Welcome to the University of Iowa!

The University of Iowa is required to ensure that J-1 and J-2 family members have adequate health insurance coverage for the duration of their stay in the United States. In addition, the University is concerned about the potential threat of high cost health care which may pose a challenge to your financial wellbeing. For this reason, the University requires that all unpaid J-1 scholars purchase health insurance through the University of Iowa. The dental insurance is voluntary. The health insurance policies are administered by Wellmark Blue Cross and Blue Shield of Iowa and the dental insurance policies are administered by Delta Dental of Iowa.

This booklet explains the choices you have for yourself and your family members while at the University of Iowa. Please review the plans that are available for you to select from. You and your family members must be in the same plan. These are monthly rates. You will have a choice of either having a University bill sent to your Iowa address that will need to be paid each month, or you may choose to have your monthly premiums withdrawn from a financial account from either a local bank or credit union. The University will not deal with nor access international addresses or financial institutions.

These insurance options cannot be waived and the University will not accept alternate plans. Again, you must purchase one of the health plans that are being offered. Failure to complete the application form could affect the immigration status of you and your family members. For additional information contact the International Student & Scholar Services (ISSS) at 1111 University Capitol Centre (UCC), call (319) 335-0335 or email isss@uiowa.edu.

To enroll, simply detach the enrollment form in the back of this booklet, complete, and return the form to the International Student & Scholars Services Office at 1111 UCC, Iowa City, IA 52242-5500 as soon as possible. Coverages will always begin on the first day of the month and will always end on the last day of the month.

Questions regarding premium charges and insurance claims 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.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHIP</td>
<td>6</td>
</tr>
<tr>
<td>HOW AN INDIVIDUAL USES THE SHIP PLAN</td>
<td>6</td>
</tr>
<tr>
<td>ADDING DEPENDENTS</td>
<td>6</td>
</tr>
<tr>
<td>IDENTIFICATION CARDS &amp; POLICY INFORMATION</td>
<td>6</td>
</tr>
<tr>
<td>BILLINGS</td>
<td>6</td>
</tr>
<tr>
<td>PRIVACY NOTICE AND RELEASE FORM</td>
<td>6</td>
</tr>
<tr>
<td>CANCELLATIONS</td>
<td>7</td>
</tr>
<tr>
<td>COVERAGE TERMINOLOGY</td>
<td>7</td>
</tr>
<tr>
<td>Deductibles:</td>
<td>7</td>
</tr>
<tr>
<td>BENEFIT SUMMARY</td>
<td>8</td>
</tr>
<tr>
<td>OTHER FACTS YOU SHOULD KNOW</td>
<td>8</td>
</tr>
<tr>
<td>OUT-OF-POCKET MAXIMUM (OPM) EXPENSES FOR INDIVIDUALS</td>
<td>8</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS (3-TIER PLAN)</td>
<td>9</td>
</tr>
<tr>
<td>REPATRIATION BENEFIT</td>
<td>9</td>
</tr>
<tr>
<td>MEDICAL EVACUATION BENEFIT</td>
<td>9</td>
</tr>
<tr>
<td>HEALTH CARE FOR INDIVIDUALS WHO ARE AWAY FROM IOWA</td>
<td>9</td>
</tr>
<tr>
<td>UIChoice</td>
<td>10</td>
</tr>
<tr>
<td>COVERAGE</td>
<td>10</td>
</tr>
<tr>
<td>UIChoice</td>
<td>10</td>
</tr>
<tr>
<td>Co-payments, Co-insurance, and Deductibles</td>
<td>10</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (OPM) Expenses for Individuals and Families</td>
<td>11</td>
</tr>
<tr>
<td>Coverage for Prescription Drugs</td>
<td>11</td>
</tr>
<tr>
<td>HEALTH INSURANCE OPTIONS</td>
<td>12</td>
</tr>
<tr>
<td>DENTAL INSURANCE PLANS</td>
<td>15</td>
</tr>
<tr>
<td>HOW AN INDIVIDUAL USES THE DENTAL INSURANCE PLAN</td>
<td>15</td>
</tr>
<tr>
<td>HOW MUCH AN INDIVIDUAL PAYS FOR DENTAL SERVICES</td>
<td>15</td>
</tr>
<tr>
<td>VISION DISCOUNT PROGRAM</td>
<td>15</td>
</tr>
<tr>
<td>DENTAL INSURANCE OPTIONS</td>
<td>16</td>
</tr>
<tr>
<td>UNPAID J-1 SCHOLARS ENROLLMENT FORM</td>
<td>18</td>
</tr>
<tr>
<td>Please complete, sign, and return this enrollment form to:</td>
<td>18</td>
</tr>
<tr>
<td>AGREEMENT AND CERTIFICATION</td>
<td>18</td>
</tr>
<tr>
<td>UNPAID J-1 SCHOLARS &amp; J-2 FAMILY MEMBERS ENROLLMENT FORM</td>
<td>19</td>
</tr>
<tr>
<td>University Benefits Office</td>
<td>20</td>
</tr>
<tr>
<td>Personal Health Information Release Form</td>
<td>20</td>
</tr>
</tbody>
</table>
PRINT NAME, ADDRESS AND ID # OF THE POLICY HOLDER: ................................................................. 21
COMPLETE THE FOLLOWING BANK INFORMATION: ........................................................................ 21
AGREEMENT: ........................................................................................................................................ 21
  Questions about claims or specific SHIP and UIChoice coverage: ...................................................... 22
  Questions about claims or specific dental coverage: ........................................................................... 22
  Questions about: .................................................................................................................................. 22

