IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE ASSOCIATION

January 15, 2026

Re: Iowa Individual Health Benefit Reinsurance Program – 2025 Annual Reporting Form

Dear Association Member:

Enclosed, please find the Annual Reporting Form and the Basic and Standard Plan Experience Report for the Iowa Individual Health Benefit Reinsurance Program. The Annual Reporting Form must be completed whether your organization is an insurer, fraternal benefit society, health maintenance organization, a government self-funded plan or a self-insured company that has elected to participate in the Program.

If you are an insurer or health maintenance organization, you are required to also complete the Basic and Standard Plan Experience Report.

The deadline for returning the annual report and the basic and standard experience report is March 15, 2026.

Return completed forms to:

Iowa Individual Health Benefit Reinsurance Association
c/o Nyemaster Law Firm
700 Walnut, Suite 1300
Des Moines, IA 50309

The completed forms also may be emailed to: reports@iihbra.org.

It is important that we receive this information by March 15, 2026 in order to determine whether an assessment of the Association is necessary. If you have any questions, please contact Willard Boyd at 515/283-3172.

Enclosure

15879452

IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE PROGRAM

Annual Reporting Form

Pursuant to Iowa Statute Section 513C.10, the information on the attached page shall be required no later than March 15, 2026. **PLEASE NOTE: FAILURE TO SUBMIT THE EXPERIENCE REPORT BY MARCH 15, 2026 CAN RESULT IN YOUR COMPANY BEING ASSESSED A LATE FEE OF 1.5% PER MONTH OF THE ASSESSMENT CALCULATED FOR YOUR COMPANY FOR CALENDAR YEAR 2025.**

INSTRUCTIONS

- **Insurers, Fraternal Benefit Societies, or Health Maintenance Organizations**, complete Item I only. Submit Iowa earned premiums for the 2025 Calendar Year.

- **Self-Insured Members and Companies that have elected to participate**, complete Item II only. Submit paid Iowa health claims for the Plan Year ending during the 2025 Calendar Year.

- This form must be signed by an officer with knowledge and authority to commit the Member to these certifications.

- **DEADLINE: MARCH 15, 2026**

DEFINITIONS FOR PURPOSES OF THIS REPORT

Association: the Iowa Individual Health Benefit Reinsurance Association created under Iowa Code Chapter 513C.

Member: all persons that provide health benefit plans in this state including insurers providing accident and sickness insurance under Chapter 509, 514, or 514A; Fraternal Benefit Societies providing hospital, medical, or nursing benefits under Chapter 512B; Health Maintenance Organizations (HMO); a self-insured health plan that voluntarily elects to participate in the Association; all other entities providing health insurance or health benefits subject to state insurance regulation, and all other insurers as designated by the board of directors for the Association with the approval of the Iowa Insurance Division Commissioner.

Earned Premium: cash collected premium, plus the change in premium due, less the change in unearned premium, less the change in advance premium.

RETURN FORM TO:

Iowa Individual Health Benefit Reinsurance Association
c/o Nyemaster Law Firm
700 Walnut, Suite 1300
Des Moines, IA 50309

The form may also be emailed to: reports@iihbra.org.

QUESTIONS: Contact Willard Boyd at 515/283-3172

IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE PROGRAM
2025 ANNUAL REPORTING FORM

Item I. In order for the Iowa Individual Health Benefit Reinsurance Association to properly calculate the Assessment for each Member Company, all insurers, Fraternal Benefit Societies, and Health Maintenance Organizations must report the total Iowa earned **health** premium (premiums for group plans included) for that company **excluding** the following:

a.) Accident Only Insurance;
b.) Fixed Indemnity Insurance;
c.) Credit Health Insurance;
d.) Medicare Supplement Policies;
e.) Medicare Part D;
f.) Cost or Risk contracts with the Health Care Financing Administration for Medicare Enrollees;
g.) Risk contracts under Iowa Code Chapter 249A;
h.) Long-Term Care Insurance;
i.) Disability Income Insurance;
j.) Hawk-I
k.) Federal Employee Health Benefit Plan
l.) Coverage Issued as a Supplement to Liability Insurance;
m.) Workers' Compensation or Similar Insurance;
n.) Disease-Specific Insurance;
o.) Automobile Medical Payment Insurance;
p.) Dental Insurance;
q.) Vision Insurance;
r.) Self-Insured Group Health Plan or Self-Insured Multiple Employer Group Health Plan; or
s.) Stop-Loss Insurance Premiums

Earned Premium in Iowa for the 2025 Calendar Year: $_____

NOTE: Complete Item I or Item II, but not both Item I and Item II.

