ORIENTATION CHECKLIST

- Turn in your Retirement Plan Election form (within 60 days of your hire date).
- Enroll in Benefits on Self Service site or submit your Personal Enrollment Form to the University Benefits Office at 120 USB. You can deliver in person or send them through campus mail. This is very important because you will not be covered if you do not communicate your benefit elections.
- Review Voluntary Insurance programs here on the Benefits website.
- Sign up for Direct Deposit if you haven’t already. You can do this online at the Employee Self Service website.
- Find out where you receive your campus mail.
MEDICAL INSURANCE PROGRAMS

Medical insurance coverage is available on a voluntary basis. The University contributes towards the medical insurance cost for each regular staff member who holds a 50% time or greater appointment.

Coverage is effective the first of the month following a thirty-day waiting period after your hire date unless your hire date is the first working day of the month, then the effective date is the first of the next month.

An annual open enrollment is held for employees wishing to enroll or change coverage. If you have a qualifying event during the calendar year, you may change health plans or go from single to family or family to single coverage or add a dependent if it is within 30 days of an event (60 days for birth, adoption or loss of Medicaid or SCHIP coverage). An event consists of a change in your family status due to a birth, death, adoption, marriage, divorce, or if your spouse/dependent obtains or loses a job.

Coverage is offered under either a single or a family contract basis. In addition to the subscriber, the family contract may cover:

1. Spouse or common law spouse.
2. Same or opposite-sex domestic partner.
3. Dependent child through the end of the calendar year in which the turn age 26.
4. Dependent children, regardless of age, as long as they are unmarried full-time students.
5. Dependent children, regardless of age, who are totally and permanently disabled, provided such disability was in existence while the child was insured.

The premium rates are computed on a monthly basis and the staff member’s share is deducted from payroll checks as applicable.

You may elect to participate in one of four State of Iowa health insurance plans. All of the plans combine hospital, medical/surgical and major medical coverage into one program. The plans differ in their deductibles, co-insurance, out-of-pocket maximums, and freedom to select providers and facilities.

All plans have a mail-order prescription provision that allows you to receive three months of a prescription medication while only paying two months of co-payments.

If your spouse is also a state employee, you cannot be covered as both an employee and a dependent under the state’s health and dental insurance plans.

If you and your spouse are both state employees, you have four coverage choices under the health and dental plans:

1. You and your spouse may enroll separately in single coverage.
2. You or your spouse my elect single coverage and the other spouse may enroll themselves and dependents in family coverage. The spouse electing single coverage may not be listed as a dependent on the family plan.
3. One spouse may elect to waive coverage and the other spouse may enroll both spouses and dependents in family coverage.
4. The couple may elect family coverage for themselves and their dependent(s) under double-spouse family coverage. One spouse would be designated as the contract holder and make the election for family coverage and the other spouse would be designated as the contributing spouse.

If you and your spouse have children together, only one of you can enroll the eligible children under your insurance plans.
Blue Access Plan
Health care under this plan will be provided by physicians, advanced registered nurse practitioners, certified nurse midwives, and specialists at the University of Iowa Hospitals and Clinics, the University Community Medical Services clinics, and community physicians and facilities that are part of the Wellmark Health Plan of Iowa Directory of Plan Providers for Blue Access. A primary Care Physician is not required.

Referrals are needed for:

- Out-of-network providers – except for emergencies. Prior approvals are needed for all referrals outside the network.
- Chiropractic care beyond 12 visits in a year.

How Much an Individual Pays for Health Care Services
Insureds will pay a $10 co-payment for routine office calls and routine eye and hearing exams. There is no co-insurance on most services.

Insureds will pay 20% co-insurance for durable medical equipment.

When an individual goes to an emergency room for emergency care, the insured will pay a co-payment of $50 – this is waived if the individual is admitted to the hospital.

There is no charge for hospital room and board.

The Blue Access Plan provides an annual maximum limit for the Out of Pocket (OPM) expense for both individuals and families. The OPM for an individual’s expenses is $750. The OPM for Family contracts is $1,500.

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 co-insurance and co-pays are cumulated and determine the annual OPM expense.

When a 30 day supply of prescription drugs are purchased from participating pharmacies, you pay $5 for preferred generic drugs, $15 for preferred name brand drugs, and $30 or 25% (whichever is greater) for non-preferred drugs. There is no OPM for prescription drugs.

Health Care for Individuals Who are Out of Network
The Blue Access Plan provides coverage for any Blue Access network provider, and coverage for emergencies anywhere in the world. An emergency can be considered to be a medical condition that a prudent layperson (with an average knowledge of health and medicine) could reasonably expect to result in serious jeopardy to a person’s health in the absence of immediate medical attention. The emergency services must be provided in an emergency room setting.
**Blue Advantage Plan**

Health care under this plan will be provided by physicians, advanced registered nurse practitioners, certified nurse midwives, and specialists at the University of Iowa Hospitals and Clinics, the University Community Medical Services Clinics, and community physicians and facilities that are part of the Blue Advantage Network of Iowa network. In Iowa City, this network includes Mercy Hospital providers covered under the network. A Primary Care Provider is required. This plan requires you to select and see your Primary Care Provider for routine care.

Referrals are needed for:

- Out-of-network providers – except for emergencies. Prior approvals are needed for all referrals outside the network.
- Chiropractic care beyond 12 visits in a year.

**How Much an Individual Pays for Health Care Services**

Insureds will pay a $10 co-payment for routine office visits and routine eye and hearing exams. There is no co-insurance on most services.

Insureds will pay 20% co-insurance for durable medical equipment.

There is no charge for hospital room and board.

When an individual goes to an emergency room for emergency care, the insured will pay a co-payment of $50 – this is waived if the individual is admitted to the hospital.

The Blue Advantage Plan provides an annual maximum limit for the OPM expense for both individuals and families. The OPM for an individual’s expenses is $750. The OPM for Family contracts is $1,500.

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 a co-insurance and co-pays are accumulated and determine the annual OPM expense.

When a 30 day supply of prescription drugs are purchased from participating pharmacies, you pay $5 for preferred generic drugs, $15 for preferred name brand drugs and $30 or 25% (whichever is greater) for non-preferred drugs. There is no OPM for prescription drugs.

