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

Administered by Value Health Benefit Administrators

# IMPORTANT NOTICE

**Re:**
- **Premium Rates Effective January 1, 2024**
- **Coverage Options for 2024**
- **How to Renew Your HIPIOWA Coverage or Buy New Coverage for 2024**

| Your Current Plan is:<br><br><plan> |
|---|

Dear Member:

This letter contains important information about your **premium rates effective January 1, 2024,** and **how to renew your HIPIOWA plan or purchase new coverage for 2024.**

You can **keep your HIPIOWA coverage or obtain new coverage outside of HIPIOWA.** Several key provisions of the Affordable Care Act (ACA) went into effect in 2014 that changed health coverage for individuals and families. These changes provide HIPIOWA enrollees with additional options for coverage since insurance companies are no longer able to deny coverage or charge more in premium if you have a pre-existing condition. **HIPIOWA** premiums may continue to be higher than premiums in the market, so we strongly encourage you to look at these new options. Please read this information carefully and contact us at 1-877-793-6880 if you have any questions or need assistance.

## 2024 HIPIOWA Premium Rates

Your HIPIOWA monthly premium rate will change effective January 1, 2024. 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 and your corresponding age to confirm your rate.

## Coverage Options for 2024

You may continue to renew your coverage with HIPIOWA or obtain new coverage through the Marketplace. The 2024 Open Enrollment Period runs through **December 15, 2023.**
You can preview plans and prices by visiting https://www.healthcare.gov/see-plans. This will help you compare the plans and premiums **HIPIOWA** currently offers with the available Marketplace plans.

### Open Enrollment Timeline for the Marketplace

- **November 1, 2023**: Open Enrollment started – first day to enroll for a 2024 insurance plan through the Health Insurance Marketplace.
- **December 15, 2024**: Last day to enroll in or change plans for 2024 coverage that starts January 1, 2024.
- **January 1, 2024**: 2024 coverage starts, if you have enrolled by December 15, 2023, and paid your first premium.

## Here are some important things to know about your 2024 coverage options:

- **You can keep your HIPIOWA coverage, <u>or</u> you may want to explore obtaining new coverage through the Marketplace - or directly from an insurance company.**
    - You cannot be turned down or charged more because you have a pre-existing condition.
    - New coverage may only be purchased during the open enrollment period which ends on December 15, 2023.
    - You may find new coverage that meets your needs at a lower cost than **HIPIOWA.** These savings may be even greater if you qualify for federal tax credits or financial help available for coverage purchased through the Marketplace.
- You may be eligible for coverage through Iowa Medicaid or the Iowa Health and Wellness Plan, the Medicaid program created to provide comprehensive health care coverage. You may visit **www.healthcare.gov**.
- **Individuals and families can <u>only</u> purchase new coverage during defined open enrollment or special enrollment periods.** (Not to be confused with HIPIOWA's open enrollment period which is the time each year when enrollees verify eligibility and have an opportunity to switch to a different HIPIOWA plan.)
    - The open enrollment period for purchasing new coverage in the Marketplace or from an insurance company in the state of Iowa is **November 1, 2023, through December 15, 2023.**
- **Premium tax credits are <u>only</u> available for coverage purchased through the Marketplace.**
    - Tax credits or financial help are <u>not</u> available for HIPIOWA coverage or coverage purchased directly from an insurance company – they are only available for coverage purchased through the Marketplace and then only if you qualify.