The University of Iowa prohibits discrimination in employment, educational programs, and activities on the basis of race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associated preferences, or any other classification that deprives the person of consideration as an individual. The University also affirms its commitment to providing equal opportunities and equal access to University facilities. For additional information on nondiscrimination policies, contact the Director, Office of Equal Opportunity and Diversity, the University of Iowa, 202 Jessup Hall, Iowa City, Iowa 52242-1316. 319-335-0705 (voice), 319- 335-0697 (TDD), diversity@uiowa.edu.
SHIP (STUDENT HEALTH INSURANCE PLAN)

SHIP is a 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.

HOW AN INDIVIDUAL USES THE SHIP PLAN
Health care under this plan is provided by various groups of health care practitioners, suppliers, agencies, programs, and facilities called Select Providers who have agreed to join with Blue Cross and Blue Shield to offer affordable health care.

ADDING DEPENDENTS
- If you acquire eligible dependents while insured by this plan, J-2’s must 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. Those wishing to insure a domestic partner must complete an Affidavit for Domestic Partnership available in the University Benefits Office or on the University Benefits website.
- Children over the age of 26 may continue to be covered if they are full-time students or disabled.

IDENTIFICATION CARDS & POLICY INFORMATION
You will receive identification (ID) cards 10-15 days after your enrollment 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. A list of providers may be accessed at Wellmark’s website.

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 Authorization for Automatic Withdrawal of Insurance Premiums form located in the back of this booklet or it is also available in the University Benefits Office or through the forms link via the University Benefits Office website.

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 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 you are no longer affiliated with the University of Iowa.
• Coverage can only be terminated through the International Student & Scholars Services Office at 1111 University Capitol Centre (UCC), Iowa City, IA 52242.
• The University Benefits Office will cancel coverage for non-payment of premium, which could result in the loss of visa rights!

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 costs will generally be less when you when you use a Blue Cross & Blue Shield facility or practitioner.

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

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

Out-of-Pocket Maximum (OPM):
The OPM is the maximum amount you pay for most covered services in a calendar year including amounts you pay for per-service deductible, co-insurance amounts and 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 at 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 in the back of this booklet 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 at University Benefits Website 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.
- 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 FOR INDIVIDUALS

SHIP provides an OPM of $1,700 for Single and $3,400 for Family. There is also a separate OPM for prescription drugs of $1,000 for Single and $2,000 for Family. 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 drugs are drugs that are on Wellmark’s preferred list which are available on their website.

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

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

Self-administered, self-injectable specialty drugs are covered under your medical insurance with 10% co-insurance.

REPATRIATION BENEFIT

A repatriation benefit applies to you, 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 you 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 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.
Coverage

Coverage is provided through Wellmark Blue Cross and Blue Shield of Iowa.