**Health Care for Individuals Who are Out of Network**

The Blue Advantage Plan provides coverage for any Blue Advantage network provider, and coverage for emergencies anywhere in the world. An emergency can be considered to be a medical condition that a prudent layperson (with an average knowledge of health and medicine) could reasonably expect to result in serious jeopardy to a person’s health in the absence of immediate medical attention. The emergency services must be provided in an emergency room setting.
Iowa Select Plan

Health care under Iowa Select may be obtained from any provider you wish. However, there are advantages to using providers in the Wellmark Alliance Select Network.

Select providers will accept payment arrangements with Wellmark Blue Cross and Blue Shield of Iowa. When using select providers, you also pay a lower co-insurance percentage and the deductible is waived for services in the office setting.

Non-participating providers may charge more for health care than participating providers. You will also be responsible for charges beyond usual, reasonable, and customary.

In an emergency, if you cannot reasonably reach a participating provider, emergency care received during the course of the emergency will be reimbursed as though the service was received from a participating provider.

Deductibles: The deductible is $250 for single and $500 for family coverage. The family deductible is reached from deductible amounts accumulated on behalf of any combination of members. The deductible is waived for services in the office setting from Select providers.

How Much an Individual Pays for Health Care Services

Co-payments: This is a fixed dollar amount you pay each time you receive many covered services. Insureds pay a $15 co-payment for the exam portion of each office visit. There is a $50 co-pay for emergency room visits. Emergency room co-payments on this plan do apply toward your out-of-pocket maximum (OPM) and continue after the OPM is met. The emergency room co-payment is waived if you are admitted.

Co-insurance: This is the amount, using a fixed percentage, you pay each time you receive most covered services. The co-insurance percentage for select providers is 10% and it is 20% for non-select providers. There is no co-insurance for emergency room care.

The OPM for the individual’s expenses is $600. The OPM for a family contract is $800. This does not include prescription medication – there is a separate $250 Single and $500 Family OPM for prescription medication.

When the amount paid 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 the percentage portion of charges are cumulated when determining the annual OPM expense.

When a 30 day supply of prescription drugs are purchased from participating pharmacies, you pay $5 for generic formulary drugs, $15 for name brand formulary drugs, and $30 for non-formulary drugs.

Health Care for Individuals Who are Away from Iowa

Out-of-State: If you are in a state other than Iowa and require medical care, you may call Wellmark Blue Cross and Blue Shield of Iowa for assistance in locating the closest participating provider in that state. For covered services received in a state other than Iowa there are advantages in using providers who participate with the Blue Cross and Blue Shield Plan in that state.

Out-of-Country: If it is necessary to receive covered services in a country other than the United States, it is advisable to contact Blue Cross and Blue Shield for assistance in locating the closest participating provider in that country.
**Program III Plus**

Health care under the Program III Plus may be obtained from any provider. However, there are advantages to using participating providers who have contracts with Blue Cross and Blue Shield.

In Iowa, participating providers will accept payment arrangements and file claims for you with Wellmark Blue Cross and Blue Shield of Iowa. Payment is made directly to these providers. All hospitals in Iowa are participating providers and over 4,000 physicians in Iowa are also participating providers.

Non-participating providers do not have contracts with Blue Cross and Blue Shield. They do not agree to accept payment arrangements and are not responsible for filing claims for you. Non-participating providers may charge more for health care than participating providers. Payment is made to you and you are responsible for paying the provider. You will be responsible for charges beyond usual, reasonable, and customary.

In an emergency, if you cannot reasonably reach a participating provider, emergency care received during the course of the emergency will be reimbursed as though the service was received from a participating provider.

**How Much an Individual Pays for Health Care Services**

**Deductibles:** The only place this plan has a deductible is Inpatient hospital services. The deductible is $300 for single and $400 for family coverage. The family deductible is reached from deductible amounts accumulated on behalf of any combination of members.

**Co-payments:** This is a fixed dollar amount you pay each time you receive many covered services. The co-payment for the exam portion of office visits on this plan is $15.

**Co-insurance:** This is the amount, using a fixed percentage, you pay each time you receive most covered services. The co-insurance percentage for Program III Plus is 20%. There is no co-insurance for emergency room care.

**Out-of-Pocket Maximum (OPM) Expenses for Individuals**

Program III Plus has an individual OPM of $600. The OPM for a family contract is $800. This does not include prescription medication – there is a separate $250 single and $500 family OPM for prescription medication.

Once the OPM is reached, the plan pays 100% of the remaining covered expenses.

When a 30 day supply of prescription drugs are purchased from participating pharmacies, you pay $5 for generic formulary drugs, $15 for name brand formulary drugs, and $30 for non-formulary drugs.

**Health Care for Individuals Who Are Away from Iowa**

**Out-of-State:** If you are in a state other than Iowa and require medical care, you may call Wellmark Blue Cross and Blue Shield of Iowa for assistance in locating the closest participating provider in that state. For covered services received in a state other than Iowa there are advantages in using providers who participate with the Blue Cross and Blue Shield Plan in that state.

**Out-of-Country:** If it is necessary to receive covered services in a country other than the United States, it is advisable to contact Blue Cross and Blue Shield for assistance in locating the closest participating provider in that country.
MAKING BENEFIT CHANGES: MERIT PLANS

Most changes in your benefits must happen at open enrollment or when you have a qualifying event. Per IRS section 125, different qualifying events allow different benefit changes. If you experience a qualifying event during the calendar year, you may be able to make a benefit change that corresponds with the event. A request for change must be within thirty (30) days of the date of the event.

Steps to Follow:

1. Complete a Benefit Change Request for Merit Staff and return it to the University Benefits Office. This form is available on the Benefits website here.
2. You must make your new benefit selections online under Benefits Enrollment on the Employee Self-Service website here. You will have access to your Benefits Enrollment approximately 48 hours after the Benefits Office receives the Benefits Change Request form. If the form is received within six working days prior to the end of a month, Benefits Enrollment will not be available until the second working day of the following month.
3. To request a paper Enrollment form, send an e-mail to benefits@uiowa.edu.