## How to Renew Your HIPIOWA Coverage or Buy New Coverage for 2024

<table>
<tr><td>Step 1</td><td>Review the enclosed HIPIOWA 2024 Monthly Premium Rates.</td></tr>
<tr><td>Step 2</td><td>Find out if you are eligible for financial help to purchase new coverage offered through the Marketplace.<br><br>Contact the Marketplace at 1-800-318-2596 or visit www.healthcare.gov to find out if you qualify for financial help for plans offered through the Marketplace. They will also check to see if you are eligible for Medicaid.<br><br>• If you are eligible for financial help, you may find coverage in the Marketplace that meets your needs at a much lower cost than HIPIOWA coverage.<br>• Financial help is <u>not</u> available for HIPIOWA coverage or coverage purchased directly from an insurance company.</td></tr>
<tr><td>Step 3</td><td>Compare your options. Compare your HIPIOWA plan and 2024 premium to other coverage options available through the Marketplace or directly from insurance companies. When comparing plans, be sure to also look at the provider network and prescription drug formulary. Out-of-pocket costs can be substantially higher if you use out-of-network providers or non-formulary prescription drugs.<br><br>Help is available!<br><br>Marketplace customer support is available by phone, or in person through local organizations, insurance brokers or agents. Call 1-800-318-2596 or visit www.healthcare.gov.<br><br>HIPIOWA Customer Service is also available to help answer your questions or direct you to those who can. Call HIPIOWA Customer Service at 1-877-793-6880.</td></tr>
<tr><td>Step 4</td><td>To renew your HIPIOWA coverage or switch HIPIOWA plans:<br><br>1. Fill out and return the enclosed (Green) Eligibility Verification Form <u>by December 15, 2024.</u><br>2. If you decide to switch to a different HIPIOWA plan, please make sure that you have marked your choice on the form prior to mailing the form back.<br><br><u>OR</u><br><br>To cancel your HIPIOWA coverage and buy new coverage:<br><br>1. Please contact HIPIOWA Customer Service by mail to let us know you are cancelling your HIPIOWA plan.<br>2. Contact the Marketplace at 1-800 318-2596 or visit www.healthcare.gov or an insurance company to enroll in new coverage.</td></tr>
</table>

## Enclosures in the Packet Include:

- **2024 HIPIOWA Premium Rates** – Effective January 1, 2024

- **Eligibility Verification Form** (Green Paper) – For enrollees continuing coverage with HIPIOWA in 2024, this form is **due by December 15, 2023.**

- **HIPIOWA Highlights and Comparison Chart**

If you have questions or need assistance during this year's HIPIOWA open enrollment, please call **HIPIOWA Customer Service** at **1-877-793-6880**. Updated information is also available at our website at **www.HIPIOWA.com**.

Information for the **Marketplace** is available at **www.healthcare.gov** or by calling **1-800-318-2596**.

Table 1

Iowa Comprehensive Health Association (HIPIOWA)