UIChoice

Health care under the UICHOICE PLAN may be obtained from any provider you wish. This plan includes three benefit levels; the provider you choose automatically determines the plan benefit level within UICHOICE.

Plan Benefit Level 1 = Providers from University of Iowa Hospitals and Clinics, the Carver College of Medicine (CCOM), and UI Community Medical Services Clinics (CMSC), and UI Health Alliance Facilities and Primary Care Clinics. Locations are listed on the Benefits website.

Plan Benefit Level 2 = Providers from the Wellmark Blue Choice Network. Locally, Level 2 includes Mercy Hospital and most Iowa City community providers.

Plan Benefit Level 3 = Any provider that does not belong to Level 1 or 2.

YOU DO NOT HAVE TO PICK A PLAN LEVEL. THE PROVIDER YOU CHOOSE AUTOMATICALLY DETERMINES AT WHICH LEVEL THAT PARTICULAR CLAIM IS PROCESSED AND HOW MUCH YOU PAY.

You can use any provider. Level 1 will result in the lowest out-of-pocket costs for you. While you can use any provider you want, there are advantages to using providers who have contracts with Blue Cross and Blue Shield.

Co-payments, Co-insurance, and Deductibles

Office visits with Level 1 providers have a $10.00 co-payment. Level 2 providers have a $25.00 co-payment. Level 3 providers have 50% co-insurance.

Emergency Room co-payment for all levels, is $100 followed by 10% co-insurance.

There is no physician charge or co-payment for a routine annual physical examination in levels 1 & 2. Labs, tests, and x-rays may have a charge on all levels.

There is no co-payment or co-insurance for well-child care and/or immunizations on any of the levels.

Insureds will pay 20% for durable medical equipment.

When an individual is admitted to a hospital, the individual will pay a $400 deductible for Level 1, $600 for Level 2, and $800 for Level 3. After the deductible is paid, the individual will pay 10% of the charges for Level 1 and 2 providers and 40% of the charges for Level 3 providers, subject to the out-of-pocket maximum limits.
Out-of-Pocket Maximum (OPM) Expenses for Individuals and Families

The UIChoice Plan provides an annual maximum limit for certain out-of-pocket expenses for both individuals and families. When the amount paid in co-payments, co-insurance and deductibles equals the applicable OPM, the plan pays 100% of the covered charges for most additional medically-necessary expenses incurred during the remainder of the calendar year.

The OPM for the individual’s expenses for Levels 1 and 2 combined is $1,700. The OPM for all other contracts (family, employee and children, employee and spouse, etc.) is $3,400 for Levels 1 and 2 combined.

The OPM for Level 3 services is separate from the Level 1 and 2 OPM. The OPM for Level 3 services is $2,000 for individuals and $4,000 for all other contracts. If you are out of state, contact Wellmark’s toll-free telephone number on the back of your ID card to determine if the provider will be considered in Network.

The OPM for prescription drugs is $1,100 for individuals (a single contract) and $2,200 for all other contracts.

The amount paid by an individual, for the treatment or care of infertility, or due to contract limitations are not included in the annual out-of-pocket amount.

When a plan member in a contract other than “individual” meets their OPM, the additional plan member/s will continue to pay co-insurance and deductibles until the overall OPM for their contract is met.

Coverage for Prescription Drugs

This plan has a tiered prescription benefit. This means for each prescription you will pay co-insurance, which will vary depending on the tier (or category) of the drug.

The co-insurance amounts are:

- Tier 1: 0% - Generic drugs are provided at no cost to the insured
- Tier 2: 30% - Preferred name brand drugs
- Tier 3: 50% - Non-preferred name brand drugs

The OPM expense provision for prescription drugs is separate from the medical OPM. The insured is responsible for paying co-insurance on prescriptions (as described above) up to $1,100 for individuals or $2,200 for family in prescription drug cost. Once the OPM has been met, the plan pays 100% of covered expenses incurred during the rest of the calendar year for drugs.
### University of Iowa