Qualifying Events for Health Insurance:

- Birth/Adoption/Foster child (changes must be made within sixty [60] days)
- Death of spouse/dependent/domestic partner
- Marriage/Domestic Partner Affidavit
- Divorce/legal separation/termination of domestic partnership
- Spouse or dependent loss or gain of coverage
- Employee’s own loss of coverage under another plan
- Dependent no longer eligible
- Your retirement
- Spouse’s retirement from another employer
- Employee, spouse or dependent becomes eligible for, or loses eligibility for Medicare/Medicaid/SCHIP
- Beginning or returning from an unpaid leave of absence

All of the above qualifying events may allow for change within the current plans. Of these, there are some which allow a change from one plan to another.
Change of Health Plans Allowed for the Following:

- Open Enrollment
- Your Retirement
- Beginning or returning from an unpaid leave of absence
- A family member is being added because of:
  - Loss of other health coverage
  - Marriage or domestic partner affidavit
  - Divorce or termination of domestic partner agreement
  - Death of spouse/domestic partner or dependent
  - Birth/Adoption

Coverage begins the first month following the event (except for birth or adoption, in which case coverage begins the first of the month in which the child is born or, in the case of adoption, enters the home).

Change from Single to Family Coverage: Must be done within 30 days of event except for birth and adoption, which are 60 days.

Changes to Dental Insurance: Employees may add dependents only if they are affected by marriage or domestic partnership, divorce or termination of domestic partnership, a dependent becoming a full-time student (within 30 days of the event), or birth/adoption (within 60 days of the event). Other existing family members cannot be added unless the state or has an open enrollment. Spouse & dependents may be added if they lose coverage under the employee’s spouse due to involuntary termination of employment, however they **must** also enroll in health insurance.

Merit Changes For Spending Accounts: Any of the above events are considered qualifying events for making changes to spending account deductions. The changes below may also be qualifying events for spending account deductions. More detailed information on this topic can be found here.

- Change of work schedule or work site for yourself or spouse or dependent
- Change of residence for yourself or spouse or dependent
- Termination or commencement of employment of your spouse or dependent
- A change in a child-care provider
ADULT CHILD COVERAGE ENHANCEMENT:  
2015 TAXABLE HEALTH & DENTAL INSURANCE

Children may be covered until the end of the calendar year that they turn 26. Coverage for children who are full-time students or disabled can continue as long as they continue in that status.

The Internal Revenue Service (IRS) has determined that if an employer allows employees to insure dependent children age 26 and above, there is a value that must be added to the employee’s taxable salary when reporting income earned on the annual W-2. This income is based upon the following table.

AGE 26 AND OVER TAXABLE MONTHLY INCOME
ADDITIONAL TAXABLE VALUE BY PLAN AND NUMBER OF DEPENDENTS

<table>
<thead>
<tr>
<th>Number of taxable dependents covered by the Family Plan of the select Insurance Plan</th>
<th>1</th>
<th>2</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC/BS PROGRAM III PLUS</td>
<td>$462.28</td>
<td>$924.55</td>
<td>$1,104.84</td>
</tr>
<tr>
<td>BC/BS IOWA SELECT</td>
<td>$460.87</td>
<td>$921.73</td>
<td>$1,101.47</td>
</tr>
<tr>
<td>WELLMARK BLUE ADVANTAGE</td>
<td>$315.30</td>
<td>$630.60</td>
<td>$753.57</td>
</tr>
<tr>
<td>WELLMARK BLUE ACCESS</td>
<td>$327.03</td>
<td>$654.07</td>
<td>$781.61</td>
</tr>
<tr>
<td>DENTAL</td>
<td>$31.72</td>
<td>$49.16</td>
<td>$49.16</td>
</tr>
</tbody>
</table>

If the child is age 26 and above and a tax dependent, there is no additional income applied to the employee’s taxable salary. You must inform the University Benefits Office annually if this is the case.

Also, please note that if you participate in the Health Care Spending Account program, you will not be able to submit any claims for a dependent age 26 and above unless they are your tax dependent.

The University of Iowa Benefits Office does not advise on any personal income tax requirements or issues. Use of any information referred to is for general information only, and does not represent personal tax advice either expressed or implied. You are encouraged to seek professional tax advice for tax questions and assistance.

Taxable Health and Dental Insurance (Merit)
Revised 01/15
## University of Iowa

### MERIT HEALTH INSURANCE BENEFIT COMPARISON

*Monthly Employee Premium after UI Contribution: Effective January 1, 2015*

<table>
<thead>
<tr>
<th>Plan</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellmark Blue Access</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Wellmark Blue Advantage</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>BC/BS Iowa Select</td>
<td>$0.00</td>
<td>$288.32</td>
</tr>
<tr>
<td>BC/BS Program III Plus</td>
<td>$0.00</td>
<td>$294.32</td>
</tr>
</tbody>
</table>

