IMPORTANT:
Health science and International students will be billed for insurance unless proof of coverage is provided annually by the printed deadline (see pages 15 - 17). There will be no refunds for charges after these dates.
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The University of Iowa prohibits discrimination in employment, educational programs, and activities on the basis of race, national origin, color, creed, religion, sex, age, disability, veteran status, sexual orientation, gender identity, or associational preference. The University also affirms its commitment to providing equal opportunities and equal access to University facilities. For additional information on nondiscrimination policies, contact the Office of Equal Opportunity and Diversity, (319) 335-0705 (voice), and (319) 335-0697 (text), 202 Jessup Hall, University of Iowa, Iowa City, Iowa 52242-1316.
MEMORANDUM

TO: Graduate, Health Science, and Professional Students
FROM: Richard G. Saunders, Assistant Vice President for Human Resources
SUBJECT: Health and Dental Insurance Coverage

Welcome to the University of Iowa

The University of Iowa is concerned about the potential threat the high cost of health and dental care may pose to a student’s financial well-being. For this reason, health and dental insurance coverage has been made available for Graduate, Health Science, and Professional students through the University of Iowa Student Health Insurance Plan (SHIP) and UIGRADCare, two group policies administered by Wellmark Blue Cross and Blue Shield of Iowa and a group policy administered by Delta Dental of Iowa. To be eligible for student health insurance you must be registered for classes at the time coverage begins. Your coverage will end on the last day of the month in which you cease to be a student. After graduation from the University of Iowa, or no longer a registered student, you may apply to continue coverage for up to 12 months.

If you decide that you want the SHIP or UIGRADCare coverage, your signed and completed application must be returned to the University Benefits Office by the appropriate enrollment deadline. Contact the University Benefits Office at 120 University Services Building or call (319) 335-2676 or toll-free (877) 830-4001, for additional information. Once you have enrolled in the plans, you will be sent membership cards to present to care providers. The cards include phone numbers to call if you have questions or require pre-certification for certain procedures. You will not need to re-enroll at the beginning of each academic year unless changing your coverage. Coverage will end on the last day of the month in which you cease to be a student. After leaving the University of Iowa, you may enroll in SHIP for Departing Students to continue your coverage up to 12 months.

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

The University of Iowa recommends that all students be covered under some type of insurance. We urge you to give the following information your immediate attention.

INTERNATIONAL STUDENTS: You are required to have health insurance in order to attend the University of Iowa and will be billed automatically for student-only, SHIP coverage for each semester in which you are registered. You do not need to return an enrollment form unless you wish to cover your dependents, want to change to the UIGRADCare plan, want to include dental insurance coverage, or you are a graduate student eligible for a University
contribution toward the cost of coverage (see next page). If you do not want the University of Iowa health insurance coverage, you must provide proof of other health insurance coverage that meets the exemption guidelines for international students. The guidelines are found on page 17 of this booklet. Proof of Coverage forms for International Students are included in this booklet and are available in the University Benefits Office. No refund of premiums will be given if proof of insurance is not received by the deadline.

HEALTH SCIENCE STUDENTS IN THE GRADUATE COLLEGE AND THE COLLEGES OF MEDICINE, DENTISTRY, NURSING, AND PHARMACY: You are required to have health insurance in order to attend the University of Iowa and will be billed automatically for student-only, SHIP coverage for each semester in which you are registered. You do not need to return an enrollment form unless you wish to cover your dependents, want to change to the UIGRADCare plan, want to include dental insurance coverage, or are a graduate student eligible for a University contribution towards the cost of coverage (see below). If you do not want the University of Iowa health insurance coverage, you must provide proof of other coverage. This proof must be presented at the beginning of each academic year by the stated deadline. Proof of Coverage forms for Health Science students are included in this booklet and are also available in our office. No refund of premiums will be given if proof of insurance is not received by the specified deadlines.

GRADUATE ASSISTANTS WITH AN APPOINTMENT OF 25% TIME OR MORE OR GRADUATE STUDENTS WITH A FELLOWSHIP OF AT LEAST $9,500 PER YEAR: You may be eligible to receive a contribution toward the purchase of SHIP or UIGRADCare, in addition to dental insurance. Information regarding this will be sent, upon notification of your appointment, to you. You must complete an Employed Graduate Student Insurance Application which will be included in the booklet you receive. If you have questions regarding eligibility, contact the University Benefits Office at (319) 335-2676.
GRADUATE STUDENTS
HEALTH & DENTAL MONTHLY INSURANCE RATES

