

Current Date

Member Name
Address
City, ST ZIP

RE: Member Name State ID

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

As a member of the Iowa Wellness Plan, you are responsible for a contribution (also called a premium) toward your health coverage. You are receiving this letter because you have not completed the Healthy Behaviors program. If you complete your Healthy Behaviors in January, you will not have a contribution in 2015.

If you do not participate in the Healthy Behaviors program, you will get a billing statement for your health coverage. An example is enclosed to help you understand how your Iowa Health and Wellness Plan billing statement will look each month. **THE ENCLOSED STATEMENT IS FOR YOUR INFORMATION ONLY. THIS IS NOT A BILL.** Please do not return a payment with this sample statement.

The statements you will get in the future will have a pre-addressed, postage paid envelope for you to return your contribution and your payment coupon. Your first statement will have the contribution amount due for both January and February 2015. Statements after this will be for one month only.

For more information on how to read your coming statements, please visit <http://dhs.iowa.gov/ime/members/member-resources> or call Iowa Medicaid Member Services at 1-800-338-8366, Monday through Friday, from 8:00 a.m. until 5:00 p.m.

Sample Iowa Health and Wellness Plan Billing Statement

THIS IS NOT A REAL STATEMENT



000000
John Doe
123 Main Street
Anytown, Iowa 00000-0000

Statement Date: 12/25/14
Due Date: 00/00/00
Statement: 0000000000000000
Member ID: 0000000X

Hi John Doe,

As a member of the Iowa Health and Wellness Plan it is your responsibility to pay a member contribution. **THIS IS NOT A REAL STATEMENT**, the purpose of this piece is to show you a sample of the statements to come.

1

The total amount that you'd owe along with the date that it is due will be shown below on the payment coupon.

2

The amount owed should be returned with the payment coupon below. Make your check out to *Iowa Health and Wellness Plan*. Please do not send cash or any other documents with your payment.

3

If you are unable to pay your coming contribution, please check the hardship box below and return the payment coupon OR call Member Services at 1-800-338-8366. **Important note: Checking the box below to claim financial hardship will apply to this month's amount due only. You will still be responsible for amounts due from past months.**

If you have any questions please call Member Services at **1-800-338-8366** Monday through Friday, from 8:00 a.m. to 5:00 p.m.

TEAR HERE, KEEP ABOVE FOR YOUR RECORDS

RETURN BELOW WITH PAYMENT



Hardship: By checking this box I am claiming financial hardship (see more information about hardship on back side).

Due Date: 00/00/00
Member ID: 0000000X 0
Amount Due: \$5.00

John Doe
123 Main Street
Anytown, Iowa 00000-0000

Make check or money order out to:
Iowa Medicaid Enterprise
Iowa Health and Wellness Plan Contributions
PO Box 00000
Anytown, IA 00000-0000

Amount Due: \$5.00

Paid: \$



DO NOT SEND CASH
THIS IS NOT A REAL STATEMENT

0000000X 0 00000000000 06152015 001500 1

470-5301(01/15)