### PLAN PROVISIONS

<table>
<thead>
<tr>
<th>Plan Provisions</th>
<th>Wellmark Blue Access &amp; Blue Advantage</th>
<th>BC/BS Iowa Select</th>
<th>BC/BS Program III Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Providers</td>
<td>Care from network providers ONLY; Life threatening emergencies covered anywhere</td>
<td>Any provider; Select providers have lower co-insurance percentage and deductible is waived for services in the office setting</td>
<td>Any provider; Blue Cross/Blue Shield (BC/BS) providers can result in lower out-of-pocket expenses.</td>
</tr>
<tr>
<td>Benefits Available from Non-member providers</td>
<td>None without prior approval</td>
<td>Normal plan benefits; For non-BC/BS providers, employee pays charges over usual reasonable and customary limit</td>
<td>Normal plan benefits; For non-BC/BS providers, employee pays charges over usual reasonable and customary limit</td>
</tr>
<tr>
<td>Deductible Single/Family</td>
<td>None</td>
<td>$250 / $500; Deductible is waived for Select providers only if service is in office setting</td>
<td>$300 / $400 inpatient services only</td>
</tr>
<tr>
<td>Co-Insurance Percentage</td>
<td>20% in limited situations</td>
<td>Select: 10%; Non-Select 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Out-of-Pocket Limit Single/Family</td>
<td>$750 / $1,500 (except prescription drugs)</td>
<td>$600 / $800 ($250 / $500 for prescription drugs)</td>
<td>$600 / $800 ($250 / $500 for prescription drugs)</td>
</tr>
<tr>
<td>Pre-approval of Inpatient Admissions</td>
<td>Required (Plan physician will determine)</td>
<td>Required (Subscriber must obtain approval from BC/BS)</td>
<td>Required (Subscriber must obtain approval from BC/BS)</td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>WELLMARK BLUE ACCESS &amp; BLUE ADVANTAGE</td>
<td>BC/BS IOWA SELECT</td>
<td>BC/BS PROGRAM III PLUS</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------</td>
<td>-------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Voluntary</td>
<td>Voluntary</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Plan physician will determine, 0%</td>
<td>Mandatory for certain procedures; Paid according to normal plan benefits when procedure done on outpatient basis; 50% benefit reduction on all associated hospital and surgical services for non-compliance; Select 10%; Non-select 20% after deductible</td>
<td>Mandatory for certain procedures; Paid according to normal plan benefits when procedure done on outpatient basis; 50% benefit reduction on all associated hospital and surgical services for non-compliance, 0%</td>
</tr>
<tr>
<td>Office Calls</td>
<td>$10 co-payment per visit</td>
<td>Select: $15 co-payment per visit &amp; 10% Non-Select: $15 co-payment per visit &amp; 20%</td>
<td>$15 co-payment per visit &amp; 20%</td>
</tr>
<tr>
<td>X-Ray and Lab</td>
<td>0%</td>
<td>Select: Deductible waived if in office setting then 10%; Non-Select: deductible then 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Routine Eye / Hearing Exam</td>
<td>$10 co-payment; One exam covered per calendar year</td>
<td>Limit one exam per year; $15 co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maternity</td>
<td>$10 co-payment for initial visit</td>
<td>$15 co-pay; Once per date of service for exam only. Other office services: Network 10%, deductible waived Non-Network 20%, after deductible</td>
<td>$15 co-pay exam only Other office services: 20%, no deductible</td>
</tr>
<tr>
<td>Infertility</td>
<td>Not covered</td>
<td>Select: 10%; Non-Select: deductible then 20%; $25,000 lifetime maximum per couple</td>
<td>20%; $25,000 lifetime maximum per couple</td>
</tr>
<tr>
<td>HOSPITAL SERVICES</td>
<td>WELLMARK BLUE ACCESS &amp; BLUE ADVANTAGE</td>
<td>BC/BS IOWA SELECT</td>
<td>BC/BS PROGRAM III PLUS</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------</td>
<td>-------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>0%; Semi-private basis unless medically necessary to use a private room</td>
<td>Select: 10% after deductible; Non-Select: 20% after deductible; No limit on days; Semi-private basis unless medically necessary to use private room</td>
<td>20% after inpatient services deductible $300/$400; No limit on days; Semi-private basis unless medically necessary to use private room</td>
</tr>
<tr>
<td>Physicians’ Services</td>
<td>0% if authorized</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td>20%; No deductible; Must be approved as inpatient procedures</td>
</tr>
<tr>
<td>Inpatient Supplies, Drugs, Medicines, Tests, ICU, OR, Specialized Care, etc.</td>
<td>0% if authorized</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MISCELLANEOUS SERVICES</th>
<th>WELLMARK BLUE ACCESS &amp; BLUE ADVANTAGE</th>
<th>BC/BS IOWA SELECT</th>
<th>BC/BS PROGRAM III PLUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs (30 day supply)</td>
<td>$5 co-payment preferred generic drugs; $15 co-payment preferred brand name drugs; $30 or 25% co-payment non-preferred drugs; (does not apply to out-of-pocket maximum)</td>
<td>$5 co-payment preferred generic drugs; $15 co-payment preferred brand name drugs; $30 co-payment non-preferred drugs; Separate $250/$500 out-of-pocket maximum</td>
<td>$5 co-payment preferred generic drugs; $15 co-payment preferred brand name drugs; $30 co-payment non-preferred drugs; Separate $250/$500 out-of-pocket maximum</td>
</tr>
<tr>
<td>Immunizations</td>
<td>0%</td>
<td>Select: 0%; Non-Select: 10%</td>
<td>20%</td>
</tr>
<tr>
<td>Allergy Treatments</td>
<td>$10 co-payment per visit</td>
<td>Select: 10%; Non-Select: deductible then 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>$10 co-payment per visit; Prior approval may be required</td>
<td>Select: 10%; Non-Select: deductible then 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>0% if authorized</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%; Pre-certification required</td>
<td>20%; Pre-certification required</td>
</tr>
<tr>
<td>Eyeglasses / Hearing Aids</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ambulance</td>
<td>0% if medically necessary</td>
<td>Deductible then 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>0% if authorized</td>
<td>Prior approval required</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>0% for facility;</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%;</td>
<td>20% after deductible; $300 single / $400 family;</td>
</tr>
<tr>
<td>MISCELLANEOUS SERVICES</td>
<td>WELLMARK BLUE ACCESS &amp; BLUE ADVANTAGE</td>
<td>BC/BS IOWA SELECT</td>
<td>BC/BS PROGRAM III PLUS</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------</td>
<td>-------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>$10 co-payment for physician visit; 120 day maximum; Pre-approval required</td>
<td>Unlimited days; Pre-certification required</td>
<td>No limit on days; Pre-certification required</td>
<td></td>
</tr>
<tr>
<td>ER Care</td>
<td>$50 co-payment per visit (waived if admitted)</td>
<td>$50 co-payment per visit (waived if admitted) and co-insurance</td>
<td>0%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$10 co-payment per visit; 60 visit maximum</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td>Office – 10$ co-pay</td>
<td>$15 co-pay plus Select: 10%; Non-Select: deductible then 20%</td>
<td>0% for treatment within 72 hours</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>0%; Prior approval required</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td>20%; Pre-certification required</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20%; Prior approval required</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td>20%</td>
</tr>
<tr>
<td>Speech, Occupational, and Respiratory Therapy</td>
<td>$10 co-payment; 60 visit maximum (of each type) Prior approval required</td>
<td>Select: deductible then 10%; Pre-approval required; Non-Select: deductible then 20%; Pre-approval required</td>
<td>20%; Pre-approval required; Must be hospital –based billed</td>
</tr>
<tr>
<td>Dental Accident Care</td>
<td>20% if authorized; Within 6 months of injury</td>
<td>Select: 10% Non-Select: deductible then 20% Within 72 hours of accident</td>
<td>0%; No deductible; Service must be provided within 72 hours of injury; 20% thereafter to six months of accident</td>
</tr>
<tr>
<td>Dependent Child Age Limit</td>
<td>End of the year they turn 26; unlimited if a full time single student or disabled before age 27</td>
<td>End of the year they turn 26; unlimited if a full time single student or disabled before age 27</td>
<td>End of the year they turn 26; unlimited if a full time single student or disabled before age 27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL AND NERVOUS AND SUBSTANCE ABUSE</th>
<th>WELLMARK BLUE ACCESS &amp; BLUE ADVANTAGE</th>
<th>BC/BS IOWA SELECT</th>
<th>BC/BS PROGRAM III PLUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Room and Board</td>
<td>0%</td>
<td>Select: deductible then 10%; Non-Select: deductible then 20%</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Inpatient Physician Care</td>
<td>0%</td>
<td>Select: deductible then 10% Non-Select: deductible then 20%</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$0 co-payment</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Pre-certification</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