<table>
<thead>
<tr>
<th>PLAN</th>
<th>GRADUATE STUDENT</th>
<th>GRADUATE STUDENT+SPOUSE</th>
<th>GRADUATE STUDENT+CHILDREN</th>
<th>GRADUATE STUDENT+FAMILY</th>
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<tbody>
<tr>
<td>SHIP</td>
<td>$135.00</td>
<td>$464.00</td>
<td>$800.00</td>
<td>$1,495.00</td>
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<tr>
<td>UIGRADCare</td>
<td>$247.00</td>
<td>$533.00</td>
<td>$1,409.00</td>
<td>$1,041.00</td>
</tr>
<tr>
<td>Dental</td>
<td>$25.00</td>
<td>$41.00</td>
<td>$49.00</td>
<td>$64.00</td>
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- Coverage will begin the first of the month following receipt of your enrollment form unless the form is received during the open enrollment period (see below).
- Coverage for International and Health Science Mandatory students will begin the first of the month in which the student is registered and class begins.
- Premiums will be billed in monthly installments on your University student bill, or charged to your bank account. To have your monthly premiums billed to your bank account, you must fill out an ACH authorization form that is available at the University Benefits Office or on the web here.
- Rates for the SHIP and UIGRADCare plans are valid until August 31, 2015.

OPEN ENROLLMENT PERIODS

- FALL: August 1 to September 5, 2014
- SPRING: January 1 to January 30, 2015
- SUMMER: May 1 to June 5, 2015

Students can only make changes to these plans during the above open enrollment periods, unless there is a significant change in family status or eligibility or coverage under another insurance plan. A change in status can be the result of any of the following events:

- Marriage or divorce, domestic partner affidavit
- Death of a spouse or child
- Birth or adoption of a child
- Change of employment for yourself or spouse

Coverage will begin on the first day of August, January, or May if applications are received within the open enrollment period unless the student indicates another date.
ENROLLMENT, BILLINGS, AND COST
To enroll, simply detach the enrollment form in this brochure, complete it, and return to the University Benefits Office, 120 University Services Building, Iowa City, IA 52242-1911 during the appropriate enrollment period.

All premiums will be charged on a monthly basis to your University account. You may choose to have premiums deducted from a savings or checking account by completing an Authorization for Automatic Withdrawal of Insurance Premiums form, available in the University Benefits Office or through the forms link via the web here.

ELIGIBILITY
SHIP and UIGRADCare are available to Graduate, Health Science and Professional students who are registered for University of Iowa courses at the time coverage begins and who continue to be registered. Students registered for Guided Independent Study courses only are not eligible to participate.

Adding Dependents:
- If a student acquires eligible dependents while insured by this plan, they may only be added within 30 days after becoming eligible or during an open enrollment period (60 days for birth, adoption, or loss of Medicaid or SCHIP coverage).
- Eligible dependents are spouse or same-sex or opposite sex domestic partner. Dependent children, adopted children, stepchildren, and foster children up to the end of calendar year in which they turn 26. Students wishing to insure a domestic partner must complete the Affidavit for Domestic partnership available in the University Benefits Office or on the web here.
- Children over the age of 26 may continue to be covered if they are full-time students.

IDENTIFICATION CARDS AND COVERAGE MANUAL
Insured students will receive identification (ID) cards 10-15 business days after their application has been processed. A Coverage Manual detailing complete information on benefits, terms, and exclusions is available on the University Benefits Office website here or a printed copy may be obtained by contacting the University Benefits Office. A list of providers may be accessed at the Benefits website here.

CANCELLATIONS
Coverage will be continuous unless one of the following occurs:

- Coverage will terminate at the end of the month in which a student ceases to be registered for classes. This includes graduation and withdrawal during a semester. A student wishing coverage for the summer session must either be registered for that session or pre-registered for fall prior to the end of the spring semester.
- Coverage can only be terminated during a semester if a student obtains other insurance or withdraws from school. Coverage will terminate the last day of the month in which one of these events occurs. If cancellation is being requested due to other coverage, the student must provide written documentation to the University Benefits Office.
  No refunds of premiums will be given. If a student withdraws from school, they may continue coverage up to twelve months.
- The University Benefits Office reserves the right to cancel coverage for non-payment of premium.

International students and health science students cannot cancel coverage unless they can provide proof of acceptable coverage under another policy by the specified deadlines.
PRIVACY NOTICE AND RELEASE FORM
Changes in federal law require individuals to sign a release 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 the release is on file in the University Benefits Office. If you wish health information released to anyone, complete the Personal Health Information Release Form at the end of this brochure or through the forms link via the web here.

HEALTH INSURANCE PLANS
The University of Iowa offers Graduate students and Health Science and Professional students two health insurance plans. Both plans are administered by Wellmark Blue Cross and Blue Shield of Iowa.