**HEALTH INSURANCE OPTIONS**

<table>
<thead>
<tr>
<th>PLAN TYPE (RATES EFFECTIVE DATE)</th>
<th>SHIP (SEPTEMBER 1, 2017)</th>
<th>UIChoice (JANUARY 1, 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$190</td>
<td>$605</td>
</tr>
<tr>
<td>Scholar/Spouse</td>
<td>$950</td>
<td>$1,443</td>
</tr>
<tr>
<td>Scholar/Children</td>
<td>$882</td>
<td>$1,177</td>
</tr>
<tr>
<td>Family</td>
<td>$1,512</td>
<td>$1,547</td>
</tr>
</tbody>
</table>

### PLAN PROVISIONS EFFECTIVE JANUARY 1, 2018

<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>SHIP</th>
<th>UIChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Any Provider: The provider or facility category you use determines the plan benefit level. This is one plan with three different benefit levels: <strong>Providers covered at each level:</strong> <strong>Level 1:</strong> University of Iowa Hospitals and Clinics, Carver College of Medicine (CCOM) and UI Community Medical Services Clinics (CMSC), and UI Health Alliance Facilities and Primary Care Clinics. Locations are listed on the Benefits website. <strong>Level 2:</strong> Blue Choice Network Providers not included in Level 1 <strong>Level 3:</strong> Any provider outside of Level 1 or 2. <strong>Blue Cross/Blue Shield (BC/BS) providers can result in lower out-of-pocket costs. For non-BC/BS providers, insured pays charges over the maximum allowable fee.</strong> Visit the <a href="#">Wellmark website</a> for a list of providers.</td>
<td></td>
</tr>
</tbody>
</table>
| Co-insurance Percentage | 10%; participating/non participating providers | Level 1 – 10%  
Level 2 – 20%  
Level 3 – 40% |
| Out-of-Pocket Maximums | $1,700 for single / $3,400 for family  
Prescription Drugs: $1,000 for single / $2,000 for family | Combined OPM for Level 1 & Level 2 Services & Level 3 Blue Card participating providers- $1,700 / $3,400; OPM for Level 3 Services-$2,000 / $4,000; OPM for prescription drugs-$1,100 / $2,200 |
<p>| Pre-approval of Inpatient Admissions | Required | Required |
| Second Surgical Opinion | Voluntary | Voluntary |</p>
<table>
<thead>
<tr>
<th>PREVENTIVE CARE</th>
<th>SHIP</th>
<th>UIChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>Covered; $0 co-payment</td>
<td>$0 co-payment</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>Covered; $0 co-payment</td>
<td>$0 co-payment</td>
</tr>
<tr>
<td>Gynecological Pelvic Exams &amp; Pap Smears</td>
<td>Covered; $0 co-payment (one per calendar year unless medically necessary)</td>
<td>Level 1, 2 &amp; Level 3 Blue Card participating providers– $0 co-payment Level 3 – 40% co-insurance</td>
</tr>
<tr>
<td>Routine Physicals</td>
<td>Covered, $0 co-payment (one per calendar year unless medically necessary)</td>
<td>Level 1 - $10 co-payment Level 2 – 20% Level 3 – 40% co-insurance</td>
</tr>
<tr>
<td>Routine Eye Exam</td>
<td>Not Covered</td>
<td>Level 1 - $5 co-payment Level 2 - $20 co-payment Level 3 – 40% co-insurance</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES</th>
<th>SHIP</th>
<th>UIChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Semi-Private Room</td>
<td>10% co-insurance after $300 deductible</td>
<td>Level 1 - $400 deductible; Level 2 - $600 deductible; Level 3 - $800 deductible; followed by co-insurance</td>
</tr>
<tr>
<td>Inpatient / Outpatient Surgery &amp; Supplies</td>
<td>10% co-insurance</td>
<td>Level 1 – 10% Level 2 – 20% Level 3 – 40%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$50 co-payment</td>
<td>Level 1 &amp; Level 2 - $100 co-payment (waived if admitted) followed by 10% co-insurance Level 3 – Same as Level 1 or 2 if coded as an emergency, $100 co-payment followed by 40% co-insurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT SERVICES</th>
<th>SHIP</th>
<th>UIChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Treatments, Ambulance, Physical Therapy, Speech, Occupational &amp; Respiratory Therapy, Dental Accident Care (completed within 6 months)</td>
<td>$15 co-payment</td>
<td>Level 1 – 10% Level 2 – 20% Level 3 – 40%</td>
</tr>
<tr>
<td>Imaging and Lab</td>
<td>$15 co-payment</td>
<td>Level 1 &amp; 2 – 10% co-insurance Level 3 – 40% co-insurance</td>
</tr>
<tr>
<td>Office visits</td>
<td>$10 co-payment</td>
<td>Level 1 - $10 co-payment Level 2 - $25 co-payment Level 3 – 50% co-insurance</td>
</tr>
<tr>
<td>Chiropractic visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT SERVICES (continued)</td>
<td>SHIP</td>
<td>UIChoice</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>----------</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Tier and what you will pay per tier 1. Generic Drugs: 25% 2. Preferred name brand drugs: 30% 3. Non-preferred name brand drugs: 50%</td>
<td>3-tiered co-insurance plan; 1 – Generic drugs have 0% co-insurance; provided at no cost to plan member; 2 – Name-brand Wellmark Formulary drugs have 30% co-insurance; 3 – Name-brand non-formulary drugs have 50% co-insurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Maximum of 30 visits per calendar year.</td>
<td>Level 1 &amp; 2: 10% co-insurance Level 3: 40% co-insurance</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Prior approval; cornea, kidney coverage only.</td>
<td>Level 1 &amp; 2: 10% co-insurance Level 3: 40% co-insurance</td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>Maximum of 30 days per calendar year</td>
<td>Maximum of 30 days per calendar year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered</td>
<td>Level 1 &amp; 2: 10% co-insurance Level 3: 40% co-insurance</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>Yes, same sex or opposite sex</td>
<td>Yes, same sex or opposite sex</td>
</tr>
<tr>
<td>Dependent Child Age Limit</td>
<td>End of calendar year after the individual turns 26 or unlimited if full-time student</td>
<td>End of calendar year after the individual turns 26 or unlimited if full-time student</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>Not Covered</td>
<td>Level 1: 10% co-insurance Level 2: 30% co-insurance Level 3: 40% co-insurance</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Not Covered</td>
<td>20% co-insurance Maximum benefit $2,000 every 5 years</td>
</tr>
</tbody>
</table>
DENTAL INSURANCE PLANS

