider by calling 1-866-246-9041 or use the online directory.
- When scheduling your appointment, inform the office that you are a Delta Dental member with an EyeMed discount plan.
- Once you arrive, present your Delta Dental ID card or download a discount card to receive discount services. Your EyeMed provider will take care of the rest!

For full details on the discount program visit Delta Dental website.
DEPARTING STUDENT INSURANCE PLANS
2015-2016

ENROLLMENT FORM
Please complete, sign, and return this enrollment form to:

UNIVERSITY OF IOWA
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING
IOWA CITY, IOWA  52242-1911
FAX:  319-335-2776

You will be billed monthly through the University of Iowa student billing system or bank account, if appropriate.

AGREEMENT AND CERTIFICATION
I certify that I am legally authorized to apply for coverage myself and for all persons named in this enrollment form. I understand that I am making application for the coverage sponsored by the University of Iowa, offered by Wellmark, Inc., doing business as Blue Cross and Blue Shield of Iowa and by Delta Dental of Iowa.

I certify that, after this enrollment form was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Wellmark Blue Cross and Blue Shield of Iowa and Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statement made, and that if I have made any fraudulent statements or intentional misrepresentations of any material fact, Wellmark Blue Cross and Blue Shield of Iowa or Delta Dental of Iowa will be entitled to declare the contract applied for void and to refuse allowance of benefits to any person thereunder.

I authorize any provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa and Delta Dental of Iowa when reasonably related to the care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

The University of Iowa is hereby authorized to charge my University bill or bank account, as appropriate, for the premium. I understand that if the University bill on which the premium first appears is not paid when due, the coverage may be canceled.

(Visit the next page)
DEPARTING STUDENT ENROLLMENT FORM

PART 1: ENROLLMENT BEGINNING DATE

Coverage will begin the first day of the month following your departure from the University of Iowa.

□ 09/01/2016  □ 01/01/2016  □ 06/01/2016  □ Other: _____ / 01 / 2_____

PART 2: YOUR INFORMATION

Full Name (Last, First, Middle Initial): ________________________________
University ID Number (8 digits): ________________________________ Date of Birth: ________________________________ Sex (M/F): ________________________________
Residing Address, City, State & Zip Code: ________________________________
Telephone Number: ________________________________ E-mail: ________________________________

PART 3: HEALTH INSURANCE

Select your health plan: □ SHIP
□ ENROLL me in Health Insurance
□ CANCEL my Health Insurance

PART 4: DENTAL INSURANCE

Select your dental plan: □ Student Dental Insurance
□ ENROLL me in Dental Insurance
□ CANCEL my Dental Insurance

PART 5: DEPENDENT INFORMATION

<table>
<thead>
<tr>
<th>NAME: Last, First, Middle Initial</th>
<th>Relationship Code</th>
<th>Sex (M/F)</th>
<th>Birthdate (MM/DD/YY)</th>
<th>Social Security #</th>
<th>Health</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: Last, First, Middle Initial</td>
<td>Relationship Code</td>
<td>Sex (M/F)</td>
<td>Birthdate (MM/DD/YY)</td>
<td>Social Security #</td>
<td>Health</td>
<td>Dental</td>
</tr>
<tr>
<td>NAME: Last, First, Middle Initial</td>
<td>Relationship Code</td>
<td>Sex (M/F)</td>
<td>Birthdate (MM/DD/YY)</td>
<td>Social Security #</td>
<td>Health</td>
<td>Dental</td>
</tr>
</tbody>
</table>

PART 6: OPTIONAL ACH AUTHORIZATION

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU WISH TO HAVE YOUR HEALTH INSURANCE PREMIUMS DEDUCTED FROM A CHECKING ACCOUNT RATHER THAN BILLED TO YOUR UNIVERSITY BILL. AUTHORIZATION FOR PRE-AUTHORIZED PAYMENTS OF STUDENT HEALTH INSURANCE PLAN PREMIUMS TO BE PAID TO THE UNIVERSITY OF IOWA.

