



11467 Huebner Rd
San Antonio, TX 78230

(888) 277-9134

Administered by 90 Degree Benefits

ACTION REQUIRED: 2026 Premium Rates & Coverage Renewal

November 2025

Dear Member,

This notice contains important updates about your HIPIOWA coverage, including premium changes effective **January 1, 2026**, and instructions for renewing your plan. To continue your coverage, you must return the enclosed **Eligibility Verification Form by December 30, 2025**.

2026 HIPIOWA Premium Rates

Starting January 1, 2026, your monthly premium will change. Rates are determined by law and reflect the charges other insurers in the state make for similar benefits. Please refer to the enclosed **Premium Rate Chart** and locate your age bracket, gender, and tobacco user status to confirm your updated premium rate.

Premium Payments

Premiums must be paid by the due date or within a 31-day grace period. If payment is not received by the end of the grace period, your coverage will end on the last day of the paid period.

Eligibility Verification – Required to Renew

HIPIOWA requires annual verification of eligibility. To renew your coverage:

- Complete and return the enclosed **Eligibility Verification Form**
- Complete and return the enclosed **Tobacco User Affidavit Form**
 - **Note** – Failure to return the affidavit will result in application of the tobacco user rate.



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- Submit both forms by **December 30, 2025**, using the enclosed return envelope or email the completed form to hipiowa_eligibility.t8@90degreebenefits.com.

Questions or Assistance

HIPIOWA Customer Service

Phone: **1-888-277-9134**

Enclosures

- 2026 HIPIOWA Premium Rate Chart
- Eligibility Verification Form
- Tobacco User Affidavit
- Return Envelope

Iowa Comprehensive Health Association (HIPIOWA)
2026 Monthly Premium Rates
Medicare Carveout Plan - Without Prescription Drug Benefits
\$1000 Deductible

Rate Class	Non Tobacco User		Tobacco User	
Age \ Gender	Male	Female	Male	Female
0 - 17	\$122.66	\$135.51	\$141.68	\$156.51
18	\$128.96	\$153.69	\$148.96	\$177.52
19	\$135.27	\$171.88	\$156.23	\$198.53
20	\$141.81	\$190.05	\$163.80	\$219.52
21	\$148.12	\$208.24	\$171.06	\$240.53
22	\$154.41	\$226.44	\$178.35	\$261.51
23	\$156.83	\$231.98	\$181.15	\$267.94
24	\$159.76	\$238.54	\$184.53	\$275.51
25	\$162.43	\$244.83	\$187.58	\$282.78
26	\$164.35	\$248.72	\$189.83	\$287.27
27	\$165.10	\$248.72	\$190.67	\$287.27
28	\$168.73	\$256.96	\$195.23	\$297.33
29	\$171.38	\$261.33	\$198.64	\$302.87
30	\$173.32	\$263.49	\$201.22	\$305.93
31	\$175.02	\$264.96	\$203.56	\$308.15
32	\$177.21	\$267.40	\$206.44	\$311.51
33	\$181.34	\$274.67	\$211.62	\$320.54
34	\$185.46	\$281.68	\$216.80	\$329.29
35	\$189.57	\$288.48	\$221.97	\$337.81
36	\$194.19	\$295.98	\$227.77	\$347.18
37	\$199.25	\$304.48	\$234.11	\$357.76
38	\$207.03	\$308.84	\$243.46	\$363.19
39	\$214.80	\$314.44	\$252.81	\$370.08
40	\$223.27	\$320.74	\$263.00	\$377.82
41	\$232.24	\$326.55	\$273.79	\$384.99
42	\$242.41	\$331.62	\$286.07	\$391.34
43	\$248.95	\$338.90	\$294.27	\$400.59
44	\$256.96	\$345.44	\$304.26	\$409.01
45	\$265.44	\$351.76	\$314.82	\$417.18
46	\$274.19	\$358.29	\$325.72	\$425.65
47	\$282.18	\$365.33	\$335.81	\$434.75
48	\$291.62	\$369.47	\$348.23	\$441.12
49	\$300.84	\$374.06	\$360.43	\$448.11
50	\$309.82	\$378.91	\$372.38	\$455.44
51	\$319.26	\$383.50	\$385.04	\$462.52
52	\$328.96	\$387.13	\$398.04	\$468.47
53	\$340.86	\$395.15	\$413.80	\$479.72
54	\$352.73	\$402.42	\$429.63	\$490.15
55	\$365.08	\$409.20	\$446.14	\$500.05
56	\$377.93	\$416.47	\$463.35	\$510.60
57	\$391.52	\$424.96	\$481.57	\$522.70
58	\$412.84	\$431.99	\$507.80	\$531.32
59	\$434.43	\$440.00	\$534.34	\$541.19
60	\$456.73	\$448.48	\$561.77	\$551.63
61	\$480.95	\$457.20	\$591.58	\$562.39
62	\$507.87	\$465.70	\$624.70	\$572.81
63	\$532.35	\$474.17	\$654.80	\$583.25
64	\$558.04	\$483.16	\$686.40	\$594.29
65	\$605.34	\$519.07	\$744.55	\$638.46
66	\$614.83	\$522.17	\$756.21	\$642.29
67	\$624.47	\$525.28	\$768.10	\$646.13
68	\$641.08	\$534.33	\$788.51	\$657.21
69	\$658.15	\$543.52	\$809.51	\$668.53
70+	\$730.37	\$597.62	\$898.36	\$735.06



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HIPIOWA Medicare Carveout Verification Form – 2026

Eligibility Questions

Please circle Yes or No for each question and provide dates if applicable:

1. Are you currently a resident of the State of Iowa? Yes / No

2. Are you currently eligible for employee group insurance or health insurance from any other source? Yes / No

If yes, eligibility date: _____

Update Your Contact Information

Please confirm your address and contact information below:

Physical Address (Required)	Mailing Address (if different)
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State & ZIP: _____	State & ZIP: _____
Telephone: (____) _____	
Cell: (____) _____	
Email: _____	



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Medicare Carveout Plan Selection

Please confirm your plan below:

I acknowledge that my current HIPIOWA Medicare Carveout plan does not cover prescription drugs unless they are covered under Medicare Part B benefits and I wish to remain on my current Medicare Carveout plan.

Return Instructions

This form must be returned by December 30, 2025, to remain eligible for HIPIOWA coverage.

- Mail to the address provided (self-addressed envelope enclosed), OR
- or you may email the completed, signed form to hipiowa_eligibility.t8@90degreebenefits.com.

Signature: _____

Date of Birth: _____ Today's Date: _____



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Tobacco User Affidavit

Question:

Have you smoked or used any tobacco products within the 12 months immediately preceding the date of this affidavit? (Tobacco products include smokeless tobacco, cigarettes, pipes, cigars, vapes, e-cigarettes, or any other tobacco products, regardless of frequency or method of use.)

Answer:

YES NO

If you answered NO, you are eligible for the Non-Tobacco User Rate.

You understand that:

- If your status changes, you must notify HIPIOWA immediately.
- You may be required to re-certify this status in the future.
- If we determine this status is incorrect, we will retroactively collect premium differences before claims are paid and apply the Tobacco-User Rate going forward.

Member Information

Date: _____

Printed Name: _____

Signature: _____

For Members Under 18 Years of Age

I am the:

Custodial Parent Legal Guardian of the applicant.

I declare that the above statements made by or on behalf of the applicant are true.

Date: _____

Printed Name: _____

Signature: _____