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.**

Table 4 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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«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 _____

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Iowa Comprehensive Health Association

Outline of Benefit Plans

This document is intended for descriptive purposes only.

All benefits are subject to the terms, conditions, limitations, exclusions, deductibles, copayments, and any and all other contract provisons. Actual contract provisions prevail in the event of conflict with this document.

Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Coinsurance	80%
Deductible	$1,000
Stop Loss Limit (Coinsurance Maximum)	$7,500
Out-of-Pocket Maximum (OOP)* *OOP includes Deductible & Coinsurance	$2,500
Lifetime Maximum Benefit	$3 million
Benefit Year Definition	Calendar Year (CY)
Deductible Carryover Provision	Yes, deductible carryover of expenses in last 90 days of CY.
Pre-Existing Conditions	6 months prior / coverage excluded for 6 months after effective date of policy.
Covered Benefits Eligible expenses are payable for the following benefits, and are subject to the deductible and coinsurance unless otherwise noted. Certain benefits may be subject to inside limits as noted.	
Inpatient Medical / Surgical Services	
Hospital room & board [1]	Covered, no limit.
General nursing care	Covered
Medical and surgical supplies	Covered
Accidental injury care	Covered
Hospital intensive care units (including cardiac care et	Covered
Inpatient physician and professional services	Covered
Anesthetics and their administration	Covered
Diagnostic services - lab, X-ray, MRI,	Covered
Chemotherapy and hemodialysis services	Covered
Drugs and biologicals	Covered
Dressings and casts	Covered
Intravenous injections and solutions	Covered
Skilled Nursing Facility (SNF)	Covered. Covered expenses limited to semi-private room charge with maximum 60 days benefit/CY. Pre-certification required.
Short-Term Inpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	 Covered Covered Covered Covered Covered
Emergency care	Covered
Outpatient Medical / Surgical Services	
Doctor's office visits & related expenses, consultations, medical treatments, office surgery	No Copay [2]
	Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance.
Allergy treatment including allergy injections,	Covered
Outpatient facility charges (hospital, ambulatory	Covered
Outpatient physician and professional services	Covered
Medical and surgical supplies	Covered
Accidental injury care	Covered
Anesthetics and their administration	Covered
Diagnostic services - lab, X-ray, MRI,	Covered
Chemotherapy and hemodialysis services	Covered
Drugs and biologicals	Covered
Dressings and casts	Covered
Intravenous injections and solutions	Covered
Outpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	Covered subject to case management and limit of 15 visits/CY. Subject to deductible and coinsurance.
Emergency care	No Copay [3]
Urgent care facility	No Copay [3]

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Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Mental Health and Chemical Dependency Services (MHCD)	
Mental Health (MH)	MHCD combined benefits - In network coverage only - subject to deductible and coinsurance.
Inpatient	Limited to 20 days/year; combined with CD.
Outpatient	Limited to 45 visits/year, combined with CD.
Chemical Dependency (CD) (Alcoholism, Substance Abuse)	
Inpatient	Limited to 20 days/year, combined with MH.
Outpatient	Limited to 45 visits/year, combined with MH.
Preventive Services	
Well-child care including physical exams, immunizations, and lab services	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.
Adult routine physical Routine pap smear Routine mammogram Prostatic specific antigen (PSA) tests Lead screening	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.
Prescription Drugs	Not Covered Unless Covered by Medicare
Transplants	
	Covered, subject to standard limits of plan, but required to receive treatment at "in-network" facility (i.e., centers of excellence, etc.).
Types of organ or tissue transplants covered: Cornea Heart Heart-lung Kidney Kidney-pancreas Pancreas Liver Liver-pancreas Bone marrow Single lung transplants Double lung transplants Small bowel	Those certified as medically necessary (any transplants not considered experimental are covered).
Donor-related expenses	Donor-related expenses for surgery and physician visits are covered to same extent benefits available under the policy.
Maternity	
Complications of pregnancy	Covered
Routine maternity benefit	Optional Rider, pays up to $5000 covered expenses for normal pregnancy and childbirth including routine hospital and nursing services for newborn child during mother's confinement. Not subject to policy's deductible or coinsurance provisions.

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Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Other Covered Services	
Ambulance Services (air or ground)	Covered
Home Health Care	Covered, 40 visits per calendar year.
Hospice Care	Covered. Counseling for immediate family covered subject to 90 visits per family, bereavement counseling for immediate family covered subject to $250 maximum.
Durable Medical Equipment (DME)	Covered (no limit, must be medically necessary, subject to prior approval).
Blood administration; oxygen	Covered
Oxygen and equipment	Covered
Prosthetic appliances	Covered
Oral surgery for certain services	Covered
Home infusion therapy	Covered
Chiropractic care	Subject to rehabilitation limits.
Temporomandibular joint syndrome	Covered with a $1000 lifetime maximum.
Tubal ligation or vasectomy	Covered
Dental Treatment for Injury	Covered
Breast reconstruction after mastectomy surgery	Covered
Diabetes treatment	Covered
Diabetes education	Diabetes education program expenses covered. Subject to coinsurance. Not subject to deductible.
Services Not Covered	
Sex transformations, penile implants, complications	Not covered
Infertility treatment	Not covered
Dental care, surgery, or treatment (except reconstructive surgery due to covered injury)	Not covered
TMJ or surgery of the jaw except as above	Not covered
Family planning visits	Not covered
Nutrition counseling	Not covered
Routine vision exams	Not covered
Routine hearing exams	Not covered
Cosmetic surgery or complications; breast augmentation or reduction	Not covered
Weight modification; treatment of obesity	Not covered
Eyeglasses, hearing aids, related exams	Not covered
Orthopedic shoes, foot inserts, support devices for	Not covered
Convalescent, rest, or nursing facility care except as provided above	Not covered
Experimental or investigative services, supplies,	Not covered
Private duty nursing, except for covered HHC or	Not covered
Acupuncture	Not covered
Smoking cessation classes	Not covered
Custodial care expenses	Not covered
Routine podiatry (treatment of feet)	Not covered
Biofeedback	Not covered
Massage therapy	Not covered
Behavior modification and learning disabilities	Not covered
Growth therapy treatment	Not covered.
Private duty nursing	Not covered
Infertility treatment	Not covered
Transportation/lodging	Not covered
Alternative medicine	Not covered

Footnotes

[1] Semi-private or private if medically necessary

[2] $20 copay applies when the service is not covered by Medicare

[3] $100 copay applies when the service is not covered by Medicare