I HEREBY AUTHORIZE THE UNIVERSITY OF IOWA TO INITIATE DEBIT ENTRIES TO MY ACCOUNT INDICATED BELOW AND THE FINANCIAL INSTITUTION NAMED BELOW. HEREAFTER TO DEBIT THE SAME TO SUCH ACCOUNT.

The University of Iowa requests this information for the purpose of establishing the payment of your Student Health Insurance Plan premiums. Individuals outside the University employed by the institution who will administer this benefit will have access to this information. No other persons outside the University are routinely provided this information. If you fail to provide the required information, the University cannot authorize the direct payment from your institution to the University of your health insurance premiums.

(PLEASE ATTACH A VOIDED CHECK OR OTHER DOCUMENT CONTAINING THE INFORMATION BELOW)

FINANCIAL INSTITUTION: ________________________________ ADDRESS: ________________________________ CITY, STATE: ________________________________

TRANSIT/ABA NUMBER: 8 OR 9 DIGIT #: ________________________________ YOUR ACCOUNT NUMBER: ________________________________ □ CHECKING □ SAVINGS

SIGNATURE OF ACCOUNT HOLDER: ________________________________ DATE: ________________________________

PART 7: AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification language on the back of this form.

Student’s Signature: ________________________________ Date: ________________________________

Return Form To: University Benefits Office, 120 University Services Bldg., Iowa City, IA 52242; e-mail: benefits@uiowa.edu; fax: 319-335-2776

© University of Iowa, 2016

For Benefits Use: [008-00876]
Universi ty Benefits Office
Personal Health Information Release Form

{THIS FORM IS OPTIONAL}
Please complete this form in its entirety. This release is not valid if it does not contain the employee or student's original signature and date signed or if it has expired as described below. This form will replace any that were previously submitted. Only those people listed on this form will have information released to them.

I, (employee/student full name) ____________________________________________, employee/student ID #__________________ hereby authorize; University of Iowa Benefits Office, 120 University Services Building, Iowa City, IA 52242, to disclose information from my benefit and health records to the individual(s) or Agency(s) named below:

Please print the name of the person/s you want to be able to receive information:

Full Name(s)/Company: ______________________________________________________

Relation to you: ____________________________________________________________

(Leave “To” blank, if you would like this form to be open ended)

Covering the periods (print date MM/DD/YY): From: _______________ To: _______________

Affirmation of Release:

I give the University of Iowa Benefits Office permission to release my benefit and health information to the individual(s) or agency(s) I have named. I understand that this release is valid from the date I sign it and I may revoke this authorization at any time. Any revocation of this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. I have the right to access the records of who has contacted the Benefits Office for information about me. Copies of the records may be obtained with reasonable notice and payment of copying costs.

Signature: ________________________________ Date: ____________________
AFFIDAVIT OF DOMESTIC PARTNERSHIP
CONFIDENTIAL

We, (Print Name of Employee/Student) __________________________________________, and
(Print Name of Domestic Partner) __________________________________________ certify that:

1. We are not married to anyone.
2. We are at least eighteen (18) years of age or older.
3. We are not related by blood closer than would bar marriage in the State of Iowa and are mentally competent to consent to contract.
4. We are each other’s sole domestic partner and intend to remain so indefinitely.
5. We agree to support each other during the term of our domestic partner relationship by being jointly responsible for each other’s necessities, including without limitation, food, clothing, housing and medical care.
6. Our relationship meets at least two of the following four conditions (please check those that apply, A-D):
   
   A. □ We have a common or joint ownership of a residence (home, condominium, or mobile home) or a lease for a residence identifying both partners as tenants.
   
   B. □ We have at least two of the following (please check which two apply)
      
      1. □ Joint ownership of a motor vehicle
      2. □ Joint checking account
      3. □ Joint credit account
      4. □ Durable power of attorney for health care or financial management
   
   C. □ The Domestic Partner has been designated as the primary beneficiary for at least one of the following (please check which one applies):
      
      1. □ Employee’s life insurance
      2. □ Employee’s will
      3. □ Employee’s retirement contract
   
   D. □ A “relationship contract” has been executed which obligates each of the parties to provide support for the other party and provides, in the event of the termination of the relationship, for a substantially equal division of any property acquired during the relationship.

