

## UIGRADCare & SHIP Health Insurance Options

### Effective September 1, 2009 – December 31, 2010

Plan Provisions	UIGRADCare	SHIP
Care Providers/Network	University of Iowa Hospitals & Clinics providers ONLY; life-threatening emergencies are covered in a hospital ER	Alliance Select (Select) provider network; Life-threatening emergencies are covered in a hospital ER
Deductible Single/Family	None	Inpatient only: \$300 per covered admission for Select providers and \$600 per covered admission for non-Select providers
Out-of-Pocket Maximum (OPM) Single/Family	Medical care: \$1,200/\$1,800 Prescription drugs: \$1,200/\$1,800	\$1,000 per hospital inpatient stay
Coinsurance	10% - applies toward OPM	10% for Select inpatient hospital charges; 20% for non-Select inpatient hospital charges
Co-Payment	See plan details – does not apply toward OPM	See plan details – does not apply toward OPM
<b>OUTPATIENT/AMBULATORY SERVICES</b>		
Office Visits	\$10 co-payment	\$10 co-payment for Select providers; \$30 co-payment for non-Select providers; \$1,500 maximum benefit*
Outpatient Mental Health Visits	\$10 co-payment for Blue Advantage psychiatrists; 10% co-insurance for all other Blue Advantage network mental health providers; 50% coinsurance for all other Blue Cross/Blue Shield mental health providers	\$10 co-payment for Select providers; \$30 co-payment for non-Select providers
Outpatient Substance Abuse Visits	\$10 co-payment for Blue Advantage psychiatrists; 10% co-insurance for all other Blue Advantage network substance abuse providers; 50% co-insurance for all other Blue Cross/Blue Shield substance abuse providers	\$10 co-payment for Select providers; \$30 co-payment for non-Select providers
Routine Physicals	\$0 (10% co-insurance for lab and imaging)	Not covered
Gynecological pelvic examinations and Pap Smears	Covered	Covered (1 per calendar year unless medically necessary)
Well-Child Care	\$0, including required immunizations	No cost for children to age 7 (includes required Immunizations)
X-ray and Lab	10% co-insurance	Diagnostic only - \$10 co-payment at Physicians Office; \$50 co-payment at Outpatient Facility; \$1,500 maximum benefit **
Outpatient Surgery	10% co-insurance	\$50 co-payment for Select hospital; \$150 co-payment for non-Select hospital
Allergy Treatments	\$10 co-payment	\$10 copayment for Select physician; \$30 copayment for non-Select physician; \$1,500 maximum benefit*
Immunizations	\$10 copayment; \$0 required child immunizations < 7 years old	\$0 for Children under 7 years of age; no coverage for children over 7 years of age
Routine Eye Exam	\$10 co-payment (\$0 at UIHC)	Not covered
Eyeglasses	Not covered	Not covered
Routine Hearing Exam	\$10 co-payment	Not covered
Hearing Aid	Not covered	Not covered
Infertility Treatment	Not covered	Not covered
Chiropractor	\$10 copayment	\$10 copayment for Select provider; \$30 copayment for non-Select provider; \$1,500 maximum benefit*
Durable Medical Equipment	10% coinsurance	\$10 copayment for Select provider; \$30 copayment for non-Select provider \$1,500 maximum benefit*
Dental Accident Care	10% coinsurance, treatment must be completed within 12 months of injury	\$10 copayment for Select provider; \$30 copayment for non-Select provider; treatment must be completed within 6 mo of injury; \$1,500 maximum benefit*
<b>INPATIENT/HOSPITAL SERVICES</b>		
Emergency Room Care	10% coinsurance after \$50 co-payment	\$50 copayment for Select hospital; \$150 copayment for non-Select hospital
Inpatient Hospital Room and Board for Medical and Mental Health care	10% coinsurance after \$125 daily deductible; semi-private room	10% coinsurance after \$300 deductible for Select hospital; 20% coinsurance after \$600 deductible for non-Select hospital; semi-private room
Inpatient Physician Services	10% coinsurance	Included in hospital deductible and coinsurance
Inpatient and Outpatient Surgery	10% coinsurance	10% coinsurance after \$300 deductible for Select hospital; 20% coinsurance after \$600 deductible for non-Select hospital
Inpatient Supplies, Drugs, Medicines, Etc	10% coinsurance	10% coinsurance after \$300 deductible for Select hospital; 20% coinsurance after \$600 deductible for non-Select hospital
<b>PRESCRIPTIONS</b>		
Prescription Drugs and Contraceptives	25% co-insurance \$1,200/\$1,800 out-of-pocket maximum	3 tier-plan \$500 maximum benefit for single contract \$750 for all other contracts
Injectable Drugs	10% coinsurance – applied toward medical OPM	

\* Combined annual \$1,500 maximum benefit

\*\* Separate annual \$1,500 maximum benefit