1. The Student Health Insurance Plan (SHIP) is a Blue Cross & Blue Shield Classic Blue plan. Health care under this plan is provided by various groups of health care practitioners, suppliers, agencies, programs, and facilities.

   Coverage includes hospitalization, surgery, maternity, preventive care, well-baby/well-child care, emergency care for accidents or illness, medically-necessary physician care, imaging and laboratory services, prescription drugs, and mental health.

   Students are urged to take advantage of the University of Iowa Student Health Service when they need health care. SHIP may be used to help pay for laboratory and imaging services incurred at Student Health Service.

2. UIGRADCare is a comprehensive health care program. Under this plan health care is provided by primary care physicians from the University of Iowa Student Health & Wellness, primary care providers at the University of Iowa Hospitals and Clinics, or Community Medical Service Clinics. A woman may also select a UIHC obstetrician/gynecologist as her co-care manager.

   Coverage includes hospital, medical, surgical, outpatient, and other health care services such as physical therapy. In addition, routine physicals, newborn care (including immunizations, scheduled visits, etc.), well-child checkups, prescription drugs, and mental health/chemical dependency are covered.
COVERAGE TERMINOLOGY

**Per-Service Co-payment:** A per-service co-payment is an amount that you pay to your provider each time you receive care. Your costs 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.

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

**Pre-certification:** *(Non-Emergency Admission)* Before you are admitted to a hospital or nursing facility for a non-emergency procedure, or before you use home health care or hospice program services, you must contact Wellmark Blue Cross and Blue Shield of Iowa and receive pre-certification to determine if your care is medically necessary.

**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 that are paid.

**Medical Necessity Provision:** 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 for SHIP or 1-800-355-2031 for UI GradCare) before treatment or services are performed.**

**Pre-certification:** *(Non-Emergency Admission)* Before you are admitted to a hospital or nursing facility for a non-emergency procedure, or before you use home health care or hospice program services, you must contact Wellmark Blue Cross and Blue Shield of Iowa and receive pre-certification to determine if your care is medically necessary.

**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.

BENEFIT SUMMARY

More detailed information is provided in the Coverage Manual, available on line [here](#) or by contacting the University Benefits Office. The benefit summary in this brochure provides a brief description of the important features of your Coverage Manual. This brochure is not your Coverage Manual. Only the actual benefit provisions in your Coverage Manual will determine your benefits. Please read your Coverage Manual carefully.
SHIP
(STUDENT HEALTH INSURANCE PLAN)

SHIP is a Blue Cross & Blue Shield Classic Blue Plan, which provides coverage for hospitalization, surgery, maternity, preventive 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 who have agreed to join with Blue Cross and Blue Shield of Iowa to offer each student affordable health care. Students may also purchase coverage for their spouse or domestic partner and/or dependent children.

The SHIP plan is designed to work in conjunction with Student Health & Wellness. Students are encouraged to take advantage of the University of Iowa Student Health & Wellness when they need health care in order to maximize their benefits. Unlimited office visits at the Student Health & Wellness for general medicine services, surgery, allergy treatment, sexually transmitted diseases, mental health services, and the Health Iowa Education Program are covered by a mandatory health service fee, which is included in tuition charges if a student is enrolled for five (5) or more semester hours of classes. Students who are enrolled for less than five (5) semester hours may choose to pay the health fee and obtain these same benefits. Contact Student Health & Wellness for additional information.

Laboratory and imaging services are available at Student Health & Wellness. Any charges incurred for such services are the responsibility of the student. SHIP may be used to pay for these services up to the payment limits of the plan.

Students may also purchase coverage for their spouse or domestic partner and/or dependent children. Family members are not eligible to use the University of Iowa Student Health & Wellness. To receive the greatest benefits from SHIP, dependents are advised to use the physicians from the Blue Cross & Blue Shield Provider list, which can be accessed at either our website here or on Wellmark’s website here.

OUT-OF-POCKET MAXIMUM (OPM) EXPENSES

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 a calendar year.

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

BLUE CROSS & BLUE SHIELD CARE PROVIDERS

A directory of providers can be accessed on the web at University Benefits Office website, Wellmark’s website or by contacting the University Benefits Office.
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.

MEDICAL EVACUATION BENEFIT
Medical evacuation services will be covered in the event of illness or injury to students and covered family members 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 student’s home country. Pre-certification of medical evacuation services is required.

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.

PRESCRIPTION DRUGS (3-TIER PLAN)
Preferred name brand drugs are drugs that are on Wellmark’s preferred list available at the Wellmark website

If you purchase a brand name drug when an FDA-approved “A”—rated generic equivalent is available, you are responsible for your 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 specialty drugs are covered under your medical insurance with 10% co-insurance.
The UIGRADCare Plan is a comprehensive health care program that covers hospital, medical, surgical, outpatient, and other health care services such as physical therapy. Coverage is also provided for routine physicals, newborn care (including immunizations, scheduled visits, etc.), well-child checkups, mental health/chemical dependency and prescription drugs.