There are two dental plans available and enrollment is voluntary. Eligibility is based upon the health plan you elect. If electing dental coverage, the Student Dental plan is available for those enrolling in the Student Health Insurance Plan (SHIP) and the Dental II plan is available for those enrolling in the UIChoice health plan.

HOW AN INDIVIDUAL USES THE DENTAL INSURANCE PLAN

Dental care under these plans 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 on our website. 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. A person using a Preferred Participating Provider (PPO) will see a reduced cost for their care.

Non-participating providers have not agreed to accept Delta Dental's payment arrangements. This means you are 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 may be deductibles per person, and co-insurance for the remainder of covered services.

VISION DISCOUNT PROGRAM

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

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

Using Your EyeMed Discount Program:

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

For full details on the discount program visit Delta Dental website.
# University of Iowa

## DENTAL INSURANCE OPTIONS

<table>
<thead>
<tr>
<th>PLAN TYPE (RATES EFFECTIVE DATE)</th>
<th>STUDENT DENTAL (SEPTEMBER 1, 2017)</th>
<th>DENTAL II (JANUARY 1, 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$25</td>
<td>$45</td>
</tr>
<tr>
<td>Scholar/Spouse</td>
<td>$45</td>
<td>$93</td>
</tr>
<tr>
<td>Scholar/Children</td>
<td>$67</td>
<td>$100</td>
</tr>
<tr>
<td>Family</td>
<td>$80</td>
<td>$133</td>
</tr>
</tbody>
</table>