2024 Monthly Individual Premium Rates with -6.3% Rate Change Over 2023

Effective 1/1/2024

# NonTobacco User Rates

| Plan | Plan B $1,000 Deductible | | Plan C $1,500 Deductible | | Plan D $2,500 Deductible | | Plan E $5,000 Deductible | | Plan F $10,000 Deductible | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age / Gender | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 0 - 17 | $432.23 | $477.50 | $397.04 | $438.61 | $349.89 | $386.52 | $238.84 | $263.87 | $214.39 | $236.84 |
| 18 | 454.44 | 541.56 | 417.43 | 497.47 | 367.86 | 438.40 | 251.12 | 299.27 | 225.40 | 268.61 |
| 19 | 476.65 | 605.62 | 437.83 | 556.33 | 385.85 | 490.26 | 263.39 | 334.67 | 236.41 | 300.39 |
| 20 | 499.69 | 669.67 | 459.05 | 615.17 | 404.50 | 542.12 | 276.14 | 370.07 | 247.86 | 332.18 |
| 21 | 521.93 | 733.75 | 479.43 | 674.01 | 422.49 | 593.98 | 288.40 | 405.48 | 258.86 | 363.94 |
| 22 | 544.13 | 797.83 | 499.81 | 732.87 | 440.46 | 645.86 | 300.68 | 440.87 | 269.89 | 395.71 |
| 23 | 552.64 | 817.45 | 507.69 | 750.91 | 447.39 | 661.74 | 305.41 | 451.74 | 274.13 | 405.48 |
| 24 | 562.90 | 840.51 | 517.10 | 772.11 | 455.67 | 680.40 | 311.07 | 464.47 | 279.22 | 416.90 |
| 25 | 572.30 | 862.73 | 525.71 | 792.49 | 463.29 | 698.39 | 316.27 | 476.75 | 283.86 | 427.92 |
| 26 | 579.15 | 876.39 | 532.00 | 805.04 | 468.82 | 709.44 | 320.03 | 484.30 | 287.26 | 434.69 |
| 27 | 581.70 | 876.39 | 534.35 | 805.04 | 470.91 | 709.44 | 321.44 | 484.30 | 288.53 | 434.69 |
| 28 | 594.52 | 905.44 | 546.13 | 831.75 | 481.27 | 732.95 | 328.52 | 500.34 | 294.88 | 449.11 |
| 29 | 603.92 | 920.82 | 554.76 | 845.85 | 488.88 | 745.40 | 333.72 | 508.84 | 299.56 | 456.73 |
| 30 | 610.76 | 928.49 | 561.03 | 852.92 | 494.39 | 751.63 | 337.50 | 513.09 | 302.93 | 460.55 |
| 31 | 616.72 | 933.63 | 566.53 | 857.64 | 499.24 | 755.77 | 340.82 | 515.92 | 305.89 | 463.09 |
| 32 | 624.41 | 942.17 | 573.58 | 865.47 | 505.46 | 762.69 | 345.04 | 520.63 | 309.72 | 467.33 |
| 33 | 638.93 | 967.80 | 586.92 | 889.01 | 517.22 | 783.44 | 353.07 | 534.82 | 316.90 | 480.05 |
| 34 | 653.45 | 992.57 | 600.26 | 911.78 | 528.96 | 803.51 | 361.08 | 548.49 | 324.14 | 492.32 |
| 35 | 667.98 | 1,016.48 | 613.59 | 933.73 | 540.72 | 822.85 | 369.13 | 561.72 | 331.32 | 504.19 |
| 36 | 684.21 | 1,042.97 | 628.49 | 958.06 | 553.87 | 844.28 | 378.09 | 576.35 | 339.37 | 517.31 |
| 37 | 702.14 | 1,072.87 | 644.98 | 985.53 | 568.40 | 868.50 | 388.00 | 592.86 | 348.27 | 532.14 |
| 38 | 729.47 | 1,088.23 | 670.10 | 999.66 | 590.52 | 880.94 | 403.11 | 601.35 | 361.82 | 539.77 |
| 39 | 756.82 | 1,107.89 | 695.20 | 1,017.69 | 612.65 | 896.83 | 418.22 | 612.24 | 375.39 | 549.52 |
| 40 | 786.70 | 1,130.10 | 722.68 | 1,038.09 | 636.84 | 914.82 | 434.73 | 624.49 | 390.22 | 560.52 |