Merit Health Insurance Effective 01/01/2015 (Updated 12/14)
DELTA DENTAL BENEFITS, STATE OF IOWA

The University contributes towards the cost of dental insurance for Merit employees who hold a 50% time or greater regular appointment.

COVERAGE
Coverage is provided through Delta Dental of Iowa. Details of the plan and exceptions are covered in your benefits certificate, which will be mailed to you after you have completed the enrollment application.

Coverage is offered under either a single or a family contract basis. In addition to the subscriber, the family contract may cover:

1. Spouse or common law spouse.
2. Same or opposite-sex domestic partner.
3. The dependent child age limit is the end of the year turning 26.
4. Dependent children, regardless of age, as long as they are single full-time students.
5. Dependent children, regardless of age, who are totally and permanently disabled, provided such disability was in existence while the child was insured.

(Visit Taxable Health and Dental Insurance for Merit Staff on page 7)

Existing family members must be enrolled during the initial enrollment and cannot be added to your plan until the next dental open enrollment.

ENROLLMENT
Merit employees must apply for coverage within the first thirty (30) days of employment. Coverage begins the first of the month following thirty (30) days of employment. If you start on the first working day of the month, your benefits begin the first of the following month.

CHANGES IN WHO IS COVERED
You may make a change to your plan during the year if there is a significant change in family status as a result of any of the following events:

- Birth/Adoption
- Death in the immediate family
- Marriage
- Divorce/Legal separation
- Spouse’s involuntary loss of employment (retirement of a spouse is not an event)
- Dependent no longer eligible

If you wish to make a change, due to one of the above listed events, the Benefits Office must be contacted no later than 30 days (60 days for birth or adoption) following the date of the event.

- **Deductible:** None
- **Benefits Period Maximum:** $1,500.00
- **Orthodontia Lifetime Maximum:** $1,500.00 per eligible dependent in a lifetime.
CO-INSURANCE

Check Ups and Teeth Cleaning (Diagnostic and Preventative Services): 0%
- Dental Cleaning: once every 6 months
- Oral Evaluations: once every 6 months
- Fluoride Applications: once every 12 months for unmarried, dependent children under age 19
- Imaging

Cavity Repair and Tooth Extractions (Routine and Restorative Services): 20%
- Contour of Bone
- Emergency Treatment
- General Anesthesia/Sedation
- Restoration of Decayed or Fractured Teeth
- Limited Occlusal Adjustment
- Routine Oral Surgery
- Sealant Applications – only under age 15, $120/lifetime (only under age 15)
- Space Maintainers

Root Canals (Endodontic Services): 50%
- Apicoectomy
- Direct Pulp Cap
- Pulpotomy
- Retrograde Fillings
- Root Canal Therapy

Gum and Bone Diseases (Periodontal Services): 50%
- Conservative Procedures (non-surgical)
- Maintenance Therapy

High Cost Restorations (Cast Restorations): 50%
- Crowns
- Inlays
- Onlays
- Posts and Cores

Straighter Teeth (Orthodontics): 50%
- Only for unmarried dependent children under age 19
GROUP AND SUPPLEMENTAL LIFE

GROUP LIFE INSURANCE
This University-paid benefit provides life insurance coverage for all Faculty, Professional and Scientific, Merit Supervisory Exempt, Merit Confidential, and Merit staff.

MANDATORY PARTICIPATION
Participation in the University’s group term life insurance program is a condition of employment for regular University faculty and staff members who hold a 50% time or greater appointment; coverage is required.

Merit Staff are automatically covered by Group Life Insurance at a set coverage level as a function of their salary.

No Statement of Health or physical exam is required for this program.

SCHEDULE OF LIFE INSURANCE
Your Annual Benefits Salary determines the amount of insurance available under this program. If your salary is not an even thousand dollars, it is rounded to the next highest thousand dollars, and then multiplied by 2 times your annual Benefits salary.

EXAMPLE:
Employee salary = $29,750 annually. The salary is rounded to $30,000 and then multiplied by 2 providing staff member with $60,000 in life insurance.

TAXABLE LIFE INSURANCE
The Internal Revenue Service (IRS) has determined that if an employer allows employees access to life insurance in excess of $50,000, the amount in excess of $50,000 has a value to the employee. This value must be added to the individual’s taxable salary when reporting income earned on the annual W-2. This income is based upon the following IRS table:

<table>
<thead>
<tr>
<th>Age</th>
<th>Life Insurance Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.60</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.72</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.96</td>
</tr>
<tr>
<td>35-39</td>
<td>$1.08</td>
</tr>
<tr>
<td>40-44</td>
<td>$1.20</td>
</tr>
<tr>
<td>45-49</td>
<td>$1.80</td>
</tr>
<tr>
<td>50-54</td>
<td>$2.76</td>
</tr>
<tr>
<td>55-59</td>
<td>$5.16</td>
</tr>
<tr>
<td>60-64</td>
<td>$7.92</td>
</tr>
<tr>
<td>65-69</td>
<td>$15.24</td>
</tr>
<tr>
<td>70 and older</td>
<td>$24.72</td>
</tr>
</tbody>
</table>

Example:
Salary: $50,000
2 x life insurance selected: $100,000
Age: 46

Calculation:
100,000 - 50,000 = 50,000
50,000 ÷ 1,000 = 50
50 x 1.80 = $90.00
($90.00 is added to W-2 as taxable income)
In determining the amount of life insurance in excess of $50,000, the employer must total all life insurance programs in which the employee participates. For the University of Iowa, this would include the basic group program, the supplemental life insurance program. If you have any questions concerning this calculation and the possible effect on your taxable income, please contact the University Benefits Office.