## PLAN PROVISIONS EFFECTIVE JANUARY 1, 2018

<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>STUDENT DENTAL</th>
<th>DENTAL III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Any Provider</td>
<td>Any Provider</td>
</tr>
<tr>
<td></td>
<td>There are advantages to using participating providers who have contracts with Delta Dental of Iowa.</td>
<td>There are advantages to using participating providers and preferred participating providers who have contracts with Delta Dental of Iowa.</td>
</tr>
<tr>
<td></td>
<td>A list of plan providers can be found at <a href="#">Delta Dental</a></td>
<td>A list of plan providers can be found at <a href="#">Delta Dental</a></td>
</tr>
</tbody>
</table>
|                  | Participating Providers: Will accept payment arrangements and file claims for you. Payment is made directly to these providers. | 3 Tier Provider Network:  
  ✐ Tier 1 is a PPO network  
  ✐ Tier 2 is the regular Delta Dental network  
  ✐ Tier 3 are dentists who do not participate with Delta Dental |
<p>|                  | Non-participating Providers: Do not have contracts with Delta Dental of Iowa. They do not agree to accept payment arrangements and are not responsible for filing claims for you. Non-participating providers may charge more for dental care than participating providers. | Using Tier 1 will result in lower out-of-pocket costs for care. Visit <a href="#">Delta Dental website</a> for participating providers. |</p>
<table>
<thead>
<tr>
<th>DENTAL CARE SERVICES</th>
<th>STUDENT DENTAL</th>
<th>DENTAL II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic &amp; Preventative Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part A:</strong></td>
<td>Deductible: None Co-insurance: 0% Maximum Annual Benefit: $1,000 for parts A &amp; B Services Included: Routine exam, teeth cleaning, and x-rays</td>
<td>Annual Deductible (Per Member): None Co-insurance: 0% Maximum Annual Benefit (Per Member): Two per year (effective 1/1/17) Services Included: Routine examination, teeth cleaning</td>
</tr>
<tr>
<td><strong>Part B:</strong> Deductible: $25 / $75 Co-insurance: 20% Maximum Annual Benefit: $1,000 for parts A &amp; B Services Included: Cavity Repair and Tooth Extractions: Consultations, emergency treatment for pain, general anesthesia/sedation anesthesia or analgesia, restoration of decayed or fractured teeth, limited occlusal adjustment, routine oral surgery, and antibiotic drug injections. Root Canals, Gum &amp; Bone Diseases</td>
<td>Annual Deductible (Per Member): None Co-Insurance: PPO: 0%; PREMIER: 20%; NON-PAR: 20% Maximum Annual Benefit (Per Member)*: $2,000, up to $4,000 with annual carryover Services Included: Regular cavity fillings; Emergency treatment for relief of pain; Routine Oral surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Prosthesis, Surgical Care, Endodontics &amp; Periodontal Services</strong></td>
<td><strong>Part B (continued):</strong> Deductible: $25/$75 Co-Insurance: 50% Maximum Annual Benefit: $1,000 for parts A &amp; B Services Include: Crowns, inlays, onlays, posts and cores, bridges, dentures, denture relining and implants.</td>
<td>Annual Deductible: $0 Co-Insurance: PPO: 10%; PREMIER: 20%; NON-PAR: 20% Maximum Annual Benefit (Per Member)*: $2,000, up to $4,000 with annual carryover Services Included: Bridges, partial &amp; complete dentures, Oral surgery, Crowns, Root canal</td>
</tr>
<tr>
<td><strong>Orthodontic Care</strong></td>
<td>Not Covered</td>
<td>Annual Deductible (Per Member): $0 Co-Insurance: 50% Maximum Annual Benefit (Per Member)*: $2,000, up to $4,000 with annual carryover Services Include: Treatment necessary for the proper alignment of teeth, orthodontic benefits paid quarterly</td>
</tr>
</tbody>
</table>

Dental II Note: *$2,000 includes all covered services per member. Effective January 1, 2016, the annual benefit maximum for Dental II includes a carryover feature from one calendar year to the next. If you do not use all of your $2,000 maximum, have been covered the full year, and submitted at least one claim, what remains will carryover and be added to your annual maximum in the following year up to $4,000.*
INSURANCE PLANS
2017-2018

UNPAID J-1 SCHOLARS ENROLLMENT FORM

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

UNIVERSITY OF IOWA
INTERNATIONAL STUDENT & SCHOLAR SERVICES
1111 UNIVERSITY CAPITOL CENTRE
IOWA CITY, IA 52242-5500
FAX: 319-335-0280

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.

