IMPORTANT:
International students will be billed for insurance unless proof of other coverage is provided annually by the printed deadlines (visit page 11-13). There will be no refunds for charges after these dates.
DEADLINES FOR RECEIVING EXEMPTIONS AND MAKING POLICY CHANGES ...................... 14

PROOF OF COVERAGE FORM ........................................................................................................... 15

YOU WILL ONLY NEED TO COMPLETE THIS FORM IF ANY OF THE FOLLOWING APPLIES TO YOU:.............................................................................................................................. 15

INSURANCE POLICY INFORMATION .................................................................................................. 15

STATEMENT OF FINANCIAL RESPONSIBILITY ............................................................................... 15

STUDENT INSURANCE PLANS ........................................................................................................... 16

ENROLLMENT FORM .......................................................................................................................... 16

AGREEMENT AND CERTIFICATION ................................................................................................ 16

UNDERGRAD STUDENT ENROLLMENT FORM ................................................................................ 17

University Benefits Office .................................................................................................................. 18

Personal Health Information Release Form .......................................................................................... 18

AFFIDAVIT OF DOMESTIC PARTNERSHIP ......................................................................................... 19

QUESTIONS AND ANSWERS ............................................................................................................ 21

WHO TO CONTACT ............................................................................................................................ 22

Questions about claims or specific SHIP coverage: ......................................................................... 22

Questions about claims or specific dental coverage: .......................................................................... 22
MEMORANDUM

TO: Undergraduate Students
FROM: Richard G. Saunders, Asst. V.P. 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, the University offers health and dental insurance coverage to students through the University of Iowa Student Health Insurance Plan (SHIP), a group policy administered by Wellmark Blue Cross and Blue Shield of Iowa, and Student Dental Plan, a group policy administered by Delta Dental of Iowa.

The premium for a student-only health policy is $135.00 per month while the dental policy is $25 per month. To be eligible for the student insurance you must be a registered student attending classes at the time coverage begins. You will not need to re-enroll at the beginning of each academic year unless changing your coverage. Your coverage will end on the last day of the month in which you cease to be a student. After graduating from the University of Iowa, or no longer a registered student, you may enroll in SHIP for Departing Students to continue coverage for up to 12 months.

Insurance coverage is in effect at school and during vacation periods, 24 hours a day, worldwide. You may seek care from any provider you choose. However, if you use a Wellmark Blue Cross & Blue Shield Classic Blue provider or Delta Dental provider, your costs will generally be much lower. The University of Iowa Hospitals and Clinics (UIHC), Mercy Hospital, Family Practice Clinic, and the Student Health & Wellness are Blue Cross & Blue Shield Providers in Iowa City. The College of Dentistry is a Delta Dental provider in Iowa City.

Once you have enrolled in the plan you will be sent 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.

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

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

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

INTERNATIONAL STUDENTS: You are required to have health insurance in order to attend the University of Iowa and will automatically be billed for SHIP, student only 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 or if you want dental insurance coverage. If you do not want the University of Iowa health insurance coverage, you must provide proof of other coverage that meets the exemption guidelines for international students. The guidelines may be found on page 12 of this booklet, along with the deadlines for requesting an exemption. No refunds of premiums will be given if proof of acceptable coverage is not received by the deadline.
### Student Health Insurance Rates

*Effective September 1, 2014 through August 31, 2015*

<table>
<thead>
<tr>
<th>Type of Contract</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$135.00</td>
</tr>
<tr>
<td>Student &amp; Spouse/Domestic Partner</td>
<td>$464.00</td>
</tr>
<tr>
<td>Student &amp; Children</td>
<td>$800.00</td>
</tr>
<tr>
<td>Student, Spouse/Domestic Partner &amp; Children</td>
<td>$1,495.00</td>
</tr>
</tbody>
</table>

### Student Dental Insurance Rates

*Effective September 1, 2014 through August 31, 2015*

<table>
<thead>
<tr>
<th>Type of Contract</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$25.00</td>
</tr>
<tr>
<td>Student &amp; Spouse/Domestic Partner</td>
<td>$41.00</td>
</tr>
<tr>
<td>Student &amp; Children</td>
<td>$49.00</td>
</tr>
<tr>
<td>Student, Spouse/Domestic Partner &amp; Children</td>
<td>$64.00</td>
</tr>
</tbody>
</table>

### Open Enrollment Periods

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

### Enrollment Information

To enroll, simply detach the enrollment form in this booklet, complete it, and return the form to the University Benefits Office, 120 University Services Building, Iowa City, IA 52242 during the appropriate enrollment period or anytime during the year.