**SUPPLEMENTAL LIFE INSURANCE**
This optional program allows you to obtain additional life insurance, for yourself only, in excess of the amount provided by the group life coverage.

**Schedule of Life Insurance**
The optional Supplemental Life Insurance plan allows you to acquire additional life insurance from ½ to 3 ½ times your salary. The amount of coverage is based upon your annual benefits salary. If your salary is not an even thousand, it will be rounded to the next highest thousand and then multiplied by the coverage chosen.

**Rates**
The Supplemental Life Insurance plan is age rated and the rates change as a person reaches 40, 50, and 60.

Rates are keyed to the coverage levels in the Schedule of Life Insurance. The rates for coverage are:

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 40</td>
<td>$0.04</td>
</tr>
<tr>
<td>40 but less than 50</td>
<td>$0.10</td>
</tr>
<tr>
<td>50 but less than 60</td>
<td>$0.26</td>
</tr>
<tr>
<td>60 and up</td>
<td>$0.56</td>
</tr>
</tbody>
</table>

For Merit Staff: the amount of insurance and the rate paid for the insurance will adjust monthly, reflecting a change in age or budgeted salary.

**SPOUSE/DOMESTIC PARTNER/DEPENDENT LIFE INSURANCE**
Term life insurance coverage is available for your spouse/domestic partner and dependents (children must be at least 14 days old to 26 years old, unless the dependent is disabled; if dependent is disabled and classified as a dependent for tax purposes, there is no maximum age for coverage). You may choose one of the following plans:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner only in the amount of $10,000</td>
<td>$3.49</td>
</tr>
<tr>
<td>Spouse/partner only in the amount of $20,000</td>
<td>$6.66</td>
</tr>
<tr>
<td>Dependent only in the amount of $5,000 per child</td>
<td>$1.02</td>
</tr>
<tr>
<td>Dependent only in the amount of $10,000 per child</td>
<td>$1.94</td>
</tr>
<tr>
<td>Spouse/partner and Dependent in the amount of $10,000 for the spouse and $5,000 per child</td>
<td>$4.51</td>
</tr>
<tr>
<td>Spouse/partner and Dependent in the amount of $20,000 for the spouse and $10,000 per child</td>
<td>$8.60</td>
</tr>
</tbody>
</table>

*Please note that this premium may only be paid after-tax as a deduction from your net pay.*
LONG-TERM DISABILITY
Your disability insurance benefits are based on salary. Coverage is mandatory and is paid for by the University. The plan provides 60% of your base salary.

VOLUNTARY GROUP ACCIDENT INSURANCE PROGRAM
The Voluntary Group Accident Insurance Program provides coverage at all times for most accidents that occur on or off the job, at home or away, anywhere in the world (when traveling by train, airplane, or other conveyances). However, there are some exclusions listed in the master policy. Coverage includes loss of life and limbs. Benefits include worldwide travel assistance and a waiver of premium provision. In case of your death, benefits also include dependent children education assistance and a day care allowance if family coverage was elected.

Coverage is available in $100,000 increments up to a maximum of $1,000,000 for:

- **Plan I: Employee only**
- **Plan II: Employee and spouse or domestic partner:**
  - Your spouse or domestic partner is covered at 75% of your benefit.
- **Plan III: Employee and children:**
  - Each eligible child’s coverage is 20% of your benefit up to a maximum of $100,000.
- **Plan IV: Employee and family:**
  - Your spouse or domestic partner’s coverage is 75% of your benefit and each eligible child’s coverage is 20% of your benefit up to a maximum of $100,000.

Children must be no older than age 26 unless a full-time student or disabled. If your child is totally and permanently disabled, there is no maximum age for coverage. (The disability must have existed while he or she was a covered dependent.)

Refer to the Voluntary Group Accident Insurance Program booklet.
SPENDING ACCOUNTS

ANNUAL ELECTION
You may decide each year during the annual enrollment period whether or not you wish to participate in these plans. If you do not sign up during the annual enrollment, you will not be able to participate during the following year, unless you have a qualifying event.

IRREVOCABLE ELECTION
Once you elect to participate and designate the amount to be deposited into your spending accounts, you may not stop deposits or change the amount deposited into your account unless you have a qualifying event. A change in your account must be made within 30 days of the event, otherwise you must wait until the next annual enrollment period.

ADVANTAGES

HEALTH CARE
- You do not pay FICA, Federal, and State income taxes on flexible spending account contributions.
- Medical expenses are tax deductible only if they are over 10% of your adjusted gross income. A medical spending account allows you to use tax-free money for medical expenses below 10% of your Adjusted Gross Income (AGI).

DEPENDENT CARE
- You do not pay FICA, Federal, and State income taxes on flexible spending account contributions.
- The tax deductibility of dependent care expenses goes down as income goes up. By participating in the flexible spending account, you have the advantage of avoiding the taxes regardless of income.
- While dependent care expenses are tax deductible up to certain levels, participating in the spending account may also let you avoid the 7.65% FICA tax.

DISADVANTAGES
There may be some disadvantages to using these accounts:

1. Deposits to such an account may reduce your Social Security wage base, and consequently your Social Security tax contributions may be slightly reduced.

2. Once you decide to participate in this plan for any given year and designate the amount to be deposited in such an account, you cannot change this decision until the next open enrollment or you have a qualifying event. The University must continue to deposit the specified amount into your account. Furthermore, any amount which is not expended for eligible expenses incurred during the calendar year by December 31st of that year and claimed by the last business day in April of the next year revert to the University.
DISBURSEMENTS
You may request reimbursements daily, weekly, monthly, semi-annually, or annually, whichever is the most convenient for you. Instructions for submitting claims can be found under “Spending Accounts” on the University Benefits Office website. Expenses submitted must be incurred after your first payroll deduction under this program. The actual day when the payment is made could vary depending on holidays. Your spending account reimbursements will be direct deposited to the same institution and account where your monthly paycheck is deposited. If you would like payment made to a different checking or savings account, you must fill out an Authorization for Payroll, Benefits, and Travel Direct Deposit form which can be found on the Employee Self Service website. Reimbursement forms are available on the University Benefits Office website. You may file for reimbursement at any time during the year, but no later than the last business day of the following April.