**HOW AN INDIVIDUAL USES THE UIGRADCARE PLAN**

Health care under this plan is provided by primary care physicians, advanced registered nurse practitioners, certified nurse midwives, specialists at the University of Iowa Hospitals and Clinics (UIHC), Student Health & Wellness, and Community Medical Service Clinics.

Unlimited office visits at the Student Health & Wellness for general medicine services, surgery, allergy treatment, sexually transmitted diseases, mental health services, and the Health Iowa Education Program are included in a mandatory health service fee which is included in tuition charges if a student is enrolled for five (5) or more semester hours of classes. Students who are enrolled for less than five (5) semester hours may choose to pay the health fee and obtain these same benefits. Contact Student Health & Wellness for additional information.

The graduate student can choose to receive primary care from Student Health & Wellness, Family Practice or Internal Medicine with the UIHC, or Community Medical Service Clinics. Students are encouraged to develop a relationship with one provider. Female graduate students may also select OB/GYN services from the OB/GYN department at the UIHC. Spouses/domestic partners and children can select their primary care from Family Practice, Internal Medicine and/or Pediatrics. Female spouses and dependents who wish an OB/GYN Co-Care Manager must select them from the UIHC OB/GYN department.

If a student or family member requires care by a specialist, they may contact the appropriate department at UIHC directly.

**HOW MUCH AN INDIVIDUAL PAYS FOR HEALTH CARE SERVICES**

Insureds will pay a $10 co-payment for physician charges associated with an office visit, routine eye and hearing exams. Co-pay is waived for preventive exams and well child care.

Insureds will pay a 10% co-insurance for most other health care services that are covered by the plan.

When care is necessitated by an emergency or an accident, the individual’s share of the costs will be 10% of the charges without regard to where the services are provided or who provides the care. However, when an individual goes to an emergency room, the insured will also pay a co-payment of $50 and then 10% of the remaining charges for treatment. The co-payment is waived upon admission to the hospital.

Whenever an insured is admitted to the University of Iowa Hospitals and Clinics, the individual will pay the first $125 of the hospital charges each day, then 10% of the remaining charges.
OUT-OF-POCKET MAXIMUM (OPM) EXPENSES FOR INDIVIDUALS & FAMILIES

The UIGRADCare Plan provides an annual maximum limit for the OPM expense for both individuals and families.

The OPM for an individual’s expenses is $1,200. The OPM for all other contracts is $1,800.

When the amount paid by the insured equals the applicable OPM, the plan pays 100% of the charges for most additional medically-necessary expenses incurred during the remainder of the calendar year.

Amounts an insured pays as deductibles and co-insurance and co-pays are included when determining the annual OPM expense.

COVERAGE FOR PRESCRIPTION DRUGS

When prescription drugs are purchased from pharmacies that are participating in the plan, the individual will either pay $7 or 25% of the amount charged, whichever is higher. Cost could be higher if the individual uses a non-generic or non-formulary drug. Most pharmacies in Iowa City, Coralville, and North Liberty participate in this plan.

The OPM expense provision for prescription drugs is $1,200 per person. The OPM for all other contracts is $1,800. This OPM is separate from the medical OPM. Once the OPM has been met, the plan pays 100% of the expenses incurred during the rest of the calendar year.

COVERAGE FOR MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

The individual pays 10% co-insurance after a $125 daily deductible for inpatient care.

Note: If care is received from a non-participating provider or facility, you will be required to pay 50% co-insurance. Approved mental health and chemical dependency providers can be accessed from Wellmark’s website here under the Blue Access network, or by calling the University Benefits Office at (319) 335-2676.

CARE PROVIDERS AT UNIVERSITY OF IOWA HOSPITALS AND CLINICS

A Care Manager works with each patient to develop a comprehensive and coordinated plan for health care. When care is provided at UIHC, the individual and Care Manager will agree on the role Residents play in the individual’s care. An individual may choose to have all primary health care provided by faculty members. When an individual is hospitalized, Residents and medical students are an integral part of the staff which provides support for treatment by the faculty.

HEALTH CARE FOR INDIVIDUALS WHO ARE AWAY FROM IOWA CITY

The UIGRADCare Plan provides coverage when:

- an individual is traveling
- an individual is temporarily living somewhere else
- an individual is attending another college or university

Care for an accident or an emergency will be covered as if the incident had happened in the Iowa City area. Out-of-area hospitalization will not be authorized unless it results from an accident or an emergency.