7. We understand that domestic partners are subject to the same window period governing all other individuals who are covered by or applying for benefit plan coverage. Any children, new employment, adoptions, new marriages, and domestic partnerships are all subject to a thirty (30) day limit on the enrollment period beginning on the date of the event.
8. If our domestic partnership relationship terminates, we will notify the University of Iowa Benefits Office within thirty (30) days of the termination of our domestic partnership. A written termination statement shall be provided to the University Benefits Office and shall affirm that the partnership is terminated and that a copy of the termination statement has been mailed to the other partner.

9. We understand that any person, employer, or company who suffers any loss because of false statements contained in an “Affidavit of Domestic Partnership” may bring a civil action against us to recover their losses, including reasonable attorney fees.

10. We provide the information in this affidavit to be used by the University Benefits Office for the sole purpose of determining our eligibility for domestic partnership benefits. We understand that this information will be held confidential and will be subject to disclosure only upon our expressed written authorization or pursuant to a court order.

11. We affirm, under penalty of perjury, that the ascertainments in this affidavit are true to the best of our knowledge.

Signature of Employee/Student: __________________________________________

Employee/Students Social Security Number: ________________________________

Employee’s Date of Birth: ________________ Today’s Date: _________________

Signature of Domestic Partner: ____________________________________________

Domestic Partner’s Social Security Number: _________________________________

Domestic Partner’s Date of Birth: ________________ Today’s Date: ________________

SUBMIT DECLARATION TO:

University of Iowa Benefits Office
120 University Services Building
Iowa City, IA  52242-1911
Fax: 319-335-2776
QUESTIONS AND ANSWERS

Q: Will all my expenses be covered by insurance?
A: No. “Insurance” does not mean “all your care is free”. Review the information about what is and is not covered. If you have questions about a specific service or procedure, call Wellmark Blue Cross and Blue Shield at 1-800-535-6099 or Delta Dental of Iowa at 1-800-544-0718.

Q: What do I do if I get a bill and I can’t pay?
A: Call the doctor or hospital’s billing office. Generally, they will try to set up a payment plan that you can afford. If you meet certain low-income guidelines and have small children, you may be eligible for help from the county, state, or federal government. Check listings in the phone book for places to contact.

If your insurance has not paid their portion of the claim, contact them to see if there is a problem. Pay the co-payment or co-insurance for which you are responsible and contact the doctor or hospital’s billing office to explain the situation.

DON’T IGNORE THE BILL. It won’t go away and may end up on your credit report, which could affect your ability to rent an apartment or buy a house or car.

Q: What if I think there is fraud involved?
A: For reporting potential health care fraud and abuse, visit the University of Iowa’s Benefits website under Health Information.
WHO TO CONTACT

Questions about claims or specific SHIP coverage:
If you have questions about claims or specific questions about your SHIP coverage, you should call Wellmark Blue Cross and Blue Shield of Iowa.

Wellmark Blue Cross and Blue Shield of Iowa
P.O. Box 9232
Des Moines, IA  50306-9232
Wellmark website

Claims Inquiries (toll-free)
1-800-535-6099

For Pre-certification call (toll-free)
1-800-558-4409

Mail order prescription claims:
CVS/caremark
P.O. Box 94467
Palatine, IL  60094-4467
Register at Caremark
1-866-611-5961

Questions about claims or specific dental coverage:
If you have questions about claims or specific questions about your dental coverage, you should call Delta Dental of Iowa.

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA  50131-9000
1-800-544-0718

Questions about SHIP or dental coverage, eligibility, adding dependents, brochures and enrollment forms, enrollment periods, or premium charges:

University of Iowa Benefits Office
120 University Services Building
Iowa City, IA  52242-1911

Benefits website
benefits@uiowa.edu

Office:  319-335-2676
Toll-Free:  877-830-4001
Fax:  319-335-2776