In order to comply with IRS regulations, dependent care expenses cannot be reimbursed until after the service has been provided.

TERMINATION OF EMPLOYMENT

HEALTH CARE

When terminating employment, services must be incurred by the last day of the month of your termination to be reimbursable. You have until April of the following year to submit any claims for services incurred prior to your termination date. All funds remaining after April of the following year are forfeited to the University.

DEPENDENT CARE

When terminating employment, services must be incurred prior to the end of the calendar year to be reimbursable. You have until April of the following year to submit any claims for services incurred in the prior year. All funds remaining after April of the following year are forfeited to the University.

HEALTH CARE SPENDING ACCOUNT

PARTICIPATION

A Health/Dental Care Spending Account allows you to arrange for a portion of your earnings, not to exceed the annual federal limit, to be deposited into a special account that is then used to reimburse you for health/dental care expenses incurred during the calendar year. IRS regulations provide that earnings allocated to a spending account are not subject to Federal income taxes, State income taxes, or FICA taxes. If you elect to participate in this plan, you are reimbursed for these expenses with income that is not subject to these taxes.

Services must be incurred during the current year of participation. Funds that are not claimed for eligible health/dental expenses by the following April revert to the University and may not be claimed by the individual. When an individual terminates, all services and expenses must be incurred by the last day of the month of the termination date and be claimed by April of the next year. Any funds not spent by this date will be forfeited. This program is not available for use of expenses for a Domestic Partner who is not a qualified tax dependent.
EXPENSES THAT CAN BE PAID BY A HEALTH/DENTAL CARE SPENDING ACCOUNT

This account may be used to pay for any expenses connected with health/dental care for you, your spouse, or any eligible dependent as defined by the IRS. The eligible expenses reimbursed must be for services or items that you will not be reimbursed for from any health/dental insurance program, whether with the University of Iowa and/or any other employer or individual policy.

Eligible expenses are:

1. Deductibles and co-payments
2. Over-the-counter drugs used to treat a medical condition but only with a physician prescription (e.g. aspirin, antacids, cold medicines)
3. Dental expenses, including preventive, diagnostic restorative, orthodontic, and therapeutic care
4. Vision expenses, including examinations, eyeglasses, contact lenses, and seeing dogs
5. Hearing expenses, including examinations and hearing aids
6. Artificial limbs
7. Physical examinations
8. Psychoanalysis and psychologist fees
9. Psychiatric fees and psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center
10. Chiropractic expenses
11. Acupuncture
12. Smoking cessation program as prescribed by a physician
13. Alcoholism or Drug Treatment, including meals and lodging if needed
14. Prescription medicine and prescription drugs including birth control pills
15. Massage Therapy

Your account cannot be used for certain expenses, such as:

1. Fitness club memberships, unless your physician classifies you as obese by having a BMI of 30+
2. Cosmetic surgery
3. Insurance Premiums
4. Dietary supplements or multivitamins
5. Contact lens insurance
6. Long-term care expenses
7. Prescription drugs purchased outside the U.S.

Note: This list is not all-inclusive. If you have a specific question about whether or not an expense is eligible for reimbursement, please check the “Covered Expenses” area under Spending Accounts on the University Benefits Office website.
DEPENDENT CARE SPENDING ACCOUNT

PARTICIPATION
A Dependent Care Spending Account allows you to arrange for a portion of your earnings, not to exceed $5,000.00 per family, to be deposited into a special account that is then used to reimburse you for dependent care expenses incurred during the year for the custodial care of children or other eligible dependents. IRS regulations provide that earnings allocated to a Spending Account are not subject to Federal income taxes, State income taxes, or FICA taxes. If you elect to participate in this plan, you are reimbursed for these expenses with income that is not subject to these taxes. Your deposit is limited by your tax filing status. If you file your Federal taxes as married filing separately, you may deposit up to a maximum of $208.33 monthly or $2,500 annually. All other tax filing statuses may deposit up to maximum of $416.66 monthly or $5,000.00 annually. The combined maximum that a couple may contribute to this account is also $5,000.00 annually.

Services must be incurred during the current year of participation. Funds that are not claimed for eligible dependent care expenses by the following April revert to the University and may not be claimed by the individual. When an individual terminates, all services and expenses must be incurred by the end of the calendar year in which termination occurs and must be claimed by the following April. Any funds that are not spent by this date will be forfeited.

EXPENSES THAT CAN BE PAID BY A DEPENDENT CARE SPENDING ACCOUNT
This account may be used to pay for certain expenses connected with the custodial care of children under the age of 13 years who are claimed as an exemption on the employee’s Federal income tax return. It may also be used for reimbursing costs for the care of other eligible dependents such as a disabled spouse or dependent parents.

In order to participate, both the eligible employee and spouse must work or be a full-time student. The expenses must be for the following types of dependent care provided during work hours:

- Nursery schools
- Licensed day care centers and before and/or after school programs
- Private baby-sitters
- Institutions that provide custodial care for dependent adults

The account cannot be used to make payments to an eligible employee’s spouse, to an eligible employee’s child who is under the age of 19 years, or to any person the eligible employee claims as a dependent on an income tax return. Any expenses associated with kindergarten, lessons, or overnight camps may not be used.
DOMESTIC PARTNER BENEFITS

Merit Employees

The University of Iowa offers you the opportunity to insure your domestic partner under various benefit programs, including health, dental, and accidental death and dismemberment insurance. The University contributes toward the cost of health insurance for your domestic partner.

In order to insure a partner, you must file a State of Iowa Affidavit of Domestic Partnership (which is valid for same or opposite-sex partners), or a State of Iowa Affidavit of Common Law Marriage (opposite-sex partners only) with the University Benefits Office. You need only to complete this affidavit once and it will remain in effect until such time as the relationship ends. A new affidavit would have to be filed for any new relationship. After you have filled out the affidavit, you will need to use the Health and Dental insurance companies’ enrollment materials to enroll your partner. A domestic partner is eligible at the same time as a new employee if the affidavit is signed within 30 days of the signed benefit forms.