For covered individuals who are temporarily living away from the Iowa City area for 30 days or more while attending school, it is necessary to notify the University of Iowa Benefits Office at the beginning of the residency. Furthermore, when health care necessitates an admission to a hospital in situations that do not involve an emergency or an accidental injury, prior approval must be secured by telephoning the Plan’s toll-free number.
An individual must arrange for routine health care, such as annual physical examinations, to be done by the individual’s Care Manager. However, scheduled newborn or well-child care, such as immunizations, will be covered regardless of where the services are provided.

**MEDICAL EVACUATION BENEFIT**

Medical evacuation services will be covered in the event of illness or injury to students and covered family members if necessary and adequate medical care cannot be provided at the location where the illness or injury occurs. Medical evacuation expenses to the nearest appropriate medical facility and/or to the student’s home country. Pre-certification of medical evacuation services is required.

**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.
**University of Iowa**

**UIGRADCare CLINICS AND LOCATIONS**

**PLEASE READ THE FOLLOWING:**

- Internal Medicine does not accept patients under the age of 16.
- All Family Practice providers provide GYN Services.

**UNIVERSITY STUDENTS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Health &amp; Wellness</td>
<td>Newton Road 4189 Westlawn</td>
<td>(319) 335-8370</td>
</tr>
<tr>
<td></td>
<td>Iowa City, IA 52242</td>
<td></td>
</tr>
<tr>
<td>OB/GYN Clinic at UIHC</td>
<td>200 Hawkins Drive</td>
<td>(319) 384-7999</td>
</tr>
<tr>
<td></td>
<td>Iowa City, IA 52242</td>
<td></td>
</tr>
</tbody>
</table>

**UNIVERSITY STUDENTS, SPOUSES AND DEPENDENTS**

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa City</td>
<td>Family Practice Clinic at UIHC</td>
<td>200 Hawkins Drive Iowa City, IA 52242</td>
</tr>
<tr>
<td></td>
<td>Internal Medicine at UIHC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OB/GYN Clinic at UIHC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pediatrics Clinic at UIHC</td>
<td></td>
</tr>
<tr>
<td>Southeast Iowa City</td>
<td>1130 Scott Boulevard Iowa City, IA 52240</td>
<td>(319) 339-7472</td>
</tr>
<tr>
<td>Muscatine</td>
<td>UI Health Care 3465 Mulberry Avenue</td>
<td>(563) 263-0339</td>
</tr>
<tr>
<td></td>
<td>Muscatine, IA 52761</td>
<td></td>
</tr>
<tr>
<td>North Liberty</td>
<td>UI Family Care Center 3 Lions Drive, Hwy 965 North Liberty, IA 52317</td>
<td>(319) 626-5680</td>
</tr>
<tr>
<td>Riverside</td>
<td>UI Health Care –River Crossing 3056 River Crossing Court Riverside, IA 52327</td>
<td>(319) 467-8355</td>
</tr>
<tr>
<td>Sigourney</td>
<td>UI Family Care Center 1314 S. Stuart Street Sigourney, IA 52591</td>
<td>(641) 622-3840</td>
</tr>
</tbody>
</table>
### PLAN PROVISIONS

<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>SHIP</th>
<th>UIGRADCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-insurance Percentage</td>
<td>10%; participating/non-participating providers</td>
<td>10%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximums</td>
<td>$1,700 for single / $3,400 for family Prescription Drugs: $1,000 for single and $2,000 for family</td>
<td>$1,200 for single / $1,800 for family Prescription Drugs: $1,200 for single / $1,800 for family</td>
</tr>
<tr>
<td>Pre-approval of Inpatient Admissions</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Voluntary</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Benefits Available from Non-member Providers</td>
<td>Individual is responsible for charges above the maximum allowable fee</td>
<td>Not available without approved referral</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>Yes, same sex or opposite sex</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>
<td>End of calendar year in which the individual turns 26 or unlimited if full-time student</td>
</tr>
</tbody>
</table>

### PREVENTIVE CARE

<table>
<thead>
<tr>
<th>PREVENTIVE CARE</th>
<th>SHIP</th>
<th>UIGRADCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>Covered; $0 co-payment</td>
<td>Covered; $0 co-pay</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>Covered; $0 co-pay</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>
<td>Covered $0 co-pay (1 per calendar year unless medically necessary)</td>
</tr>
<tr>
<td>Routine Eye &amp; Hearing Exam</td>
<td>Not covered</td>
<td>$10 co-payment ($0 co-pay at UIHC)</td>
</tr>
</tbody>
</table>