| 41 | 818.32 | 1,150.60 | 751.70 | 1,056.92 | 662.43 | 931.41 | 452.20 | 635.82 | 405.88 | 570.70 |
| 42 | 854.20 | 1,168.52 | 784.65 | 1,073.41 | 691.47 | 945.94 | 472.03 | 645.72 | 423.68 | 579.60 |
| 43 | 877.26 | 1,194.15 | 805.84 | 1,096.95 | 710.14 | 966.67 | 484.76 | 659.89 | 435.13 | 592.32 |
| 44 | 905.44 | 1,217.23 | 831.75 | 1,118.13 | 732.95 | 985.34 | 500.34 | 672.63 | 449.11 | 603.75 |
| 45 | 935.34 | 1,239.43 | 859.20 | 1,138.53 | 757.16 | 1,003.31 | 516.87 | 684.91 | 463.94 | 614.76 |
| 46 | 966.11 | 1,262.50 | 887.43 | 1,159.72 | 782.05 | 1,022.00 | 533.86 | 697.65 | 479.19 | 626.21 |
| 47 | 994.27 | 1,287.27 | 913.34 | 1,182.48 | 804.87 | 1,042.05 | 549.44 | 711.32 | 493.18 | 638.50 |
| 48 | 1,027.58 | 1,301.76 | 943.94 | 1,195.81 | 831.84 | 1,053.82 | 567.86 | 719.38 | 509.68 | 645.69 |
| 49 | 1,060.05 | 1,318.00 | 973.75 | 1,210.73 | 858.11 | 1,066.93 | 585.79 | 728.35 | 525.79 | 653.73 |
| 50 | 1,091.65 | 1,335.09 | 1,002.79 | 1,226.41 | 883.70 | 1,080.75 | 603.25 | 737.78 | 541.46 | 662.22 |
| 51 | 1,124.96 | 1,351.32 | 1,033.40 | 1,241.31 | 910.66 | 1,093.91 | 621.66 | 746.76 | 558.00 | 670.28 |
| 52 | 1,159.13 | 1,364.14 | 1,064.77 | 1,253.10 | 938.32 | 1,104.27 | 640.54 | 753.83 | 574.95 | 676.63 |
| 53 | 1,200.99 | 1,392.31 | 1,103.21 | 1,278.98 | 972.20 | 1,127.10 | 663.66 | 769.40 | 595.69 | 690.60 |
| 54 | 1,242.85 | 1,417.95 | 1,141.66 | 1,302.52 | 1,006.09 | 1,147.83 | 686.80 | 783.58 | 616.46 | 703.31 |
| 55 | 1,286.42 | 1,441.86 | 1,181.70 | 1,324.49 | 1,041.35 | 1,167.19 | 710.88 | 796.78 | 638.08 | 715.18 |
| 56 | 1,331.68 | 1,467.50 | 1,223.28 | 1,348.04 | 1,078.00 | 1,187.96 | 735.88 | 810.94 | 660.52 | 727.90 |
| 57 | 1,379.53 | 1,497.38 | 1,267.22 | 1,375.51 | 1,116.73 | 1,212.14 | 762.32 | 827.46 | 684.26 | 742.72 |
| 58 | 1,454.67 | 1,522.18 | 1,336.27 | 1,398.26 | 1,177.57 | 1,232.20 | 803.84 | 841.14 | 721.53 | 755.01 |
| 59 | 1,530.70 | 1,550.33 | 1,406.09 | 1,424.16 | 1,239.12 | 1,255.03 | 845.86 | 856.74 | 759.25 | 768.98 |
| 60 | 1,609.30 | 1,580.25 | 1,478.29 | 1,451.61 | 1,302.74 | 1,279.22 | 889.30 | 873.25 | 798.23 | 783.82 |
| 61 | 1,694.70 | 1,611.00 | 1,556.76 | 1,479.86 | 1,371.88 | 1,304.11 | 936.49 | 890.22 | 840.59 | 799.06 |
| 62 | 1,789.52 | 1,640.88 | 1,643.86 | 1,507.32 | 1,448.64 | 1,328.31 | 988.88 | 906.76 | 887.62 | 813.90 |
| 63 | 1,875.80 | 1,670.79 | 1,723.11 | 1,534.78 | 1,518.46 | 1,352.52 | 1,036.56 | 923.28 | 930.41 | 828.73 |
| 64 | 1,966.34 | 1,702.40 | 1,806.26 | 1,563.82 | 1,591.77 | 1,378.09 | 1,086.59 | 940.74 | 975.32 | 844.41 |
| 65+ | 2,060.29 | 1,733.15 | 1,892.58 | 1,592.08 | 1,667.83 | 1,403.00 | 1,138.52 | 957.75 | 1,021.92 | 859.67 |