Item II. In order for the Iowa Individual Health Benefit Reinsurance Association to properly calculate the assessment for each Member Company, all self-insured companies subject to any assessment must report the total paid Iowa claims for Iowa employees and their dependents by that company from the health benefit plans covering individuals.

Paid health Claims for the Plan Year <u>ending</u> during the 2025 Calendar Year
(Exclude: any amounts unrelated to medical expenses, expenses for dental plans, vision plans and third party administrator costs. Include: any reinsurance and stop loss premiums for medical expenses):

$_____

_____ Name of Member Company

_____ Officer's Name (printed)

_____ NAIC Code or Federal ID# (whichever is applicable)

_____ Officer's Title

_____ Address

_____ City State Zip

_____ Phone E-mail

I hereby certify that, to the best of my knowledge and belief, the information set out in this Annual Reporting form is true and correct.

_____ Signature

_____ Date

15879454

IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE PROGRAM
2025 Basic and Standard Plan Experience Report

Pursuant to Iowa Statute, Section 513C.10, the information on the attached page shall be required no later than March 15, 2026 and each year thereafter.

INSTRUCTIONS

- Complete only if you are an insurer or health maintenance organization. Do not fill out if you are a public self-funded fund.
- Provide your Iowa Earned Premium for both the Standard and Basic Plan for the 2025 Calendar Year.
- Provide Iowa Claims Paid during the 2025 Calendar Year, regardless of the incurred date.
- This form must be signed by an officer with knowledge and authority to commit the insurer to these certifications.

IMPORTANT: SINCE JANUARY 1, 2005, THERE IS TO BE NO NEW ISSUANCE OF BASIC OR STANDARD POLICIES.

DEFINITION FOR PURPOSES OF THIS REPORT

Earned Premium: Cash collected premium, plus the change in premium due, less the change in unearned premium, less the change in advance premium. The result of such calculation shall be reduced by two percent *(i.e., multiplied by .98),* which shall be the Earned Premium reported on this form.

RETURN FORM TO:

Iowa Individual Health Benefit Reinsurance Association
c/o Nyemaster Law Firm
700 Walnut, Suite 1300
Des Moines, IA 50309

The form may also be emailed to: reports@iihbra.org.

QUESTIONS: Contact Willard Boyd at 515/283-3172

IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE PROGRAM
2025 Basic and Standard Plan Experience Report
(TO BE FILLED OUT ONLY BY COMPANIES THAT HAVE ISSUED BASIC OR STANDARD POLICIES UNDER IOWA CODE CHAPTER 513C. PUBLIC SELF-FUNDED PLANS DO NOT NEED TO COMPLETE THIS FORM.)

Pursuant to Iowa Statute, Section 513C.10, the following information shall be required no later than March 15, 2026 and each year thereafter.

_____
Name of Carrier

_____
NAIC Code

For the plan year ending 2025, please provide the following:

Number of **Standard Plans** in effect at 12/31/25 _____

Number of **Basic Plans** in effect at 12/31/25 _____

Number of **Standard Plans** issued during calendar year _____

Number of **Basic Plans** issued during calendar year _____

Earned Premium for **Standard Plans** for calendar year _____

Earned Premium for **Basic Plans** for calendar year _____

Paid Claims for **Standard Plans** for calendar year _____

Paid Claims for **Basic Plans** for calendar year _____

I hereby certify that, to the best of my knowledge and belief, the information set out in this Basic and Standard Plan Experience Report is true and correct.

_____
Officer's Signature

_____
Officer's Name (Printed)

_____
Phone Number

_____
Title

_____
Date