### HOSPITAL SERVICES

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES</th>
<th>SHIP</th>
<th>UIGRADCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Semi-private Room</td>
<td>10% co-insurance after $300 deductible</td>
<td>10% co-insurance after $125 daily deductible</td>
</tr>
<tr>
<td>Physicians Services</td>
<td>10% co-insurance</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Inpatient / Outpatient Surgery &amp; Supplies</td>
<td>10% co-insurance</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>OUTPATIENT SERVICES</td>
<td>SHIP</td>
<td>UIGRADCare</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$15 co-payment</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Allergy Treatments</td>
<td>$15 co-payment</td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Imaging and Lab</td>
<td>$15 co-payment</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Dental Accident Care</td>
<td>$15 co-payment; treatment must be completed within 6 months of injury</td>
<td>10% co-insurance; treatment must be completed within 12 months of injury</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$15 co-payment</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Speech, Occupational, Respiratory, and Physical Therapy</td>
<td>$15 co-payment</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Office visit</td>
<td></td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Chiropractor visit</td>
<td></td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Mental Health visit</td>
<td></td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Tier and what you pay per tier:</td>
<td>$7 or 25%, whichever is greater; $1,200 OPM for single contract</td>
</tr>
<tr>
<td></td>
<td>1. Generic drugs; 25%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Preferred name brand drugs; 30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Non-Preferred name brand drugs; 50%</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Maximum of 30 days/calendar year</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$50 co-pay</td>
<td>$50 co-pay; followed by 10% co-insurance</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Prior approval; cornea, kidney coverage only</td>
<td>Prior approval</td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>Maximum of 30 visits per calendar year</td>
<td>10% co-insurance after $125 daily deductible</td>
</tr>
<tr>
<td>Not Covered</td>
<td>Eyeglasses, Hearing Aid, Infertility Treatment</td>
<td>Eyeglasses, Hearing Aid, Infertility Treatment</td>
</tr>
</tbody>
</table>
ENROLLMENT
Students may only enroll in the dental plan during open enrollment periods (see page 1).

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 Benefits website here. You will receive an identification (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, x-rays, 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 a 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
ALL INTERNATIONAL STUDENTS are required to have health insurance in order to attend the University of Iowa. International students will be automatically billed for a student-only policy under SHIP. Coverage and premium charges will begin the first of the month in which the student is registered and class begins. International students must have insurance beginning the first day of classes and, therefore, will be billed for the months of August and January.

Coverage will extend over the summer unless the student graduates. Students who are pre-registered for fall, but will be out of the U.S. over the summer must bring proof of travel to the University Benefits Office prior to departure in order to avoid being billed for summer insurance premiums.

ADDING DEPENDENTS: If you have a spouse or children who need insurance, you must complete an application to add them to your policy. Applications are available on the University Benefits Office website here. You have only 30 days from the date of arrival, or date of eligibility to add dependents to your policy. You have 60 days from the date of birth to add a dependent to your policy.

EXEMPTION GUIDELINES
1. Must include hospitalization coverage.
2. The insurance must be non-cancelable and fully paid for a minimum period of one semester.
3. The insurance must be renewable for continuous coverage. Conditions covered under the initial policy must not constitute a pre-existing condition under the renewal policy.

ADDITIONAL EXEMPTION REQUIREMENTS FOR STUDENTS WITH A J-1 VISA
1. Medical benefits of at least $50,000 per accident or illness;
2. Repatriation of remains in the amount of $7,500;
3. Expenses associate with medical evacuation of the exchange visitor to his or her home country in the amount of $10,000;
4. A deductible no to exceed $500 per accident or illness.

ATTENTION:
• Monthly payment plans will not be accepted.
• Exemptions will not be made for students or family members leaving the U.S. for a period of less than one month.

SCHOLARSHIPS, SPONSORING AGENCIES OR GOVERNMENT COVERAGE
If you have a scholarship or are sponsored by an agency that provides insurance or assumes payment of your medical costs, you must provide documentation to the University Benefits Office by the deadlines shown on this page.

DEADLINES FOR RECEIVING EXEMPTIONS AND MAKING POLICY CHANGES

<table>
<thead>
<tr>
<th>FALL SEMESTER</th>
<th>SPRING SEMESTER</th>
<th>SUMMER SEMESTER</th>
</tr>
</thead>
</table>

Contact your advisor or the University Benefits Office before the deadline if you have problems or questions regarding the insurance requirement.