**Age/Rate is calculated as of age upon enrollment, then attained age on January 1st.**

Iowa Comprehensive Health Association (HIPIOWA)
2024 Monthly Individual Premium Rates with -6.3% Rate Change Over 2023
Effective 1/1/2024

# Tobacco User Rates

| Plan | Plan B $1,000 Deductible | | Plan C $1,500 Deductible | | Plan D $2,500 Deductible | | Plan E $5,000 Deductible | | Plan F $10,000 Deductible | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age / Gender | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 0 - 17 | $499.22 | $551.52 | $458.58 | $506.61 | $404.13 | $446.46 | $275.87 | $304.77 | $247.62 | $273.56 |
| 18 | 524.86 | 625.49 | 482.16 | 574.57 | 424.87 | 506.34 | 290.04 | 345.65 | 260.34 | 310.25 |
| 19 | 550.52 | 699.48 | 505.70 | 642.55 | 445.66 | 566.24 | 304.22 | 386.52 | 273.06 | 346.95 |
| 20 | 577.15 | 773.49 | 530.18 | 710.52 | 467.22 | 626.14 | 318.95 | 427.42 | 286.27 | 383.67 |
| 21 | 602.82 | 847.46 | 553.73 | 778.48 | 487.98 | 686.03 | 333.10 | 468.32 | 299.00 | 420.34 |
| 22 | 628.46 | 921.48 | 577.30 | 846.48 | 508.73 | 745.95 | 347.28 | 509.21 | 311.71 | 457.06 |
| 23 | 638.32 | 944.17 | 586.37 | 867.31 | 516.74 | 764.30 | 352.75 | 521.75 | 316.61 | 468.32 |
| 24 | 650.16 | 970.80 | 597.26 | 891.79 | 526.29 | 785.86 | 359.29 | 536.46 | 322.50 | 481.52 |
| 25 | 661.00 | 996.46 | 607.20 | 915.34 | 535.11 | 806.64 | 365.28 | 550.65 | 327.86 | 494.24 |
| 26 | 668.91 | 1,012.24 | 614.45 | 929.82 | 541.50 | 819.40 | 369.63 | 559.36 | 331.78 | 502.08 |
| 27 | 671.86 | 1,012.24 | 617.17 | 929.82 | 543.89 | 819.40 | 371.27 | 559.36 | 333.25 | 502.08 |
| 28 | 687.85 | 1,047.59 | 631.88 | 962.31 | 556.81 | 848.04 | 380.09 | 578.90 | 341.17 | 519.61 |
| 29 | 699.93 | 1,067.21 | 642.97 | 980.35 | 566.60 | 863.92 | 386.77 | 589.74 | 347.18 | 529.35 |
| 30 | 709.07 | 1,077.99 | 651.35 | 990.26 | 573.99 | 872.64 | 391.83 | 595.69 | 351.69 | 534.71 |
| 31 | 717.25 | 1,085.80 | 658.87 | 997.45 | 580.60 | 878.97 | 396.36 | 600.03 | 355.76 | 538.57 |
| 32 | 727.43 | 1,097.63 | 668.21 | 1,008.28 | 588.86 | 888.53 | 401.97 | 606.54 | 360.83 | 544.43 |
| 33 | 745.65 | 1,129.43 | 684.93 | 1,037.47 | 603.60 | 914.27 | 412.04 | 624.13 | 369.84 | 560.22 |
| 34 | 763.88 | 1,160.32 | 701.70 | 1,065.86 | 618.38 | 939.29 | 422.11 | 641.19 | 378.91 | 575.52 |
| 35 | 782.20 | 1,190.30 | 718.54 | 1,093.40 | 633.20 | 963.55 | 432.24 | 657.76 | 387.98 | 590.38 |
| 36 | 802.58 | 1,223.39 | 737.23 | 1,123.81 | 649.71 | 990.34 | 443.49 | 676.06 | 398.08 | 606.82 |
| 37 | 825.02 | 1,260.62 | 757.86 | 1,157.99 | 667.88 | 1,020.49 | 455.90 | 696.63 | 409.22 | 625.28 |
| 38 | 857.87 | 1,279.77 | 788.04 | 1,175.59 | 694.44 | 1,035.98 | 474.06 | 707.19 | 425.51 | 634.77 |
| 39 | 890.78 | 1,303.99 | 818.26 | 1,197.83 | 721.09 | 1,055.59 | 492.23 | 720.57 | 441.82 | 646.78 |
