HIPIOWA
Iowa Comprehensive Health Association

P.O. Box 1090
Great Bend, KS 67530
(877) 793-6880
Fax: (620) 793-1199
www.HIPIOWA.com

Administered by Benefit Management, LLC

IMPORTANT NOTICE

Re: - Premium Rate Change Effective January 1, 2023
- Eligibility Verification Form - DUE December 15, 2022

Dear <Name>,

This letter contains important information about your **premium rates effective January 1, 2023** and **Eligibility Verification Form that is due to us by December 15, 2022.**

2023 HIPIOWA Premium Rates, Benefits & Cost-Sharing

Your HIPIOWA monthly premium rate will not change for 2023. By law, we are required to base our rates on what other carriers in the state charge for similar benefits. Please consult the enclosed rate chart to verify your new rate.

There are no changes to your HIPIOWA benefits or cost-sharing arrangements for 2023.

Eligibility Verification Form Due December 15, 2022

HIPIOWA combines the yearly eligibility verification requirement with this notice to simplify the process of returning this important information to us.

Please RETURN the enclosed Eligibility Verification Form (green paper)
BY December 15, 2022

Enclosures in This Packet:

- **2023 HIPIOWA Premium Rates** – Effective January 1, 2023
- **Eligibility Verification Form** (Green Paper) – For enrollees continuing coverage with HIPIOWA in 2023, this form is **due by December 15, 2022**

Questions?

If you have questions or need assistance during this year's HIPIOWA open enrollment, please call HIPIOWA Customer Service at **1-877-793-6880.**

Iowa Comprehensive Health Association (HIPIOWA)
2023 Monthly Premium Rates with 0.0% Rate Change Over 2022
Medicare Carveout Plan - Without Prescription Drug Benefits
$1000 Deductible

Rate Class	Non Tobacco User		Tobacco User [1]	
Age \ Gender	Male	Female	Male	Female
0 - 17	$119.01	$131.47	$137.46	$151.85
18	125.12	149.11	144.52	172.23
19	131.24	166.76	151.58	192.61
20	137.59	184.39	158.92	212.98
21	143.70	202.04	165.97	233.36
22	149.81	219.69	173.04	253.72
23	152.16	225.07	175.75	259.96
24	155.00	231.43	179.03	267.30
25	157.59	237.54	182.00	274.35
26	159.46	241.31	184.17	278.71
27	160.18	241.31	184.99	278.71
28	163.70	249.31	189.41	288.47
29	166.28	253.54	192.72	293.85
30	168.15	255.65	195.23	296.82
31	169.81	257.07	197.49	298.98
32	171.93	259.43	200.29	302.23
33	175.93	266.49	205.32	310.99
34	179.94	273.29	210.34	319.48
35	183.93	279.88	215.36	327.75
36	188.41	287.16	220.98	336.84
37	193.32	295.41	227.14	347.11
38	200.86	299.64	236.21	352.37
39	208.40	305.07	245.28	359.06
40	216.62	311.18	255.17	366.56
41	225.33	316.82	265.64	373.52
42	235.19	321.74	277.55	379.68
43	241.54	328.81	285.51	388.66
44	249.31	335.15	295.20	396.83
45	257.54	341.28	305.44	404.75
46	266.02	347.62	316.02	412.97
47	273.78	354.45	325.81	421.80
48	282.94	358.46	337.86	427.98
49	291.88	362.91	349.69	434.76
50	300.59	367.62	361.29	441.88
51	309.75	372.08	373.58	448.74
52	319.16	375.60	386.18	454.51
53	330.70	383.38	401.47	465.43
54	342.22	390.44	416.83	475.55
55	354.21	397.01	432.85	485.15
56	366.67	404.07	449.55	495.39
57	379.86	412.31	467.22	507.13
58	400.54	419.12	492.68	515.50
59	421.49	426.89	518.42	525.07
60	443.13	435.12	545.04	535.20
61	466.63	443.59	573.96	545.64
62	492.74	451.82	606.09	555.75
63	516.49	460.04	635.29	565.88
64	541.42	468.77	665.95	576.58
65	587.31	503.61	722.37	619.45
66	596.52	506.62	733.68	623.16
67	605.87	509.64	745.22	626.88
68	621.99	518.41	765.03	637.63
69	638.55	527.33	785.40	648.61
70+	708.61	579.82	871.60	713.17

Footnotes:

[1] Tobacco User rates = Percentage of Non-Tobacco User, Varies by Attained Age from 115.5% to 123.0%

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Reply to:
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2023 Eligibility Verification Form must be returned to our office prior to December 15, 2022.

«First» «Last»
«Addr»
«Addr2»
«City», «ST» «Zip»

Policy Number: «Partic»

1. Are you currently a resident of the State of Iowa? **Yes / No (circle one)**

2. Have you enrolled or do you plan to enroll in Medicare Part D or a PDP?

   Yes / No (circle one) If yes, please enter effective date: _____

3. Are you currently *eligible* for employee group insurance or health insurance from any other source?

   Yes / No (circle one) If yes, please enter eligibility date: _____

4. If any of the above address or phone information is incorrect, indicate the correct information below.

Physical Address of your current residence - Required		Mailing Address **if different** than physical address	
Name		Name	
Address		Address	
City		City	
State & Zip		State & Zip	
Telephone Number: ( )		**Email Address:**	
Cell Number: ( )			

Please indicate your choice below:

☐ I wish to remain on my current plan with HIPIOWA, Medicare Carveout *without drug benefits.* I understand that I do have the option to change to a Medicare Advantage or Supplement Plan. I understand that if I need prescription drug benefits, I will need to enroll in a Medicare PDP or Part D plan in early December 2022.

This form must be returned to us **prior to December 15, 2022** at the above address if you do elect to change your plan or have changes in your information. For your c1nvenience we have enclosed a self-addressed envelope. As an alternative you may fax this form to us at (620) 793-1199. Please do not respond more than once.

Signature _____

Date of Birth _____ Today's Date_____

HIPIOWA Medicare Carveout w/o Rx 2023

Office use only
☐ Elig
☐ SS
☐ LX
☐ CS
By _____