After the deadlines shown above, only partial exemptions will be given. You will then be required to pay for coverage through the end of the month in which your insurance documents are accepted. If your documents are not in English, you will be required to have them translated.
HEALTH INSURANCE REQUIREMENTS
FOR GRADUATE AND HEALTH SCIENCE STUDENTS
WITH SIGNIFICANT CLINICAL EXPOSURE

All registered students in the Graduate College and the Colleges of Medicine, Dentistry, Nursing, and Pharmacy who experience significant clinical exposure as part of their training will be required to maintain health insurance (or an equivalent alternative care plan) sufficient to satisfy minimum standards of coverage. Such insurance coverage shall be maintained continuously throughout each year of attendance at the University of Iowa.

Upon registration, and annually thereafter, the student will be required to provide documentation of proof of coverage, by the deadlines stated on the Proof of Coverage form.

Until acceptable documentation is provided, students shall be automatically enrolled and will be charged for participation in SHIP administered through Wellmark Blue Cross and Blue Shield of Iowa.* Charges will be fully deleted for students who provide acceptable documentation of other insurance by the deadline. After the deadline, students will be exempted the first day of the month following receipt of documentation in the University Benefits Office. Students will be responsible for paying all charges up to that date.

International students may be required to comply with additional insurance requirements in accordance with University policies and Federal law.

The minimum standards for complying with the University’s proof of coverage policy is as follows:

1. **Policy Limit**: The health plan/policy should provide coverage for hospitalization including coverage for room and board, physician visits and surgeon services, imaging and lab, and miscellaneous services.
2. **Inpatient Coverage**: Inpatient care shall be required coverage for medically necessary care.
3. **Outpatient Coverage**: The health plan/policy shall provide coverage for medically necessary care including both physician services for treatment of emergencies, illness, accident or injury, and imaging and lab services.

**Required documentation:**

- Completed Proof of Coverage form (page 19).
- Copy of policy or ID card.

If your alternate care plan does not meet the above minimum standards of proof of coverage requirements and you wish to request a waiver, contact the University Benefits Office at 120 University Services Building for a copy of the Health Sciences Waiver Policy.

*Medicaid is not acceptable for exemption purposes, unless you submit a letter from the Department of Human Services that verifies yearly coverage to the Benefits Office.
PROOF OF COVERAGE FORM
FORM MUST BE SUBMITTED EACH ACADEMIC YEAR

YOU WILL ONLY NEED TO COMPLETE THIS FORM IF ANY OF THE FOLLOWING APPLIES TO YOU:

☐ Graduate and Health Science Student (with significant Clinical Exposure)
☐ International Student
☐ J-1 Visa Student

The following information is requested for the purpose of compliance with the University’s health insurance requirement for University of Iowa students. The information will be used by the University Benefits Office for the purpose of identifying and evaluating health care financial responsibility information in accordance with University requirements and will not be released to any party outside the University without the student’s permission, except as permitted law. Additional documentation may be required.

Print Name: ________________________ Please Circle: Male or Female
University ID Number: ________________________ Date of Birth: ________________________

INSURANCE POLICY INFORMATION

Name of Insurance Company: ________________________ Policy #: ________________________
Name of Contract Holder: ________________________
If the insurance policy is through an employer, please give the name and address of employer:
__________________________________________________

Company contact for questions/verification:
Name: ________________________ Phone Number: ________________________

STATEMENT OF FINANCIAL RESPONSIBILITY

I, ________________________, hereby certify that I am covered by health insurance or equivalent health care plan as required by the University of Iowa and I am required to maintain coverage through the duration of my program. If the University determines that the above coverage does not comply with the University’s health insurance requirement, I understand and agree that the University may charge my University bill for health insurance coverage, and I agree to pay all such charges made in accordance with University policy. I understand and agree that I will be responsible for any and all charges for health care services, fees, or deductibles, regardless of whether or not covered by insurance or equivalent plan, which are charged in accordance with University policies and procedures. I further understand and agree that the University of Iowa is not responsible for paying for or providing any medical/hospital care or health insurance coverage for me.

Signature: ________________________ Date: ________________________

Please return this COMPLETED form to:
University Benefits Office
120 University Services Building, Iowa City, IA 52242-1911
e-mail: benefits@uiowa.edu or Fax: 319-335-2776

DEADLINES FOR PROVIDING PROOF OF COVERAGE:

FALL SEMESTER: September 5, 2014
SPRING SEMESTER: January 30, 2015
SUMMER SEMESTER: June 5, 2015

Revised 11/2014
© University of Iowa, 2014
GRADUATE STUDENT INSURANCE PLANS

2014-2015

ENROLLMENT FORM

Please complete, sign, and return the enrollment form to:

UNIVERSITY OF IOWA
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING
IOWA CITY, IOWA  52242-1911

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 have intentionally misrepresented 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)
GRADUATE STUDENT ENROLLMENT FORM