| 40 | 926.75 | 1,331.25 | 851.32 | 1,222.88 | 750.20 | 1,077.65 | 512.10 | 735.64 | 459.69 | 660.31 |
| 41 | 964.81 | 1,356.54 | 886.24 | 1,246.11 | 781.00 | 1,098.14 | 533.13 | 749.63 | 478.54 | 672.85 |
| 42 | 1,007.95 | 1,378.87 | 925.89 | 1,266.64 | 815.94 | 1,116.21 | 556.99 | 761.97 | 499.96 | 683.93 |
| 43 | 1,036.93 | 1,411.49 | 952.50 | 1,296.59 | 839.38 | 1,142.61 | 572.99 | 780.00 | 514.32 | 700.12 |
| 44 | 1,072.05 | 1,441.18 | 984.77 | 1,323.87 | 867.81 | 1,166.65 | 592.41 | 796.38 | 531.74 | 714.83 |
| 45 | 1,109.31 | 1,469.95 | 1,019.02 | 1,350.30 | 898.02 | 1,189.95 | 613.00 | 812.29 | 550.23 | 729.10 |
| 46 | 1,147.72 | 1,499.85 | 1,054.28 | 1,377.76 | 929.07 | 1,214.12 | 634.22 | 828.80 | 569.27 | 743.93 |
| 47 | 1,183.19 | 1,531.85 | 1,086.86 | 1,407.14 | 957.81 | 1,240.01 | 653.82 | 846.49 | 586.85 | 759.81 |
| 48 | 1,226.93 | 1,554.33 | 1,127.06 | 1,427.78 | 993.21 | 1,258.24 | 678.01 | 858.92 | 608.57 | 770.94 |
| 49 | 1,269.93 | 1,578.98 | 1,166.55 | 1,450.45 | 1,028.02 | 1,278.17 | 701.78 | 872.56 | 629.90 | 783.17 |
| 50 | 1,312.17 | 1,604.80 | 1,205.37 | 1,474.15 | 1,062.20 | 1,299.08 | 725.11 | 886.82 | 650.85 | 795.97 |
| 51 | 1,356.71 | 1,629.70 | 1,246.28 | 1,497.03 | 1,098.26 | 1,319.26 | 749.73 | 900.59 | 672.93 | 808.36 |
| 52 | 1,402.55 | 1,650.60 | 1,288.38 | 1,516.23 | 1,135.35 | 1,336.16 | 775.06 | 912.11 | 695.69 | 818.70 |
| 53 | 1,458.01 | 1,690.27 | 1,339.31 | 1,552.68 | 1,180.26 | 1,368.30 | 805.69 | 934.04 | 723.16 | 838.39 |
| 54 | 1,513.79 | 1,727.06 | 1,390.54 | 1,586.47 | 1,225.43 | 1,398.07 | 836.53 | 954.37 | 750.86 | 856.64 |
| 55 | 1,572.00 | 1,761.97 | 1,444.01 | 1,618.54 | 1,272.55 | 1,426.32 | 868.68 | 973.66 | 779.71 | 873.93 |
| 56 | 1,632.66 | 1,799.14 | 1,499.73 | 1,652.68 | 1,321.62 | 1,456.43 | 902.20 | 994.20 | 809.80 | 892.40 |
| 57 | 1,696.80 | 1,841.78 | 1,558.67 | 1,691.87 | 1,373.56 | 1,490.92 | 937.66 | 1,017.76 | 841.65 | 913.57 |
| 58 | 1,789.25 | 1,872.25 | 1,643.61 | 1,719.85 | 1,448.41 | 1,515.60 | 988.75 | 1,034.61 | 887.50 | 928.66 |
| 59 | 1,882.76 | 1,906.94 | 1,729.51 | 1,751.70 | 1,524.11 | 1,543.69 | 1,040.41 | 1,053.78 | 933.87 | 945.85 |
| 60 | 1,979.43 | 1,943.71 | 1,818.31 | 1,785.47 | 1,602.34 | 1,573.43 | 1,093.84 | 1,074.10 | 981.81 | 964.11 |
| 61 | 2,084.48 | 1,981.54 | 1,914.82 | 1,820.23 | 1,687.41 | 1,604.06 | 1,151.89 | 1,094.99 | 1,033.92 | 982.85 |
| 62 | 2,201.11 | 2,018.30 | 2,021.94 | 1,854.02 | 1,781.83 | 1,633.81 | 1,216.34 | 1,115.30 | 1,091.77 | 1,001.10 |
| 63 | 2,307.23 | 2,055.07 | 2,119.43 | 1,887.79 | 1,867.69 | 1,663.60 | 1,274.98 | 1,135.63 | 1,144.39 | 1,019.34 |
| 64 | 2,418.61 | 2,093.93 | 2,221.71 | 1,923.49 | 1,957.87 | 1,695.06 | 1,336.51 | 1,157.10 | 1,199.63 | 1,038.62 |
| 65+ | 2,534.17 | 2,131.77 | 2,327.86 | 1,958.25 | 2,051.43 | 1,725.68 | 1,400.37 | 1,178.02 | 1,256.97 | 1,057.38 |

