

UNDERSTANDING YOUR INSURANCE COVERAGE

Choosing a health plan can be confusing. Take a few minutes to compare your current plan with the SSHIP plan available to students and their families. Occasionally selecting a different plan makes more sense. The ISU SSHIP plan covers most services 100% at Thielen Student Health Center. **To learn more about the plan or to register for the coverage, please visit the Student and Scholar Health Insurance Plan website, visit the SSHIP office located at 3810 Beardshear Hall, or call (515) 294-4800.**

		MY PLAN	ISU SSHIP PLAN
What type of insurance plan? PPO - Preferred Provider Organization HMO - Health Maintenance Organization Other/Unknown		<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____	Other: Point-of-Service
What is the coinsurance for services?		%	TSHC 0%, all others 20%*
Do ALL my providers (doctors, hospitals, specialists, pharmacies, etc.) take this plan? Look on the insurance company's website or call to find out.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do I need referrals for specialists?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> NO
This plan covers these services (Covered essential and other services): <i>Mark off the services this plan provides by marking an "X" next to the service.</i>		<input type="checkbox"/> Medical <input type="checkbox"/> Maternity <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Mental Health <input type="checkbox"/> Dental <input type="checkbox"/> Substance Abuse	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Maternity <input checked="" type="checkbox"/> Prescription <input checked="" type="checkbox"/> Vision <input checked="" type="checkbox"/> Mental Health <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Substance Abuse
What is the amount of the out of pocket maximum or limit?		\$	\$4,100 (ind)
If I travel out-of-network, does this plan cover care outside my local area? If I travel out of country or out of state, does this plan provide coverage?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Annual Premium Amount (individual)		\$_____ per month x 12 months = \$_____	\$1,392 (year)
How much is your co-payment?	<i>Primary Care/Doctor Office Visit</i> <i>Physical Therapy</i> <i>Specialist</i> <i>Urgent Care</i> <i>Emergency Department</i> <i>Hospitalization</i>	\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____	\$ 0 \$10 \$ 0 \$ 0 \$ 100 \$ 0
How much is the annual deductible? (Medical and Hospital)		\$ _____	\$450*
Out of pocket costs you pay yearly		\$ _____	\$ _____
Prescription Drug Costs <i>Find out costs by checking online or calling the company; ask about the formulary.</i>		\$_____ co-payment per RX x _____ number of RX filled = \$ _____	\$10/20
Cost Summary			
	Insurance Premium	\$ _____	\$1,392
	Doctor Costs and Deductibles	\$ _____	\$ _____
	Prescription Drug Costs	\$ _____	\$ _____
	Total Estimated Yearly Health Care Costs	\$ _____	\$ _____

***COST ESTIMATOR ASSUMES IN-NETWORK (OUT OF NETWORK WOULD BE 40%/\$600)**