The University is prevented by the Internal Revenue Service (IRS) from allowing you to pay for coverage on a before tax basis. The exception to this rule is if your domestic partner meets the Internal Revenue Service dependency guidelines, then your domestic partner may be included under the before tax program. These dependency guidelines require that the employee must provide more than 50% of the domestic partner's support and both of you must share the same household. If you feel that you meet this qualification, you must note this on your Affidavit in order to qualify for this special program. Otherwise, you and your partner will be considered separately concerning both the University contributions and for the payment of any premiums.

When the completed enrollment form has been received by the University Benefits Office, you and your domestic partner will receive identification cards for the selected health/dental insurance plans. All claims will be filed by your partner under your insurance ID number.

Children of either you or your domestic partner may be insured under any of the benefit programs providing they meet the guidelines which have been established by the insurance carrier.

If you already have your own child (or children) and you are responsible for their insurance, adding your partner and your partner’s child/children to your coverage will not result in an increased cost to you. If you are currently classified as Single for Benefits coverage, adding a domestic partner with or without a child/or children will increase your out-of-pocket costs.

If the children are you or your partner’s legal responsibility, and you have the financial responsibility for them for health insurance, you will be given additional contributions from the University towards the cost of insuring these dependents. If this is the situation, you must supply the Benefits Office with copies of the appropriate paperwork such as birth certificates, adoption paperwork, or divorce decrees in order to prove this financial relationship.
The University will **NOT** apply the Federal COBRA regulations for your domestic partner. This means that if your domestic partner’s insurance is canceled as a result of termination of your employment, ending of the domestic partner relationship, or a child of the partner no longer qualifying as a dependent, then the individual who loses the coverage will **NOT** be eligible to continue the insurance on a voluntary basis.

The issue of benefits for your domestic partner is complex. If you have additional questions, please feel free to contact the Benefits Office directly at 319-335-2676. All information supplied by you and your domestic partner is kept confidential and this information is only released to the insurance carrier or to parties outside of the Benefits department which are involved in the processing of the enrollments and deductions.

**When One Employee is Merit and the Other is Faculty, P&S, or Merit Supervisory Exempt**

Domestic partner arrangements may or may not be beneficial when one employee is Merit and the other is Faculty, P&S, or Merit Supervisory Exempt. Due to tax and other issues, domestic partner arrangements may or may not be beneficial for employees in this situation. We recommend calling and discussing this issue with the University Benefits Office directly at 319-335-2676.

**Information on Common Law Marriage for All Employees**

Common-law marriage is generally a non-ceremonial relationship that requires “a positive mutual agreement, permanent and exclusive of all others, to enter into a marriage relationship, cohabitation sufficient to warrant a fulfillment of necessary relationship of man and wife, and an assumption of marital duties and obligations.” Black’s Law Dictionary 277 (6th ed. 1990).

The affidavit affirms that you and your partner meet the requirements of common law marriage in the state of Iowa. In Iowa to determine if a common law marriage exists the court will look to see if there was an intent or agreement between the couple, if the couple was living together continuously, and that the couple were holding themselves out as man and wife and other factors. A common law marriage can be recognized after any length of time. A common law marriage will give a couple rights as if they were married. It will also give an individual the right to claim the property of their deceased “spouse”. Reference: Iowa Code § 595 (1999).

Once parties are married, regardless of the manner in which their marriage is contracted, they are married and can only be divorced by appropriate means in the place where the divorce is granted. That means, in all 50 states, **only** by a court order.

**Tax Implications for All Employees**

There are important tax consequences to be aware of when you are covering your domestic partner.

The difference in cost between a single health insurance policy and the category that you are moving to with a domestic partner (either an Employee/Spouse or Family policy for Faculty, P&S, and Merit Supervisory Exempt Employees, or, a Family policy for Merit Employees) may not be paid with pre-tax dollars, unless your partner qualifies as a tax dependent (as defined below).

Additionally, if your domestic partner does not qualify as your tax dependent, under federal tax law the portion of the premiums the University of Iowa pays for the coverage of your domestic partner will be included in your gross income, subject to federal income tax withholding and employment taxes, and
will be reported on your Form W-2. You will also be unable to claim expenses for the domestic partner under the Health Spending Account plan.

If your domestic partner qualifies as your tax dependent, then no portion of the premiums paid by the University of Iowa will be included in your income or be subject to federal withholding or employment taxes.

1. **Who is a tax Dependent?** Your same-sex or opposite-sex domestic partner (other than a spouse) can qualify as your tax dependent under Internal Revenue Code Section 152(a), only if:
   a. For the entire calendar year in question, he or she lives with you as a member of the household you maintain and occupy, and
   b. During the calendar year in question you provide more than half of his or her total support.

   Note that it is not necessary for you to be able to claim an exemption for your domestic partner on your Form 1040. If your tax year is other than the calendar year, use that year instead.

   We will also consider your domestic partner to be a tax dependent if he or she meets the above two requirements for the first portion of the year, then you marry, and he or she remains your legal spouse the remainder of the year. Please see Qualifying Person Test under Publication 503 on the IRS website.

2. **Determining Support.** To determine whether you provide more than half of your domestic partner’s total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including social security, welfare payments, the support you provide and the support your domestic partner supplies for himself or herself. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of your partner’s support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

3. **Filing a Declaration of Dependent Domestic Partner (other than a spouse).** Please contact your tax advisor before filing an affidavit that your domestic partner is a dependent, as defined by the Internal Revenue Code.

If your domestic partner qualifies as your tax dependent, you can avoid having the premiums paid by the University of Iowa treated as taxable income. To avoid taxation, you must complete and return the attached Declaration of Domestic Partnership form. Because the determination of whether a person is a dependent for tax purposes turns on facts solely within your knowledge, the University of Iowa cannot make this determination for you. If the University of Iowa does not receive a properly completed declaration form from you, we will assume that your domestic partner does not qualify as your tax dependent. Please visit the University Benefits website [here](#) to fill out the Declaration of Domestic Partnership.
ADDITIONAL IMPORTANT RESOURCES

THE BENEFITS EDUCATION CENTER
The Benefits Education Center’s website has all of the information from orientation with additional information on getting the most from your benefits package. Click here to visit these convenient online modules.

THE STAFF RESOURCE GUIDE
Learn about the many resources available to you as a valuable employee of the University of Iowa at the Staff Resource Guide’s website.