- Coverage will begin the first of the month following receipt of your enrollment form, unless the form is received during the open enrollment period.
- Coverage will begin the first day of August, January, or May upon request if applications are received within the open enrollment period.
- Rates are valid from September 1, 2014 until August 31, 2015.
- Eligible dependents may be added during open enrollment periods and/or within 30 days of a change in status (60 days for birth or adoption or loss of Medicaid or CHIP coverage). 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 in employment for yourself or spouse

Questions regarding premium charges should be directed to the University Benefits Office at 120 University Services Building, Iowa City, IA 52242-1911, or call (319) 335-2676 or toll-free at (877) 830-4001.
SHIP is available to undergraduate and graduate students who are registered for courses at the time coverage begins and who continues to be registered. SHIP is a Wellmark Blue Cross & Blue Shield Classic Blue Plan, which provides coverage for hospitalization, surgery, maternity, well-baby/well-child care, preventive care, emergency care for accident or illness, medically-necessary physician care, prescription drugs, and mental health. Students registered for Guided Independent Study Courses only are not eligible to participate.

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 Wellmark Blue Cross and Blue Shield of Iowa to offer each student affordable health care.

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 service when they need health care in order to maximize their benefits.

Unlimited office visits at 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 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.

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 service. To receive the greatest benefits from SHIP, dependents are advised to use the physicians from the Wellmark Blue Cross & Blue Shield Classic Blue Provider list, which can be accessed at the Wellmark Blue Cross and Blue Shield of Iowa website here.

ADDING DEPENDENTS
- If a student acquires eligible dependents while insured by this plan, they may only be added within 30 days (60 days for birth or adoption) after becoming eligible.
- 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 the calendar year after turning 26. Students wishing to insure a domestic partner must complete an Affidavit for Domestic Partnership available in the University Benefits Office or on the Benefits website here.
- Children over the age of 26 may continue to be covered if they are full-time students or disabled.
IDENTIFICATION CARDS & POLICY INFORMATION
Insured students will receive identification (ID) cards 10-15 days after their enrollment form has been processed. A Coverage Manual that details complete information on benefits, definitions, terms, and exclusions is available from the University Benefits Office and on the University Benefits Office website here. A list of providers may be accessed at the Wellmark Blue Cross and Blue Shield of Iowa website here.

BILLINGS
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 the appropriate section on the enrollment form or an Authorization for Automatic Withdrawal of Insurance Premiums form, available in the University Benefits Office or through the forms link via the University Benefits Office website here.

PRIVACY NOTICE AND RELEASE FORM
Changes in federal law require individuals to sign a release form before any information can be released regarding their health benefit information. No information will be given to a spouse/domestic partner, parent, child, or other representative unless that form is on file in the University Benefits Office. If you wish for health information released to anyone, complete the Personal Health Information Release Form at the end of this booklet.

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 over summer session must either be registered for that session or pre-registered for fall prior to the end of 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 following their departure and upon the completion of the Departing Students Enrollment form.

- The University Benefits Office reserves the right to cancel coverage for non-payment of premium.
COVERAGE TERMINOLOGY
SHIP is designed for you to be responsible for some of the direct costs of your health care through per-service co-payments, deductibles and co-insurance provisions as explained below.

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

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

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

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

Medical Necessity Provision:
The benefits available through SHIP apply only to medically-necessary care. Only your medical condition is considered in determining the medical necessity of a covered service. Non-medical factors, such as your financial or family situation, are not considered.

The fact that a physician may prescribe or recommend a service does not mean it will automatically meet the standards for medical necessity. You should discuss the medical necessity of services with Wellmark (1-800-535-6099) before treatment or services are performed.

The following is a description of the notification components with which you need to comply when you use facilities or providers.

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. Participating practitioners and hospitals must do this for you; non-participating providers are not required to do so, so you must do it.

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

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

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

OTHER FACTS YOU SHOULD KNOW

- We may terminate your coverage without advance notice for fraudulent use of your policy.
- You become ineligible for coverage under the policy when you become eligible for Medicare or when you no longer qualify for this policy. You may obtain continuous coverage from Wellmark Blue Cross and Blue Shield of Iowa with no additional medical underwriting if your application is made to Wellmark Blue Cross and Blue Shield of Iowa within 30 days of the date you become ineligible.
- If you graduate or withdraw from classes at the University of Iowa, your coverage will end the last day of the month in which you graduate or withdraw. You may apply for the Student Health Insurance Continuation by completing an application. Please see the University Benefits Office website for more information.
- Wellmark Blue Cross and Blue Shield of Iowa will coordinate benefits with other group health carriers when duplicate coverage exists. Total payment from this coverage and all other group health coverages under which you are enrolled shall not exceed 100 percent of the cost of the covered services.

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

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.

PRESCRIPTION DRUGS (3-TIER PLAN)

Preferred name brand drugs are drugs that are on Wellmark’s preferred list available on the website here.

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

MEDICAL EVACUATION BENEFIT
Medical evacuation services will be covered in the event of illness or injury to 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.