PART 1: ACTION REQUESTED

If you are enrolling outside the open enrollment period, your coverage will begin the first day of the month following the receipt of your enrollment form. What month would you like your coverage to take EFFECT? ___ / 01 / 20___

<table>
<thead>
<tr>
<th>Select your enrollment type:</th>
<th>□ NEW APPLICATION</th>
<th>□ CHANGE</th>
<th>□ ADD DEPENDENT(S)</th>
</tr>
</thead>
</table>

Reason for this action: □ MARRIED □ BIRTH □ LOSS OF COVERAGE

Date of event: ________ □ DIVORCE □ DEATH □ OTHER: (explain):

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 □ UIGRADCare

Select your dental plan: □ Student Dental Insurance

□ ENROLL me in Health Insurance

□ CHANGE my Health 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>

OUT OF AREA: Please fill out this section if you and/or your dependents will be out of the area for 30 days or more.

Employee/Dependent(s): __________________________ Location, if Out of Area: __________________________

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, HEREINAFTER 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)

<table>
<thead>
<tr>
<th>FINANCIAL INSTITUTION:</th>
<th>ADDRESS:</th>
<th>CITY, STATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSIT/ABA NUMBER: 8 OR 9 DIGIT #</td>
<td>YOUR ACCOUNT NUMBER</td>
<td>□ CHECKING □ SAVINGS</td>
</tr>
</tbody>
</table>

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.

Signature (DO NOT PRINT): __________________________ 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, 2014
{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: ___________________________
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
### WHO TO CONTACT

<table>
<thead>
<tr>
<th>SHIP</th>
<th>UIGRADCare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have questions about claims or specific questions about your SHIP coverage, you may call Wellmark Blue Cross and Blue Shield of Iowa.</strong></td>
<td><strong>If you have questions about claims or specific questions about your UIGRADCare coverage, you may call Wellmark Blue Cross and Blue Shield of Iowa.</strong></td>
</tr>
<tr>
<td>Wellmark Blue Cross and Blue Shield of Iowa</td>
<td>Wellmark Blue Cross and Blue Shield of Iowa</td>
</tr>
<tr>
<td>636 Grand Avenue</td>
<td>636 Grand Avenue</td>
</tr>
<tr>
<td>Des Moines, IA 50309-2565</td>
<td>Des Moines, IA 50309-2565</td>
</tr>
<tr>
<td><a href="#">Wellmark Website</a></td>
<td><a href="#">Wellmark Website</a></td>
</tr>
<tr>
<td><strong>Claims Inquiries (toll-free)</strong></td>
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</tr>
<tr>
<td>1-800-535-6099</td>
<td>1-800-355-2031</td>
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<tr>
<td><strong>For Pre-certification call (toll-free)</strong></td>
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<tr>
<td>1-800-558-4409</td>
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<tr>
<td><strong>Prescription claim mailing address:</strong></td>
<td><strong>Prescription claim mailing address:</strong></td>
</tr>
<tr>
<td>Catamaran</td>
<td>Catamaran</td>
</tr>
<tr>
<td>Claims Department</td>
<td>Claims Department</td>
</tr>
<tr>
<td>P.O. Box 1069</td>
<td>P.O. Box 1069</td>
</tr>
<tr>
<td>Rockville, MD 20849-1069</td>
<td>Rockville, MD 20849-1069</td>
</tr>
<tr>
<td><a href="#">Catamaran Website</a></td>
<td><a href="#">Catamaran Website</a></td>
</tr>
<tr>
<td>1-866-611-5961</td>
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</tr>
<tr>
<td><strong>Mail order prescription claim:</strong></td>
<td><strong>Mail order prescription claim:</strong></td>
</tr>
<tr>
<td>Catamaran Home Delivery</td>
<td>Catamaran Home Delivery</td>
</tr>
<tr>
<td>P.O. Box 166</td>
<td>P.O. Box 166</td>
</tr>
<tr>
<td>Avon Lake, OH 44012-9927</td>
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<tr>
<td><a href="#">Catamaran Website</a></td>
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<td><strong>If you have any questions about eligibility for SHIP, adding dependents, brochures and enrollment forms, enrollment periods, premium charges, and general coverage questions, call the University of Iowa Benefits Office.</strong></td>
<td><strong>If you have any questions about eligibility for UIGRADCare, adding dependents, brochures and enrollment forms, enrollment periods, premium charges, and general coverage questions, call the University of Iowa Benefits Office.</strong></td>
</tr>
</tbody>
</table>

### Questions about claims or specific dental coverage:

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

### Questions about SHIP, UIGRADCare, 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  
[University Benefits Website](#)  
Office: (319) 335-2676  
Toll-free: (877) 830-4001  
Fax: (319) 335-2776  
Email: benefits@uiowa.edu