**Age/Rate is calculated as of age upon enrollment, then attained age on January 1st.**

Reply to:
P.O. Box 1090
Great Bend, KS 67530
(877) 793-6880
Fax: (620) 793-1199
www.HIPIOWA.com
Administered by Value Health Benefit Administrators

**2024 Plan Change & Eligibility Verification Form must be returned to our office prior to December 15, 2023.**

«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 become eligible to participate in Medicare, Medicaid or any other state program?

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

3. Have you been declared disabled by social security?

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

4. 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: _______________________

5. Have you used any Tobacco Products in the last 12 months? **Yes / No (circle one)**

6. If any of the above information is incorrect please 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:** | ( ) | | |

**<u>Plan Change Request:</u>** Your Current Plan is: **«Plan»**

If you wish to change your deductible effective January 1, 2024, please indicate below your choice of plan. Please note: You may increase your deductible as high as you feel necessary, but you may <u>not</u> lower your deductible. Please write "no change" if you wish to remain on your current plan.

**I request to change to Plan ______________________________ effective January 1, 2024.**

This form must be returned to us **<u>prior to December 15, 2023</u>** at the above address if you do elect to change your plan or have changes in your information. For your convenience 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_____________________

Office use only
❐ Elig
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By ________

# Iowa Comprehensive Health Association (ICHA)
## 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 PLANS | | | | |
|---|---|---|---|---|---|
| | Plan B - $1000 Deductible | Plan C - $1500 Deductible | Plan D - $2500 Deductible | Plan F - $5000 Deductible | Plan G - $10,000 Deductible |
| Coinsurance (In-Network / Out-of-Network) | 80% / 60% | 80% / 60% | 80% / 60% | 80% / 60% | 100% / 80% |
| Deductible (In-Network / Out-of-Network) | $1,000/$2,000 | $1,500/$3,000 | $2,500/$5,000 | $5,000/ $10,000 | $10,000/$20,000 |
| Stop Loss Limit (Coinsurance Maximum) (In-Network / Out-of-Network) | $7,500/$7,500 | $7,500/$7,500 | $12,500/$12,500 | $12,500/$12,500 | - / $12,500 |
| Out-of-Pocket Maximum (OOP) (In-Network / Out-of-Network)*<br>*OOP includes Deductible & Coinsurance | $2,500/$5,000 | $3,000/$6,000 | $5,000/$10,000 | $7,500/$15,000 | $10,000/$22,500 |
| Lifetime Maximum Benefit | $3 million | | | | |
| 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 etc.) | Covered | | | | |
| Inpatient physician and professional services | Covered | | | | |
| Anesthetics and their administration | Covered | | | | |
| Diagnostic services - lab, X-ray, MRI, electrocardiogram, etc. | 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 | Covered | | | | |
| Occupational Therapy | Covered | | | | |
| Speech Therapy | Covered | | | | |
| Cardiac Rehabilitation | Covered | | | | |
| Pulmonary Rehabilitation | Covered | | | | |
| Emergency care | Covered | | | | |
| **Outpatient Medical / Surgical Services** | | | | | |
| Doctor's office visits & related expenses, consultations, medical treatments, office surgery | $20 copay/visit in-network | $30 copay/visit in-network | $40 copay/visit in-network | Subject to deductible and coinsurance | Subject to deductible and coinsurance |
| | Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance. | | | | |
| Allergy testing and treatment including allergy injections, therapeutic injections | Covered | | | | |
| Outpatient facility charges (hospital, ambulatory surgical center) | 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, electrocardiogram, etc. | 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)<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cardiac Rehabilitation<br>Pulmonary Rehabilitation | Covered subject to pre certification. Subject to deductible and coinsurance. | | | | |
| Emergency care | $100 copay. Waived if admitted. | | | | |
| Urgent care facility | $75 copay | | | | |
| **Mental Health and Chemical Dependency Services** | | | | | |
| **Mental Health** | MHCD combined benefits - In network covg only - subject to deductible and coinsurance. | | | | |