HEALTH CARE FOR INDIVIDUALS WHO ARE AWAY FROM IOWA
SHIP provides coverage worldwide. Choosing a Blue Cross & Blue Shield Classic Blue 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.
# University of Iowa

## Health Insurance Overview

**Effective January 1, 2015**

### Plan Provisions

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

### Preventive Care

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

### Hospital Services

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>Ship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Semi-private Room</td>
<td>10% co-insurance after $300 deductible</td>
</tr>
<tr>
<td>Physicians Services</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Inpatient / Outpatient Surgery &amp; Supplies</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>OUTPATIENT SERVICES</td>
<td>SHIP</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Allergy Treatments</td>
<td>$15 co-payment</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Speech Occupational and Respiratory Therapy</td>
<td></td>
</tr>
<tr>
<td>Dental Accident Care (completed within 6 months)</td>
<td></td>
</tr>
<tr>
<td>Imaging and Lab</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Chiropractic visits</td>
<td></td>
</tr>
<tr>
<td>Mental Health visits</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Tier and what you pay per tier:</td>
</tr>
<tr>
<td></td>
<td>1. Generic drugs; 25%</td>
</tr>
<tr>
<td></td>
<td>2. Preferred name brand drugs; 30%</td>
</tr>
<tr>
<td></td>
<td>3. Non-preferred name brand drugs; 50%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$50 co-payment</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Maximum of 30 visits per calendar year</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Prior approval; cornea, kidney coverage</td>
</tr>
<tr>
<td></td>
<td>only</td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>Maximum of 30 days per calendar year</td>
</tr>
<tr>
<td>Not Covered</td>
<td>Eyeglasses</td>
</tr>
<tr>
<td></td>
<td>Hearing Aid</td>
</tr>
<tr>
<td></td>
<td>Infertility Treatment</td>
</tr>
</tbody>
</table>
DENTAL INSURANCE PLAN

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

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

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

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

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

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

There are no benefits for orthodontics.

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

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

- Discounts on eye exams
- Discounted pricing for lenses and lens options
- Savings on eyeglass frames and conventional contact lenses
- Unlimited use

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 the 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.
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  SPRING SEMESTER  SUMMER SEMESTER

Revised 11/2014
© University of Iowa, 2014
STUDENT INSURANCE PLANS  
2014-2015

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

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

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

AGREEMENT AND CERTIFICATION

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

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

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

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

(visit the next page)
UNDERGRAD STUDENT ENROLLMENT FORM

PART 1: ENROLLMENT BEGINNING DATE

☐ 08/01/2014  ☐ 01/01/2015  ☐ 05/01/2015
☐ 09/01/2014  ☐ 02/01/2015  ☐ 06/01/2015

If you are enrolling outside the open enrollment period, your coverage will begin the first day of the month following the receipt of your application. Other Enrollment Date: ☐ ______ / 01 / 20 ______

PART 2: YOUR INFORMATION

Full Name (Last, First, Middle Initial): ____________________________

University ID Number (8 digits): ____________________________ Date of Birth: ____________________________ Sex (M/F): ____________________________

Residing Address, City, State & Zip Code: ____________________________ Telephone Number: ____________________________ E-mail: ____________________________

PART 3: HEALTH INSURANCE

Select your health plan: ☐ SHIP

☐ ENROLL me in Health Insurance

☐ CANCEL my Health Insurance

PART 4: DENTAL INSURANCE

Select your dental plan: ☐ Student Dental Insurance

☐ ENROLL me in Dental Insurance

☐ CANCEL my Dental Insurance

PART 5: DEPENDENT INFORMATION

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

PART 6: OPTIONAL ACH AUTHORIZATION

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

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

FINANCIAL INSTITUTION: ____________________________

ADDRESS: ____________________________

CITY, STATE: ____________________________

TRANSIT/ABA NUMBER: 8 OR 9 DIGIT # ____________________________

YOUR ACCOUNT NUMBER: ____________________________

☐ CHECKING ☐ SAVINGS

SIGNATURE OF ACCOUNT HOLDER: ____________________________

DATE: ____________________________

PART 7: AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification language on the previous page.

Student’s Signature: ____________________________ Date: ____________________________

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

© University of Iowa, 2014

For Benefits Use: [008-00876]
{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
QUESTIONS AND ANSWERS

Q: Must I be registered full-time to enroll in SHIP or dental insurance?
A: No, the only requirement is to be registered for one semester-long class.

Q: How can I get the most out of my SHIP Plan?
A: Use Student Health & Wellness for the majority of your care. Gynecological exams, contraceptives, and contraceptive counseling are available at Student Health & Wellness, the Emma Goldman Clinic, and Planned Parenthood, sometimes at a reduced cost. Use the emergency room of a hospital only for emergencies, not for care that could wait until Student Health & Wellness or your doctor’s office is open.

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

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

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

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

Q: Can I continue this insurance when I am not a student?
A: Yes. You can continue coverage for up to 12 months after leaving the University of Iowa, otherwise your coverage ends the last day of the month you cease being an enrolled student. More information for this extension is provided online at the University Benefits Office here.

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

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

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

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

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

Prescription Claim Mailing Address:
Catamaran
Claims Department
P.O. Box 1069
Rockville, MD  20849-1069

Mail order prescription claims:
Catamaran Home Delivery
Catamaran website
P.O. Box 166
Avon Lake, OH  44012-9927
1-866-611-5961

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

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

Questions about SHIP or dental coverage, eligibility, adding dependents, brochures and enrollment forms, enrollment periods, or premium charges:
University of Iowa Benefits Office
120 University Services Building
Iowa City, IA  52242-1911

Benefits website
benefits@uiowa.edu

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