(Please visit the other side)
UNPAID J-1 SCHOLARS & J-2 FAMILY MEMBERS ENROLLMENT FORM

PART 1: ACTION REQUESTED

Select your enrollment type:  □ NEW APPLICATION  □ CHANGE  □ ADD DEPENDENT(S)

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  □ UIChoice
□ ENROLL me in Health Insurance
□ CHANGE my Health Insurance

PART 4: DENTAL INSURANCE

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

PART 5: DEPENDENT INFORMATION

<table>
<thead>
<tr>
<th>NAME:</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>Last, First, Middle Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</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>Last, First, Middle Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</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>Last, First, Middle Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</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>Last, First, Middle Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART 6: AGREEMENT AND CERTIFICATION

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

Signature (DO NOT PRINT): __________________________________________ Date: __________

Return Form To:
International Student & Scholar Services
1111 University Capitol Centre
Iowa City, IA 52242-5500
Email: isss@uiowa.edu
Fax: (319) 335-0280

EFFECTIVE DATE
___ / 01 / 20___

ISSS Approval
Initials: ______________________
{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: __________________

HIPAA/Personal Health Information Release Form
©University of Iowa, 2017
Updated 11/14

For Benefits Use: [008-886]
ACH AUTHORIZATION FOR AUTOMATIC
WITHDRAWAL OF INSURANCE PREMIUMS

PLEASE CHECK ONE:  ☐ NEW ENROLLMENT  ☐ CHANGE OF ACCOUNT  ☐ CANCELLATION

PRINT NAME, ADDRESS AND ID # OF THE POLICY HOLDER:

Name (First, Last, Middle):__________________________

Current Address:____________________________________

City, State, Zip Code:_______________________________

University/Student ID # (8 digits):____________________

Your Name (if different than above):__________________

COMPLETE THE FOLLOWING BANK INFORMATION:

Please check the appropriate box:  ☐ CHECKING ACCOUNT  ☐ SAVINGS ACCOUNT

Deductions will occur on the first business day of each month.

<table>
<thead>
<tr>
<th>Name of Bank:</th>
<th>City &amp; State:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank Routing number (ABA#) (9 digits):</th>
<th>Account Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AGREEMENT:

I hereby authorize the University of Iowa to initiate ACH credit and/or debit entries to my financial institution(s) listed below, including reversing entries to correct any erroneous transactions.

I agree to hold the University of Iowa harmless for any delay, loss of funds, or overdraft charges due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in processing the entries.

This agreement shall be effective on the next processing window and remains in force until the university receives notice of cancellation, submission of a new form for Change of Account, or by a notification of change by my financial institution(s). Cancellation or change requests must be received by the University of Iowa at least 5 business days prior to the next payment date.

Required – I hereby indicate that I have read and agree to the above:

Signature (DO NOT PRINT): ___________________________ Date: ________________

Return Form To:
UNIVERSITY BENEFITS OFFICE
120 UNIVERSITY SERVICES BUILDING
IOWA CITY, IA  52242-1911

e-mail: benefits@uiowa.edu
fax: 319-335-2776

FOR BENEFITS USE: [00848] Revised: [12.07.17]
© University of Iowa, 2017
WHO TO CONTACT

Questions about claims or specific SHIP and UIChoice 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 (SHIP)  
1-800-355-2031 (UIChoice)

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

Mail Order Prescription claim/mailing:  
CVS/caremark  
P.O. Box 94467  
Palatine, IL  60094-4467  
Register at Caremark Website  
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, UIChoice or dental coverage, eligibility, adding dependents, brochures and enrollment forms, enrollment periods, or premium charges:

University of Iowa Benefits Office  
120 University Services Building  
Iowa City, IA  52242-1911  
University Benefits Website  
SHIP email: benefits-students@uiowa.edu  
UIChoice email: benefits@uiowa.edu  
Office: 319-335-2676  
Toll-free: 877-830-4001  
Fax: 319-335-2776