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| Inpatient | Limited to 20 days/year; combined with CD | | | | |
| Outpatient | Limited to 45 visits/year, combined with CD. | | | | |
| **Chemical dependency (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 | Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum. | | | | |
| Adult routine physical | Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum. | | | | |
| Routine pap smear | | | | | |
| Routine mammogram | | | | | |
| Prostatic specific antigen (PSA) tests | | | | | |
| Lead screening | | | | | |
| **Prescription Drugs** | Rx copays do NOT apply to OOP max. Mail order copays = 2x retail. | | | | |
| Prescription Drugs | Drug card with copay = greater of $10/$30/$50 or 25% for all plans, with $1,000 maximum drug out-of-pocket limit per calendar year. Copay is actual cost of drug if less than computed copay. | | | | |
| | No separate drug deductible | | | Separate $500 Rx deductible | Separate $1,000 Rx deductible |
| | Restricted (brand copay when generic is available = generic copay $10 plus difference in cost between brand and generic). | | | | |
| Outpatient Contraceptive Services, including prescription drugs/devices | Covered. | | | | |
| **Transplants** | | | | | |
| 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:<br>Cornea<br>Heart<br>Heart-lung<br>Kidney<br>Kidney-pancreas<br>Pancreas<br>Liver<br>Liver-pancreas<br>Bone marrow<br>Single lung transplants<br>Double lung transplants<br>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. | | | | |
| Transportation/lodging | Not covered | | | | |
| **Maternity** | | | | | |
| Complications of pregnancy | Covered | | | | |
| Routine maternity care, including delivery room, pre-natal and post-natal care | 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. | | | | |
| **Other Covered Services** | | | | | |
| Ambulance Services (air or ground) | Covered | | | | |
| Home Health Care | 40 visits per calendar year. | | | | |
| Hospice Care | Covered. Counseling for immediate family covered subject to 90 days 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 | | | | |
| Private duty nursing | Not covered | | | | |
| Chiropractic care | Subject to rehabilitation limits. Maximum of 15 visits per calander year. Requires precertification. | | | | |
| Infertility treatment | Not covered | | | | |
| Temporomandibular joint syndrome | $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 at 80% (not subject to deductible). | | | | |
| Growth therapy treatment | Not covered. | | | | |
| **Services Not Covered** | | | | | |
| Sex transformations, penile implants, complications | Not covered | | | | |

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| Infertility treatment | Not covered | | | | |
| Sterilization | Covered | | | | |
| Dental care, surgery, or treatment (except reconstructive surgery due to covered injury is covered) | 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 feet, etc. | Not covered | | | | |
| Convalescent, rest, or nursing facility care except as provided | Not covered | | | | |
| Experimental or investigative services, supplies, treatments | Not covered | | | | |
| Private duty nursing, except for covered HHC or Hospice Care | 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 | | | | |
| Alternative medicine | Not covered | | | | |

Footnotes
[1] Semi-private or private if medically necessary